HEALTHY OPPORTUNITIES IN MANAGED CARE WEBINAR

Richard

Welcome everyone. Thank you for joining today's webinar. My name is Richard and I'm a producer at Webex, and I'll be your organizer for today's webinar presentation on Healthy Opportunities in Medicaid Managed Care. Today's presentation is the ninth provider education model on Medicaid transformation. Notification on additional Provider education models will be forthcoming and posted to the Medicaid Transformation website. If you experience technical difficulty at any time during this Webex event, please submit your technical issue in the Q&A panel, and I will assist you. You may also contact our Webex Technical Support at 1-866-779-3239. And please note that as an attendee, you are part of a larger audience today. However, due to privacy concerns, the attendee list is not displayed. All attendees will be in a listen-only mode for the duration of today's call, and as a reminder, this call is being recorded. We will be holding a Q&A session with the conclusion of today's presentation. You may ask a question at any time throughout the event by entering it in to the Q&A panel on the lower right of your screen. And with that, I invite you to sit back, relax, and enjoy today's presentation. I'd like to introduce your first speaker for today, Mandy Ferguson, a consultant at Manatt Health.

Mandy Ferguson

Good afternoon, everyone. The North Carolina Department of Health and Human Services knows that access to high-quality medical care is critical. But research shows that up to 80% of a person's health is determined by social and environmental factors and the behaviors that emerge as a result. DHHS is committed to promoting healthy opportunities by addressing the conditions in which people live that directly impact health, also commonly referred to as the Social Determinants of Health, or SDOH. Today's webinar on Healthy Opportunities in Medicaid Managed Care is intended to provide an overview for Providers of the ways in which DHHS is imbedding strategies to address the social needs of Medicaid beneficiaries into the managed care platform and how Providers will be involved. Time will be allotted for questions and answers. We have several team members that will be on hand to present today's webinar and help answer these questions that we receive today. These team members include Erica Ferguson, the Director of Healthy Opportunities at North Carolina's Department of Health and Human Services, Amanda Van Vleet, a Senior Program Analyst with the Quality and Population Health Division in North Carolina Medicaid, Dr. Betsy Tilson, the State Health Director and Chief Medical Officer for the North Carolina Department of Health and Human Services, and Lynne Testa, a Senior Program Analyst with North Carolina Medicaid. I would now like to introduce Erica Ferguson, who will provide the content overview for the presentation and briefly cover North Carolina's Medicaid transformation. Erica?

Erica Ferguson

Great. Thanks, Mandy. Good afternoon everyone. Thanks for joining us. So as we go to the next slide, Slide 2.

Here's a bit of what we'll cover today. We'll cover an overview of North Carolina's Medicaid Managed Care transformation, then we'll do a deep dive of how we're embedding healthy opportunities into our Medicaid transformation. We'll discuss more opportunities for engagement, and then we'll take your questions.

Just to take a step back on Slide 3, many of you are likely already familiar with our vision for Medicaid transformation and how it will improve the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care, which addresses both the medical and nonmedical drivers of health. And I want to highlight this last piece, which focuses on the medical and nonmedical drivers of health, including all the factors that affect a person's health outside the four walls of a hospital or a clinic, including food, transportation, housing and personal safety and toxic stress, which will be the focus of much of this webinar.

As you'll see on Slide 4, this is just a, a very high-level overview in the context of Medicaid transformation. As many of you know, we've been working on this for a long time. In 2015, the General Assembly enacted a law that said we will move to Medicaid managed care from our current State administered fee-for-service program. And since then, there's been a lot of work that has gone into moving our program to managed care. A lot of collaboration, with all of you on this call and our clinicians, hospitals, beneficiaries, and other stakeholders. And we've really been committed to these four main components of our transformation. The first is about delivering whole-person care through a coordinated, physical, behavioral health in intellectual developmental disability and pharmacy program. Second, we want to address the full set of factors that impact health, uniting communities and healthcare systems, which will largely be the focus of today's call. We also want to make sure we're performing localized care management at the site of care in the home or community, and we want to maintain broad provider participation by mitigating provider administrative burden.

And on Slide 5, you'll see an overview of the Medicaid transformation timeline. Back in October of 2018, our 1115 waiver was approved by CMS and our federal partners. In February of this year, our Standard Plan contracts were awarded, the four statewide plans and one regional plan. In June and July of this year, our enrollment broker will be sending out the Phase 1 enrollment packages, and open enrollment will begin. This summer, our Standard Plans will continue to work with contracting with Providers, and the Department will work with them to ensure that there's network adequacy. In November, coming up soon, our managed care Standard Plans will launch in the first two regions and our Phase 2 open enrollment will begin. And in February of next year, our managed care Standard Plans will launch in the remaining regions. Our Tailored Plans, our plans serving folks with serious mental illness, intellectual development disabilities and others are tentatively scheduled to go live in July of 2021. At this time, I would like to introduce Amanda Van Vleet, who will review the various ways in which the healthy opportunities are embedded in the Medicaid managed care program.

Amanda Van Vleet

Thanks, Erica. All right. So, I, as Erica said, will now discuss how the North Carolina Medicaid program has embedded healthy opportunities into Medicaid managed care. Next slide.

Great. So, first I'll talk a little bit about what are healthy opportunities, and why are we interested in them? So, as Mandy mentioned earlier, healthy opportunities are commonly referred to as social determinants or drivers of health. And what we mean by that are that they're all the nonmedical aspects of our lives that drive our health. These conditions can be found in all of the places where we live our daily lives, where we're born, where we live, where we learn, work, play, worship, and age. These conditions have a huge impact on our health, functioning and quality of life. In fact, research shows that up to 80% of a person's health is determined by social and environmental factors and the behaviors that emerge as a result of those factors. So, in addition to ensuring access to high-quality medical care, addressing these nonmedical drivers of health is a key component of meeting the

Department's mission to improve the health, safety and wellbeing of all North Carolinians. So, while all nonmedical drivers of health are important, and we encourage both Providers and our PHPs to address the full spectrum of nonmedical drivers of health, the Department is really focusing on four priority domains, which are housing, food, transportation and interpersonal violence or toxic stress. So, these four priority domains were chosen because they have the largest evidence base that links investment in these areas to improved health. So, throughout this presentation, when we discuss healthy opportunities, these are the four priority domains that we've built into our strategy – or, built our strategy on, and that appear in our PHP contracts and in the pilot. But still encourage Providers and PHPs to think about this whole spectrum of nonmedical drivers of health. Next slide.

So, North Carolina Medicaid has embedded healthy opportunities into our transition of Medicaid managed care. We're really encouraging providers and PHPs to think about and address these nonmedical drivers of health really in the same way that they would address medical drivers of health. And to do that, we're promoting healthy opportunities in our care management approach, our quality strategy, our value-based purchasing strategy through in lieu of services and value-added services, through PHP contributions to health-related resources, and through the Healthy Opportunities pilot. So, I'll go into a little bit more detail now on each of these initiatives. On the next slide, I'll discuss how addressing social needs through care management is incorporated into Medicaid managed care. So, the care management model requires PHPs and care managers to take steps to address members' unmet resource needs or nonmedical drivers of health. Our PHPs will identify high-need individuals, which include those with significant social needs, and address those social needs through care management. PHPs will often delegate care management to either Tier 3 advanced medical homes, local health departments, or other care management entities. So, Tier 3 advanced medical homes are AMHs by providing care management will be addressing social needs through the care management process primarily through their care manager and their multidisciplinary care teams that care for their Medicaid members.

On the next slide, I'll go into a little bit more detail on the care management process. So, as the first step of the process, our PHPs must identify and provide care management to beneficiaries with high unmet resource needs. As a reminder, care management as I said will be delegated to Tier 3 AMHs and may be delegated to local health departments or another care management entity. So, PHPs will first identify these individuals through a combination of methods. They'll use a state-standardized screening tool that's based on the four priority domains. They'll be conducting analysis of claims, encounters and other available data, and then providers or patients or family can also choose to refer themselves or a patient into care management. So, those will be the primary ways that members will be identified. And, just as a note, when we say identifying members with high unmet resource needs, what we really mean by that is that those have to at least include individuals who, as far as having high unmet resource needs, are homeless, are experiencing or witnessing domestic violence or a lack of personal safety, and who are showing unmet needs in three or more of our priority demands.

So, the next step in the process, care managers, which, again could be at a PHP or at an AMH Tier 3 or local health department, will conduct a comprehensive assessment. With, so, to address beneficiaries – oh, sorry. Sorry. Care managers will next conduct a comprehensive assessment with the identified beneficiary, but, again, to physical, behavioral health as well as social needs. And then the PHPs or Tier 3 advance medical homes or local health departments will then be accountable for addressing these identified needs that were seen through the comprehensive assessment and the care needs screening by activities such as providing in-person assistance with certain Human Service applications, such as helping a beneficiary apply for SNAP or WIC by connecting beneficiaries to needed social resources and

tracking a loop on the outcome of those referrals to see if members actually did receive the services that they were referred to. PHPs will be required to have a housing specialist on their staff, and also by providing access to medical legal partnerships for legal issues that may adversely affect health. So, providers will play a critical role in helping PHPs to meet these obligations to address the unmet resource needs of the beneficiaries, especially if that provider is a Tier 3 AMH or a local health department.

On the next slide, I'll go a little bit deeper into the Peer Needs screening tool. So, the part of the initial Peer Needs screening our PHPs will be incorporating a standardized set of screening questions on our four priority domain. These screening questions will be used to identify individuals who are varied populations for care management, and who need connections to local community resources. The PHPs must ask these screening questions to every member within 90 days of enrollment, and then at least annually after that. Providers are also encouraged but not required to use the screening questions as part of their intake process. And you can see a snapshot of the screening tool on the slide here, and that it includes questions from each of our four priority domains, as well as questions on whether those needs are immediate and need backtracking for an immediate need.

On the next slide, we'll go into a little bit about Key Tools that will be used in the care management process to connect members to community resources. And that is NC Care 360. NC Care 360 is a statewide resource and referral platform that allows stakeholders to connect individuals with necessary community resources. So, NC Care 360 is a telephonic, online and interface IT platform that serves different purposes. The first is as a statewide resource database of community-based organizations and social services, and the second is a referral platform that allows healthcare providers, insurers and human service providers all to connect people to resources in their communities. So, it allows a provider, an insurer or a CBO to go into the platform, make a referral to, for example, a food pantry or a domestic violence shelter, and then the care manager can track closed loop referrals to see if the, if the member actually did, in fact, receive food from that food pantry or did stay at the domestic violence shelter that they were referred to. And, if not, then they can follow up and see why not, and just make sure that members are getting the services that they need. So, we're really excited about it. And our PHPs, at a minimum, will be using NC Care 360 as a resource database to identify community-based organizations and social service agencies in their communities, and also to track closed loop referrals once that functionality is ready for use. And the Providers, some providers are already onboarded to NC Care 360, so they're not required but definitely encouraged to onboard and to use NC Care 360 so we can really roll it out throughout the state to have a robust way to get our members – not only Medicaid members, but other members of North Carolina, as well, who have other insurers – the social services that they need.

Okay, I'll move on on the next slide to our quality strategy, and how we're promoting healthy opportunities through our quality strategies. North Carolina quality strategy details how PHPs are held accountable for achieving desired outcomes, including those that are linked to healthy opportunities. So, addressing unmet resource needs is a critical component of the quality strategy, and PHPs as well as Providers – PHPs, I'm sorry, will be working with Providers and communities to improve population health through strategies that will include addressing unmet social needs. So, PHPs will report on rates completed toward need screenings and Year 1 of managed care, and we'll also reporting on referrals to social services and whether those loops were closed. PHPs are also encouraged to address social needs and their quality assessment and performance improvement plans that are _____. And their performance improvement plans, or PIPs. And PHPs must conduct at least one nonclinical performance improvement project each year, so they'll likely be reaching out to providers that they're contracted

with the carry out these performance improvement projects, some of which will be nonclinical and could address these four priority domains.

On the next slide, I can see how we're weaving our healthy opportunities strategy into our value-based payment strategy. So, value-based payments give providers flexibility to decide how best to use payments, including by paying for health-related social support. It may be more cost effective than traditional Medicare – or, medical care, or may help prevent certain medical care from being needed in the first place. So, there our value-based purchasing strategy will be encouraging PHPs and providers to consider how they can incorporate and promote healthy opportunities into their value-based purchasing-based contracts. And on the right-hand side, you can see a graphic of the Healthcare Payment Learning and Action Network value-based purchasing framework, which is what the Department is using to drive our value-based purchasing strategy. On the left-hand side, you'll see a link, a new link to quality through a fee for service system, and then on the right, different payments, news in accountability or risk, basically in quality and prevent you move to the right towards Category 4. And these can include for months payments, they can include bundles, they can include shared savings or shared risk arrangements, or population-based payments. So, it will be encouraging PHPs and providers to look at how they can address healthy opportunities as they advance along this continuum.

On the next slide, you can see that we are encouraging our PHPs to leverage in lieu of services and also value-added services to cover healthy opportunities services in our four priority domains. So PHPs can use in lieu of services to deliver a service or utilize a setting not covered in North Carolina's State plan or in its managed care contract. The State must ultimately determine the service to be both medically appropriate and a cost-effective substitute for a state plan service. So, for example, PHPs could offer a medically tailored meal in lieu of hiring a contracted home health aide. That could be example of an in-lieu-of-service that addresses food insecurity, which is one of our priority domains. Value-added services, the PHPs, will be, have the ability to offer on top of their standard Medicaid benefit package, so if a PHP chooses to, they could choose to offer, for example, a Boys' and Girls' Club membership, or a Boy Scouts or Girl Scouts members. For other services that address unmet social needs but may not be included in a standard Medicaid benefit package.

On the next slide, you'll see that we're also encouraging our PHPs to contribute to health-related resources in our communities. To help this, we have a hot bot map on our, on the DHHS website, that uses the GIS technology to map social resources throughout the state of North Carolina. So, there's a snapshot here shown on the slide. I encourage you all to look up this tool online. It's really great. You can go on and search by area of the State and by needs. So, you can look up which parts of the State have the biggest food insecurity or other factors, other social resource needs. So, we're encouraging our PHPs to use this tool to think about where they could view quality improvement projects or where they could make contributions to community or to areas of high needs that they noticed in their communities. So, PHPs are encouraged to do this, not required, but the State is offering some incentives if they do. If a PHP voluntarily contributes, then those contributions can count an enumerator of their MLR, and also the PHP voluntarily contributes that at least one-tenth of a percent of its annual capitation revenue in a region to health-related resources, then it could be rewarded a preference in auto assignment in that region. So, hopefully our PHPs will be making a lot of investments in community resources this way. And we encourage our providers, of course, to give input to the PHPs that you're contracted with on how to direct these contributions in your communities since you all are the ones that interact with the members and really know your communities the best. We strongly encourage you to speak with your PHPs about what investments could be the most helpful in your

communities. And now I'm going to hand it back to Erica to introduce participants to our Healthy Opportunities pilot.

Erica Ferguson

Great. Thanks, Amanda. As you can see on this slide, one of the very innovative areas of waiver is the Healthy Opportunities pilot. As you see – as we seek to reward value and meets the Department's mission of improving health safety and wellbeing for all North Carolinians, we must consider the impact of the factors beyond medical care, so that our health outcomes and our costs. The Healthy Opportunities pilot presented unprecedented opportunity to test the impact of providing selected evidence-based intervention to Medicaid enrollees, and over the next five years, the pilot will provide up to $650 million in state and federal Medicaid funding to cover the costs of select pilot services related to housing, food, transportation and interpersonal safety that directly impacts the health outcome and healthcare costs of enrollees in two to four geographic areas of the state. Note that we have not chosen these pilot regions yet, and we will choose these pilot regions through our formal RFP process that will be released later this year.

On the next slide, you will see that the pilot will serve our Medicaid enrollees that can best benefit from these kinds of interventions within these selected regions. Specifically, to be eligible for the Healthy Opportunities pilot, a Medicaid enrollee would need to have one needs-based criteria, which, and this criteria vary by age and population, as you can see on the slide. As an adult, for example, you may qualify with two or more chronic conditions, and these are either physical conditions or behavioral, while a child may qualify by experiencing three or more adverse childhood experience. This is just a high-level overview of these eligibility requirements. A much longer list is in our STCs and on our website. In addition to the needs-based criteria, an enrollee would need to have at least one social risk factor in one of the four domains of the pilot – housing, food, transportation or interpersonal safety.

Slide 19, the next slide, shows a high level overview of the types of federally approved services that we can provide through the few eligible Medicaid enrollees through the Healthy Opportunities pilot. These services were selected because of their evidence base in improving health outcomes and reducing healthcare costs. As you can see, in housing, we can provide housing navigation support and sustaining services in tenancy support services, housing quality and safety inspections and improvements to housing quality, one-time payments for security deposit and first month's rent and up to six months' housing post-hospitalization. On the food side, nutrition and cooking education, food and vegetable prescriptions and healthy food boxes or home delivered meals and medically tailored meal delivery are just some of the examples. In transportation, it could be linkages to existing transportation resources and payment for transportation to different pilot services. This could be through bus passes or taxi vouchers. Or ridesharing programs, depending on what part of the state and what's available. Interpersonal violence and toxic stress area – this includes case management and advocacy for victims of violence, evidence-based parenting support programs and home visiting services, just at a, at a, at a high level. Some of the services we can offer in the pilot.

On Slide 20, you can see the key entities that will be involved in the pilot. And this is intentionally embedded into how we're operating managed care across the whole state, with the goal of making these as routine as how we operate business as possible. Each prepaid health plan will be given a budget on top of their capitated rates for the beneficiaries they serve to specifically pay for pilot services, and the PHPs are responsible for managing this pilot budget. They'll work with the community to identify Medicaid enrollees that are eligible for the pilot and authorize services that they qualify to

receive. They will do this in partnership with their care managers, who are the frontline service providers predominantly located, as Amanda mentioned, at our Tier 3 AMHs and local health departments. They interact with our beneficiaries primarily. Care managers will assess beneficiaries for pilot eligibility, identify recommended pilot services, manage coordination of pilot services and check enrollee progress over time. Our lead pilot entities are not necessarily new organizations, but probably a new term. They will play an important role in bridging the healthcare partners, the PHPs and Medicare managers, and the human service organizations who are actually delivering the services, these pilot services, to beneficiaries. So these pilot entities will be competitive. I mentioned a bit ago, by DHHS through and RFP that will come out later this fall, through which they're establish their geographic boundaries for the pilot region. They'll develop, manage, pay and oversee a network of human service organizations in their regions. They will conduct or provide trainings and technical assistance for these Human Service organizations for care managers in implementing pilot activities. They'll convene pilot entities in their region to share best practices. And they'll support our evaluation monitoring efforts by collecting and submitting data that will be used for periodic assessment and for overall evaluation and ongoing program monitoring and oversight. And finally, the Human Service organization, which are just community-based organizations and social service agencies, will contract with the lead pilot entities to deliver the federally approved evidence based services discussed on the last slide, the pilot enrollees. And they will be reimbursed for providing those services. DHHS, as an overview, we're committed to ensuring the accountability of those pilots and maximizing the learning from the pilots, and this will be done through a rigorous evaluation, including an annual rapid cycle assessment to gain as close to real time insight as possible to see the effects of the services and the delivery system, and that will allow us to have mid-course adjustments as needed to improve the pilot, and will of course also have a summative evaluation to assess the global impact of the pilots into which – to learn which interventions are effective for which populations and allow us to determine how to best incorporate these learnings into the statewide Medicaid program ongoing. If you'd turn to the next slide. Great.

This was just a lot of really high-level overview of our pilots and all of the other areas of our Medicaid transformation where healthy opportunities are embedded. You can learn more, you can find out more information about all this healthy opportunities work that's specific to the Medicaid population as we described today, as well as our work for our whole population. On the Healthy Opportunities website, which is shown here, you can also see statistically it's also on the website that our most recent Healthy Opportunities pilot's policy paper, as well as we're in the process of developing our service definitions and fee schedules, which will soon be coming out next month for public comment. So, definitely encourage folks to give feedback on that in July, but you can have a sneak preview on the link on number 3. And as I already mentioned that we will also be releasing in addition to the fee schedule for public comment in July, we will be releasing in our fee schedule pilot entities in those regions later this fall. So, definitely look out for the healthy opportunities website and our list serve and other parts of our Medicaid website for those updates regarding those two pieces. Now I'd like to introduce Lynne Testa to review the future opportunities for Provider engagement.

Lynne Testa

Okay. Thank you, Erica. As we've said previously, the Department remains committed to ensuring that providers receive education and support during and beyond the transition to Medicaid managed care. We will look now at the provider opportunities for further engagement. Next slide, please.

Providers should know that we value their input and feedback and are making every effort to provide opportunities to connect through a multitude of activities. We are in the midst of a series of topic-based

webinars that offer education to providers on key topics to effectively serve Medicaid and North Carolina Health Choice beneficiaries in the transition to managed care and also offer fact sheets and FAQs to assist in the understanding of Medicaid changes. The North Carolina Medicaid websites serve as a central hub for Providers to access resources about the transition to managed care. In addition to the Medicaid transformation link provided on this slide, the main Medicaid Web page, www.Medicaid.NCDHHS.gov offers links to additional engagement opportunities, from the main Medicaid Web page, choose providers and providers transitioning to Medicaid managed care. In addition to the presentations and recordings for this series of webinar training courses, there is information for PHP meet and greets currently being held across the state. PHP meet and greets offer Providers and practice staff the opportunity to meet PHP representatives to ask questions about joining their networks. The Department is also hosting virtual office hours, which is an opportunity for providers to ask questions regarding the transition to Medicaid managed care in a real-time format. Please review these websites frequently to stay abreast of new information and opportunities for engagement. And because we value your feedback, we encourage you to continue submitting questions or concerns to the Medicaid Transformation email address provided on the slide. Next slide, please.

Here is a snapshot of upcoming provider education opportunities. Two additional webinars are scheduled in the coming weeks that will cover topics on overview of long-term support services in managed care and a deep dive on care management requirements

End of Webinar