



NC Department of Health and Human Services

Opportunities for Health:

Addressing Social Determinants of Health

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North Carolina is not as healthy as it could be

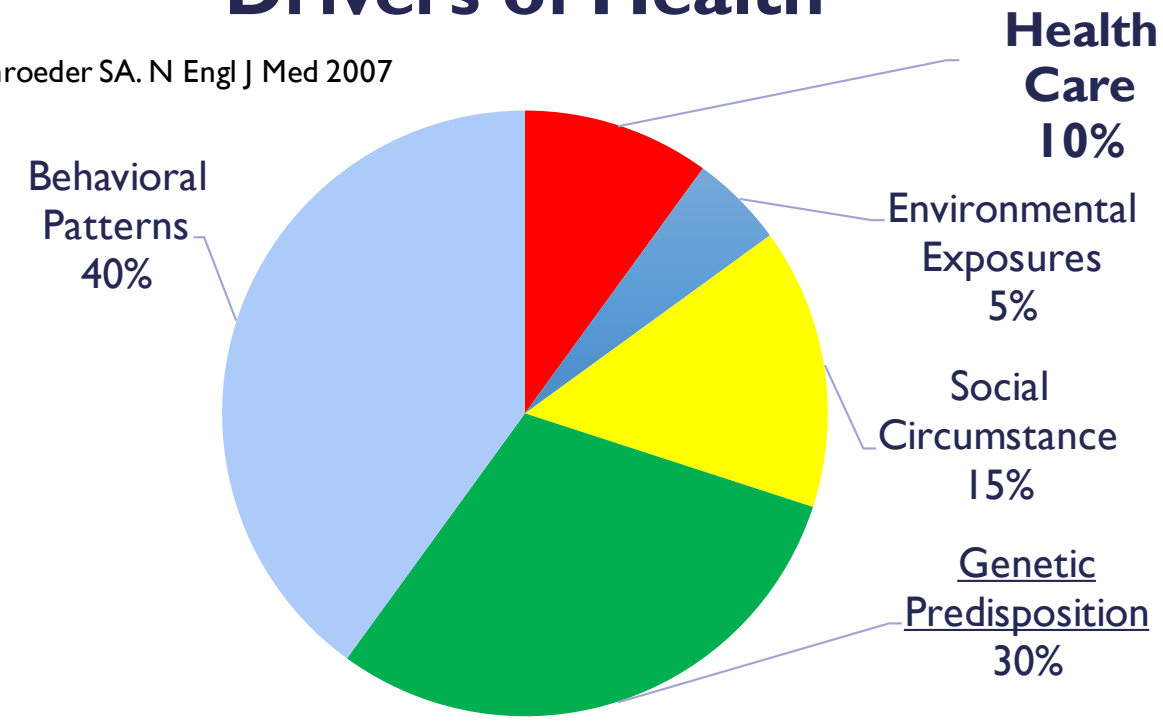
North Carolina ranks 37th in overall state health outcomes

- 21% of children do not have consistent access to food
- 20% of children have had 2 or more Adverse Childhood Experiences
- 47% of women have experienced intimate partner violence
- 10.6% of adults are uninsured (NC has not expanded Medicaid)
- 29% of low-income adults went without care due to cost
- More than 1.2 million North Carolinians cannot find affordable housing

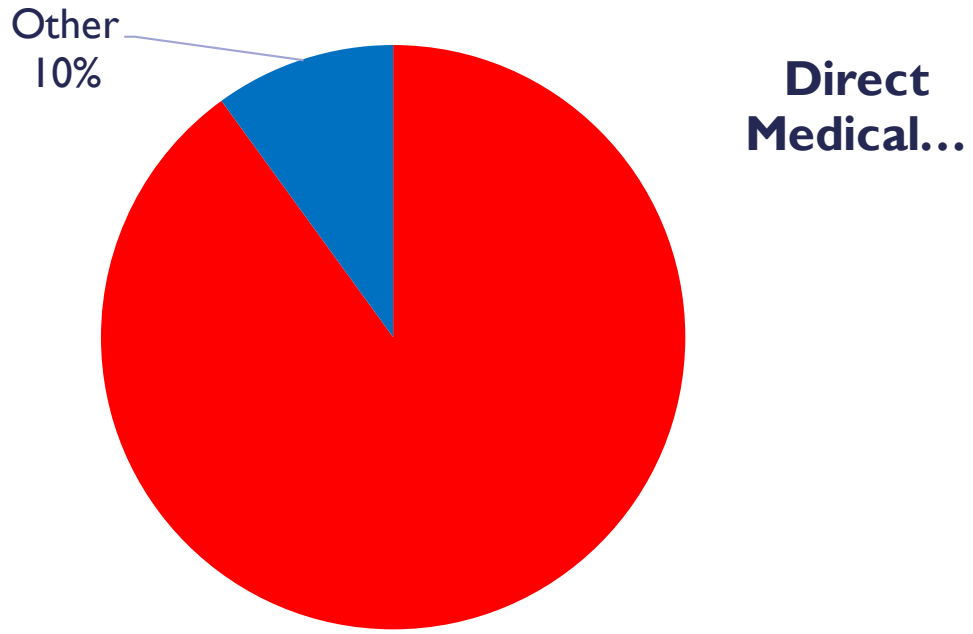
Mismatch: We are Buying Healthcare not "Health"

Drivers of Health

Schroeder SA. N Engl J Med 2007



Health Care Spending

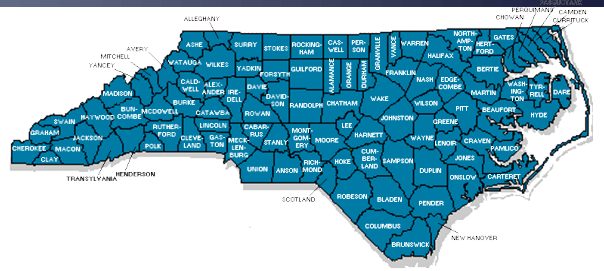


- 10% of health outcomes are attributable to medical care, while up to 70% are tied to social and environmental factors and the behaviors influenced by them.
- The greatest opportunity to improve health lies in addressing a person's **unmet essential needs**.

DHHS Vision for Addressing Social Determinants of Health

We envision a North Carolina that optimizes health and well-being for all people by effectively stewarding resources that bridge our communities and our healthcare system.

North Carolina



- 9th largest state
- "Purple"
- Rural/urban
- Racially diverse

Transition to Medicaid Managed Care (Nov 2019)

Multi-Payer Alignment

- Move to Value

- **"Buying Health" (not just healthcare) unified agenda**
  - "Whole Person" approach across DHHS portfolio
  - Integration of Health and Human Services
- **Keys to success: Data strategy and culture change**

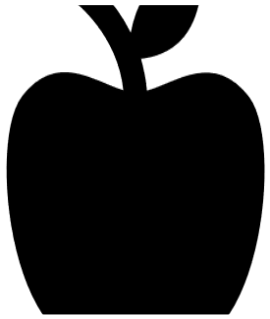
Medicaid Transformation

- Transforming from state run Medicaid program to a managed care administered system. Statewide launch – February 2020
- Using best practices from other states and building on the existing infrastructure in NC

1. **Whole Person Focused**
   - Integrate Physical and Behavioral Health
   - Focus on unmet social needs
2. **Driving towards Value**
   - Advanced Medical Home Plan
   - Move to alternative payment models
   - Support Clinicians through the transformation

Healthy Opportunities Landscape

Priority Domains



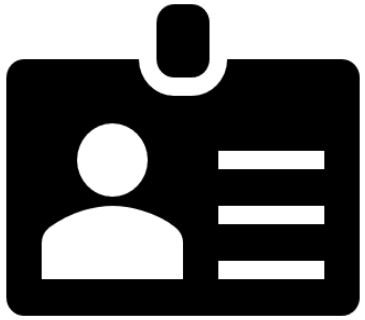
Food Security

Housing Stability

Transportation

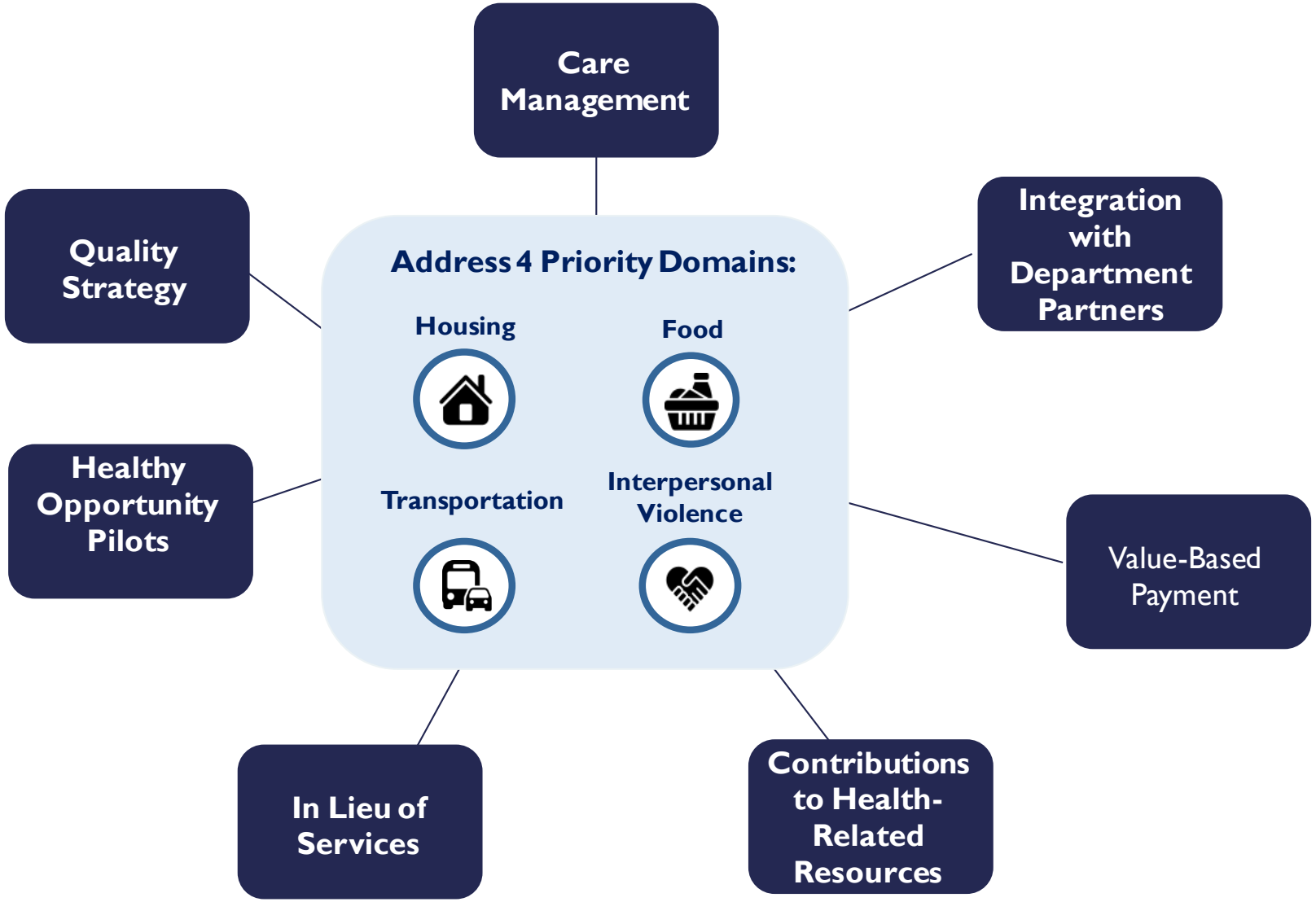
Interpersonal Violence

Employment



Toxic Stress/ Early Brain Development

Robust Elements within Medicaid Managed Care



Care Management

Care Management

- Competencies in Trauma Informed Care, Resource Navigation
- Multi-disciplinary team – RN, SWs, Housing Specialist, Legal Specialists
- Standardized screening for food, housing, transportation, interpersonal violence needs
- Navigation to resources and closed loop referrals through NCCARE360
- Providing additional support for high-need cases, such as homeless, actively experiencing interpersonal violence

Financial tools and Strategies

Value-Based Payments

- PHPs expected to incorporate non-medical drivers of health into value-based payment strategy to align financial incentives and accountability around total cost of care and overall health outcomes
- By the end of contract Year 2, the portion PHP's medical expenditures governed under VBP arrangements must either increase by twenty (20) percentage points or represent at least fifty percent (50%) of total medical expenditures.

Contributions to Health-Related Resources

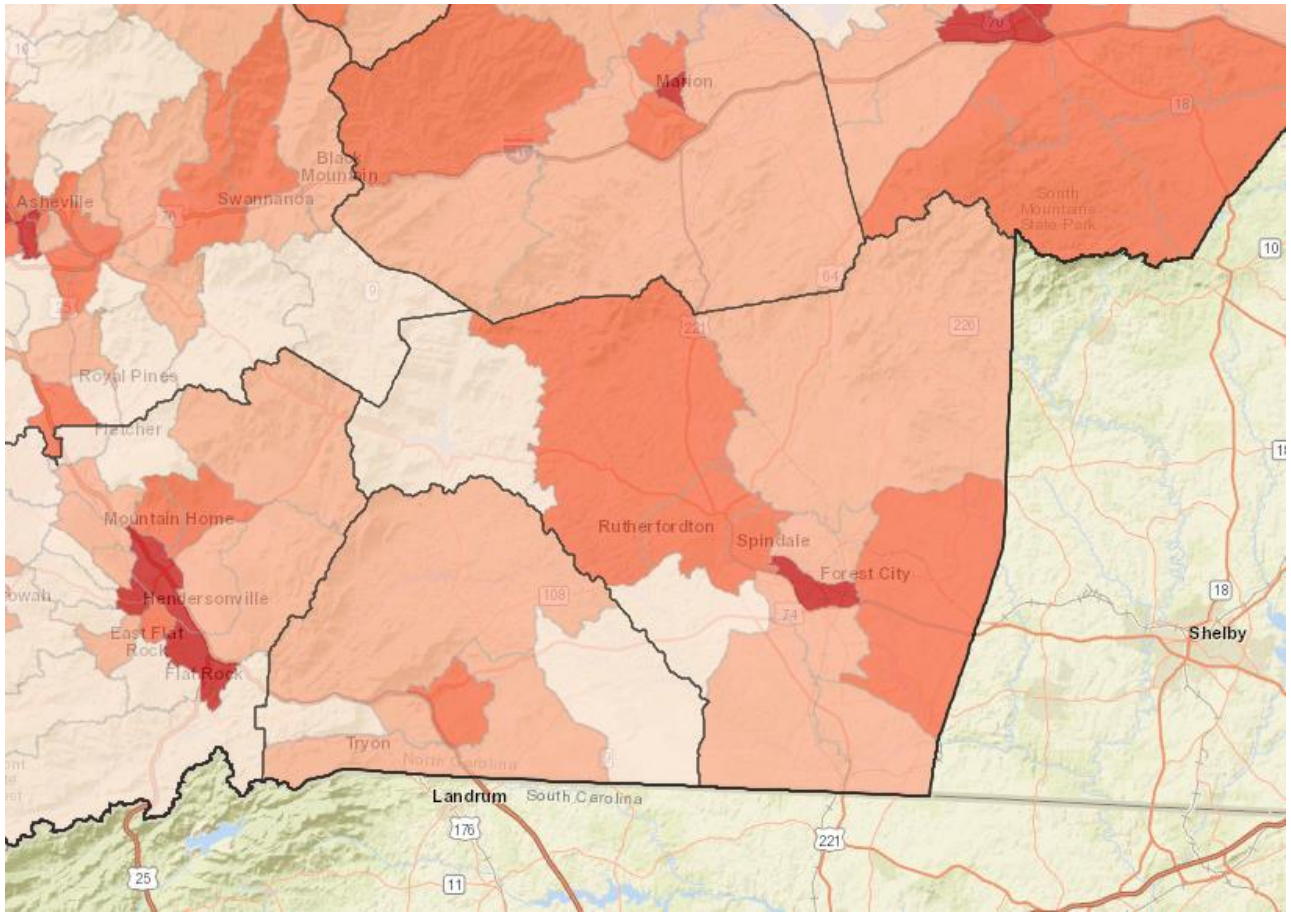
- PHPs are encouraged to voluntarily contribute to high-impact health-related resources
- PHPs that voluntarily contribute to health-related resources **may count the contributions towards the numerator of their Medical Loss Ratio (MLR) as part of Quality Improvement Activities**
- A PHP that voluntarily contributes at least one-tenth percent (0.1%) of its annual capitation revenue to health-related resources may be awarded a **preference in auto-assignment**

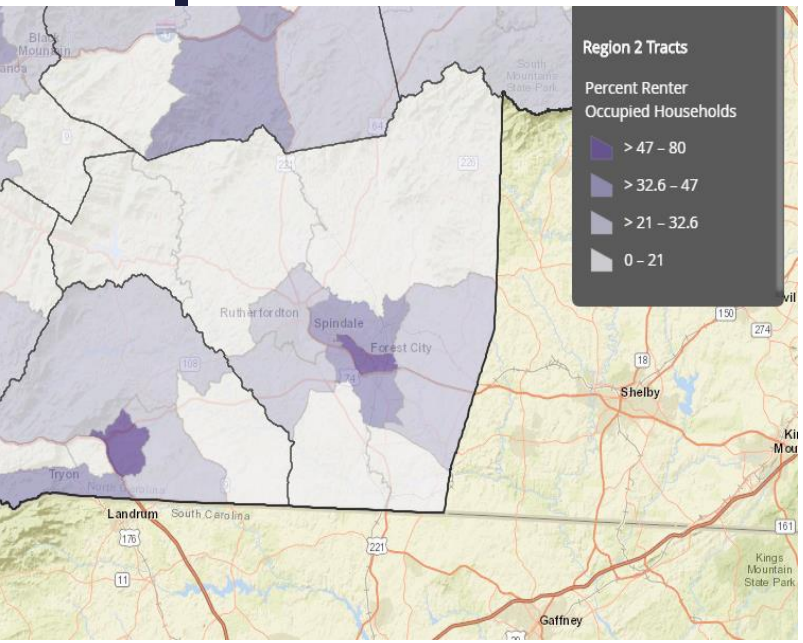
Infrastructure and Elements across all populations

Hot Spot Map	• GIS map of social determinants of health indicators at census tract level
Screening	• Statewide Standardized Screening Questions
NCCARE360	• Statewide coordinated network with shared technology platform
Workforce Development	• Community Health Workers, Permanent Supportive Housing
Back@Home	• Rapid Rehousing for Victims of Hurricane Florence
Aligning Enrollment	• Coordinating enrollment across programs e.g., Medicaid, WIC, SNAP

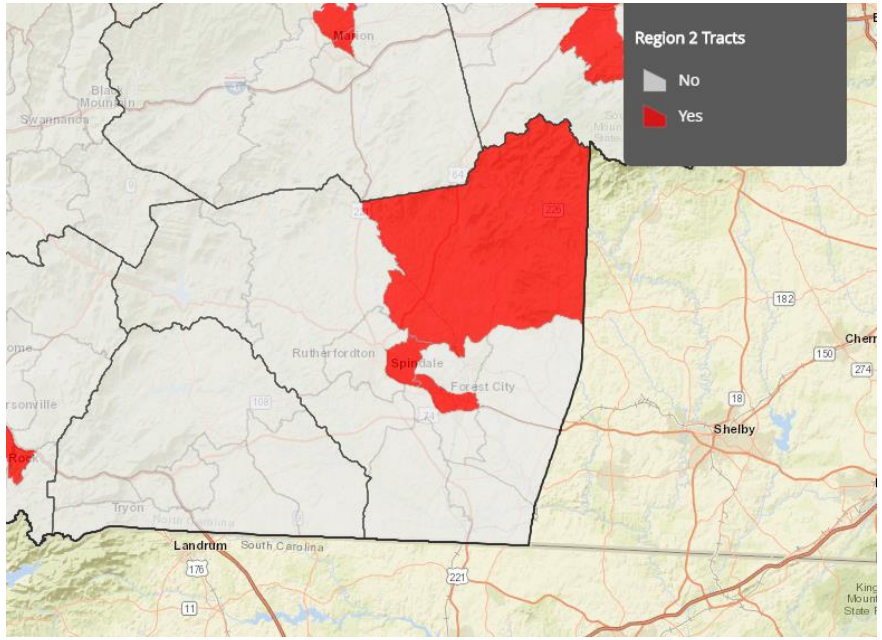
“Hot Spot” SDOH Map

- Interactive GIS Map that displays a set of SDOH indicators
- Grouped across 3 domains:
  - Economic
  - Housing and Transportation
  - Social and Neighborhood Resources
- Data from U.S. Census American Communities Survey (2012-2016) and USDA Food and Nutrition Services
- Used to understand geographical disparities in underlying drivers of health
  - Census Track 9608: Average domain Z-Score of 1.49

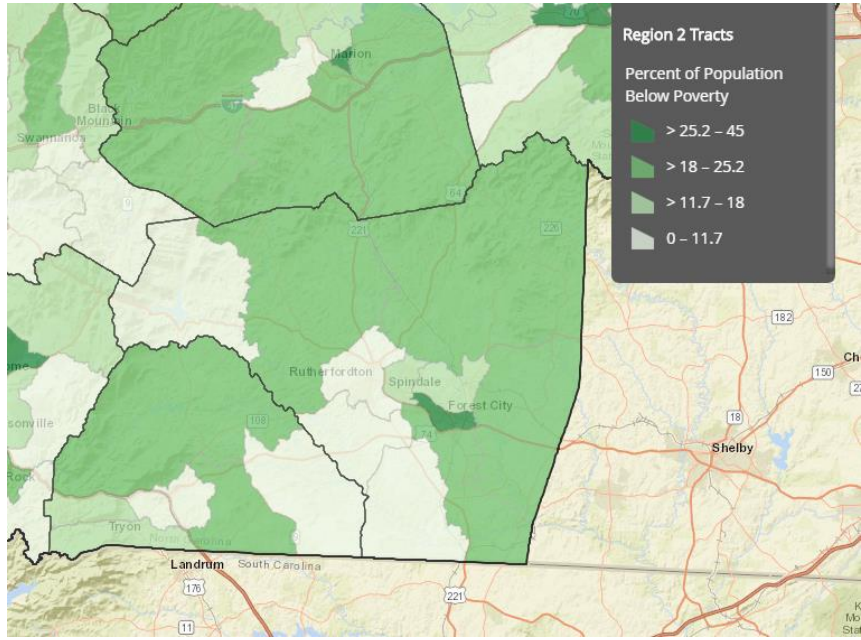




Percent of Population Paying >30% of Income on Rent
High: 60.8%



Food Deserts



Percent of Population Below Poverty
High: 46.6%

Hot Spot Map of SDOH Indicators

Screening Questions

- Developed by Technical Advisory Group
- Drew from validated and commonly used tools (e.g PRAPARE, Accountable Health Community)
- Routine identification of unmet health-related resource needs
- Statewide collection of data
- Implementation
  - Public Review
  - Fall 2018 Pilot testing in 18 clinical sites and telephonically (n=804)
  - Ready Providers/Systems adopting
  - Encouraging everyone to use for all populations
  - Launch of Managed Care
    - PHPs Required to Include in initial Care Needs Screening
- Need to tackle data flow next

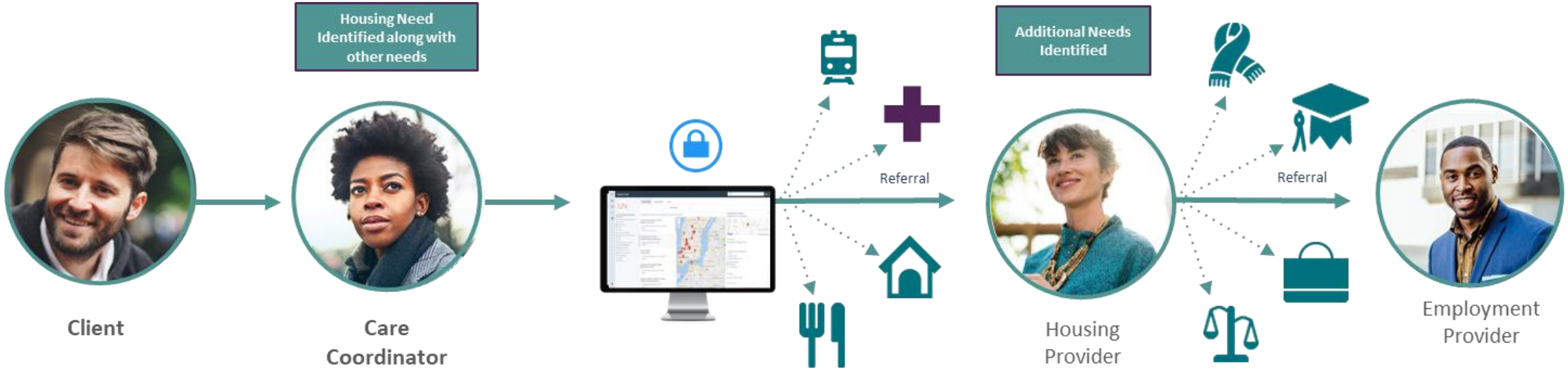
Health Screening

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

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

Statewide Resource Platform: NCCARE360

Network Model: No Wrong Door Approach



- **Investing in connections**: Statewide coordinated network to connect citizens, healthcare providers, and human service providers
- Strong **public-private partnership** to create foundation for healthy opportunities

Foundation for Health Leadership & Innovation
Moving people and ideas into action.
NCDHHS
United Way of North Carolina
NORTH CAROLINA 211
Expound
UNITE US

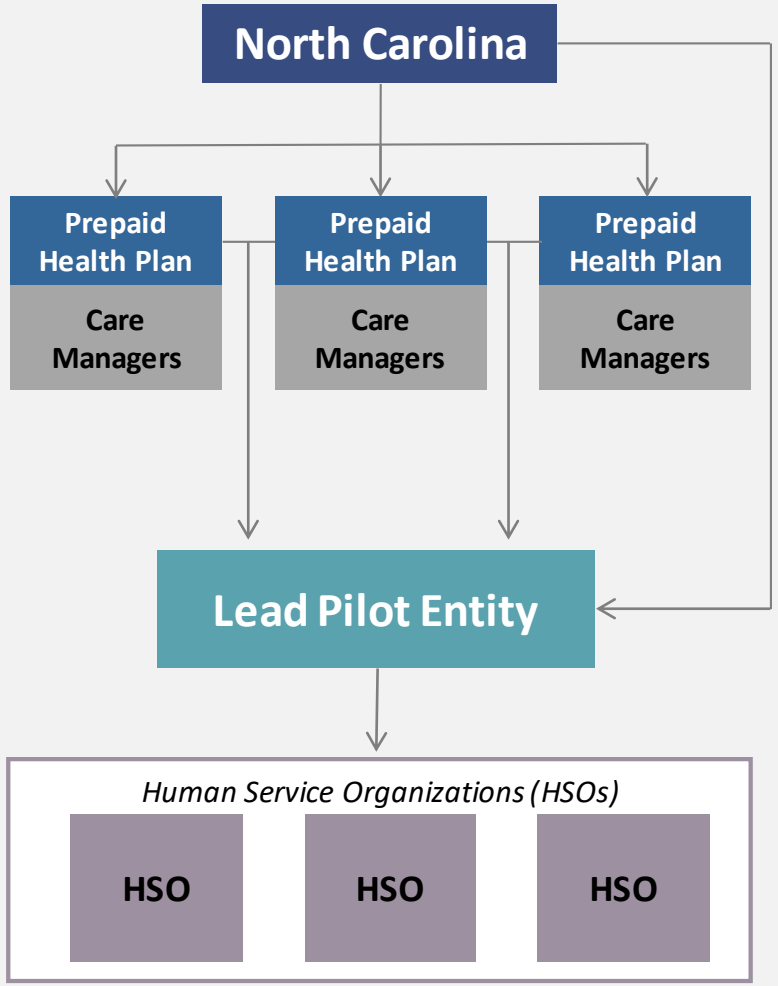
Three Functions

NCCARE360

	Functionality	Partner	Timeline
Resource Directory	Directory of statewide resources verified by a professional data team adhering to AIRS	United Way of North Carolina	Ongoing work
Call Center Support	24/7/365 call center with team of NCCARE360 Navigators, and the addition of text and chat capabilities.	NORTH CAROLINA 211	
Resource Repository	APIs integrate resource directories across the to share resource data.	Expound	Phased Approach
Referral & Outcomes Platform **Community Managers**	Referral platform with closed loop functions. Community Managers for workflow, change management, continued in person	UNITE US	Rolled out by January 2019 – December 2020

Healthy Opportunities Pilots

Sample Regional Pilot



Pilot Overview

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

Overview of Eligibility For Pilot Services

To be eligible for pilot services, Medicaid managed care enrollees must have:

☑ At least one Needs-Based Criteria:

Physical/behavioral health condition criteria vary by population:

- Adults (e.g., 2 or more chronic conditions)
- Pregnant Women (e.g., multifetal gestation)
- Children, ages 0-3 (e.g., Neonatal intensive care unit graduate)
- Children 0-21 (e.g., Experiencing three or more categories of adverse childhood experiences)

+

☑ At least one Social Risk Factor:

- Homeless and/or housing insecure
- Food insecure
- Transportation insecure
- At risk of, witnessing or experiencing interpersonal violence

*See *appendix for full list of eligibility criteria.*

Overview of Approved Pilot Services

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

Housing

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

Food

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

Transportation

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

Interpersonal Violence

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

Financing

- PHPs will have a capped amount outside of capitated rate for pilot services
- Fee schedule to include Fee-for-service, Cost-based reimbursement, Bundled payments
- Advancing value-based payment

Year 1	Year 2	Year 3	Year 4	Year 5
Incentive payments for successful implementation	Incentive payments for delivering pilot services	Withhold payments to ensure enrollees unmet resource needs are met	Withhold payments linked to health outcomes	Shared savings payments*

*Costs savings based on subset of pilot enrollees whose services are likely to result in decreased medical expenses in the short-term. Assures pilot entities are not penalized for approving effective, evidence-based upstream interventions that result in a financial return on investment over the longer-term

Evaluation - Rapid cycle/Summative

- UNC Sheps Center
- Rapid cycle assessments
  - Evaluation throughout pilots to learn in real time and make adjustments
  - Evolving metrics - Operational readiness, service delivery, resource needs met, self-reported quality of life, health outcomes, utilization, cost
- Summative evaluation
  - Health, utilization, and cost savings overall and by sub-groups
  - Determine cost-neutrality and cost-effectiveness of interventions by sub-group
  - Implementation science
  - Learn how to scale interventions that worked into Medicaid statewide

Process/Time Line

- Feb 2019: White Paper on Pilot Design/Request for Information on cost elements
- Spring 2019: Multiple forums for collecting input from stakeholders, Manatt/Commonwealth Fund - Advisory Group on Fee Schedule
- July 2019
  - Further guidance on Lead Pilot Entity (LPE)/Non-binding Statement of Interest
  - Pilot Service Definitions, Methodology for constructing fee schedule
- Fall 2019: Request for Proposals (RFP) to determine LPEs/Pilot Regions
- Early 2020: Award LPEs/Pilot Regions
- Most of 2020: Capacity building for LPEs and regions
- Early 2021: Begin Service Delivery
- October 31, 2024: End Pilots (at end of 1115 waiver)

Health Care Transformation Initiatives in NC

NC Medicaid

- Transformation from FFS to VBP
- Physical/behavioral health integration
- Healthy Opportunities
- NC Care 360

Blue Cross Blue Shield of NC

- Blue Premier - ACO program
  - Intensive Primary Care
    - Vendors
      - CareMore Health
      - City Block
      - Iora Primary Care

Medicare Shared Savings Program Participation

- 30 MSSP and NextGen ACOs
- 11 ACOs have contracts with commercial payers

For More Information

- **NC Medicaid Transformation:** https://www.ncdhhs.gov/assistance/medicaid-transformation
- **Healthy Opportunities:** https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities
- **Contact:** ben.money@dhhs.nc.gov