Community Investment Programs in Other States

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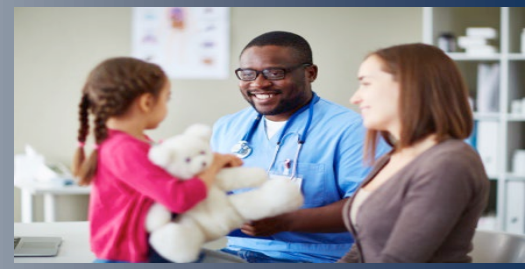

North Carolina's Healthy Opportunities Pilot: An Equity Approach

Maria Ramirez Perez
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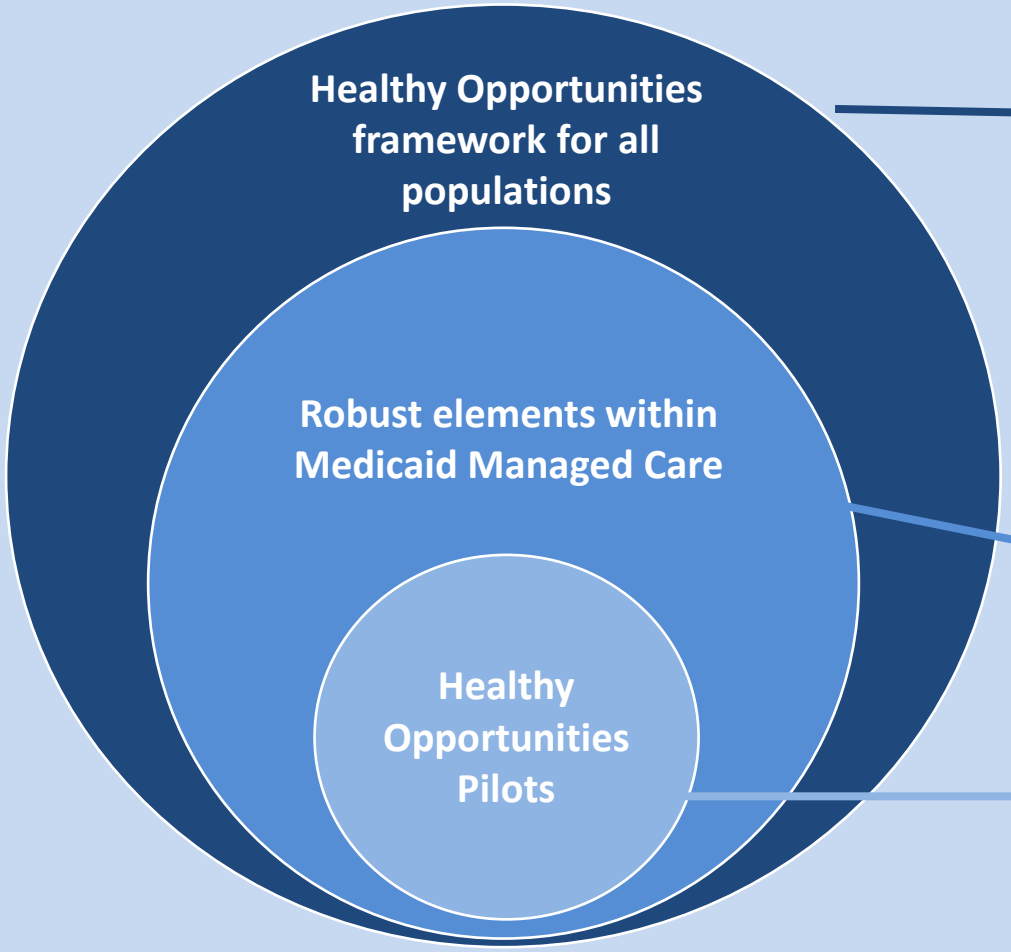
NC DHHS
September

Building Statewide Shared Infrastructure

NC DHHS has built shared assets that can be used across populations, as well as targeted initiatives to build the evidence base, to bridge health care and human services across diverse populations & geographies at scale.



Shared assets and infrastructure across all populations:

- Healthy Opportunities "Hot Spot" Map
- Standardized social needs screening questions
- NCCARE360
- Workforce development – Community Health Workers
- COVID-19 Isolation and Quarantine Supports

Embed shared assets and infrastructure in Medicaid as a base for other payers:

- Care management:
  - Standardized screening questions, NCCARE360, workforce
- Quality strategy
- Value-based payment
- Value added services and in-lieu-of-services
- Community Investments
- Integration with Department partners (DSS, LHDs, SNAP, WIC, etc.)

Targeted initiative to develop systems, financing, and evidence base to drive future policy changes: Healthy Opportunities Pilots

Why Do We Need the Healthy Opportunities Pilots?

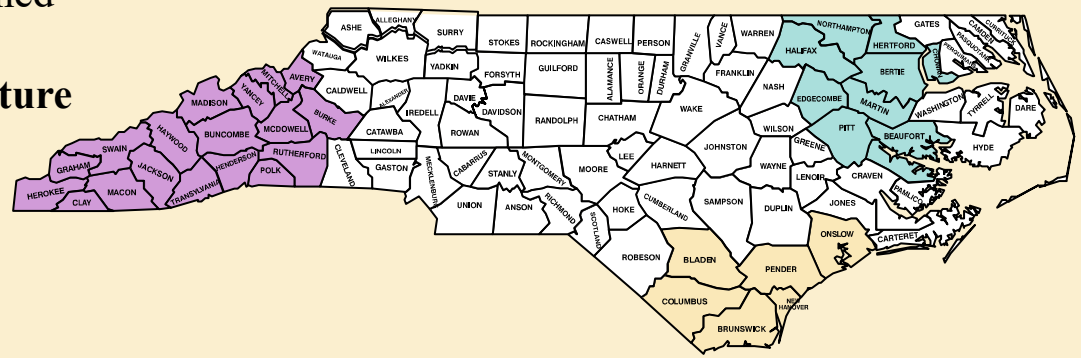
The Healthy Opportunities Pilots (the Pilots) are an unprecedented opportunity to provide selected evidence-based, non-medical interventions to Medicaid enrollees to address social needs within NC Medicaid.

- Access to high-quality medical care is critical, but research shows up to 80 percent of a person's health is determined by social and environmental factors and the behaviors that emerge as a result.
- Pilot entities—including PHPs (MCOs), Care Management Teams (Ex. CINs, LHDs, AMHs), Network Leads, and Human Service Organizations (CBOs)—will all play coordinated but distinct roles to provide "whole person care" to Pilot enrollees.
- The Pilots will test the impact of offering non-medical services on health outcomes and costs, with the ultimate goal of making them statewide offerings.

Healthy Opportunities Pilots (NC HOP) Overview

Healthy Opportunities Pilot Overview

- **NC's 1115 Medicaid transformation waiver** authorizes **up to $650M** in state and federal Medicaid funding for the Healthy Opportunities Pilots
- **Pilot funds are used to:**
  - Pay for 29 **evidence-based, federally-approved, non-medical services** defined and priced in NC DHHS' Pilot fee schedule
  - **Build capacity of local community organizations** and **establish infrastructure** to bridge health and human service providers[1]
- **Pilot Vision and Goals:**
  - Integrate evidence-based, non-medical services into Medicaid to:
    - **Improve health outcomes** for Medicaid members
    - **Promote health equity** in the communities served by the Pilots
    - **Reduce costs** in North Carolina's Medicaid program
  - **Evaluate** which services are highest value & impact for which populations
    - CMS-approved SMART design (randomized trial) to provide rapid-cycle feedback, concluding in a summative evaluation
  - Create **accountable infrastructure**, **sustainable partnerships** and **payment vehicles** that support integrating highest value non-medical services into the Medicaid program sustainably **at scale**



Awarded Healthy Opportunities Network Leads

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

Impact Health

Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

[1] Administrative, care management, and value-based payments are also being made to support and incentivize Pilot entities to perform optimally

Early Successes in HOP's First Year

NC DHHS and its partners have developed and launched a roadmap to create an ecosystem model of addressing unmet resource needs.

Serving Members and the Community:

- Delivered over 110,000 services to 12,500+ members
- Continuous steady increase in enrollees and services delivered

Creating Infrastructure, Partnerships, and Payments for Sustainability:

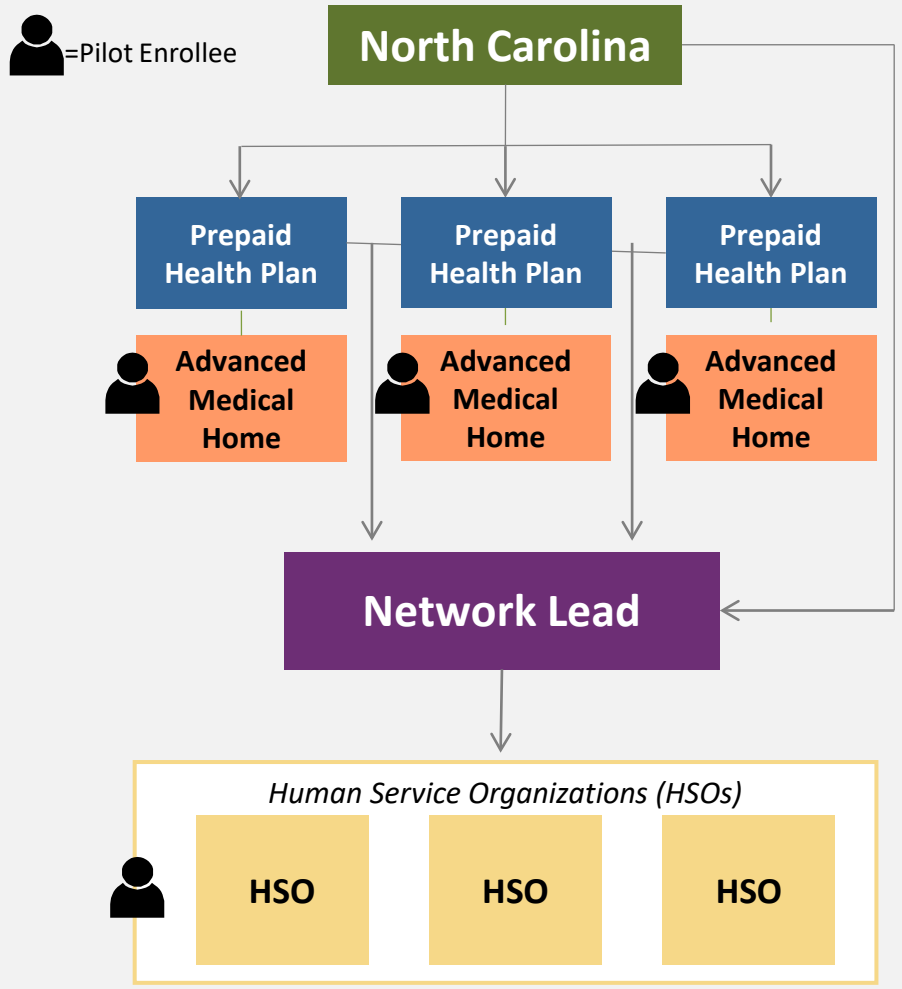
- Collaboration across sectors: 5 health plans, 23 care management organizations, 3 Network Leads, 150 HSOs
- Created an additional, sustainable funding source for HSOs, as well as necessary assistance via Network Leads and model contracts
- Adapted technology systems to support non-medical services and capturing data to evaluate
- Created non-medical service definitions, fee schedule, invoicing, claims, and encounters

Lessons Learned

- Phased Implementation
- Real-Time Monitoring and Community Engagement
- Importance of the Network Lead Organizations
- Necessary Investment in HSO Participating and Onboarding
- Data Exchange Platforms
- Invest in Member Engagement

Healthy Opportunities Pilots: How Do They Work?

Sample Regional Pilot



Key Entities' Roles in the Pilot

5 Prepaid Health Plans:

- Approve which enrollees qualify for Pilot services and which services they qualify for
- Manage a Pilot budget and pay HSOs for delivery of Pilot services

23 Care Management Entities:

- Interact directly with members to: assess for eligibility and needed services, refer to an HSO, manage coordination of Pilot services and track enrollee progress over time

3 Network Leads:

- Develop and oversee a network of HSOs and provide ongoing technical assistance/support to HSO network
- Receive, track and validate invoices from HSOs and work with PHP to ensure payment

150 Human Service Organizations:

- Deliver Pilot services, submit invoices and receive reimbursement for services delivered
- Support identification of potential Pilot-enrollees by connecting them to their PHP or Care Manager

[1] Administrative, care management, and value-based payments are also being made to support and incentivize Pilot entities to perform optimally

Who is Eligible for HOP Services?

To qualify for pilot services, Medicaid managed care enrollees must live in a Pilot Region and have:

✓ **At least one Physical/Behavioral Health Criteria**
(varies by population)

+

✓ **At least one Social Risk Factor**

North Carolina's "Pilot Service Fee Schedule" defines and prices 29 services across the following domains:

Housing

Transportation

Food

Interpersonal Violence/ Toxic Stress

Cross-Domain

California Advancing & Innovating Medi-Cal (CalAIM)

Dana Durham, Division Chief
Managed Care Quality and Monitoring

September 13, 2023

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Context: What is California Advancing and Innovating Medi-Cal (CalAIM)?

CalAIM is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. The goals of CalAIM include:

- Implement a whole-person care approach and address social drivers of health.
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation.
- Create a consistent, efficient, and seamless Medi-Cal system.

Enhanced Care Management (ECM) and Community Supports

ECM and Community Supports went live in January 2022.

Enhanced Care Management (ECM)

A **Medi-Cal managed care benefit** that addresses the clinical and non-clinical needs of high-need, high-cost individuals through the coordination of services and comprehensive care management.

Community Supports

Services addressing the social drivers of health that **Medi-Cal managed care plans are strongly encouraged, but not required, to provide** as medically appropriate and cost-effective alternatives to utilization of other services or settings such as hospital or skilled nursing facility admissions.

For more information, please see DHCS's ECM and Community Supports website.

Enhanced Care Management: DHCS Policy Overview

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What is Enhanced Care Management (ECM)?

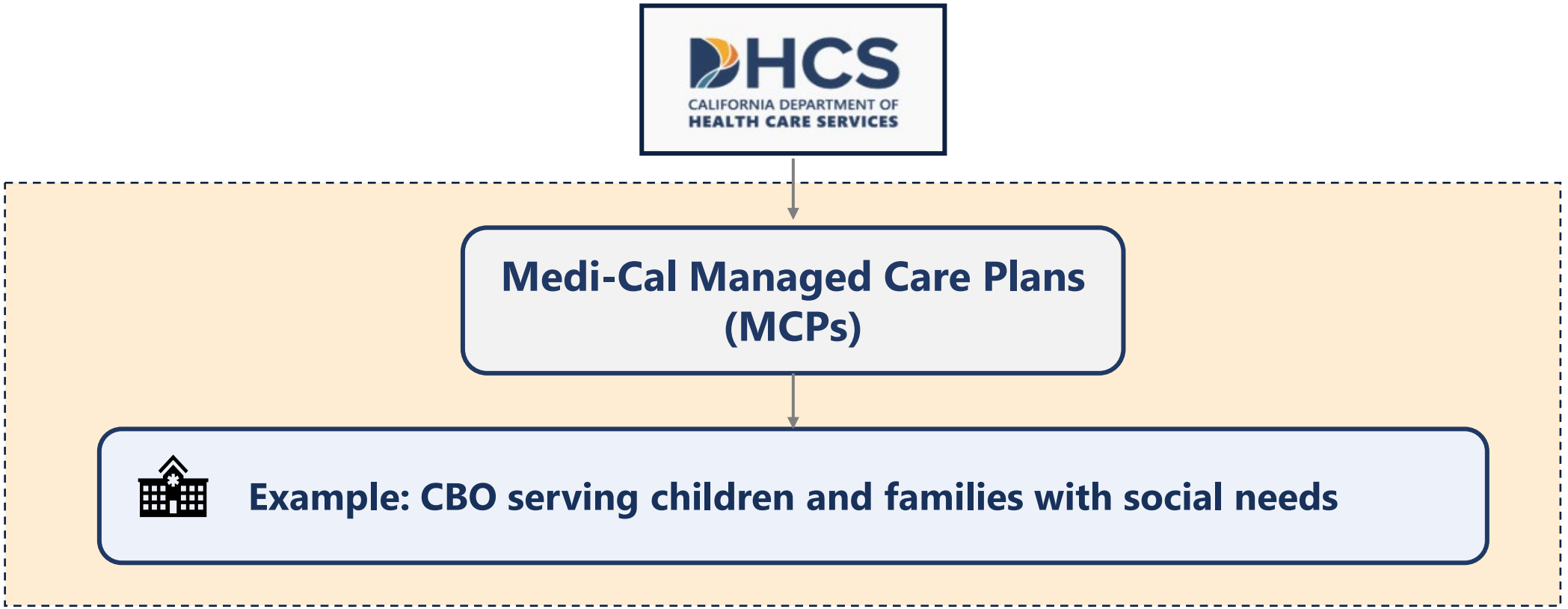
ECM is a statewide Medi-Cal Managed Care Plan (MCP) benefit to support comprehensive care management for Members with complex needs.

- DHCS' vision for ECM is to **coordinate all care for eligible Members**, including **across the physical, behavioral, and dental health delivery systems**.
- ECM is interdisciplinary, high-touch, person-centered, and **provided primarily through in-person interactions** with Members where they live, seek care, or prefer to access services.
- ECM is the **highest tier of care management** for Medi-Cal MCP Members.

Medi-Cal MCP Care Management Continuum

ECM is Administered by MCPs and Delivered by Community-Based Providers

MCPs contract with community-based providers who are experienced and skilled in serving ECM Populations of Focus.



Who is Eligible for ECM?

ECM is available to MCP Members who meet criteria for ECM "Populations of Focus" (POFs), which are launching in phases from January 2022 to January 2024.

	ECM Population of Focus	Adults	Children & Youth
1	Individuals Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization	✓	✓
3	Individuals with Serious Mental Health and/or Substance Use Disorder Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	✓
7	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	

Community Supports: DHCS Policy Overview

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HEALTH CARE SERVICES

What are Community Supports Services?

DHCS has pre-approved 14 medically appropriate and cost-effective Community Supports that MCPs are strongly encouraged but not required to offer as substitutes for utilization of other services or settings.

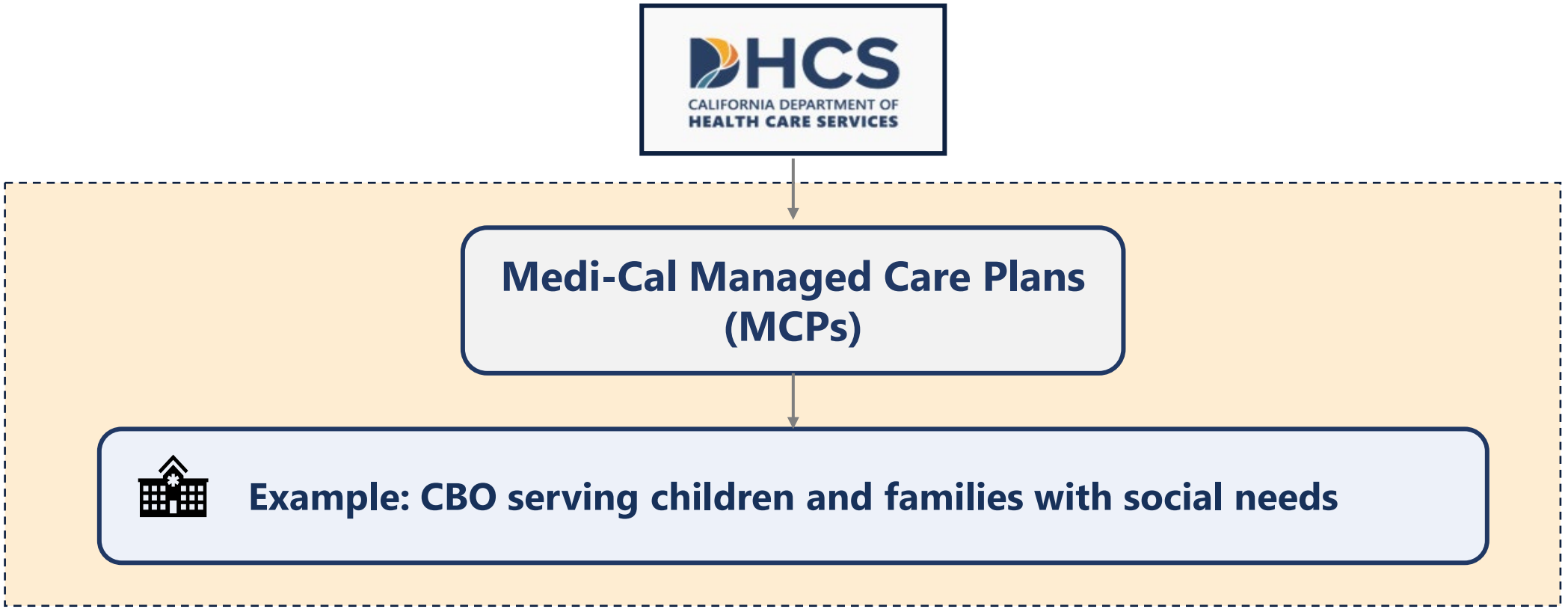
Pre-Approved DHCS Community Supports include:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals or Medically Supportive Foods
- Sobering Centers
- Asthma Remediation

See Community Supports Elections Spreadsheet on DHCS website for MCP selections statewide.

Community Supports Are Administered by MCPs and Delivered by Community-Based Providers

MCPs contract with community-based providers who are experienced and skilled in serving members who need each Community Support.



Providing Access and Transforming Health (PATH)

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Providing Access and Transforming Health (PATH)

- Five-year, $1.85 billion initiative
- Build capacity and infrastructure of on-the-ground partners, such as community-based organizations (CBOs), public hospitals, county agencies, Medi-Cal Tribal and designees of Indian Health Programs, and others, to
- Goal of preparing partners to successfully participate in the Medi-Cal delivery system as California widely implements Enhanced Care Management (ECM) and Community Supports and Justice Involved services under CalAIM.

PATH Program Initiatives

Collaborative Planning and Implementation Program (CPI)	• Funding for planning implementation of Enhanced Care Management (ECM) and Community Supports.
Technical Assistance Marketplace (TAM)	• Funding for providers, community-based organizations, counties, and others to obtain technical assistance resources needed to implement ECM and Community Supports.
Justice-Involved Capacity Building Program (JI)	• Funding for implementing pre-release Medi-Cal application and suspension processes.
Capacity and Infrastructure Transition Expansion and Development (CITED)	• Funding for transition, expansion and development of ECM and Community Supports capacity and infrastructure.

Q&A

DHCS

Thank You

Please visit the DHCS ECM & Community Supports Website for more information and access to documents and supporting resources: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx

Please send questions to CalAIMECMILOS@dhcs.ca.gov

For PATH questions contact: 1115PATH@dhcs.ca.gov

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