



NC Department of Health and Human Services

The State of Mental Health Services in North Carolina

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Agenda

1. Big Picture
2. Behavioral Health Strategic Plan
3. Medicaid Transformation / Integrated Health
4. Opioids
5. Healthy Opportunities

BIG PICTURE

North Carolina by the Numbers:

- **With over 10 million people, North Carolina is the 10th fastest growing state in the nation.**
- **2.2 million** people have **Medicaid; 1 million** people are **uninsured**
- **1 in 20** people are living with a **serious mental illness**
- **1 in 20** people are living with an **opioid use** or **heroin use disorder**
- **2nd highest death rate in the nation from opioid misuse.**
- **Over 1400** people died by **suicide** in CY2017**. Five per week were Veterans.**
- **1** in **58** children has **autism**
- There are **128,000 adults and children** in NC with an **Intellectual Developmental Disability**
  - **Only 12,738** have a slot on the Innovations waiver
- **Nearly 80,000** people sustained a **traumatic brain injury** last year
- Over **16,000 kids** in **foster care**
- **25,000** people were **re-entered society** from prison last year
- **9,000** people **experiencing homelessness**; over **800 are veterans**

Various sources.

Key Challenges:

- **Chronically underfunded mental healthcare system**
  - Over 1 million people are uninsured
  - Half of the opioid overdoses presenting in EDs are uninsured
  - 56% of adults with mental illness don't receive treatment
- **Stigma**
- **Bifurcated payment systems**
- **Imbalance of community-based services relative to inpatient and residential care**
  - ED boarding
  - Insufficient community-based resources
- **NC ranks 30th in US in ACEs prevalence**
- **Opioid Crisis –** straining an already stretched behavioral health system

Various sources.

Strategy: Vision, Mission, and Goals

In February 2017, the Department issued a behavioral health strategic plan, identifying two broad areas for strengthening the system: (1) integration and (2) access.

Vision for Behavioral Health in North Carolina: *North Carolinians will have access to integrated behavioral, developmental, and physical health services across their lifespan. We will increase the quality and capacity of services and supports in partnership with providers, clients, family members, and communities to promote hope and resilience and achieve wellness and recovery.*

The strategic plan grounds our efforts in data and key indicators of performance across our system.

DMH/DD/SAS Mission: *Through the lens of behavioral health, we aim to lead with our ideas to identify gaps, invest in promising interventions, and efficiently scale a system that promotes health and wellness for all North Carolinians across all payers, providers, and points of care.*

1. **Access**: Increase overall availability and access to high-quality behavioral health services and IDD supports; right-care, right-time, and right-setting.
2. **Integration:** Integrate behavioral healthcare into primary and physical care.
3. **System performance:** Improve oversight and regulatory regime to optimize system performance while maintaining safeguards.
4. **Operational excellence**: Strive for operational excellence and continuous improvement in our internal operations and regulatory functions.
5. **Boundless behavioral health:** Advance policies and narratives that reinforce the Division as competent thought leaders and service-oriented partners

Key system gaps and initiatives were outlined in the Behavioral Health Strategic Plan – work is underway implementing these efforts.

	Gaps	Initiatives
ACCESS	• Coverage gap – one million people in NC have no routine access to care; • Geographic imbalance to services, providers and inpatient beds • Emergency room "boarding" • Service-array imbalance or lack of evidence to services provided • Workforce - variations in provider capacities, training, and skills. • Service navigation and supports • Opioid treatment, especially in rural communities	• 1115 waiver as part of transformation – SUD amendment • Telehealth and telepsychiatry policy; UNC ECHO • Home and Community Based Services • Community collaboratives • Behavioral Health Crisis Referral System (BH-CRSys) • Peer Support • Step-down services; respite; pre/post inpatient care
INTEGRATION	• Physical and Behavioral Health • Continuum of Service • Criminal Justice System • Schools Services • Social Determinants of Health (healthy food, safe housing, transportation, etc.)	• Medicaid transformation • Transitions focused team • Jail-based MAT; ED-Induction; Jail Diversion/Re-Entry • School based interventions, training, CALM • Healthy Opportunities: NC Care 360 • Routine Screening of Children and Adults • Transitions to Community Living (TCLI) • Awareness, training • Robust communication between providers

MEDICAID TRANSFORMATION INTEGRATED HEALTH

History of Delivery

1963: Area Mental Health Programs
Local Management Entity (LME) Providing Service

2001-2003: Disinvestment & Privatization
Divest Staffing → Contractors

Period of LME Consolidation

2013: Behavioral Health MCOs implemented statewide

Today: Seven LME/MCOs

Medicaid Transformation Goals = Buy Health

- Transforming from state run Medicaid program to a managed care administered system
- Using best practices from other states and building on the existing infrastructure in NC

1. **Behavioral Health Integration**
2. **Advanced Medical Homes**
3. **Value-Based Purchasing**
4. **Healthy Opportunities**

Physical and Behavioral Health Integration

- **Single point of accountability for care and outcomes; reduces clinical risk and gives beneficiaries <u>one insurance card</u>**
- **Standard Plans**
  - "Primary care" behavioral health spend included in PHP capitation rate
  - Beneficiaries benefit from integrated physical & behavioral health services
  - Phase 1 begins – November 2019
- **Tailored Plans**
  - Specialized managed care plans targeted toward populations with significant BH and I/DD needs
  - Access to expanded service array
  - Behavioral Health Homes
  - Delayed start

Promoting Quality, Value and Population Health

- **Statewide Quality Strategy**
  - PHPs will be monitored on 33 quality measures against national benchmarks and state targets
- **Advanced Medical Homes**
  - 4 tiers of participation, with practice requirements, payment models and performance incentive payment expectations differing by tier.
  - Sophisticated data capabilities needed across the state, the plans, and the practices/CINs
- **Value-Based Payment**
  - By the end of Year 2 of PHP operations, the portion of each PHP's medical expenditures governed under VBP arrangements will either:
    - Increase by 20 percentage points, or
    - Represent at least 50% of total medical expenditures.

Prepaid Health Plans

Create single point of accountability for care and outcomes for Medicaid beneficiaries through two types of Plans

Standard Plans

- Beneficiaries benefit from integrated physical & behavioral health services
- "Primary care" behavioral health spend included in PHP capitation rate
- Phased implementation – Nov. 2019 & Feb. 2020

Tailored Plans

- Specialized managed care plans targeted toward populations with significant BH and I/DD needs
- Access to expanded service array
- Behavioral Health Homes
- Projected for July 2021

PHPs for NC Medicaid Managed Care

Statewide contracts

- **AmeriHealth Caritas North Carolina, Inc.**
- **Blue Cross and Blue Shield of North Carolina, Inc.**
- **UnitedHealthcare of North Carolina, Inc.**
- **WellCare of North Carolina, Inc.**

Regional contract – Regions 3 & 5

- **Carolina Complete Health, Inc.**

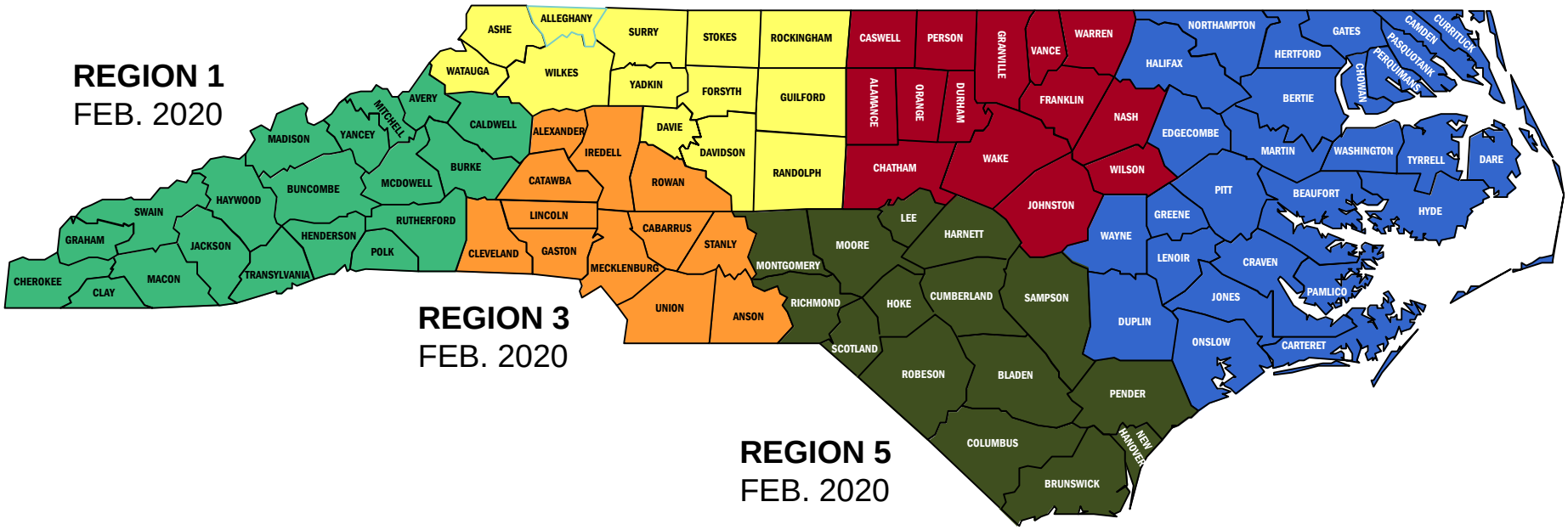
Managed Care Regions and Rollout Dates

REGION 2
NOV. 2019

REGION 4
NOV. 2019

REGION 6
FEB. 2020

REGION 1
FEB. 2020



REGION 3
FEB. 2020

REGION 5
FEB. 2020

Rollout Phase 1: Nov. 2019 – Regions 2 and 4
Rollout Phase 2: Feb. 2020 – Regions 1, 3, 5 and 6

Tailored Plans

Overview of Eligible Population

TP Populations:

- Qualifying I/DD diagnosis
- Innovations and TBI Waiver enrollees and those on waitlists
- Qualifying Serious Mental Illness (SMI) or Serious Emotional Disturbance (
  diagnosis who have used an enhanced service
- Those with two or more psychiatric inpatient stays or readmissions within 18 months
- Qualifying Substance Use Disorder (SUD) diagnosis and who have used an enhanced service
- Medicaid enrollees requiring TP-only benefits
- Transition to Community Living Initiative (TCLI) enrollees
- Children with complex needs settlement population
- Children ages 0-3 years with, or at risk for, I/DDs who meet eligibility criteria
- Children involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet eligibility criteria
- NC Health Choice enrollees who meet eligibility criteria

Benefit Packages

Only BH I/DD TPs will cover a subset of high-intensity State Plan BH services; TBI, Innovations and 1915(b)(3) waiver services; and State-funded BH, I/DD, and TBI services

BH, TBI and I/DD Services Covered by Both SPs and BH I/DD Tailored Plans	BH, I/DD and TBI Services Covered Exclusively by BH I/DD Tailored Plans (or LME-MCOs Prior To Launch)
Enhanced behavioral health services are italicized	
State Plan BH and I/DD Services • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • *Partial hospitalization* • *Mobile crisis management* • *Facility-based crisis services for children and adolescents* • *Professional treatment services in facility-based crisis program* • Peer supports (move from(b)(3) to state plan)* • *Outpatient opioid treatment* • *Ambulatory detoxification* • *Substance abuse comprehensive outpatient treatment program (SACOT)* • *Substance abuse intensive outpatient program (SAIOP) pending legislative change* • *Clinically managed residential withdrawal (aka social setting detox)** • *Research-based intensive behavioral health treatment* • *Diagnostic assessment* • EPSDT • *Non-hospital medical detoxification* • *Medically supervised or ADATC detoxification crisis stabilization*	**State Plan BH and I/DD Services** • Residential treatment facility services for children and adolescents • *Child and adolescent day treatment services* • *Intensive in-home services* • *Multi-systemic therapy services* • *Psychiatric residential treatment facilities* • *Assertive community treatment* • *Community support team* • *Psychosocial rehabilitation* • *Substance abuse non-medical community residential treatment* • *Substance abuse medically monitored residential treatment* • *Clinically managed low-intensity residential treatment services** • *Clinically managed population-specific high-intensity residential programs** • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) **Waiver Services** • Innovations waiver services • TBI waiver services • 1915(b)(3) services (excluding peer supports if moved to state plan) **State-Funded BH and I/DD Services** **State-Funded TBI Services**

*DHHS will submit a State Plan Amendment to add this service to the State Plan

Overview of BH I/DD TP Care Management Approach

NC DHHS

Establishes care management standards for BH I/DD TPs aligning with federal Health Home requirements

The BH I/DD TP will act as the Health Home and will be responsible for meeting federal Health Home requirements

BH I/DD TP Health Home

All approaches will be subject to one set of requirements and will provide care management across physical health, behavioral health, I/DD, and other services and the enrollee's unmet health-related resource needs.

Care Management Approaches

BH I/DD TPs have flexibility in how they provide care management, as long as the approach meets DHHS standards and care management is provided in the community to the maximum extent possible.

Approach 1: Tier 3 AMH with BH and/or I/DD Certification*

DHHS will create specialized BH and I/DD certifications for Tier 3 AMHs that serve a substantial number of BH I/DD TP enrollees and have experience serving these populations

Approach 2: Care Management Agencies (CMAs)*

BH I/DD TPs contract with agencies such as those that provide BH or I/DD services (e.g., mental health or substance use agencies, home care agencies, etc.) that obtain CMA certification

Approach 3: BH I/DD TP-Employed Care Managers

BH I/DD TPs may provide care management in certain circumstances that will be outlined in more detail by DHHS.

*Tier 3 AMHs or CMAs may contract with a clinically integrated network (CIN) for certain care management and data sharing functions

What beneficiaries can expect

Understanding MC Impacts to Beneficiaries

What's New

1. Beneficiaries will be able to choose their own health care plan
2. Most, but not all, people will be in Medicaid Managed Care
3. An enrollment broker will assist with choice

What's Staying the Same

1. Eligibility rules will stay the same
2. Same health services/treatments/supplies will be covered
3. The beneficiary Medicaid Co-Pays, if any, will stay the same
4. Beneficiaries report changes to local DSS

Medicaid Expansion

500,000	**New projected enrollees due to expansion, including a disproportionate number of rural North Carolinians**
$4 billion	**Annual federal dollars NC leaves on the table**
43,000+	**Jobs created in the first five years of expansion**
90%	**Share of costs paid by the federal government – no new state appropriation needed to fund the state share**

Now is the time to:

- **Improve overall health of NC (ranked 37th)**
- **Advance rural economic vitality, health**
- **Build sustainable infrastructure to combat the opioid epidemic**
- **Put downward pressure on everyone's premiums**

Beneficiary Experience – Auto Assignment

Beneficiaries who don't choose a health plan will be assigned one automatically, consistent with the following components in this order:

1. Where the beneficiary lives.
2. Whether the beneficiary is a member of a special population (e.g. member of federally recognized tribes or BH I/DD Tailored Plan eligible).
3. If the beneficiary has a historic relationship with a particular PCP/AMH.
4. Plan assignments of other family members.
5. If the beneficiary has a historic relationship with a particular PHP in the previous twelve (12) months (e.g.,"churned" off/into Medicaid Managed Care).

Member Timeline– Phase 1

2019

Feb
- Initial letter sent to beneficiaries in 2 counties
- Address verification letter sent to remaining counties

March
- Flyers posted at DSS
- Address corrections to DSS

April
- 2nd letter to members
- Member Outreach activities

May
- Public Service Announcements
- PHP marketing materials

SOFT LAUNCH

June 3RD
- EB Call Center Open
- Welcome Packets mailed

July

Aug

- Open Enrollment Begins - July 15th

Sept

- Open Enrollment Ends - Sept 13th
- Members auto assigned to PHPs based on algorithm

Oct
- Member ID cards
- Member Handbooks

Day 1 - Regions 2 & 4

Nov 1ST Managed Care Launch- Phase 1

Dec
- Member feedback
- Evaluation of materials, process

Member Timeline– Phase 2

2019

June 3RD
- EB Call Center Open
- Outreach Activities

July
- Flyers posted at DSS
- Address corrections to DSS

Aug
- Letters to members
- Member Outreach activities

SOFT LAUNCH

Sept 2nd Enrollment Welcome Packets

Oct

Nov

Dec

- Open Enrollment Begins- Oct 14th
- Open Enrollment Ends- Dec 13th

2020

Jan
- Member ID cards
- Member Handbooks

Day 1 - Regions 1, 3, 5 & 6

Feb 1st Managed Care Launch- Phase 2

March
- Member feedback
- Evaluation of materials, process

What providers can expect

Provider Experience in Managed Care

Addressing Administrative Burden:

- a centralized and streamlined provider enrollment and credentialing process;
- transparent, timely and fair payments for providers;
- a single statewide drug formulary that all PHPs will be required to utilize;
- same services covered in Medicaid managed care and fee-for-service (with exception of services carved out of Medicaid Managed Care)
- Department's definition of "medical necessity" used by PHPs when making coverage decisions; and
- providers offered some contracting "guardrails", standard PHP contract language

Managed Care Impacts on Providers

Contract/Payment

- Potential contract with multiple PHPs, CINs
- Opportunity to negotiate rates*
- Understanding contract terms, conditions, payment and reimbursement methodologies
- Network adequacy and out of networks standards
- AMH program/tiered payments

Information/Problem Solving

- Build relationships with health plans
- PHP provider assistance line
- Provider appeals procedures specified in PHP provider manual
- DHHS provider ombudsman to assist with problem solving
- Opportunities to provide feedback i.e. AMH TAG

* rate floors apply

AMH Tiers Compared

Tiers 1 and 2

- SP **retains** primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Providers will need to coordinate across multiple plans:** practices will need to interface with multiple SPs, which will retain primary care management responsibility; PHPs may employ different approaches to care management

Tier 3

- PHP **delegates** primary responsibility for delivering care management to the practice level (see next slide)
- **Single, consistent care management approach:** Practices will have the option to provide care management in-house or through a single CIN/other partner across all Tier 3 SP contracts
- **Initial attestation process closed 1/31:** based on attestation data, majority of SP beneficiaries are expected to be attributed to Tier 3 practices

Tier 4: To launch at a later date

Deep Dive on Tier 3 AMHs

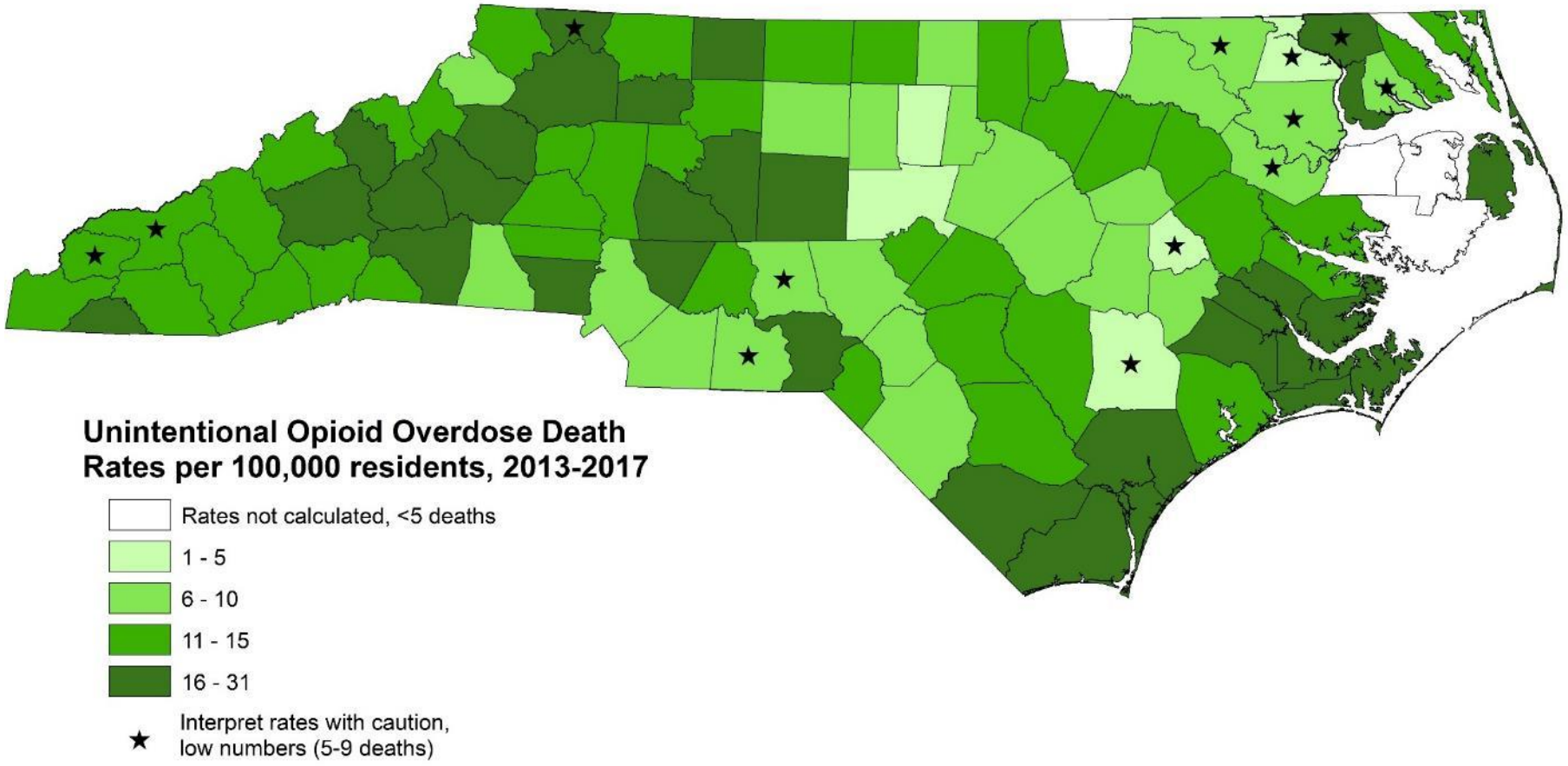
Tier 3 AMHs are responsible for delivering care management at the practice level, including:

Tier 3 Responsibilities

- **Risk stratify** all empaneled patients
- Provide **care management to high-need patients,** which includes (but is not limited to):
  - Conducting a **comprehensive assessment** of enrollees' needs
  - Establishing a **multi-disciplinary care team** for each enrollee
  - Developing a **care plan** for each enrollee
  - **Coordinating all needed services** (physical health, behavioral health, social services, etc.)
  - Providing **in-person assistance securing unmet resource needs** (e.g. nutrition services, income supports, etc.)
  - Conducting medication management, including regular medication reconciliation and support of medication adherence
  - Providing **transitional care management** as enrollees change clinical settings
- **Receive claims data feeds** (directly or via a CIN/other partner) and meet state-designated **security standards** for their storage and use

OPIOID USE DISORDER

Statewide, the unintentional opioid overdose death rate is 12.1 per 100,000 residents from 2013-2017



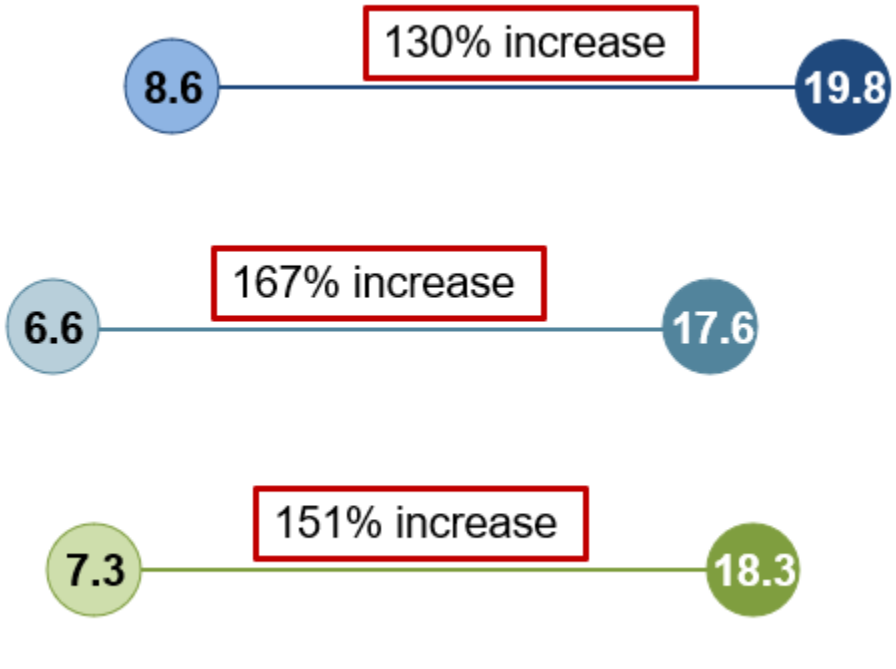
Technical Notes: Rates are per 100,000 N.C. residents, Unintentional medication and drug poisoning: X40-X44 and any mention of T40.0 (opium), T40.2 (Other Opioids), T40.3 (Methadone),T40.4 (Other synthetic opioid) and/or T40.6 (Other/unspecified narcotics)
Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 2013-2017; Population-NCHS, 2013-2017
Analysis by Injury Epidemiology and Surveillance Unit

Urban counties have seen largest increase in unintentional opioid overdose death rates

Rural
291 deaths in 2013
676 deaths in 2017

Urban
430 deaths in 2013
1,208 deaths in 2017

State
721 deaths in 2013
1,884 deaths in 2017



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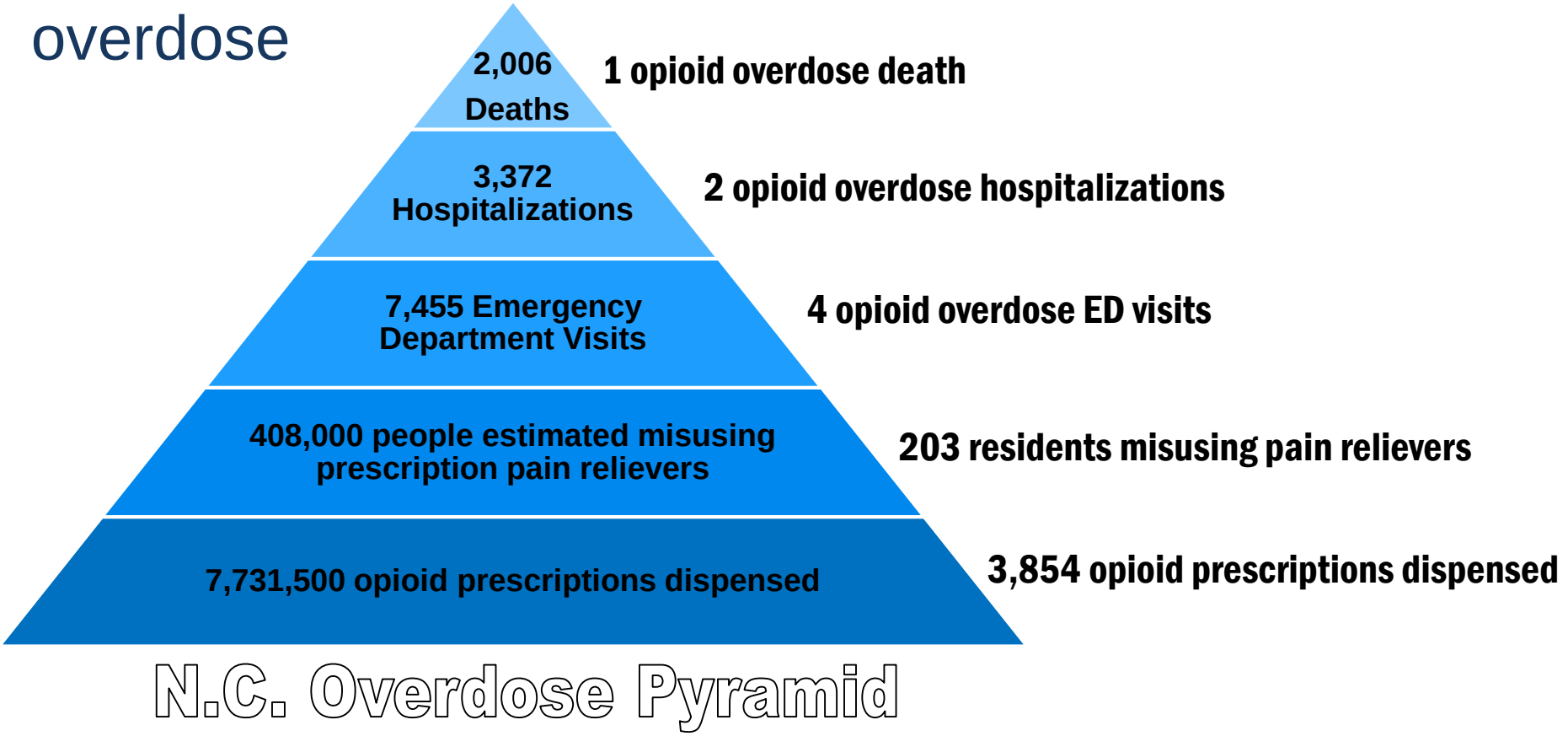
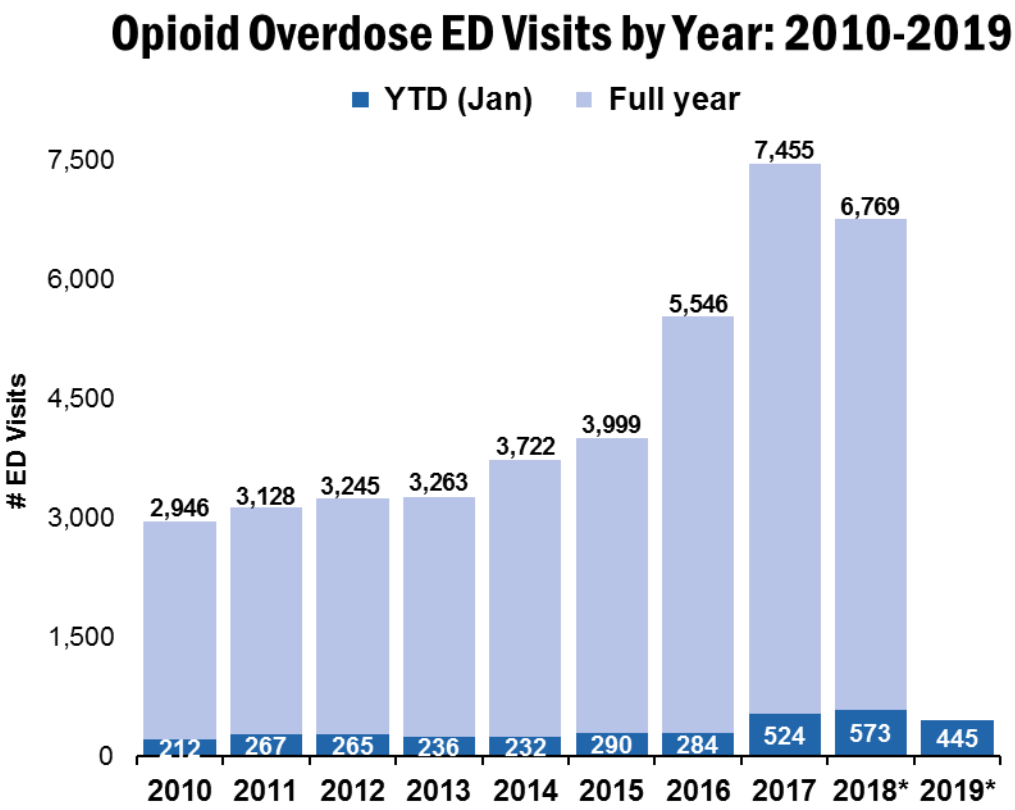
Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 2013-2017; Population-NCHS, 2013-2017; Primary Urban/Rural Designation definition consistent with N.C. Office of Rural Health
Analysis by Injury Epidemiology and Surveillance Unit

For every opioid overdose death, there were nearly 2 hospitalizations and 4 ED visits due to opioid overdose



Technical Notes: Deaths, hospitalizations, and ED data limited to N.C. residents; Includes all intents, not limited to unintentional
Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 2017/ Hospitalizations- North Carolina Healthcare Association, 2017/ED-NC DETECT, 2017/ Misuse-NSDUH, 2015-2016 applied to 2017 population data/Prescriptions-CSRS, 2017
Analysis by Injury Epidemiology and Surveillance Unit

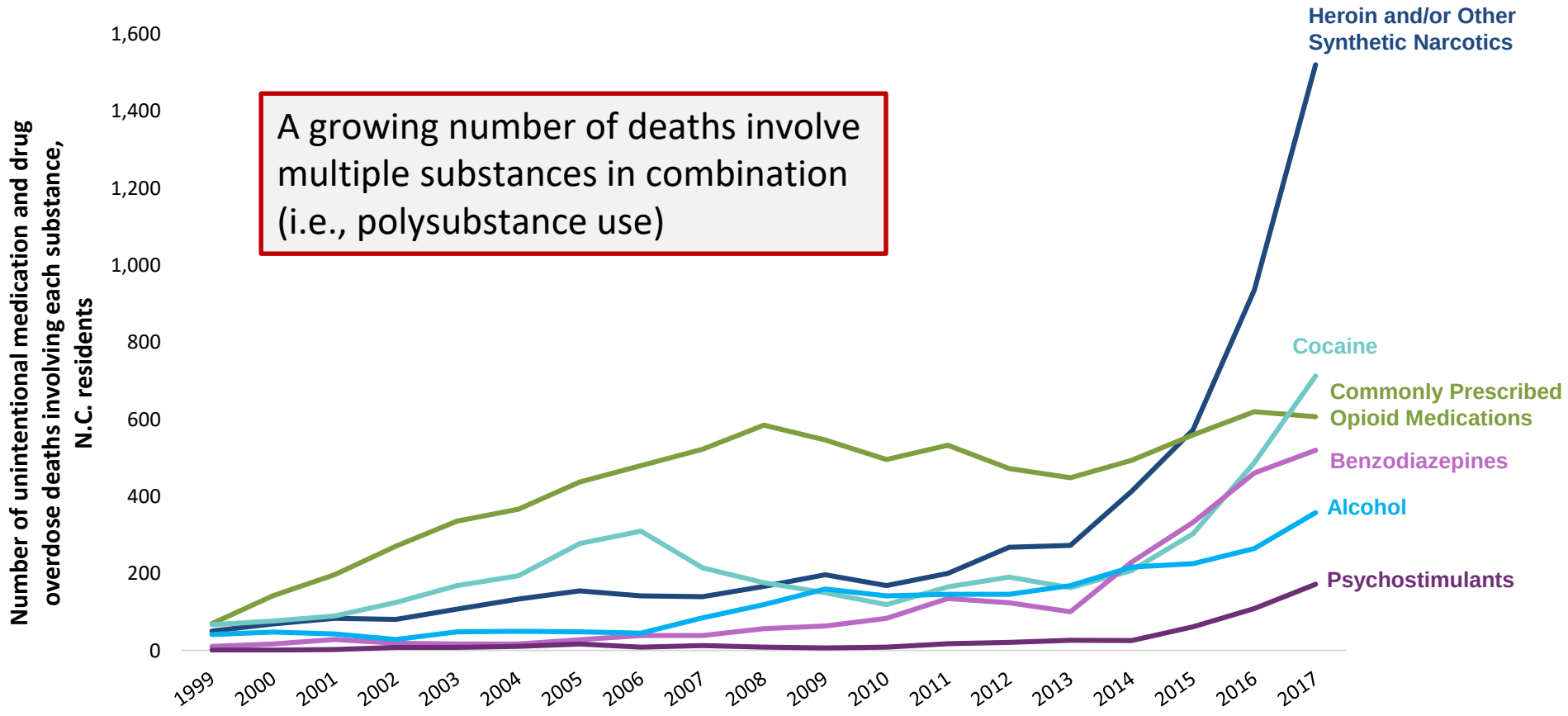
Opioid Overdose Emergency Department Visits: 2010-2019 YTD



Insurance Coverage: 2019 YTD	
Private insurance	14%
Medicaid or Medicare	29%
Uninsured/Self-pay	46%
Other/Unknown	11%

Data Source: The North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NCDETECT), 2010-2019;
*2018-2019 data are provisional and subject to change; Data as of January 31, 2019.
Analysis by Injury Epidemiology and Surveillance Unit

Broader: Unintentional overdose deaths involving illicit opioids* have drastically increased since 2013

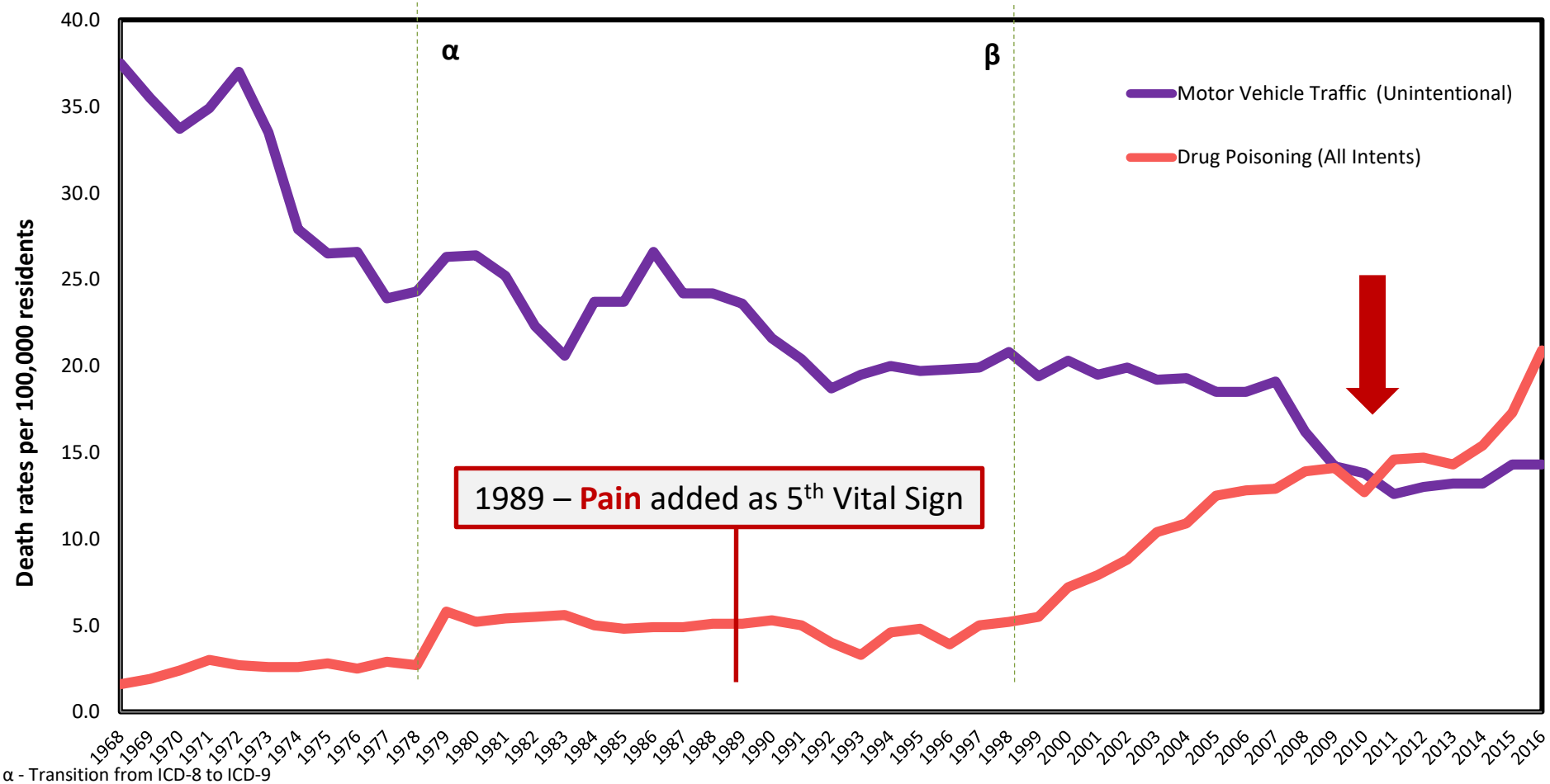


*Heroin and/or Other Synthetic Narcotics (mainly illicitly manufactured fentanyl and fentanyl analogues)

Technical Notes: These counts are not mutually exclusive; If the death involved multiple substances it can be counted on multiple lines; Unintentional medication, drug, alcohol poisoning: X40-X45 with any mention of specific T-codes by drug type; limited to N.C. residents

Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 1999-2017
Analysis by Injury Epidemiology and Surveillance Unit

Poisoning death rates are higher than traffic crash death rates in N.C.



α - Transition from ICD-8 to ICD-9
β – Transition from ICD-9 to ICD-10

Technical Notes: Rates are per 100,000 residents, age-adjusted to the 2000 U.S. Standard Population
Source: Death files, 1968-2016, CDC WONDER
Analysis by Injury Epidemiology and Surveillance Unit

OPIOID ACTION PLAN

NC's Opioid Action Plan

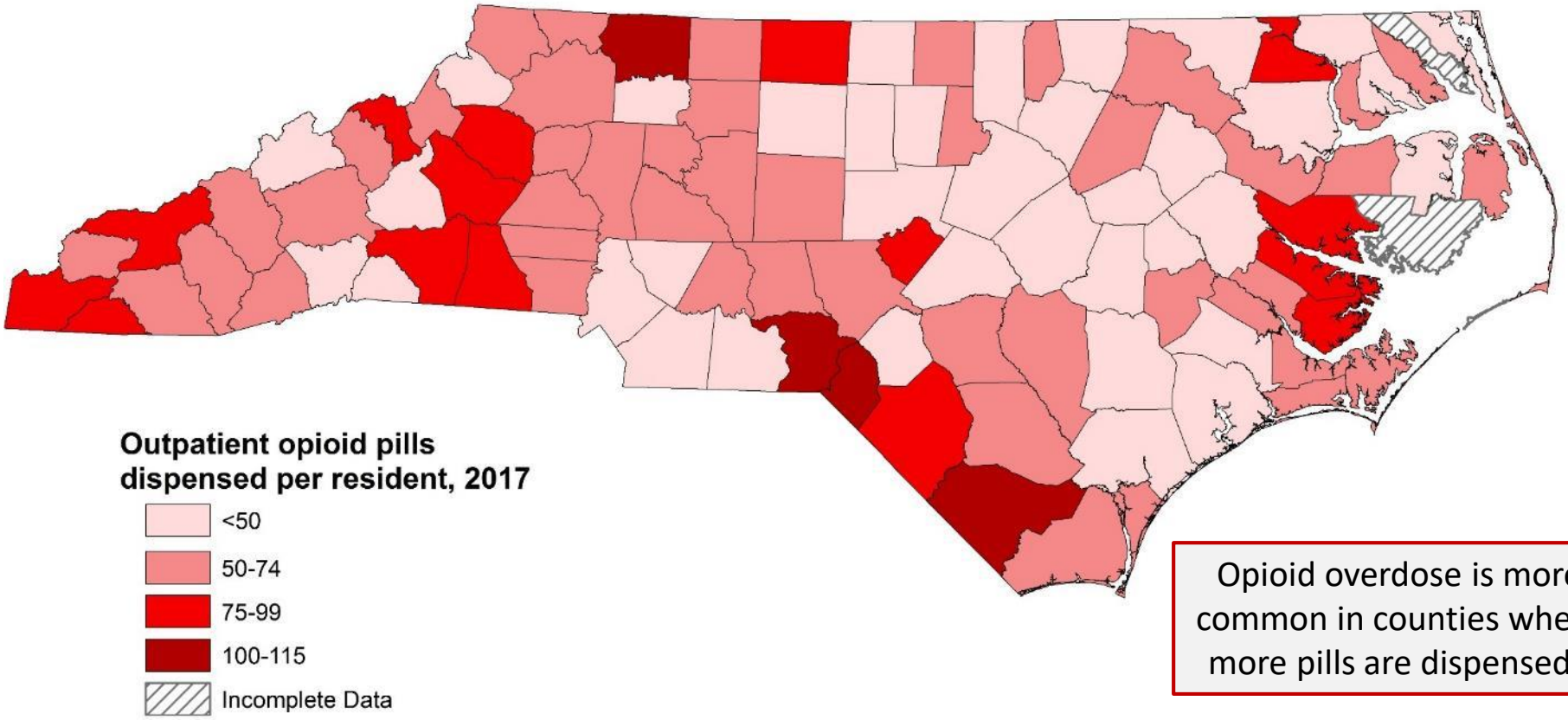
1. Coordinate the state's infrastructure to tackle opioid crisis.
2. Reduce the oversupply of prescription opioids.
3. Reduce diversion of prescription drugs and flow of illicit drugs.
4. Increase community awareness and prevention.
5. Make naloxone widely available.
6. Expand treatment and recovery systems of care.
7. Measure effectiveness of these strategies based on results.

We can do better with Medicaid expansion.

"If you're a state that does not have Medicaid expansion, you can't build a system for addressing this disease." – Dayton, OH Mayor Nan Whaley

Dayton more than halved its opioid death rate after Ohio expanded Medicaid.

Reduce oversupply of prescription opioids:
Statewide, 51 pills per resident dispensed in 2017

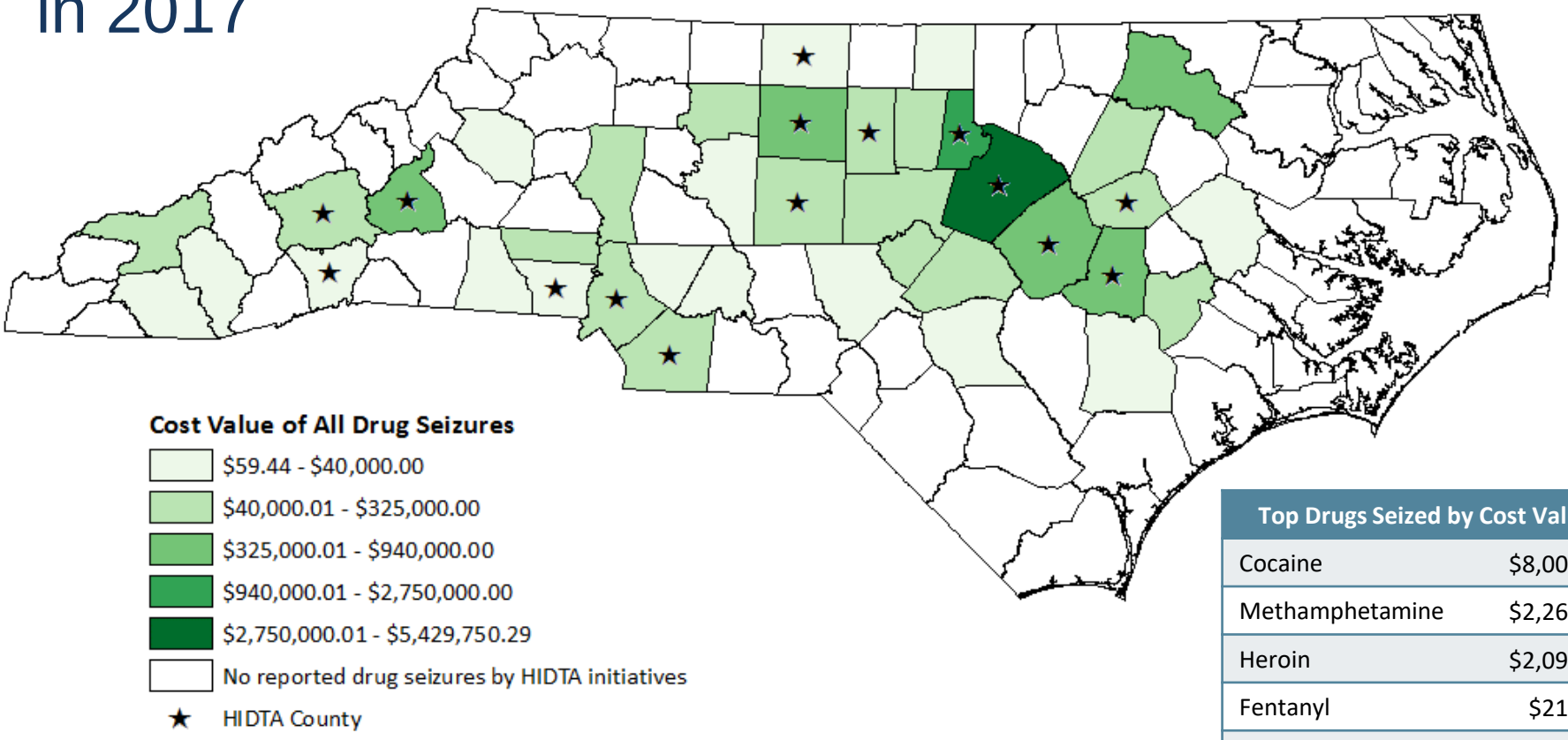


Opioid overdose is more common in counties where more pills are dispensed*

*Death Rates from Unintentional and Undetermined Prescription Opioid Overdoses and Dispensing Rates of Controlled Prescription Opioid Analgesics - 2011-2015; NCMJ 2017

Technical Notes: In 2017, CSRS data for Hyde and Camden counties are incomplete
Source: Opioid Dispensing – NC Division of Mental Health, Controlled Substance Reporting System, 2017; Population- NCHS, 2017
Analysis by Injury Epidemiology and Surveillance Unit

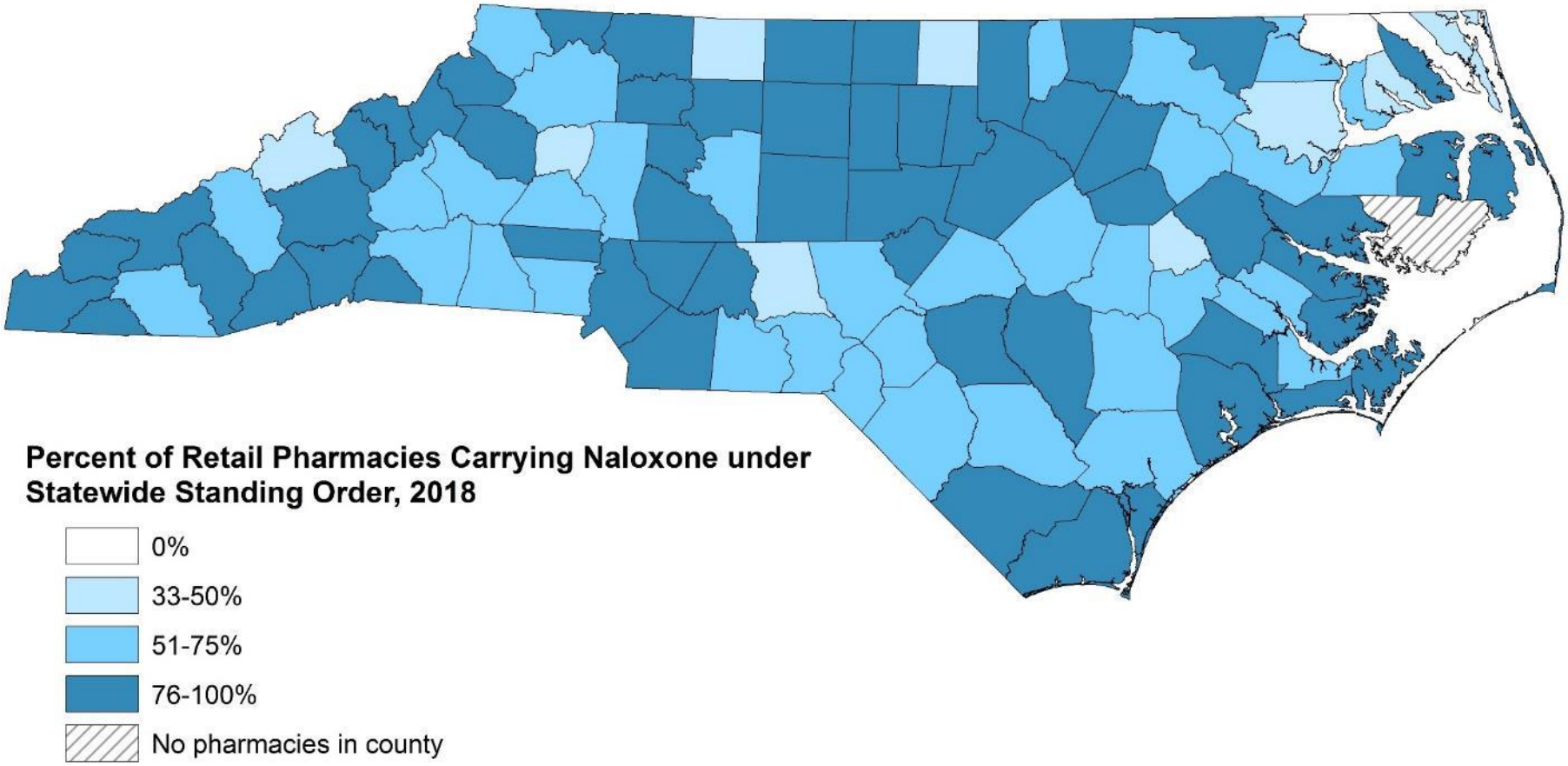
Reduce diversion of prescriptions and flow of illicit drugs: Over $12.5 million in drugs seized by HIDTA in 2017



Top Drugs Seized by Cost Value	
Cocaine	$8,007,106
Methamphetamine	$2,267,669
Heroin	$2,095,056
Fentanyl	$217,945
Prescription Opioids	$4,730

Technical Notes; Cost value of drug seizures excludes marijuana-related seizures; Cost value of drug seizures are provisional
Source: : Value of drug seizures reported by North Carolina HIDTA initiatives to Atlanta-Carolinas HIDTA in 2017
Analysis by Injury Epidemiology and Surveillance Unit

Increase community prevention: Over 85% of retail pharmacies dispense Naloxone under Standing Order

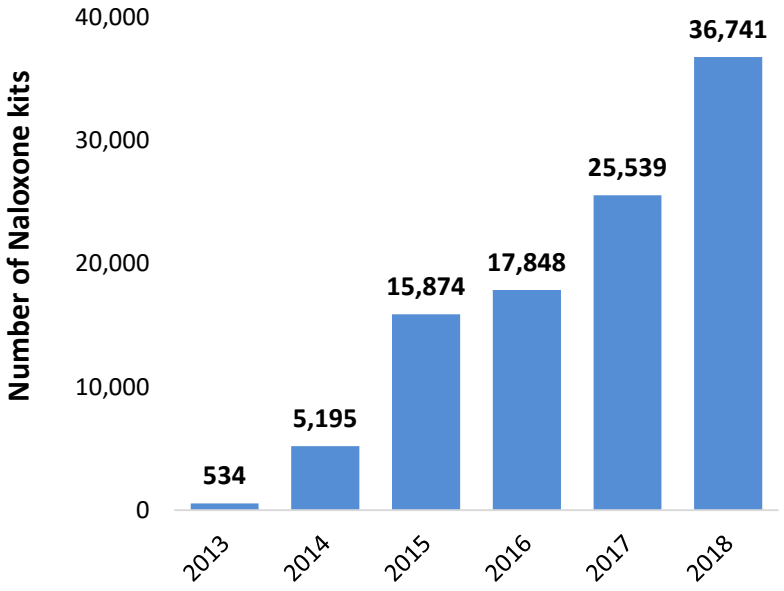


Source: Injury and Violence Prevention Branch, December 2018
Analysis by Injury Epidemiology and Surveillance Unit

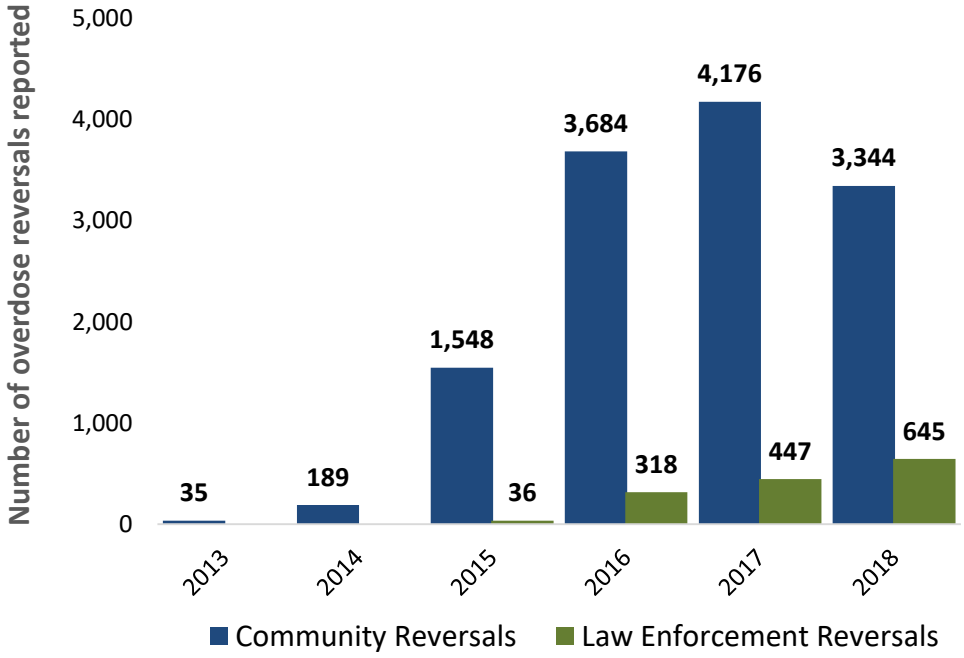
North Carolina Injury & Violence PREVENTION Branch

Make naloxone widely available: Over 101,000 naloxone kits distributed and over 14,000 reversals reported

Naloxone Kits Distributed by NCHRC

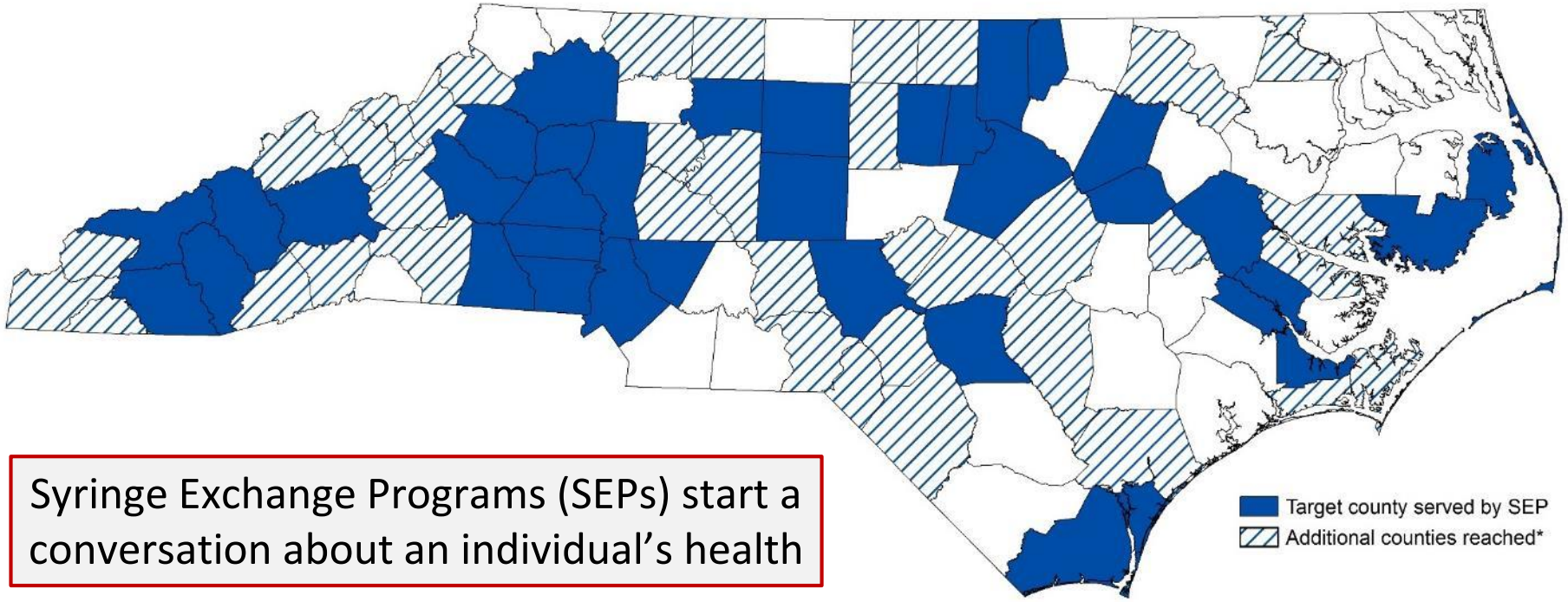


Opioid Overdose Reversals Reported to NCHRC



Technical Notes: Kit distribution and reversal reporting began in August 2013; Reversal data do not represent all reversals, just those reported to NCHRC
Source: North Carolina Harm Reduction Coalition (NCHRC)
Analysis by Injury Epidemiology and Surveillance Unit

Expand treatment and recovery: After Year 2, 29 registered SEPs covering 34 counties



Syringe Exchange Programs (SEPs) start a conversation about an individual's health

*Residents from an additional 35 counties without SEP coverage (and out of state) traveled to receive services in a SEP target county in N.C.

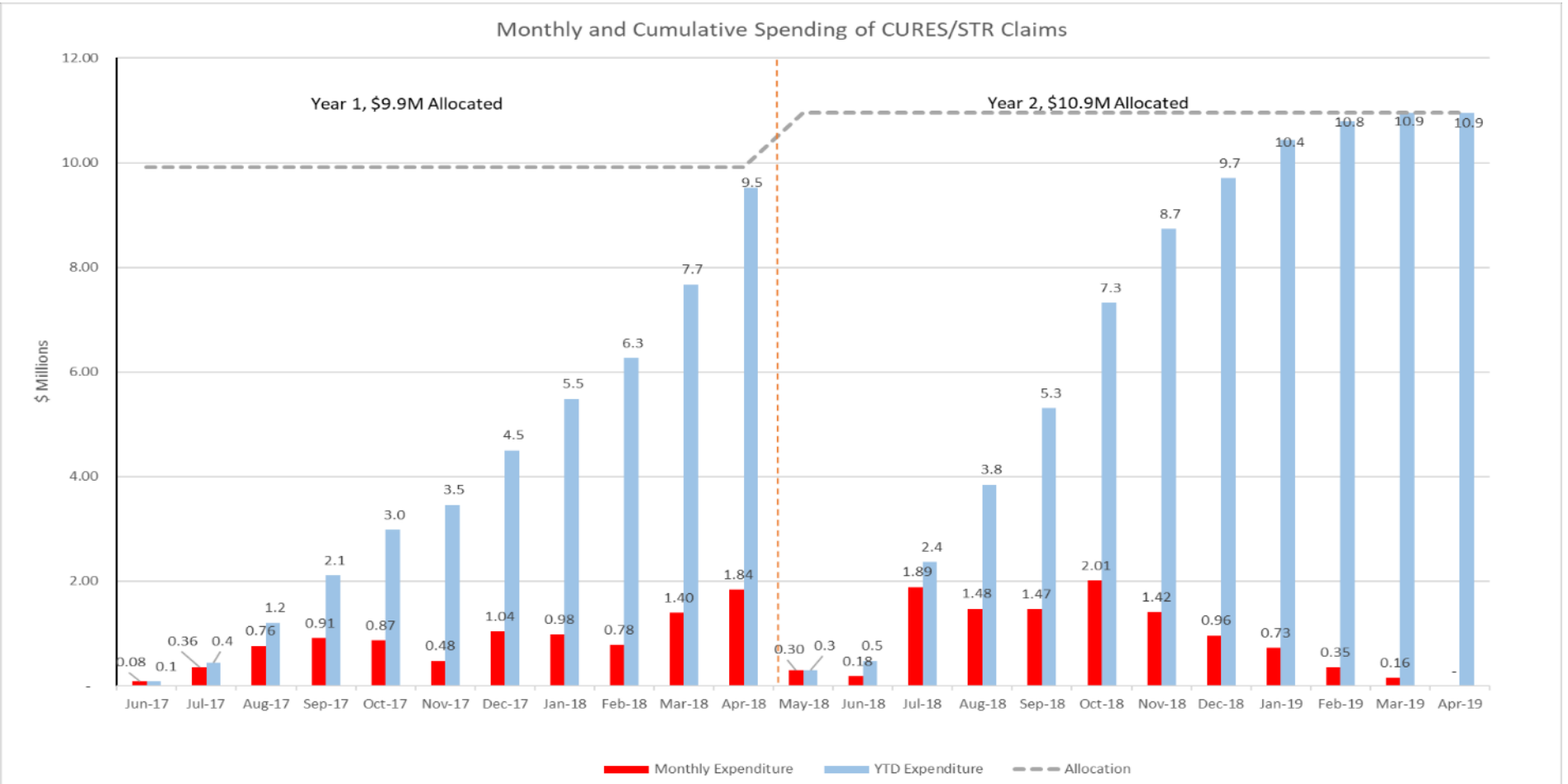
Technical Notes: There may be SEPs operating that are note represented on this map; in order to be counted as an active SEP, paperwork Must be submitted to the N.C. Division of Public Health
Source: N.C. Division of Public Health, Year 2 SEP Annual Reporting, June 2018
Analysis by Injury Epidemiology and Surveillance Unit

Federal Grants to Support Opioid Treatment

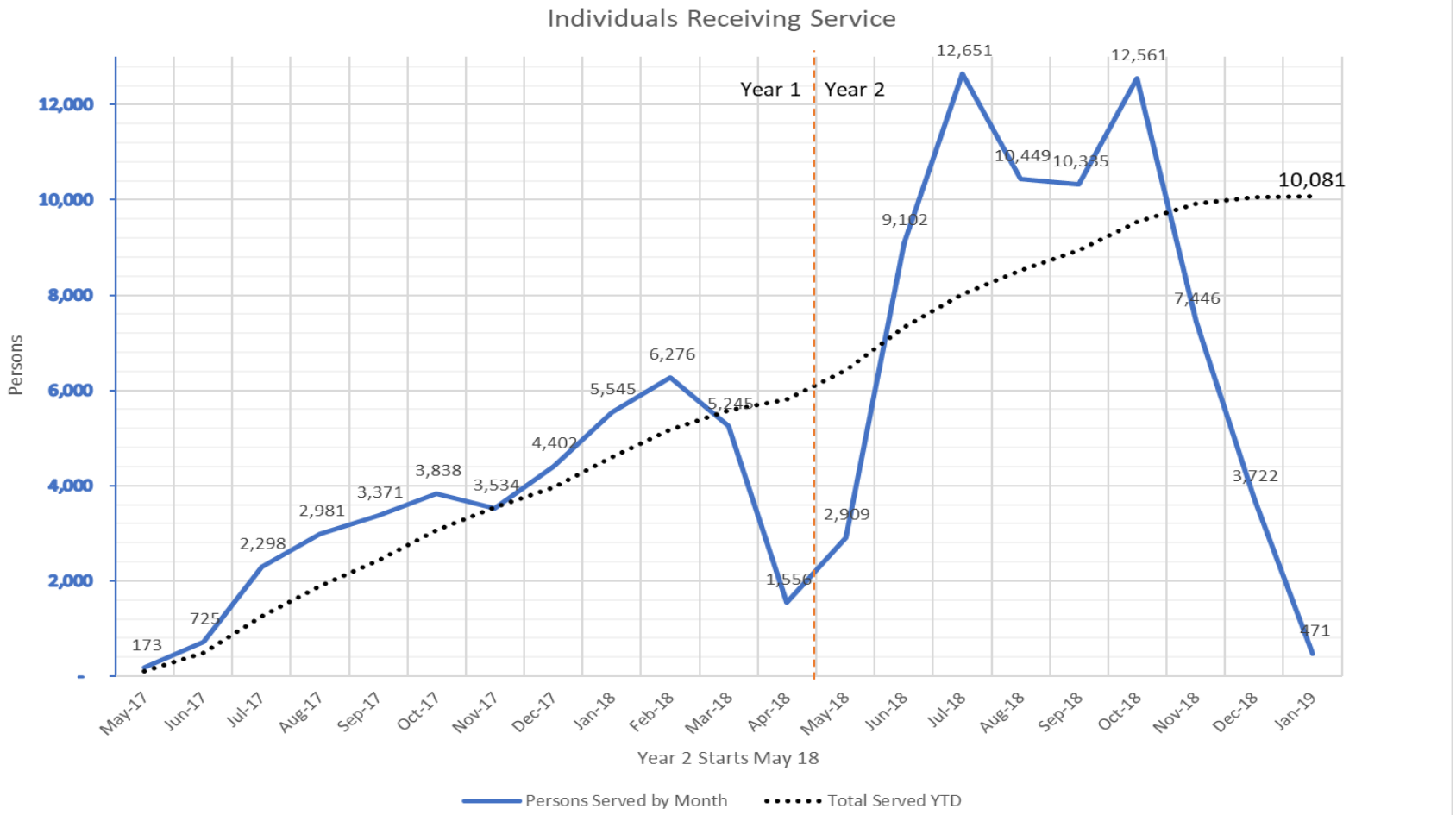
- **Cures/STR: May 1, 2017 – April 30, 2019**
  - **$15.5 M for 2 years: $31M**
  - **Renewed for two years, amount still unknown.**

- **SOR: October 1, 2018 – September 30, 2020**
  - **$23 M for 2 years: $46M**

Expand Treatment Federal CURES/STR grant:



About 10,000 individuals have received treatment from this funding:

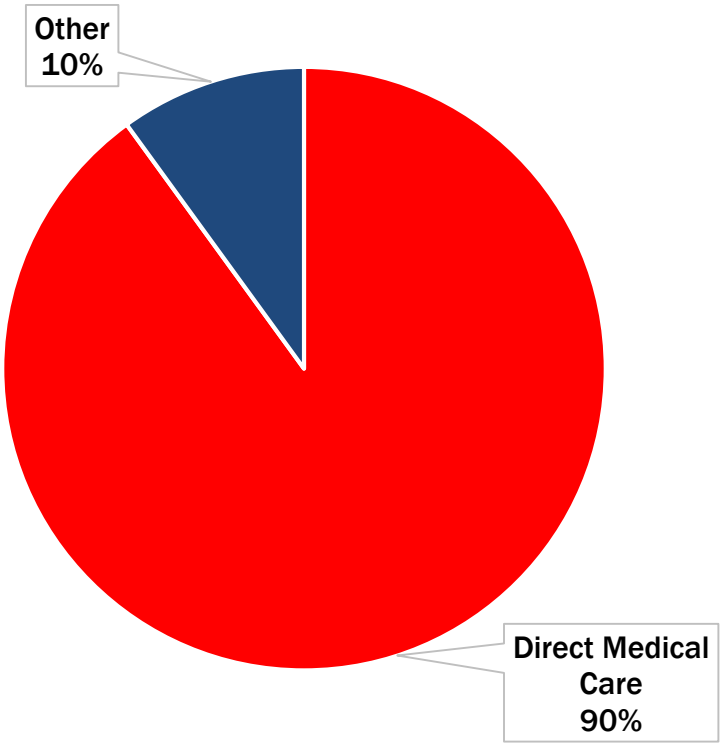


Between May 1, 2017 and April 30, 2018, 33,234 individuals with an opioid use disorder received publicly-funded (Medicaid, state, federal) treatment services. Of these, 10,081 individuals received services through Cures/STR funds. 2,279 of these individuals received services in Year 1 and Year 2 of the Cures/STR grant.

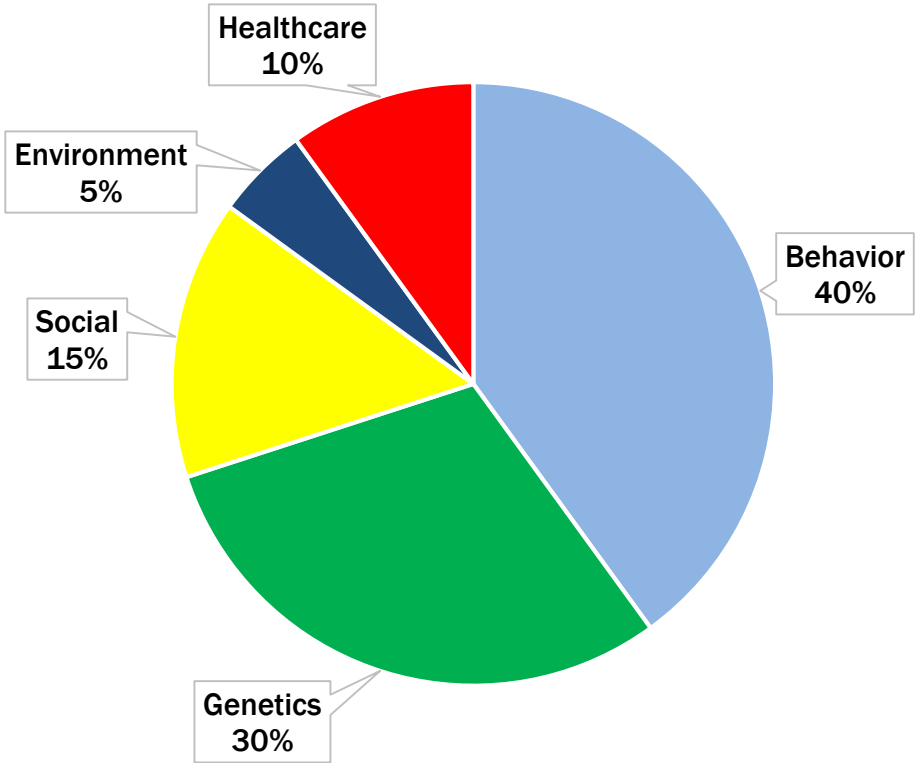
HEALTHY OPPORTUNITIES

Mismatch: We are Buying Healthcare not "Health"

Healthcare Spending



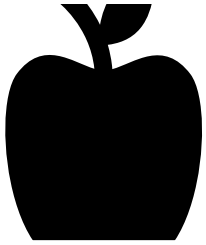
Drivers of Health



The greatest opportunity to improve health lies in addressing a person's **unmet essential needs**.

SOURCE: Schroeder SA. N Engl J Med 2007

Initial Domains

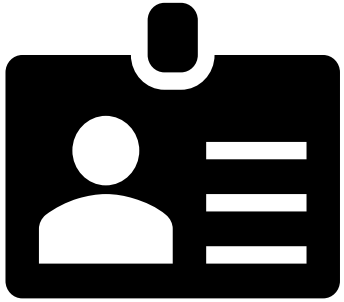


Food Security

Housing Stability

Transportation

Interpersonal Safety



Employment

Screening Questions

- Goals
  - Routine identification of unmet health-related resource needs
  - Statewide collection of data
- Development
  - Technical Advisory Group
  - Released April 2018 for Public Comment
  - Field testing in 18 clinical sites
- Implementation
  - Recommended to be used across settings and populations
  - Launch of Managed Care: PHPs Required to Include in Care Needs Assessment

Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

NCCARE360

- **The Problem:** *Connecting people to community resources is inconsistent, not coordinated, not secure, and not trackable.*
- **The Solution:**
  - Uniform system for providers, insurers, and community organizations to coordinate care, collaborate, and track progress and outcomes.
  - Tool to make it easier to connect people with the community resources they need to be healthy.
  - Track statewide, regional, and community-level data on service delivery and outcomes achieved.

NCCARE360 Functionalities

	Functionality	Partner	Timeline
Resource Directory	Directory of statewide resources that will include a call center with dedicated navigators, a data team verifying resources, and text and chat capabilities.	NORTH CAROLINA 211	Summer 2019
Data Repository	APIs integrate resource directories across the state to share resource data.	Expound	Phased Approach
Referral & Outcomes Platform	An intake and referral platform to connect people to community resources and allow for a feedback loop.	UNITE US	Rolled out by county January 2019 – December 2020

Hands on, in-person technical assistance and training to on-board providers and community organizations.

Network Model: No Wrong Door Approach

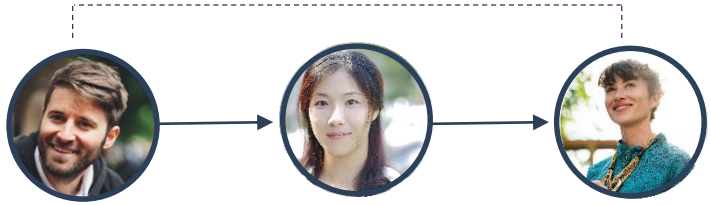
NCCARE360: Coordination Platform at Work

Traditional Referral

Client | Healthcare Provider | Housing Provider

- ✗ Service provider cannot always exchange PII or PHI via a secure method
- ✗ Limited prescreening for eligibility, capacity, or geography
- ✗ Onus is usually on the client to reach the organization to which he/she was referred
- ✗ Service providers have limited insight or feedback loop
- ✗ Client data is siloed & transactional data is not tracked

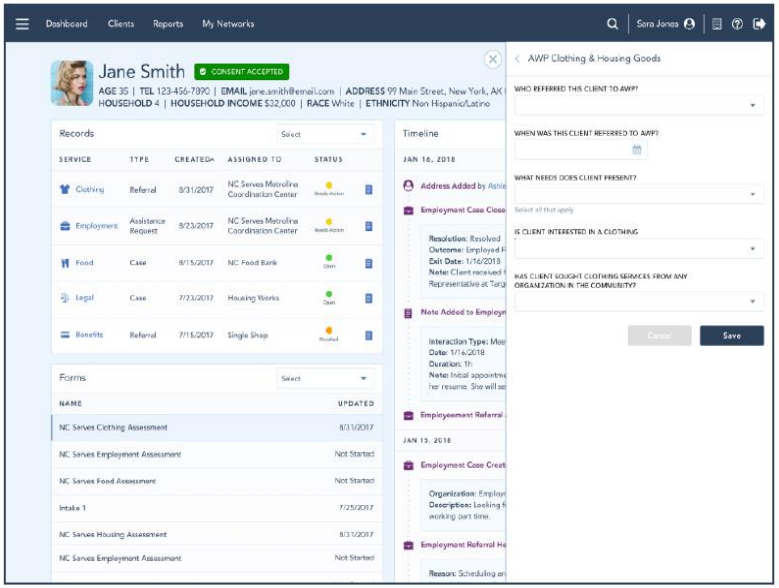
Through NCCARE360



Client | Healthcare Provider | Housing Provider

- ✓ All information is stored and transferred on HIPAA compliant platform
- ✓ Client is matched with the provider for which he/she qualifies
- ✓ Client's information is captured once and shared on his/her behalf
- ✓ Service providers have insight into the entire client journey
- ✓ Longitudinal data is tracked to allow for informed decision making by community care teams

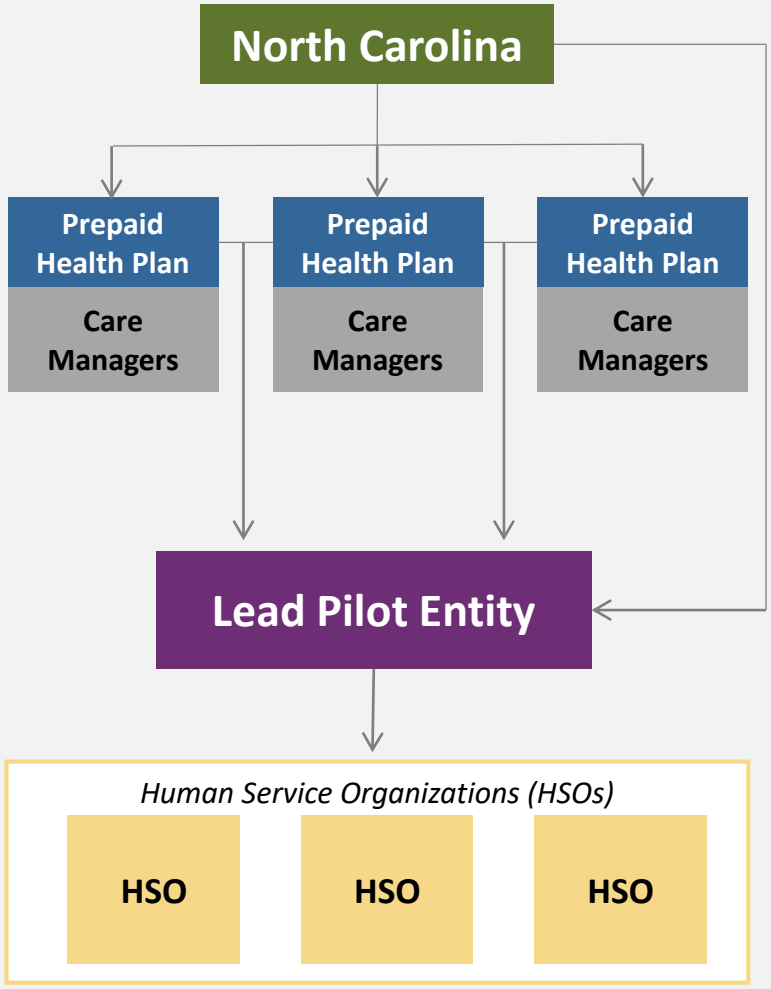
Automated Workflows with Partners



- Configurable Screening
  - Will include statewide screening tool
  - Can add additional screening questions/ tools as needed
- Electronic Referral Management
  - Seamless referral workflow sends the right data to the right provider(s) to address specific needs
- Assessment/Care Plan Management
  - Custom care plans for each service that are attached to referrals so receiving providers get a head start
- Bi-Directional Communication/Alerts
  - Automated notifications keep all organizations up to date, while care team members can securely communicate with each other
- Outcomes
  - You get to know exactly what services were delivered, and the entire history for every intervention by your external partners

Healthy Opportunities Pilots: High-Level Overview

Sample Regional Pilot



Pilot Overview

- The Healthy Opportunities Pilots will test the impact of providing selected evidence-based interventions to Medicaid enrollees.
- Over the next five years, the pilots will provide up to $650 million in Medicaid funding for pilot services in two to four areas of the state that are related to housing, food, transportation and interpersonal safety and directly impact the health outcomes and healthcare costs of enrollees.
- Pilots will allow for the establishment and evaluation of a systematic approach to integrating and financing evidence-based, non-medical services into the delivery of healthcare.

Overview of Approved Pilot Services

North Carolina's 1115 waiver specifies services that can be covered by the Pilot. Pilots will not be required to offer all approved services.

Housing

- Tenancy support and sustaining services
- Housing quality and safety improvements
- One-time securing house payments (e.g., first month's rent and security deposit)
- Short-term post hospitalization housing

Food

- Linkages to community-based food services (e.g., SNAP/WIC application support, food bank referrals)
- Nutrition and cooking coaching/counseling
- Healthy food boxes
- Medically tailored meal delivery

Transportation

- Linkages to existing public transit
- Payment for transit to support access to pilot services, including:
  - Public transit
  - Taxis, in areas with limited public transit infrastructure

Interpersonal Violence

- Linkages to legal services for IPV related issues
- Evidence-based parenting support programs
- Evidence-based home visiting services

*See appendix for full list of approved pilot services.

Process/ Timeline

- Early 2019: Request for Information (RFI)
- Mid 2019: Request for Proposals (RFP)
  - RFP will determine LPEs/ Pilot Regions
- Late 2019: Award LPEs/ Pilot Regions
- 2020: Full year of capacity building for LPEs and regions
- January 1, 2021: Begin Service Delivery
- October 31, 2024: End Pilots (at end of 1115 waiver)

Questions?

@KodyKinsley