Healthy Opportunities Pilots

NC Medicaid

Frequently Asked Questions

WHAT ARE THE HEALTHY OPPORTUNITIES PILOTS?

As a part of North Carolina's transition to NC Medicaid Managed Care, the North Carolina Department of Health and Human Services (NCDHHS) received authority from the Centers for Medicare & Medicaid Services (CMS) to conduct the Healthy Opportunities Pilot Program. The Pilots will create a unique opportunity to test the impact on health outcomes and health care costs by using Medicaid funds to pay for non-medical services specifically related to food, housing, transportation, interpersonal safety and toxic stress. Additionally, the Pilots will provide a mechanism for payers, providers and human service organizations (HSOs, e.g., community-based organizations or social service agencies) to have the tools, infrastructure and financing to integrate non-medical services into the delivery of health care for eligible Medicaid members.

The goals of the Pilot program are to:

- Evaluate the effectiveness of select, evidence-based, non-medical interventions and the role of the Healthy Opportunities Network Lead (formerly known as the Lead Pilot Entity or LPE) in improving health outcomes, reducing health care costs, and promoting health equity for high-risk NC Medicaid Managed Care members.
- Leverage evaluation findings to embed cost-effective interventions that improve health outcomes into the Medicaid program statewide, furthering NCDHHS' goals for a sustainable Medicaid program.
- Support the sustainability of delivering non-medical services identified as effective through the evaluation, including by strengthening the capabilities of HSOs and partnerships with health care payers and providers.

WHY ARE THE HEALTHY OPPORTUNITIES PILOTS IMPORTANT?

The Healthy Opportunities Pilots offer North Carolina the unprecedented opportunity to test the impact of using Medicaid to provide select non-medical, evidence-based interventions to high-risk Medicaid enrollees on their health outcomes and health care costs. These non-medical services are related to food, housing, transportation and interpersonal safety/toxic stress are not traditionally covered by Medicaid. Although other states have offered select services related to food, transportation or other domains for select Medicaid populations (such as enrollees receiving long-term services and supports) in areas of their state, the Pilots offer the opportunity to test these services on a larger scale: offering a broad range of services for broad range of Medicaid

beneficiaries in multiple regions across North Carolina. If determined successful, the Department intends to incorporate these non-medical services into its Medicaid program statewide.

WHEN WILL THE HEALTHY OPPORTUNITIES PILOTS OCCUR?

on May 27, 2021, Healthy Opportunities Network Leads began building their network of HSOs and developing the capacity of both them and their HSOs to participate in the Pilots. In order to ensure a smooth and effective launch of the Pilots, the Department made Healthy Opportunities Pilot services available in phases for eligible Standard Plan members across all three Pilot regions as follows:

March 15, 2022: Food services became available across all Pilot regions

May 1, 2022: Housing and transportation services became available across all Pilot regions

June 15 - July 31, 2022: Certain toxic stress and cross-domain services became available across all Pilot regions

The Department is currently working with its partners to set a date to launch interpersonal violence services and sensitive cross-domain services to ensure beneficiary safety.

Pilot services will be available to eligible Tailored Plan members in the second quarter of 2023. CMS has authorized the pilot program to run through October 2024.

WHAT REGIONS ARE COVERED BY THE HEALTHY OPPORTUNITIES PILOTS?

The Department conducted a competitive selection process to solicit Healthy Opportunities Network Leads and their regional networks. The following regions were awarded on May 27, 2021:

- Access East, Inc.: Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt
- Community Care of the Lower Cape Fear: Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender
- Dogwood Health Trust: Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

If a Network Lead covers a county, all parts of that county must be covered. For more information on Network Leads, see question and answer #7 below.

HOW IS SOMEONE ELIGIBLE FOR HEALTHY OPPORTUNITIES PILOT SERVICES?

To be eligible for pilot services, an individual must be enrolled in NC Medicaid Managed Care and live in a Pilot region. The Medicaid member must have a qualifying physical or behavioral health condition, a qualifying social risk factor and meet any service-specific eligibility criteria as outlined in the Pilot Fee Schedule. See the Appendix at the end of this fact sheet for qualifying physical and behavioral health criteria and qualifying social risk factors.

WHAT SERVICES WILL BE OFFERED THROUGH THE PILOTS AND HOW WILL THEY BE REIMBURSED?

The Department has defined a set of 29 services to be offered through the Pilots in the Department's four priority domains: food, housing, transportation, interpersonal safety and toxic stress. The Department will utilize three types of reimbursement for pilot services: fee-for-service, per-member-per-month (PMPM) payments and cost-based reimbursement up to a cap. Services are listed below along with their unit of service and rate/cap. Payment for these services will increasingly be linked to health outcomes and costs over the course of the Pilot. Detailed service definitions for each service can be found in the Pilot Fee Schedule.

Service Name	Unit Of Service	Rate or Cap
Housing		
Housing navigation, support and sustaining services	PMPM	$400.26
Inspection for housing safety and quality	Cost-based reimbursement up to a cap	$250 per inspection
Housing move-in support	Cost-based reimbursement up to a cap	• 1 BR: Up to $900 per month • 2 BR: Up to $1,050 per month • 3 BR: Up to $1,150 per month • 4 BR: Up to $1,200 per month • 5+ BR: Up to $1,250 per month
Essential utility setup	Cost-based reimbursement up to a cap	• Up to $500 for utility deposits • Up to $500 for reinstatement utility payment • Up to $500 for utility arrears
Home remediation services	Cost-based reimbursement up to a cap	Up to $5,000 per year[1]
Home accessibility and safety modifications	Cost-based reimbursement up to a cap	Up to $10,000 per lifetime of waiver demonstration[2]
Healthy home goods	Cost-based reimbursement up to a cap	Up to $2,500 per year

[1] The HSO that coordinates the contractors to deliver the Home Remediation Service will receive $125 per Home Remediation Service project that costs no more than $1,250 and will receive $250 per Home Remediation Service project that costs between $1,250 and $5,000.

[2] The HSO that coordinates the contractors to deliver the Home Accessibility and Safety Modification will receive $250 per Home Accessibility Modification project that costs no more than $2,500 and will receive $500 per Home Accessibility and Safety Modification project that costs between $2,500 and $10,000.

One-time Payment for Security Deposit and First Month's Rent	Cost-based Reimbursement Up to A Cap	• First month's rent: Up to 110% FMR[3] (based on home size) • Security deposit: Up to 110% FMR (based on home size) x2
Short-Term Post Hospitalization Housing	Cost-Based Reimbursement Up to A Cap	• First month's rent: Up to 110% FMR (based on home size) • Security deposit: Up to 110% FMR (based on home size) x2
Interpersonal Violence/Toxic Stress		
IPV Case Management Services	PMPM	$221.96
Violence Intervention Services	PMPM	$168.94
Evidence-Based Parenting Curriculum	One class	$22.60
Home Visiting Services	One home visit	$67.89
Dyadic Therapy	Per occurrence	$68.25
Food		
Food and Nutrition Access Case Management Services	15-minute interaction	$13.27
Evidence-based Group Nutrition Class	One class	$22.80
Diabetes Prevention Program	• Four classes (first phase) • Three classes (second phase)[4]	**Phase 1: $275.83** • Completion of 4 classes: $27.38 • Completion of 4 additional classes (8 total): $54.77 • Completion of 4 additional classes (12 total): $68.46 • Completion of 4 additional classes (16 total): $125.22 **Phase 2: $103.44** • Completion of 3 classes: $31.02 • Completion of 3 additional classes (6 total): $72.42
Fruit and Vegetable Prescription	Cost-based Reimbursement Up to A Cap	Up to $210 per month[5]

[3] Fair Market Rent (FMR) standards as established by the U.S. Department of Housing and Urban Development, available here huduser.gov/portal/datasets/fmr.html#2022

[4] The Centers for Disease Control and Prevention recognized Diabetes Prevention Program is offered in two phases, including a minimum of 16 classes in Phase 1 and 6 classes in Phase 2. The DPP program is paid for in allocations so HSOs that participate in the Pilot are able to receive pro-rated payments as enrollees complete four classes.

[5] The HSO that coordinates the Fruit and Vegetable Prescription service will receive $5.25 per person served in a given month.

Healthy Food Box (For Pick-up)	One food box	• Small box: $89.29 • Large box: $142.86
Healthy Food Box (Delivered)	One food box	• Small box: $96.79 • Large box: $150.36
Healthy Meal (For Pick-Up)	One meal	$7.00
Healthy Meal (Home Delivered)	One meal	$7.60
Medically Tailored Home Delivered Meal	One meal	$7.80
Transportation		
Reimbursement for Health-related Public Transportation	Cost-based Reimbursement Up to A Cap	Up to $102 per month
Reimbursement for Health-Related Private Transportation	Cost-Based Reimbursement Up to A Cap	Up to $267 per month[6]
Transportation PMPM Add-on for Case Management Services	PMPM	$71.30
Cross-Domain		
Holistic high-intensity enhanced case management	PMPM	$501.41
Medical respite	Per diem	$206.98
Linkage to health-related legal supports	15-minute interaction	$25.30

WHAT ENTITIES ARE INVOLVED IN THE PILOTS AND WHAT ARE THEIR ROLES?

The Healthy Opportunities Pilots rely on an ecosystem of important stakeholders to operate and be successful. Entities that play significant roles in the Pilots are PHPs, Network Leads, care management entities and HSOs. Each entity's roles and responsibilities are outlined below:

PHPs and Care Management Entities

PHPs play a vital role in implementing the Healthy Opportunities Pilots and are ultimately responsible for managing Pilot participants' physical, behavioral and social needs. PHPs' key Pilot responsibilities, some of which are shared with their delegated care management entities, include:

- Managing a capped allocation of funding to spend on Pilot services outside of its capitation rate, in accordance with Department standards and guidelines.

[6] Repairs to a Pilot Enrollee's car may be deemed an allowable, cost-effective alternative to private transportation by the Enrollee's Prepaid Health Plan. Reimbursement for this service may not exceed six months of capped private transportation services.

- Making Pilot enrollment determinations for their members that meet certain eligibility criteria and authorizing pilot services.
- Ensuring Pilot participants are enrolled in other available existing federal, state and local programs to maximize the value of Pilot expenditures.
- Making referrals to HSOs for authorized Pilot services and following up with Pilot participants to evaluate ongoing needs.
- Collecting and submitting data to support DHHS' evaluation and oversight of the Pilot program.
- Paying HSOs for authorized Pilot services provided.

Healthy Opportunities Network Leads

- Healthy Opportunities Network Leads are organizations embedded in their communities that help the Department implement the Healthy Opportunities Pilots. Network Leads connect the health care and social service sectors; their key responsibilities include:
- Establishing, managing and overseeing a network of HSOs, including assessing HSO performance.
- Ensuring an adequate network of HSOs to meet Medicaid members' needs through the Pilots and ensuring that HSOs are delivering high-quality Pilot services.
- Distributing capacity-building funding to HSOs.
- Assisting HSOs with invoicing for Pilot services and routing invoices to a member's PHP for adjudication and payment.
- Providing technical assistance and conducting quality improvement activities with its HSO network.
- Facilitating learning collaboratives for HSOs, PHPs and care management entities participating in the Pilot.
- Collecting and submitting data to support DHHS' evaluation and oversight of the Pilot program.

HSOs

- HSOs deliver authorized Pilot services to NC Medicaid Managed Care members who are Pilot participants. HSOs' key Pilot responsibilities include:
- Delivering high-quality approved Pilot services to Pilot participants.
- Tracking services delivered to Pilot participants and conducting closed-loop referrals in NCCARE360.
- Submitting invoices to the Network Lead reflecting Pilot services they have delivered to Pilot participants.
- Participating in readiness and quality improvement activities including training, technical assistance and convenings organized by a Network Lead or NCDHHS.
- Supporting NCDHHS oversight and evaluation of Pilots.

For more information about the Healthy Opportunities Pilots visit our webpage at ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

This document is for informational purposes only. NCDHHS, at its sole discretion, reserves the right to make program changes. Any discrepancy between the information contained in this document and the RFP shall be governed by the terms of the RFP.

Appendix

Qualifying Physical/Behavioral Health Criteria for Pilot Program Eligibility

Risk Factor	Definition
Homelessness and housing insecurity	Homeless, as defined in U.S. Department of Health and Human Services 42 CFR § 254(h)(5)(A) and housing insecurity definition based on questions used to establish housing insecurity in the Accountable Health Communities Health-related Screening Tool.
Food insecurity	As defined by U.S. Dept. of Agriculture commissioned report on Food Security in America: • Low Food Security – Reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake. • Very Low Food Security: Report of multiple indicators of disrupted eating patterns and reduced food intake.
Transportation insecurity	Definition based on questions used to establish transportation in the Accountable Health Communities Health-related Screening Tool.
At risk of, witnessing or experiencing interpersonal violence	Definition based on questions used to interpersonal violence in the Accountable Health Communities Health-related Screening Tool.

Qualifying Social Risk Factors for Pilot Program Eligibility

Eligibly Category	Age	Physical/Behavioral Health Criteria (at least one, per eligibility category)
Adults	21+	Two or more chronic conditions. Chronic conditions* that qualify an individual for pilot enrollment include: • BMI over 24 • Blindness • Chronic cardiovascular disease • Chronic pulmonary disease • Congenital anomalies • Chronic disease of the alimentary system • Substance abuse disorder • Chronic endocrine and cognitive conditions • Chronic musculoskeletal conditions • Chronic mental illness • Chronic neurological disease • Chronic renal failure • Repeated incidents of emergency department use (defined as more than four visits per year) or hospital admissions * In accordance with Social Security Act Section 1045(h)(2).

Pregnant Women	n/a	• Multifetal gestation • Chronic condition likely to complicate pregnancy, including hypertension and mental illness • Current or recent (month prior to learning of pregnancy) use of drugs or heavy alcohol • Adolescent ≤ 15 years of age • Advanced maternal age ≥ 40 years of age • Less than one year since last delivery • History of poor birth outcome including: • Preterm birth • Low birth weight • Fetal death • Neonatal death
Children	0-3	• Neonatal intensive care unit graduate • Neonatal Abstinence Syndrome • Prematurity, defined as births hat occur at or before 36 completed weeks gestation • Low birth weight, defined as weighing less than 2500 grams or 5 lbs., 8 oz. at birth • Positive mental depression screen at infant well-visit
	0-20	One or more significant uncontrolled chronic conditions or, one or more controlled chronic conditions with a high risk of becoming uncontrolled due to unmet social need including: • Asthma • Diabetes • Underweight or overweight/obesity as defined by having a BMI in the 85th percentile for age and gender • Developmental delays • Cognitive 67 impairment • Substance use disorder • Behavioral/mental health diagnosis (including a diagnosis under DC: 0-5) • Attention deficit/hyperactivity disorder • Learning disorders • Experiencing three or more categories of adverse childhood experiences (e.g., psychosocial, physical or sexual abuse or household disfunction related to substance abuse, mental illness, parental violence or criminal behavior in household) • Enrolled in North Carolina's foster care or kinship placement system