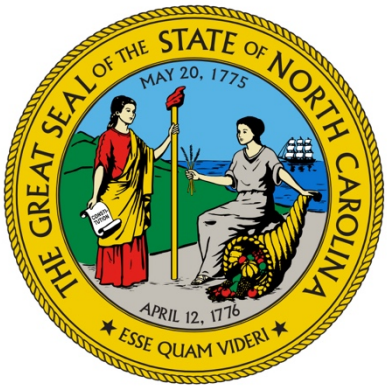

North Carolina's Healthy Opportunities Pilots: A Review of Proposed Design for Interested Stakeholders

North Carolina Department of Health and Human Services

February 15, 2019

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I. Introduction

The Healthy Opportunities Pilots (the Pilots) present an unprecedented opportunity to 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 to cover the cost of select Pilot services related to housing, food, transportation and interpersonal safety that directly impact the health outcomes and health care costs of enrollees in two to four geographic areas of the state.

The Pilots create an unprecedented opportunity to establish and evaluate a systematic approach to integrating the provision of evidence-based non-medical services into the delivery of health care. If shown to be effective after rigorous evaluation, the North Carolina Department of Health and Human Services (DHHS, or the Department) will look to systematically integrate Pilot services into NC Medicaid Managed Care on an ongoing basis statewide.

The purpose of this paper is to describe the preliminary program design for the Healthy Opportunities Pilots for interested stakeholders, including human service organizations (e.g., community-based organizations and social service agencies), health care providers, care management entities, advocates and others. This paper serves as a companion to the Healthy Opportunities Pilots Request for Information (RFI), which looks to solicit feedback from potential Pilot partners and other interested stakeholder on considerations related to Pilot design and implementation, and to solicit information specifically to inform a Pilot service fee schedule, as described in more detail in this paper.

Section II offers foundational background on the State's Medicaid transformation, the role of the Healthy Opportunities Pilots and the Medicaid Managed Care program.

Section III provides a detailed overview of the Pilots, including key player's roles and responsibilities, the Department's efforts to define and price Pilot services, and steps the Department is taking to ensure accountability for this investment. This section provides more detail on the Lead Pilot Entity's roles and responsibilities in recognition of the novel role this entity will play in the Pilots and health care and human service landscape.

The brief concludes with a review of opportunities for public input. Details on qualifying criteria for the Pilots, allowable Pilot services and other aspects of Pilot evaluation and financing are included as Appendices.

II. Medicaid Transformation

Medicaid Transformation & The Central Role of Healthy Opportunities Pilots

DHHS is committed to improving the health and well-being of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses both medical and non-medical drivers of health. Health is affected by many factors beyond the medical care provided within the four walls of a hospital or clinic.

While access to high-quality medical care is critical, research shows that up to 80 percent of a person's health is determined by social and environmental factors and the behaviors that emerge as a result.[1] A substantial body of research has established that having an unmet resource need—including experiencing housing instability,[2] food insecurity,[3] unmet transportation needs,[4] and interpersonal violence or toxic stress[5,6]—can significantly and negatively impact health and well-being, as well as increase health care utilization and costs.[7,8]

Addressing those needs can potentially improve health and lower health care costs. For example, research indicates that providing housing assistance to adults who have physical and/or behavioral co-morbidities and are experiencing homelessness decreases unnecessary use of hospital care and associated health care costs.[9,10] Similarly, reducing the presence of asthma triggers (such as moldy carpets and broken air conditioners) in a child's home can reduce hospital visits and related costs.[11,12]

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[1] Booske, B.C., Athens, J.K., Kindig, D. A., et al. Different Perspectives for Assigning Weights to Determinants of Health. University of Wisconsin Population Health Institute. February 2010

[2] A. Simon, et al. "HUD Housing Assistance Associated with Lower Uninsurance Rates and Unmet Medical Need." Health Affairs, June 2017.

[3] A.Coleman-Jensen, et al., Household Food Security in the United States in 2012, Economic Research Report No. 155 (Sept. 2013); Food Res. & Action Ctr., Food Hardship in America 2012 (Feb. 2013).

[4] S. Syed, B. Gerber, L. Sharp. "Traveling Towards Disease: Transportation Barriers to Health Care Access." Journal of Community Health. October, 2013.

[5] H. Resnick, R. Acierno, D. Kilpatrick. "Health Impact of Interpersonal Violence: Medical and Mental Health Outcomes." Journal of Behavioral Medicine, 1997.

[6] V. Felitti, et al. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults—The Adverse Childhood Experiences Study." American Journal of Preventive Medicine. May 1998.

[7] B. C. Booske, J. K. Athens, D. A. Kindig et al., Different Perspectives for Assigning Weights to Determinants of Health (University of Wisconsin Population Health Institute, Feb. 2010).

[8] L. M. Gottlieb, A. Quiñones-Rivera, R. Manchanda et al., "States' Influences on Medicaid Investments to Address Patients' Social Needs," American Journal of Preventive Medicine, Jan. 2017 52(1):31–37.

[9] Srebnik, D. et al. A Pilot Study of the Impact of Housing First–Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services. American Journal of Public Health. 2013.

[10] Sadowski, L. et al. "Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults." Journal of the American Medical Association. May, 2009;301(17):1771-1778.

[11] Gruber, KJ et al. Removing asthma triggers and improving children's health: The Asthma Partnership Demonstration Project. Annals of Allergy, Asthma and Immunology, 2016. Available: https://www.annallergy.org/article/S1081-1206(16)30086-2/fulltext.

[12] Krieger JW. Takaro TK. Song L. Weaver M. The Seattle-King County Healthy Homes project: A randomized, controlled trial of a community health worker intervention to decrease exposure to indoor asthma triggers. Am J Public Health Apr. 2005;95:652–659 Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3281289/#B53

However, much of the research conducted to date has evaluated discrete interventions for specific, high-need populations, leaving unanswered critical questions regarding whether— and how—to scale and sustainably fund the integration of non-medical services into the health care system for the entire population.

With this in mind, North Carolina is launching as part of its Medicaid Transformation efforts Healthy Opportunities Pilots. As described in detail in Section III, the Pilots create an unprecedented opportunity for payers, providers, and community-based organizations to have the tools, infrastructure and financing to integrate non-medical services directly linked to health outcomes into the delivery of care. Recognizing that North Carolina is breaking new ground with the Heathy Opportunity Pilots, the Department will rigorously evaluate them to assess their effectiveness and identify key elements that should be continued on an ongoing basis and extended statewide in the Medicaid program.

The Pilots have been authorized by the federal Centers for Medicare & Medicaid Services (CMS) for a five-year period, from Nov. 1, 2019 through Oct. 31, 2024, as part of North Carolina's 1115 demonstration waiver, which also provides North Carolina federal authority to transition its fee-for-service delivery system to Managed Care.

Overview of Medicaid Managed Care & The Care Management Approach

The Department is transitioning North Carolina Medicaid and NC Health Choice programs from predominantly fee-for-service to Medicaid Managed Care, as directed by the North Carolina General Assembly.[13]

The Healthy Opportunities Pilots will be embedded into the Medicaid Managed Care program, which will launch in late 2019. In particular, Prepaid Health Plans (PHPs) serving the regions in which Pilots operate will play a key role in overseeing and operating them, including by integrating the authorization and delivery of Pilot services into their care management strategies. This section provides a brief review of the structure of the Managed Care program and expectations for care management.

Overview of Managed Care

In Managed Care, the Department will remain accountable for all aspects of the Medicaid and NC Health Choice programs, but will delegate the direct management of certain health services and financial risks to Managed Care plans, or PHPs, that will contract with providers to deliver services for their members. PHPs will offer two types of products:

- Standard Plans: Launching in late 2019, most Medicaid beneficiaries, including nearly all pregnant women and children, will enroll in a standard plan that covers their physical health, behavioral health, long-term services and supports (LTSS) and pharmacy services.[14]

[13] Session Law 2015-245 has been amended by Session Law 2016-121; Section 11H.17.(a) of Session Law 2017-57, Part IV of Session Law 2017-186; Section 11H.10.(c) of Session Law 2018-5; Sections 4-6 of Session Law 2018-49; and Session Law 2018-48.

- Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans (BH I/DD Tailored Plans): North Carolina will launch specialized Managed Care plans, called BH I/DD Tailored Plans, starting in 2021. These are designed for those with significant behavioral health needs and intellectual/developmental disabilities (I/DD). They will also provide integrated physical health, LTSS and pharmacy services, plus a more robust behavioral health and I/DD benefit package than standard plans.

Care Management Requirements

Both Standard Plans and BH I/DD Tailored Plans must meet high standards for providing care management services, which the Department views as foundational to the success of North Carolina's Medicaid transformation, supporting high-quality delivery of the right care at the right place and at the right time.

The Department's care management approach emphasizes the importance of local care management—care management that is performed at the site of care, in the home, or in the community where face-to-face interaction is possible. To achieve this vision, Standard Plans will be required to contract with local care management entities including:

- ***Advanced Medical Homes (AMHs).*** Primary care practices certified as AMHs that have the capacity to provide advanced care management capabilities (known as Tier 3 practices) will take on direct responsibility for providing care management for Medicaid beneficiaries at the local level either independently or in collaboration with a Clinically Integrated Network or other partner.[15] *For more information on the State's Advanced Medical Home policies, see the Advanced Medical Home Provider Manual.*
- ***Local Health Departments (LHDs).*** PHPs will be required to contract with LHDs for the provision of care management for high-risk pregnant women and for at-risk children. *For more information on the State's Local Health Department policies in Medicaid Managed Care, see the Management of High-Risk Pregnancies and At-Risk Children in Managed Care Program Guide.*

For beneficiaries who do not receive care management from a Tier 3 AMH or LHD, the PHP may either directly provide care management services or delegate these responsibilities to a different qualified local entity.

Beginning in 2021, BH I/DD Tailored Plans will be required to contract with designated Tier 3 AMHs, community-based care management agencies, or other local entities to provide care management to the maximum extent possible for all enrollees. For more information on BH I/DD Tailored Plan care management, see the recent *Stakeholder Update on Tailored Plan Design*.

[14] Standard plans will serve most Medicaid beneficiaries eligible for full Medicaid benefits who are not dually eligible for Medicare and Medicaid.

[15] The Department plans to add an additional AMH Tier – Tier 4 – in or after 2021. Tier 4 will encompass advanced value based payment arrangements beyond those contemplated in Tier 3. For the purposes of the Pilots, Tier 4 practices and care managers will be expected to participate in the same way as those in Tier 3.

Standard Plan Requirements to Support Healthy Opportunities

All PHPs will have a role in addressing non-medical factors that drive health outcomes and costs. For example, PHPs must implement standardized screening questions to assess all enrollees' non-medical needs, such as unstable housing, insufficient food, lack of transportation and experience with interpersonal violence.

If an unmet need is identified, PHPs will connect beneficiaries to community resources and, in high-need cases, provide more support, such as connecting to a local food bank or domestic violence shelter. A statewide tool, called NCCARE360, administered by the Foundation for Health Leadership and Innovation, will serve as a platform to identify community resources, create a coordinated network of community providers, refer and connect patients directly to community resources, and track and monitor those referrals.

In addition to these statewide efforts, in select regions of North Carolina, PHPs will work with community-based human service organizations to launch the Healthy Opportunity Pilots, as described in more detail in the remainder of this paper. The Pilots will build on the standard requirements that apply to all PHPs, creating the opportunity to provide more intensive support navigating the human service system; allowing Medicaid funds to cover the cost of selected Pilot services; and providing resources to a regional entity and affiliated community-based organizations to establish the infrastructure needed to work with health care providers and PHPs.

NCCARE360: A Statewide Resource and Referral Platform to Bridge Health Care and Social Services

NCCARE360 is a statewide, resource and referral platform that makes it easier for providers, insurers and human service organizations to connect people with the community resources they need to stay healthy. The platform is a public-private partnership of a broad group of stakeholders, and will be administered by the Foundation for Health Leadership and Innovation (FHLI). While the Department will not administer NCCARE360, the tool is an integral component of the State's Healthy Opportunities Strategy. NCCARE360 has two innovative, core functionalities:

1. **Resource Database**: NCCARE360 will include a robust directory of community-based resources throughout the State accessible online and through a call center.
2. **Referral Platform**: Health care providers, insurers and human service providers using NCCARE360 will be able to connect people who have identified unmet needs with resources in their communities. The referral platform will allow users to perform "closed-loop referrals," giving them the ability to track whether individuals accessed the community-based services to which they were referred.

PHPs will be expected to use NCCARE360 as their platform to connect patients directly to needed community resources, and to track and monitor those referrals.
The State anticipates that NCCARE360 will be an essential community organization and technology infrastructure for the Healthy Opportunities Pilots, and will be critical for creating a single statewide, uniform platform for tracking referrals to community resources.

II. Healthy Opportunities Pilots

Healthy Opportunities Pilots Overview

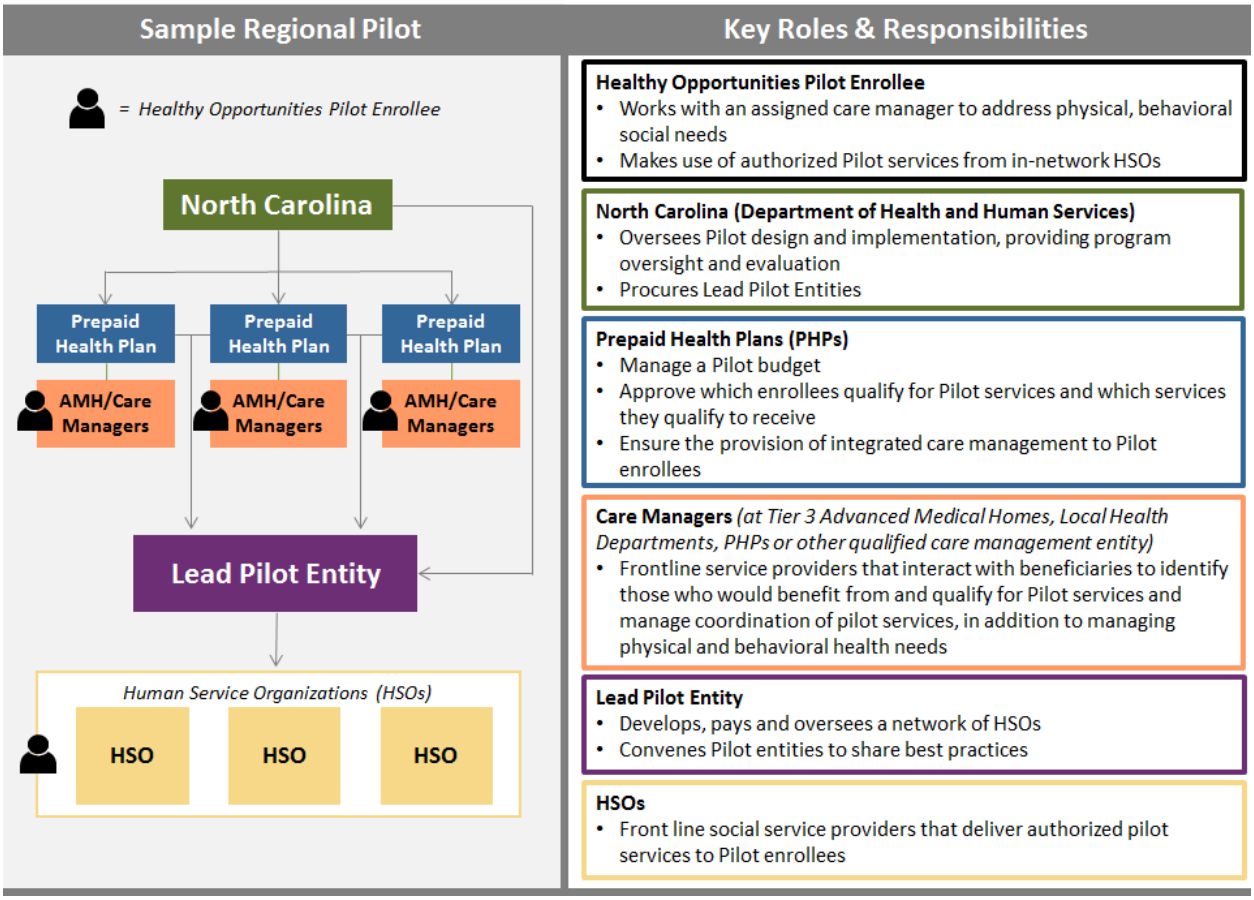
As described above, North Carolina will implement an innovative five-year Pilot program that enables PHPs to pay for non-medical services directly related to health outcomes for high-need Medicaid enrollees living in selected communities (see Section IV for additional detail on the Pilot procurement process and timing).

These Healthy Opportunities Pilots will operate in two to four geographic areas of the state and, where they are operational, PHPs will be able to pay for CMS-approved evidence-based interventions designed to reduce costs and improve health by directly addressing housing instability, transportation insecurity, food insecurity, interpersonal violence and toxic stress. All PHPs who have enrollees in the geographic regions of the Pilots will be required to participate.

Within any given Pilot region, many players will have important and varying roles in the successful implementation of a Pilot:

- **All PHPs** serving a Pilot region will be responsible for approving which enrollees qualify for Pilot services (based on State-defined criteria) and which services they qualify to receive. PHPs will work closely with care managers at Tier 3 AMH practices, LHDs and other contracted local care management entities to carry out these responsibilities.
- **Care managers** who work with Medicaid enrollees on their full range of physical, behavioral and non-medical needs will help identify people who would benefit from and qualify for Pilot services, propose services that may benefit the enrollee, and manage and coordinate services.
- **Human service organizations**, (HSOs) also known as community-based organizations or social service agencies, will deliver Pilot services to Medicaid enrollees. In recognition that it will be a new experience for human service organizations to receive Medicaid payments for their services, the Pilot design calls for providing them with resources to build the necessary infrastructure and expertise.
- A **Lead Pilot Entity** will play a critical role in bridging the gap between health and human service organizations, contracting with PHPs to manage a network of HSOs providing Pilot services. The Department will procure one Lead Pilot Entity for each Pilot region and provide resources to support the establishment of the HSO network.

Visual 1: Key Pilot Players and Their Roles & Responsibilities



The federal government has authorized up to $650 million in total Medicaid funding for the Pilots over the five-year life of the waiver. The funds can be used:

- To cover the cost of the federally-approved Pilot services, and
- To support, in the early years of the demonstration, capacity building for Lead Pilot Entities and to strengthen the ability of human services organizations to participate effectively in the Pilots. Up to $100 million of the $650 million in Pilot funds may be used for these infrastructure investments.

Since the Pilots have been created to test the effectiveness of evidence-based interventions, the Department and the federal government have established a rigorous approach to evaluation. It includes rapid cycle assessments to determine what implementation strategies and which services are proving most and least effective and allow the Department to re-deploy resources to those that are most promising.

In the later years of the Pilots, part of the design will be a Sequential Multiple Assignment Randomization Trial (SMART) methodology to understand when and who would most benefit from services of escalating intensity. The Department will also conduct a summative evaluation to assess the

impact of the services on health outcomes and health care costs of participating populations. Additionally, over time, the Department will increasingly rely on value-based payments, tying payments to PHPs, Lead Pilot Entities, and HSOs to their performance against a range of process and outcome-based benchmarks.

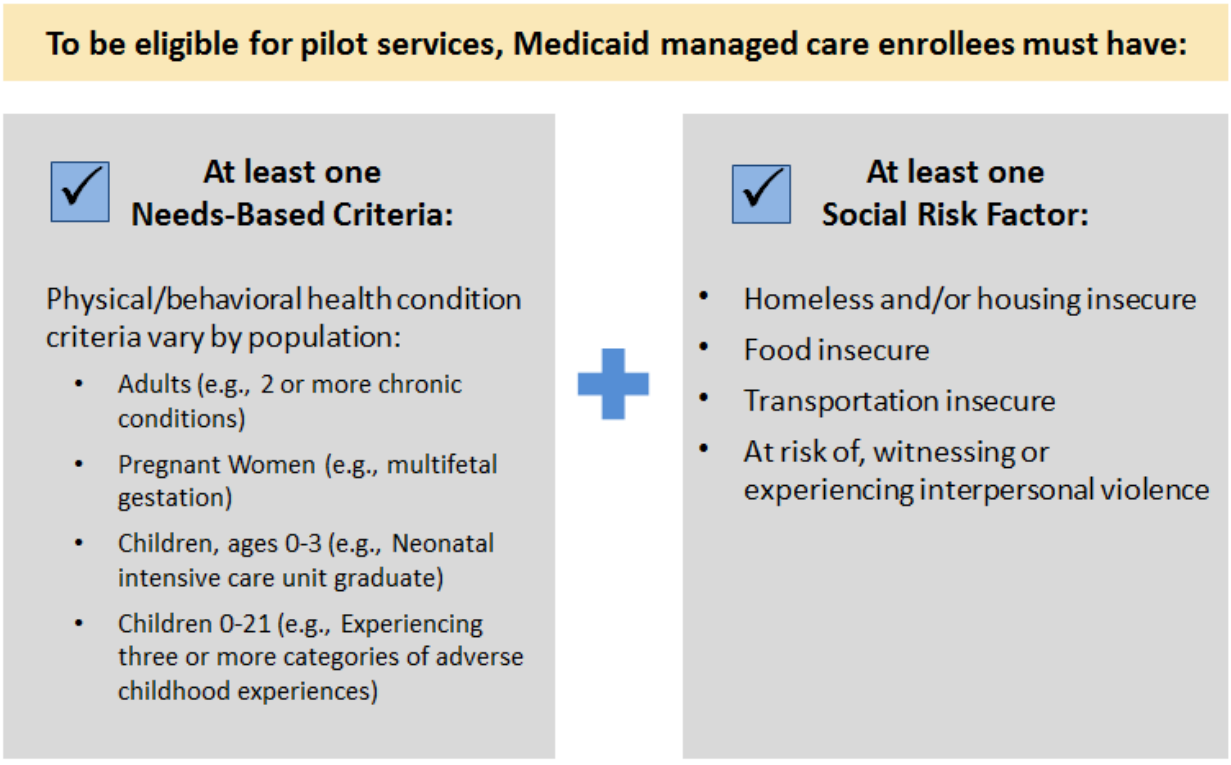
Pilot Qualifying Criteria, Services & Expenditures

Pilot Qualifying Criteria

Pilot services are intended to be used by Medicaid enrollees who can benefit most from them, to maximize the benefit of limited Pilot funding. With this in mind, the Department worked with the federal government to establish qualifying criteria for Pilots that takes into account a person's health status (including both physical and behavioral health) and unmet non-medical needs.

Specifically, a Medicaid enrollee must meet at least one State-defined health criteria and at least one State-defined social risk factor, as depicted below in Visual 2 and further detailed in Appendices A and B. In addition, a Medicaid enrollee must be enrolled in Managed Care to be eligible for Pilot services.

Visual 2: Overview of Qualifying Criteria for Pilot Services:



Pilot Services

PHPs will use Pilot funds to pay for a list of federally-approved Pilot services, found in Appendix C. The allowable services fall into one of the four key domains identified by the Department as a priority (such

as, housing, food, transportation and interpersonal safety) and were selected because there is evidence indicating that addressing them will have a positive impact on health outcomes and health care costs. Examples of approved services include:

Table 1: Overview of Approved Pilot Services by Priority Domain

Priority Domain	Overview of Approved Services
Housing	• Targeted tenancy support and sustaining services • Housing quality and safety improvements • One-time payments to secure housing (e.g., first month's rent and security deposit) • Short-term post hospitalization housing
Food	• Linkages to community-based food services (e.g., Supplemental Nutrition Assistance Program (SNAP)/Women, Infants and Children (WIC) application support, food bank referrals) • Nutrition and cooking coaching/counseling • Healthy food boxes • Medically tailored meal delivery

Transportation	• Linkages to transportation resources
	• Payment for transit to support access to Pilot services, including:
	  o Public transit
	  o Taxis, in areas with limited public transit infrastructure

Interpersonal Violence/Toxic Stress	• Linkages to legal services for interpersonal violence (IPV) related issues • Services to help individuals leave a violent environment and connect with behavioral health resources • Evidence-based parenting support programs • Evidence-based home visiting services

Playing it Out on the Ground: Examples of How Pilot Services May be Used to Improve Health Outcomes for Beneficiaries Enrolled in the Healthy Opportunities Pilot

Housing Modifications. A Medicaid-enrolled child with asthma has repeated visits to the emergency department (ED) because of asthma attacks brought on by her apartment's moldy carpet or broken air conditioner. This is both traumatic for the child and her family, and costly for the health system. Pilot funds can be used to replace her carpet or fix her air conditioner, improving control of her asthma and reducing ED visits and hospitalizations.

Improved Access to Healthy Foods. A Medicaid-enrolled adult with diabetes lives in a rural food desert, does not have a car or access to public transportation and experiences repeated hospitalizations due to uncontrolled high blood sugar. This interrupts his life, increases the risk of further medical complications and increases medical expenditures. The Pilot can finance travel vouchers to a community-based food pantry or a medically-targeted healthy food box, providing access to nutritious medically-appropriate food not otherwise available. With sustained access to healthy food, this Medicaid enrollee can better control his diabetes, leading to fewer complications and hospitalizations.

Addressing Interpersonal Violence. A Medicaid-enrolled pregnant woman with hypertension experiences intimate partner violence, creating concerns for her personal safety, contributing to her high blood pressure and adding a risk factor for a poor birth outcome. Through the Pilot she is connected to a domestic violence shelter and targeted services as part of her ongoing medical treatment to help her transition out of her traumatic condition (e.g. helping her secure safe housing and establishing a new phone number). This helps control her hypertension and leads to an improved birth outcome.

Financing

As referenced above, the federal government has authorized up to $650 million over the five-year life of the Medicaid 1115 waiver for the Pilots, including up to $100 million in the early years of the Pilot for infrastructure investments. Federal funding for the Healthy Opportunities Pilots will be available throughout the duration of the five-year waiver, from Nov. 1, 2019 through Oct. 31, 2024.

These resources offer an unprecedented opportunity for North Carolina to finance innovation and strengthen the infrastructure required to better integrate health and non-medical services. The majority of the resources will be used to finance the cost of providing Pilot services. In addition, PHPs, HSOs and the newly created Lead Pilot Entities will have new responsibilities and opportunities under the Pilots that require funding. While the Department continues to work through the details of Pilot financing, an overview of the funding system follows:

- **PHPs*:*** Each PHP serving a Pilot region will qualify for a capped allotment (outside of their Medicaid Managed Care capitation payments) from which to finance Pilot services for their beneficiaries. The funding will be spent on approved Pilot services in accordance with State guidelines addressing eligibility criteria, Pilot service definitions, Pilot service payment rates and the circumstances under which specific services should be provided to an enrollee.

In addition, the Department will establish parameters that require a minimum share of Pilot funds be dedicated to each of the four key domains of non-medical need and across populations (including adults, pregnant women and children), ensuring that PHPs do not use Pilot funding exclusively for a single domain, such as housing, or a single population, such as adults, who have high health care costs and utilization.

  - This will help to ensure that Pilot funding is invested in a range of interventions—including those that result in financial return on investment and improved population health over the longer-term.
  - PHPs will have a several tools to help ensure they do not breach the cap, including limiting enrollment in the Pilot, if necessary.
  - Payments to PHPs will also include an administrative fee, to be determined by the Department. The administrative fee will be a component of the Pilot service payment, but most of the payments to PHPs must be used to pay for the delivery of Pilot services.

- **Tier 3 AMHs, Local Health Departments and other Local Care Management Entities.** Care management entities will receive payments from PHPs for the Pilot-related responsibilities they will assume, in addition to care management payments they already receive, to the extent that a PHP has delegated care management responsibilities to a Tier 3 AMH, LHD or other qualified care management entity.
- **Lead Pilot Entities.** The Department recognizes that Lead Pilot Entities require funding for start-up activities, such as hiring and training staff, establishing initial contracts with HSOs, and supporting HSOs in preparing to participate in the Pilots and the infrastructure and information technology (IT) systems needed to support Pilot activities on an ongoing basis. For the first two years after a Lead Pilot Entity is awarded a contract, it will have access to a limited amount of capacity building funding for activities that the Department will further define during procurement. Once the Pilots are operational, Lead Pilot Entities will also qualify for funding for their ongoing administrative and operational expenses, including their responsibility to pay HSOs on behalf of PHPs for specific Pilot services.
- **HSOs**. Many HSOs are likely to require support to prepare for participation in the Pilot, including hiring staff to provide Pilot services, providing training and developing systems for submitting invoices to bill for Pilot services. The Department anticipates working with the Lead Pilot Entities to provide some direct capacity building funding to HSOs before they begin providing Pilot services. When HSOs start providing services, they will be reimbursed by the Lead Pilot Entity, which, in turn will secure payment from the PHP whose enrollee received the Pilot service.

Pilot funds cannot pay for duplicative services or displace services already available through other sources of federal funding and should be used to maximize access to services already supported through other Federal and State funding streams. This is required by the terms of North Carolina's waiver, and reflects North Carolina's strong interest in maximizing use of Pilot funding to finance and evaluate interventions that otherwise would not be possible. For example, if a Pilot enrollee can access tenancy support and sustaining services through the United States Department of Housing and Urban Development (HUD) and the U.S. Department of Veterans Affairs (VA) Housing Assistance for Veterans

program, the Pilot funds might be used to help the veteran find out about and enroll in this program, but not to provide supportive housing services that otherwise are covered.

Roles & Responsibilities

North Carolina Department of Health and Human Services

The Healthy Opportunities Pilots are a key component of the Department's strategy to develop an innovative, whole-person centered and well-coordinated system of care that addresses both medical and non-medical drivers of health. The Department will design, operationalize and oversee the Healthy Opportunities Pilots. The Department is designing the Pilots in collaboration with stakeholders and local communities based on input gathered through a variety of channels, including the accompanying Request For Information

The Department will oversee implementation of the Pilots throughout the course of the demonstration, including contracting with and paying PHPs a capped allocation of Pilot funding, on top of their capitation rates, to cover the cost of approved Pilot services. Additionally, the Department will select Lead Pilot Entities through a competitive procurement process and contract directly with awardees (as further described in Section IV). The Department will administer capacity-building funds to Lead Pilot Entities in the first two years of the demonstration and will require the Lead Pilot Entity to distribute a portion of those funds to the HSOs in their network.

To ensure accountability for state and federal funding spent on the Pilots, the Department will:

- Work with the University of North Carolina, Cecil G. Sheps Center for Health Services Research to execute rigorous rapid cycle assessments and a summative evaluation of the Pilots (as described further in "*Evaluation of the Healthy Opportunities Pilots");*
- Incorporate value-based payment arrangements into payments to PHPs and Lead Pilot Entities that will increasingly be linked to operational ability, enrollees' health outcomes and health care costs (as described further in "*Linking Payments to Outcomes (Value-Based Payments*");
- Provide program oversight and monitoring to ensure the highest level of program integrity and PHPs', Lead Pilot Entities' and HSOs' compliance with contractual obligations (as described further in "*Program Oversight*"); and
- Develop a data strategy to promote information exchange among all Pilot entities to evaluate the Pilots, manage the value-based payment program and oversee program integrity (as described further in "*Data Exchange to Support Pilot Implementation*"). PHPs, care management entities, Lead Pilot Entities and HSOs will be subject to data collection and reporting requirements to support these efforts.

Prepaid Health Plans (PHPs)

A defining feature of North Carolina's Healthy Opportunities Pilots is their integration into Medicaid Managed Care and the central role of the PHP. Operating the Pilots through PHPs will offer scalability and a smooth transition to statewide implementation after the conclusion of the Pilots. It also ensures

that PHPs retain ultimate responsibility for managing and integrating an enrollee's care using a whole-person approach that considers physical health, behavioral health, pharmaceutical needs and non-medical needs.

All PHPs serving beneficiaries who live in a Pilot region will be required to participate in the Pilots. As described in the financing section, each participating PHP will have a capped allocation of funding outside of its Medicaid Managed Care capitation rate dedicated to Pilot services. Because PHPs are accountable for Pilot funds, they are ultimately responsible for approving which of their enrollees qualify for Pilot services and authorizing the delivery of specific Pilot services. though care managers will play a significant role in assessing eligibility and identifying recommended services which will aid the PHPs in making these determinations.

Care Managers

A major goal of North Carolina's Medicaid transformation is to develop a community-based, single point of accountability for integrated, whole-person care. A strong care management platform, rooted in primary care, is foundational for achieving this vision and improving Medicaid enrollees' health. North Carolina established principles for its Medicaid care management strategy, including that Medicaid enrollees will have access to appropriate care management and coordination across primary care, specialty care and community-based resources.

The Department is requiring PHPs to contract with all AMH Tier 3 practices and LHDs for care management – with only limited exceptions. The Department will be monitoring PHPs against a requirement that the majority of all care management be delivered locally —performed at the site of care, in the home, or in the community where face-to-face interaction is possible.[16] As noted in the *Overview of Medicaid Managed Care & the Care Management Approach*, this approach predominantly relies on local entities to deliver care management services, provided through a Tier 3 AMH, LHD or a local care management entity.[17]

The Healthy Opportunities Pilots are designed to be embedded within the Medicaid care management infrastructure, leveraging care managers who will be responsible for enrollees' physical, behavioral and social needs. For all assigned enrollees, care managers will perform standard functions such as: completing a comprehensive assessment, developing a person-centered care plan, and managing physical and behavioral health needs. In Pilot regions, these same care managers will also have new Pilot responsibilities for which they will receive additional funding. As detailed further below, the additional Pilot responsibilities of care managers include:

[16] See Programmatic Guidance: https://files.nc.gov/ncdma/documents/Providers/Programs_Services/amh/AMH_Programmatic_Guidance_Contracting_12.17.18.pdf

[17] If an enrollee does not have such a locally-based care manager, the PHP is responsible for ensuring local care management, including Pilot-related responsibilities for such enrollees. PHPs will have flexibility in how they meet these requirements and may delegate care management to an approved local community-based organization that meets State requirements.

- **Assessing Criteria and Need for Pilot Services.** While PHPs will maintain ultimate responsibility for determining which of their enrollees will receive which Pilot services, care managers will leverage their interactions with enrollees to collect information needed for this determination and assess which Pilot services are most appropriate. In particular, care managers will review whether an enrollee's physical or behavioral health conditions meet Pilot criteria (see Appendix A) and assess the enrollee's social needs related to Pilot eligibility. The care manager will recommend specific Pilot services that are the lowest intensity level that can reasonably be expected to meet their needs based on the enrollee's responses and State-developed guidelines.
- **Obtain Consent and Authorization for Pilot Services.** As part of the evaluation process, care managers will need to obtain consent from the enrollee to participate in the Pilot, as well as authorization from the enrollee's PHP to provide specific Pilot services.
- **Coordinating and Tracking Pilot-Related Care.** Care managers will develop a person-centered care plan that reflects an enrollee's health care-related needs, goals and preferences. For Pilot enrollees, the care plan also will include Pilot-related goals and an approach for connecting the enrollee to authorized Pilot services. Care managers will use NCCARE360 to identify appropriate HSOs (but may also consult with experts at the Lead Pilot Entity, as needed) and to make an electronic referral. Care managers will then monitor and track an enrollee's access to Pilot services and progress against their care plan goals. For the Pilot, the care manager will be required to:
    - Review the enrollee's experience in the Pilot, and the Pilot services the enrollee is receiving at least every three months to assess if they are meeting the enrollee's needs. If the current mix of services is not meeting the enrollee's needs, the care manager will recommend a higher intensity of services.
    - Reassess the enrollee's eligibility for Pilot services based on the qualifying criteria every six months.

  Care managers will need to consult regularly and directly with HSO staff who are likely to have regular and ongoing contact with the enrollee.

Lead Pilot Entities

Lead Pilot Entities serve as the central connection between PHPs and HSOs and support creation of an effective network of HSOs. Lead Pilot Entities will facilitate collaboration with health care and human service providers, and invest in HSOs - growing their capacity to serve. The Lead Pilot Entity will be in a unique position to empower both health care and social service organizations to better meet the needs of their community. The Lead Pilot Entities are new entities, which the Department will procure in 2019.

TYPES OF ENTITIES

It is critical that a Lead Pilot Entity be rooted in its community, understand its community dynamics, and be able to pull together a range of organizations with disparate expertise and experience to build partnerships, and create a smooth experience for Pilot enrollees. The Department anticipates that a

Lead Pilot Entity will be an existing community-based social service organization, health organization, or a partnership of such organizations.

While the Department will accept a Lead Pilot Entity bid from many entity types, entities likely best positioned for the Lead Pilot Entity role include: community-based organizations, county-based public agencies, LHDs, social services or multiservice agencies, community health centers, community health foundations, or associations. A partnership of agencies may come together to form a Lead Pilot Entity. In this case, the Department expects there to be a single point of accountability for contracting purposes and for all interactions with the Department.

The Lead Pilot Entity will be expected to establish or have a governance structure, such as an advisory board, through which it can seek feedback and approval from key community partners. While Lead Pilot Entities may partner with health systems, the Department anticipates that Lead Pilot Entities will not be led by them, but will be anchored by an experienced community-based health or social service organization. PHPs and Local Management Entity-Managed Care Organizations (LME-MCOs) may not serve as Lead Pilot Entities.

The Department plans to evaluate potential Lead Pilot Entities based on their ability to meet the organizational capacities and fulfill the functions of a Lead Pilot Entity. Among other responsibilities, Lead Pilot Entities will be expected to demonstrate:

- Strong knowledge of, experience in and connections to local community resources and organizations;
- Capacity to identify community resources across all four Healthy Opportunities domains (such as, housing, food, transportation and interpersonal safety);
- Financial stability, as indicated by an organization's current financial position based on audited financial statements and projection of future financial stability;
- Capacity to invoice and receive payment from PHPs, pay HSOs and serve as a responsible fiscal steward of government resources, and evidence of sound financial management practices;
- Ability to function in a region that crosses county lines; and
- Experience performing key roles and responsibilities, as further described below.

In its capacity as the Lead Pilot Entity, this organization will not interact directly with Pilot beneficiaries, but rather will play a behind-the-scenes role by establishing a network of HSOs to provide Pilot services and connecting PHPs and HSOs.[18]

As described in more detail in the *Pilot Qualifying Criteria, Services and Financing* section, for the first two years after a Lead Pilot Entity is awarded a contract, it will have access to targeted funds to build its capacity and that of participating HSOs to adequately prepare for launching its Pilot region.

[18] The organization selected as the Lead Pilot Entity is not prohibited, however, from having additional beneficiary-facing capacities.

DEFINING PILOT GEOGRAPHIC BOUNDARIES AND SERVICE OFFERINGS

Lead Pilot Entities will define their Pilot's geographic boundaries based on their assessment of the reach of counties they can effectively serve. The geographic area served by a Pilot must:

- Consist of at least two contiguous counties that preferably cover both urban and rural areas;[19] and
- Not cross over more than one Medicaid PHP region.

Note: The Pilot region does not need to fill an entire Medicaid PHP region.

The Department envisions Pilot regions offering services in each priority domain—housing, food, transportation and interpersonal violence/toxic stress. At the time of application submission, Lead Pilot Entities must ensure their network of HSOs can offer at least one approved service within each domain.

By the time service delivery begins, it is expected that Lead Pilot Entities' HSO networks will have the capacity to deliver all Pilot services in all domains. However, the Department will take into consideration that Lead Pilot Entities developing HSO networks in rural and underserved areas may face a greater challenge and require more time to meet this expectation. In these cases, Lead Pilot Entities should develop strategies that enable HSOs in the region to provide new or expanded services, including attracting HSOs from other regions to come into the area given new funding streams and technical assistance from the Lead Pilot Entity. The Lead Pilot Entity and the Department will finalize which services its Pilot region will offer during the procurement and contracting process.

CONTRACTING WITH PHPS

As described above, all PHPs will be required to participate in any Pilot operating in regions it serves. Each PHP will enter a contract with each Lead Pilot Entity serving its enrollees outlining the terms by which the PHP and Lead Pilot Entity will collaborate to execute the Pilot. This contract will address, for example, how information and payments will be exchanged between the two entities and how they will collaborate to discuss and improve Pilot policies and processes over time. The Department is considering providing a model contract to standardize the policies and processes between PHPs and Lead Pilot Entities.

DEVELOPING, CONTRACTING WITH AND PREPARING AN HSO NETWORK

The Lead Pilot Entity will establish and maintain a network of HSOs to promote the availability of services for enrollees within the geographic boundaries of the region. Lead Pilot Entities will conduct outreach to potential HSOs across all four priority domains to educate them about the Pilots and explore the opportunity to contract as an HSO.

[19] The Office of Management and Budget defines "urban" areas as a statistical geographic entity consisting of the county or counties associated with at least one core (urbanized area or urban cluster) of at least 10,000 population, plus adjacent counties containing the core. North Carolina's Office of Rural Health defines 30 out of 100 counties in North Carolina as "urban," and the remaining 70 as "rural."

Lead Pilot Entities will determine whether an HSO meets qualifications prior to entering into a contract in accordance with state guidelines. Lead Pilot Entities may also establish their own HSO qualifications but would need State approval. The Department expects HSOs to be assessed on criteria such as:

- Demonstrated capacity to provide Pilot services and commitment to delivering high-quality services that support improved health outcomes and whole-person care;
- Timeliness of services to support the delivery of high-quality care to enrollees in the right place at the right time;
- Demonstrated readiness to participate successfully in Pilots and effectively serve beneficiaries with complex physical, behavioral and social needs;
- Staff education, experience and knowledge;
- Hours of operation that meet the needs of most Pilot beneficiaries;
- Physical access and accommodations for individuals with disabilities, inclusive of behavioral health issues;
- Cultural and linguistic competency;
- Non-discriminatory practices, including the willingness to serve all enrolled Pilot beneficiaries referred to their organization;
- Licensing and accreditation that meets industry standard or may be applicable to service provider;
- Demonstrated history of responsible financial stewardship and integrity; and
- Willingness to comply with all reporting and oversight requirements.

Lead Pilot Entities will also be expected to provide education and technical assistance to ensure HSOs understand and can meet their contractual obligations, including how to collect and submit data about services provided to Medicaid Pilot enrollees to allow for payment, evaluation and program oversight.

PROVIDING FINANCIAL STEWARDSHIP AND QUALITY/PERFORMANCE OVERSIGHT

As described in *Pilot Qualifying Criteria, Services & Financing*, Lead Pilot Entities will be responsible for paying HSOs based on the services delivered to Pilot enrollees. As a key player in managing and paying the HSO network, the Lead Pilot Entity will serve an essential role in accounting for Medicaid expenditures for Pilot services and be accountable for the quality of those services. To that end, the Lead Pilot Entity will need to have infrastructure in place to:

- Account for and track payments from PHPs to the Lead Pilot Entity;
- Account for and track payment distribution to HSOs for services delivered to Pilot enrollees;
- Report to the Department and PHPs on payments processed for services delivered to Pilot enrollees;
- Account for, track and report its expenditures on capacity building, including funds provided to HSOs for capacity building; and
- Monitor HSO performance, quality of services delivered and beneficiary satisfaction with HSOs for purposes of evaluation and distribution of value-based payments; and, where issues are identified, intervene through corrective action and/or terminating services that do not meet appropriate quality standards.

ADVISING CARE MANAGERS

The Lead Pilot Entity, serving as the expert on its provider network, will be expected to ensure staff are available to advise care managers during Pilot enrollees' care plan development on available Pilot services and appropriate in-network HSO(s) based on an enrollee's circumstances. While care managers will generally be able to rely on NCCARE360 for identifying HSOs and making referrals, Lead Pilot Entity staff can supplement the platform, troubleshooting with care managers if challenges arise and working in partnership with care managers in resolving barriers to care.

CONVENING AND ESTABLISHING LEARNING COMMUNITIES OF PILOT ENTITIES

The Lead Pilot Entity will support coordination and communication within its Pilot region by convening PHP and HSO representatives on a regular basis, identifying issues arising in Pilot implementation and potential solutions, sharing best practices and facilitating stronger relationships between HSOs and the health care sector. Lead Pilot Entities will also be expected to participate in statewide learning communities to ensure best practices are shared across regions. These learning communities will be hosted by the Department and include representatives from PHPs, Lead Pilot Entity representatives, HSO representatives, and other stakeholders such as enrollees and health care providers.

Human Services Organizations

Human service organizations, including community-based organizations and social service agencies, will deliver Pilot services to Medicaid beneficiaries—providing locally based, high-quality services. For the first time, Medicaid will be able to pay HSOs systematically for these services and invest in expanding HSOs' capacity. The Pilots will invest in North Carolina's communities and the organizations on-the-ground that can address the health-related needs that directly impact health outcomes and cost. The Pilots offer a unique and compelling opportunity for HSOs to play an essential role in improving the health of their community's members in a more structured and supported way.

To participate in a Pilot, an HSO will need to provide Pilot services in a Pilot region, be deemed as qualified by the Lead Pilot Entity, and enter into a contract with the Lead Pilot Entity. HSOs will not have to be enrolled as Medicaid providers to participate in the Pilots. However, the Department envisions working toward enrolling select HSOs in later Pilot years, to better position HSOs for long-term sustainability after the conclusion of the Pilots.

Key HSO responsibilities include:

- **Delivering Pilot Services.** The success of the Pilots will rely on HSOs providing high-quality, efficient, and timely services to Pilot enrollees (for additional detail on federally-approved Pilot services, see Appendix C). HSOs will receive electronic referrals from care managers through the NCCARE360, allowing them to know an enrollee requires services. Under many circumstances, HSO staff are likely to have ongoing contact with the enrollee and should remain in contact with the enrollee's care manager to help with tracking an enrollee's progress, care plan updates and

reassessments of need for Pilot services. To facilitate payment for services delivered, HSOs will need to complete an invoice and submit it to the Lead Pilot Entity.

- **Participating in Readiness Activities, Training and Convenings.** While some HSOs may have experience with processes, like identifying insurance status and billing for discrete services, many will not. The Department and the Lead Pilot Entity will provide technical assistance and education to HSOs in Pilot areas to ensure their success. HSOs participating in a Pilot will need to partake in these educational and training opportunities to ensure their readiness for and success in the Pilots. They will also be expected to actively participate in convenings facilitated by the Lead Pilot Entity and the Department that will promote communication, sharing of best practices, quality improvement and coordination across all Pilot entities.

HSOs will be required to undertake corrective actions, as necessary and required by the Lead Pilot Entity, to ensure continued compliance with Pilot requirements and continued Pilot participation.

Defining & Pricing Pilot Services

The Healthy Opportunities Pilot will test evidence-based interventions designed to improve health and reduce costs by addressing housing instability, transportation insecurity, food insecurity, interpersonal violence and toxic stress for eligible Medicaid enrollees. This is the first time Medicaid funding will systematically pay for these types of services for a broader swath of Medicaid enrollees, necessitating the development of a Pilot service fee schedule that is transparent, fair, and sustainable for HSOs providing pilot services, PHPs, and the Department.

The Department seeks information from North Carolina's HSOs and other interested parties to inform this schedule, which will be based on the federally-approved services listed in Appendix C. Questions in the complementary *Request for Information* are designed to solicit information on the nature of services HSOs provide, how HSOs define these services and the cost of providing these services. As described further below, the 1115 demonstration waiver requires the Department to develop three types of payment structures: fee-for-service, cost-based reimbursement and bundled payments.

The Department will submit a fee schedule to federal officials by July 1, 2019, as required in the 1115 demonstration waiver, and then work closely with CMS as the agency reviews and approves the fee schedule.

Types of Service Reimbursement

In the Healthy Opportunities Pilots, HSOs providing Pilot services will be paid through fee for service payments, cost-based reimbursement, or bundled payments, depending on the service. The table below defines the payment types in greater detail:

Table 2: Payment Types for Service Reimbursement

Payment Type	Description	Likely Services for Payment Type
Fee for Service	A rate set prior to care delivery for a discrete service. May include a base rate and adjustments for region, acuity, etc.	• Services for which costs may be reasonably calculated in advance (e.g., medically-tailored meals; consultation with a specialized social worker to address specific need)
Cost-based reimbursement	A payment for actual billed cost of services. May include guardrails such as maximums per beneficiary or per type of service.	• Services for which prices are set by a contractor (e.g., first month's rent and security deposit; extermination or mold remediation services)
Bundled payments	A rate set prior to care delivery for an estimated bundle of services that may be delivered in a variety of ways depending on beneficiary needs.	• Services provided as part of a longitudinal relationship (e.g., troubleshooting problems with landlord or roommates; skill-building on fostering healthy parent-child relationships) • Services that meaningfully address a need when provided in a complementary package

Bundled Payment Design

Developing payment rates for bundles of complementary services provides flexibility for HSOs to deliver a variety of services together to address an enrollee's specific needs. In designing bundled payments, the Department hopes to:

- Reinforce care delivery approaches that integrate and co-locate services;
- Reduce administrative burden associated with fee for service billing and siloed funding streams;[20]
- Support HSO sustainability by accurately reflecting providers' costs in bundled payment rates, and
- Offer a pathway for HSOs to eventually take risk and share in savings, in preparation for further value-based payment initiatives in later years of the Pilot.

The Department aims to develop bundled payments that reflect and amplify, as much as possible, approaches to care integration that are already working in communities. The Department envisions

[20] Note that during the demonstration, HSOs will be asked to submit more specific data on services delivered within bundled payments to facilitate evaluation of the bundled payment approach.

potentially including in a service bundle costs related to both staff time and discrete, tangible goods (such as a medical condition-specific food box, bus pass, etc.) when appropriate, while acknowledging the challenge of predicting the precise cost and bundle of services that will be well-suited for individuals with unique and evolving needs. In light of this, the Department seeks to understand through the *Request for Information* how North Carolina organizations are already delivering complementary services and solicit suggestions for how organizations might be paid through a bundled payment for those care models.

Tools for Accountability & Implementation

Evaluation of the Healthy Opportunities Pilots

To ensure accountability for state and federal funding, the Department has developed a preliminary design for rigorously evaluating the Pilots, including rapid cycle assessments and a summative evaluation delivered upon the conclusion of the demonstration. The Department intends to introduce a process, called *sequential multiple assignment randomized trials*, or SMART design, to randomize higher intensity services during the later years of the Pilots to allow for the most reliable evaluation findings.

As part of this design, beneficiaries enrolled in the Pilots will be assigned to the lowest intensity of Pilot services that can reasonably be expected to meet their needs, will be intensified as deemed necessary by a care manager's reassessment of beneficiary needs and contingent on a randomization process. It is important to note that all beneficiaries enrolled in the Pilots, even if they are receiving the least intensive Pilot services, are receiving enhanced services beyond what is available for Medicaid enrollees not in the Pilot regions. Additionally, the randomization will inform an understanding of when and who would benefit most from services of escalating intensity. This learning will inform scaling of the interventions to the statewide level.

Comprehensive evaluation of the Pilots will be conducted by the University of North Carolina, Cecil G. Sheps Center for Health Services Research. All Pilot participating entities will be expected to support the data collection and reporting efforts needed to support the Department's evaluation efforts. Participating Pilot entities will not need to conduct their own evaluations of the Pilots.

RAPID CYCLE ASSESSMENTS

Throughout the duration of the waiver, the Department will use a rapid cycle assessment approach to gain real-time insights on whether Pilot services are having their intended effects on targeted enrollees. As the Departments collects data and examines the results, it can modify or discontinue implementation strategies and services that are less effective to ensure funding is spent on effectively delivering services with a demonstrated impact on health status, outcomes and cost.

As part of the preliminary evaluation design, the Department will evaluate the Pilots against key process metrics (e.g., the adequacy of the Lead Pilot Entity's HSO network and number of Pilot enrollees) and outcomes-based metrics (e.g., measurable improvement in Pilot enrollees' self-reported unmet health-related resource needs or health care utilization) related to Pilot implementation annually. Appendix D

illustrates additional example metrics and their shift from process to outcomes over the course of the demonstration.

SUMMATIVE EVALUATION

In addition to the rapid cycle assessments, the Department has proposed a rigorous summative evaluation of the Pilots to assess their global impact on enrollees and the Medicaid program. Unlike the rapid cycle assessment, which is designed to drive real-time modifications, the summative evaluation will focus more granularly on evaluating and understanding who benefits from enhanced services and what services have a demonstrated impact on outcomes and cost. This will ensure services are scalable across diverse Pilots and regions and appropriate to incorporate into Medicaid Managed Care statewide after the conclusion of the demonstration. North Carolina will consider incorporating findings from the summative evaluation into the Medicaid program through various means, including changes to State Plan benefits, payment models, including value-based payments, risk adjustment based on social needs, or other methods.

Linking Payments to Outcomes (Value-Based Payments)

Payments to PHPs and Lead Pilot Entities for Pilot services will increasingly be linked to operational ability, enrollees' health outcomes and health care costs through various value-based payment (VBP) arrangements over the course of the demonstration, including:

- *Incentives*: Additional payments earned for meeting specified targets;
- *Withholds*: A portion of payments withheld up front and paid out only once Lead Pilot Entities and PHPs meet specified benchmarks; and
- *Shared savings*: Payments distributed based on savings accrued from decreases in total cost of care attributable to the Pilot program for interventions and populations expected to have a decreased cost of care (e.g., adults with high cost and high utilization).

The key outcome metrics tied to the value-based payment arrangements for PHPs and Lead Pilot Entities will evolve over the course of the five years to reflect the stage of the demonstration. A summary follows:

- *Year 1:* Incentive payments promote successful Pilot implementation,
- *Year 2:* Incentive payments offer rewards for delivering Pilot services to meaningful numbers of enrollees,
- *Year 3:* Withhold payments are tied to ensuring that enrollees unmet resource needs are addressed (for example, ensuring that services to promote housing security in fact increase housing security),
- *Year 4:* Withhold payments are linked to health outcomes, ensuring that addressing unmet resource needs improves enrollee health, and
- *Year 5:* Shared saving payments offer rewards for reducing overall health care costs for the Pilot population. Costs savings will be based on subset of Pilot enrollees whose services are likely to result in decreased medical expenses in the short term. This assures that Lead Pilot Entities are

not penalized for delivering effective, evidence-based upstream interventions that result in a financial return on investment over the long term.

Additional detail on example metrics to support value-based payments for Lead Pilot Entities and PHPs is available in Appendix E.

The Lead Pilot Entity will be required to share any earned incentive or withhold payments received in Years 2 through 5 with its HSO network and will work with the Department to develop a methodology for distributing payments to high-performing HSOs. The Department expects Lead Pilot Entities to measure their HSOs using metrics such as successful delivery of Pilot services to enrollee to receive Pilot services, timeliness of service delivery and enrollee satisfaction scores.

PHPs, Lead Pilot Entities, and HSOs will be responsible for collecting data and reporting required to execute the above responsibilities.

Program Oversight

North Carolina is committed to maintaining the highest standards of program integrity throughout its Medicaid program, including for the Healthy Opportunities Pilots. The State's standards and requirements to uphold program integrity will leverage and adapt the rigorous compliance, oversight, and program integrity requirements developed for PHPs and extend responsibilities to the Lead Pilot Entities and HSOs. Proposed strategies the Department will employ to assure the Pilots' program integrity include:

- Receiving a quarterly report from PHPs describing what Pilot services have been authorized and how much has been spent from a PHP's limited Pilot funds;
- Ensuring services are being delivered as represented, including requiring PHPs and/or Lead Pilot Entities to analyze and report on invoice data and to conduct on-site visit verification procedures that proactively verify qualifications and services provided;
- Ensuring action is taken to address any identified areas of non-compliance, overpayment or fraudulent behavior; and
- Reviewing PHPs' and Lead Pilot Entities' compliance with Pilot obligations as part of the State's regular Medicaid program integrity audits.

PHPs, care management entities, Lead Pilot Entities, and HSOs will be responsible for collecting data and reporting required to execute the above responsibilities.

Data Exchange to Support Pilot Implementation

Successful implementation of the Healthy Opportunities Pilots will require the exchange of a substantial amount of information among a wide range of entities, many of them new to the Medicaid program, for a variety of purposes. The Department will leverage its data strategy to support AMHs, as described further in *Data Strategy to Support the Advanced Medical Home Program in North Carolina*, to support the Healthy Opportunities Pilots, as it will be critical that Pilot-related information be embedded into

existing Managed Care tools and care management platforms. The Pilots will require additional and unique data exchange. The Department is developing a Healthy Opportunities Pilot data strategy that addresses an information exchange needed to:

- Assess need for Pilot services, requiring PHPs and care managers to access and exchange physical, behavioral and social needs information for select Medicaid Managed Care enrollees;
- Support care managers connecting enrollees to HSOs and track their progress against care plan goals related to addressing unmet health-related resource needs;
- Send and receive invoices and payments between HSOs, Lead Pilot Entities and PHPs; and
- Enable PHPs, care managers, Lead Pilot Entities, and HSOs to report data that will support the Department's efforts to evaluate the Pilots, manage the value-based payment program, and oversee program integrity**.**

Conclusion

North Carolina's Healthy Opportunities Pilots present an unprecedented opportunity to test the impact of providing selected evidence-based interventions to Medicaid enrollees. . The Pilots provide payers, providers, and community-based organizations with the necessary tools, infrastructure and financing to sustainably integrate non-medical services into the delivery of care to improve health outcomes and reduce health care costs on a population scale. Recognizing that North Carolina is breaking new ground with the Heathy Opportunity Pilots and that many organizations within a community will need to work together to effectively execute these Pilots, the Department has released a complementary Healthy Opportunities Pilot Request For Information (RFI). The Department welcomes and encourages feedback from potential Pilot partners and other interested stakeholders on options and considerations related to Pilot design and implementation.

III. Overview of Procurement Process and Pilot Timing

The Department has released a complementary Healthy Opportunities Pilot Request For Information (RFI) to solicit feedback from potential Pilot partners and other interested stakeholders on options and considerations related to Pilot design and implementation. Responses will inform the design of the program and the development of the Lead Pilot Entity Request for Proposal, scheduled for release in mid-2019. It will also inform the design of the Pilot service fee schedule, which the Department will submit to CMS by July 1, 2019, as required in the 1115 waiver, and then work closely with CMS as the agency reviews and approves the fee schedule.

The Department anticipates awarding Lead Pilot Entity contracts at the end of 2019 and expects Pilots to begin delivering services in late 2020.

The following table outlines in greater detail a timeline of Pilot procurement and launch:

Table 4: Current Timeline for Pilot Procurement, Launch and Service Delivery

Milestone	Date
Request for Information (RFI)	
RFI released	Feb. 15, 2019
RFI responses due	March 15, 2019
Request for Proposals (RFP)	
RFP released	Mid 2019
RFP responses due	Fall 2019
Lead Pilot Entity contracts awarded	Late 2019
Pilot Planning and Service Delivery	
Post-award planning and preparation for PHPs, care management entities and Lead Pilot Entities	8-12 Months Post-Contract Awards
Expected Pilot service delivery launch	Late 2020
Availability of funding for Healthy Opportunities Pilot services in the waiver approved by CMS on Oct. 24, 2018, ends[21]	Oct. 31, 2024

[21] Federal funding for the Healthy Opportunities Pilots will be available throughout the duration of the five-year waiver, beginning Nov. 1, 2019 through Oct. 31, 2024.

IV. Appendices

Appendix A: Needs-Based Criteria

Eligibility Category	Age	Needs-Based Criteria (at least one, per eligibility category)
Adults	22+	• 2 or more chronic conditions. Chronic conditions that qualify an individual for Pilot enrollment include: BMI over 25, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, substance use disorder, chronic endocrine and cognitive conditions, chronic musculoskeletal conditions, chronic neurological disease and chronic renal failure, in accordance with Social Security Act section 1945(h)(2). • Repeated incidents of emergency department use (defined as more than four visits per year) or hospital admissions.
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 by births that occur at or before 36 completed weeks gestation • Low birth weight, defined as weighing less than 2,500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit
	0-21	• One or more significant uncontrolled chronic conditions or one or more controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need, including: asthma, diabetes, underweight or overweight/obesity as defined by having a BMI of <5th or >85th %ile for age and gender, developmental delay, cognitive impairment, substance use disorder, behavioral/mental health diagnosis (including a diagnosis under DC: 0-5), attention-deficit/hyperactivity disorder, and learning disorders

		• Experiencing three or more categories of adverse childhood experiences (e.g. Psychological, Physical, or Sexual Abuse, or Household dysfunction related to substance abuse, mental illness, parental violence, criminal behavioral in household) • Enrolled in North Carolina's foster care or kinship placement system

Appendix B: Social Risk-Factors

Risk Factor	Definition
Homelessness and Housing Insecurity	Homelessness, as defined in 42 C.F.R. § 254b(h)(5)(A), and housing insecurity, as defined based on questions used to establish housing insecurity in the Accountable Health Communities Health Related Screening Tool.
Food Insecurity	As defined by the US Department of Agriculture commissioned report on Food Insecurity 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: Reports of multiple indications of disrupted eating patterns and reduced food intake
Transportation Insecurity	Defined based on questions used to establish transportation insecurities in the Accountable Health Communities Health Related Screening Tool.
At risk of, witnessing, or experiencing interpersonal violence	Defined based on questions used to establish interpersonal violence in the Accountable Health Communities Health Related Screening Tool.

Appendix C: Approved Healthy Opportunities Pilots Services

Service Sub-Category	Enhanced Case Management Services
Housing	
Housing and Tenancy Supports	• Assisting the individual with identifying preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration • Supports to assist the individual in budgeting for housing/living expenses, including financial literacy education on budget basics and locating community based consumer credit counseling bureaus. • Assisting the individual to connect with social services to help with finding housing necessary to support individual in meeting their medical care needs. This Pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan. • Assisting the individual with housing application and selection process, including filling out housing applications and obtaining and submitting appropriate documentation • Assisting the individual to develop a housing support plan based on upon the functional needs assessment, including establishing measurable goal(s) as part of the overall person centered plan • Developing a crisis plan, which must identify prevention and early intervention services if housing is jeopardized • Participating in the person centered plan meetings to assist the individual in determination or with revisions to housing support plan • Assisting the individual to review, update and modify his or her housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers • Assisting the individual to complete reasonable accommodation requests as needed to obtain housing • Supporting individuals in the development of independent living skills, such as skills coaching, financial counseling and anger management • Connecting the individual to education and training on tenants' and landlords' role, rights, and responsibilities • Assisting in reducing risk of eviction by providing services such as services that help the enrollee improve his or her conflict resolution skills, coaching, role-playing and communication strategies targeted towards resolving disputes with landlords and neighbors; communicate with landlords and neighbors to reduce the risk of eviction; address biopsychosocial behaviors that put housing at risk; and provide ongoing support with activities related to household management • Assessing potential health risks to ensure living environment is not adversely

	affecting occupants' health • Providing services that will assist the individual with moving into stable housing, including arranging the move, assessing the unit's and individual's readiness for move-in, and providing assistance (excluding financial assistance) in obtaining furniture and commodities. This Pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. • Providing funding related to utility set-up and moving costs provided that such funding is not available through any other program. This Pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources.
Housing Quality and Safety Improvement Services	• Repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost-effective method of addressing occupant's health condition, as documented by a health care professional, and remediation is not covered under any other provision such as tenancy law. This Pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. • Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs) when necessary to ensure occupant's health and modification is not covered under any other provision such as the Americans with Disabilities Act.
Legal Assistance	• Assistance with connecting the enrollee to expert community resources to address legal issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions. This Pilot service does not include legal representation or payment for legal representation.
Securing House Payments	• Provide a one-time payment for security deposit and first month's rent provided that such finding is not available through any other program. This payment may only be made once for each enrollee during the life of the demonstration, except for state determined extraordinary circumstances such as a natural disaster. This Pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources.
Short-Term Post-Hospitalization	• Post-hospitalization housing for short-term period, not to exceed six [6] months, due to individual's imminent homelessness provided that such a service is not available under any other programs. Temporary housing may not be in a congregate setting. To the extent temporary housing services are available under

	other programs, this service could cover connecting the individual to such program and helping them secure housing through that program.
Food	
Food Support Services	• Assist the enrollee with applications for SNAP and WIC • Assist the enrollee with identifying and accessing school based food programs • Assist the enrollee with locating and referring enrollees to food banks or community-based summer and after-school food programs • Nutrition counseling and education, including on healthy meal preparation • Providing funding for meal and food support from food banks or other community based food programs, including funding for the preparation, accessibility to, and food for medical condition specific "healthy food boxes," provided that such supports are not available through any other program. Meal and food support services must be provided according to the enrollee's care plan and must not constitute a "full nutritional regimen" (three meals per day per person).
Meal Delivery Services	• Providing funding for targeted nutritious food or meal delivery services for individuals with medical or medically-related special dietary needs provided such funding cannot be obtained through any other source. Meals provided as part of this service must be provided according to the enrollee's care plan and must not constitute a "full nutritional regimen" (3 meals per day, per person).
Transportation	
Non-emergency health-related transportation	• Transportation services to social services that promote community engagement. • Providing educational assistance in gaining access to public or mass transit, including access locations, Pilot services available via public transportation, and how to purchase transportation passes. • Providing payment for public transportation (i.e., bus passes or mass transit vouchers) to support the enrollee's ability to access Pilot services and other community-based and social services, in accordance with the individual's care plan. • Providing account credits for cost-effective private forms of transportation (taxi, ridesharing) in areas without access to public transit. Pilot transportation services must be offered in accordance with an enrollee's care plan, and transportation services will not replace non-emergency medical transportation as required under 42 CFR 431.53. Whenever possible, the enrollee will utilize family, neighbors, friends, or community agencies to provide transportation services.
Interpersonal Violence (IPV)/Toxic Stress	
Interpersonal Violence-Related Transportation	• Transportation services to/from IPV service providers for enrollees transitioning out of a traumatic situation.
IPV and	• Assistance with linkages to community-based social service and mental health

Parenting Support Resources	agencies with IPV expertise. • Assistance with linking to high quality child care and after-school programs. • Assistance with linkages to programs that increase adults' capacity to participate in community engagement activities. • Providing navigational services focusing on identifying and improving existing factors posing a risk to the safety and health of victims transitioning out of traumatic situations (i.e., obtaining a new phone number, updating mailing addresses, securing immediate shelter and longer-term housing, school arrangements to minimize disruption of school schedule, connecting enrollees to medical-legal partnerships to address overlap between healthcare and legal needs).
Legal Assistance	• Assistance with directing the enrollee to available legal services within the legal system for interpersonal violence related issues, such as securing a Domestic Violence Protection Order. This Pilot service does not include legal representation or payment for legal representation.
Child-Parent Support	• Evidence-based parenting support programs (i.e., Triple P – Positive Parenting Program, the Incredible Years, and Circle of Security International). • Evidence-based home visiting services by licensed practitioners to promote enhanced health outcomes, whole person care and community integration. • Dyadic therapy treatment for children and adolescents at risk for or with an attachment disorder, or as a diagnostic tool to determine an attachment disorder.

Appendix D: Example Metrics for Rapid Cycle Assessment by Demonstration Year

Year	Approach	Example Metrics
1	Determine Pilots' operational readiness for successful implementation	• Adequacy of Lead Pilot Entity's HSO network • Readiness assessment of Lead Pilot Entity's infrastructure for reimbursing HSOs • Readiness assessment of PHPs' contractual relationships with and infrastructure for reimbursing Lead Pilot Entities
2	Determine Pilots' active implementation and service delivery	• Number of Pilot enrollees • Aggregate measure of utilization of Pilot services • Assessment of payment process functionality (i.e., completion rates, lag times)
3	Determine impact of services on enrollees' unmet health-related resource need	• Metrics used in year 2 • Measurable improvement in Pilot enrollees' self-reported unmet health-related resource need
4	Determine impact of services on enrollees' health outcomes	• Metrics used in year 3 • Evaluation of population/service-specific effectiveness, based on measures of enrollees' health, utilization and cost outcomes (e.g., has there been measurable improvements in reductions of HbA1c scores for adult enrollees with diabetes who are food insecure and received medically tailored meals through the Pilot?)
5	Determine impact on enrollees' healthcare costs	• Metrics used in year 4 • Reductions in total Medicaid spend per enrollee

Note that in Years 3 through 5, the metrics are cumulative, such that both process and outcomes-based metrics are continually being examined.

Appendix E: Example Metrics Supporting Value-Based Payments for Lead Pilot Entities and PHPs

Year	Type of VBP	Type of Metrics for Lead Pilot Entities	Types of Metrics for PHPs
1	Incentive	• Process-related metrics, such as: ○ Establishing provider networks and payment/reporting systems	• Process-related metrics, such as: ○ Completing implementation of a robust Pilot-specific training series for care managers ○ Completion of readiness testing on data collection and reporting systems
2	Incentive	• Service delivery performance metrics, such as: ○ Percentage of Pilot enrollees that have accessed Pilot services ○ Timeliness standards for communications and payments with HSOs ○ HSO satisfaction with Lead Pilot Entity communications and payment ○ Enrollee satisfaction scores with in-network HSOs ○ Access to in-network HSOs with hours of operation that include evenings and weekends	• Reporting, evaluation and performance monitoring metrics, such as: ○ Exceeding timeliness and accuracy standards related o data collection and reporting ○ Developing a system to seamlessly share information and feedback with Lead Pilot Entities to improve their performance
3	Withhold	• Resource outcomes metrics, such as: ○ Improvement in enrollees' self-reported unmet resource needs	• Reporting, evaluation and performance monitoring metrics that support the state's rapid cycle assessments, including timelines of reporting and accuracy standards.
4	Withhold	• Health and utilization outcome metrics that account for population and service type, such as: ○ Reductions in hospital admissions related to adults' uncontrolled diabetes	• Reporting, evaluation and performance monitoring metrics that support the state's rapid cycle assessments, including timelines of reporting and accuracy standards.
5	Shared Savings	• Total cost of care metrics, such as:	• PHPs are rewarded for reductions in total cost of care as savings on medical

		○ Reduction in average total cost of care per enrollee in comparison to a control group (*Note*: Shared Savings will be based on costs of a subset of Pilot enrollees whose services are likely to result in short-term decreased medical expenses, as to not penalize PHPs and Lead Pilot Entities for effective interventions that result in a longer-term ROI.)	and behavioral health service expenditures under their capitated payments.