Café Connect: Payment Arrangements for Social Needs Screening and Referral

Social Determinants of Health (SDOH) Social Needs Screening & Referral Measure

January 23, 2023

Oregon Health Authority

ORPRN Oregon Rural Practice-Based Research Network

OHSU

Agenda

- Context (5 mins)
- Dr. Tilson, North Carolina Department of Health & Human Services (35 mins)
- Q&A with Dr. Tilson (15 mins)
- Next Steps & Upcoming Technical Assistance Opportunities (5 mins)

How are Other States Approaching SDOH Screening, Referral, & Payment Arrangement Strategies?

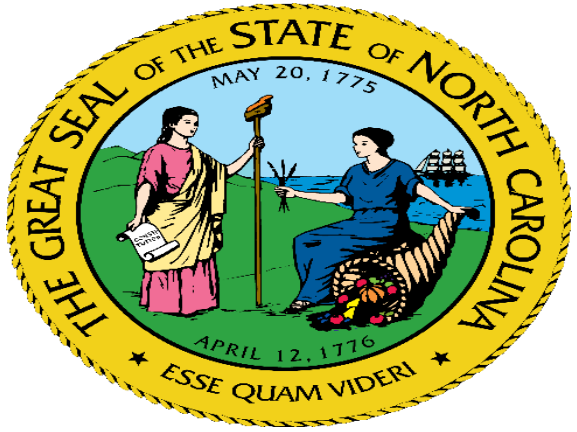
Social Needs Screening & Referral Initiatives Oregon vs North Carolina

Similarities	Differences
• Both states aim to address social determinants of health and health equity, considering factors beyond medical care, such as housing, food, and transportation. • Both states use a quality incentive framework for social needs screening and referral • Collaboration among health care providers, social service agencies, and community-based organizations is often a key element in both social needs screening initiatives. • Both states promote use of Electronic Health Records (EHRs) to allow efficient communication across sectors.	• North Carolina's initiative involved multiple components and a shared infrastructure, including a standardized screening tool and uniform Community Information Exchange (CIE) platform. • Oregon's model highlights the significance of allowing flexibility and innovation regionally, within a quality incentive framework, providing lessons for adaptability. • North Carolina has a state-sponsored pilot initiative (Healthy Opportunities) to inform future policy changes

Consider...

- What are some of the programs or pieces of the North Carolina system that Oregon also has or is utilizing?
- In your region or CCO service area, what infrastructure, programs or initiatives are in place to support your social needs screening and referral efforts?
- What aspects of North Carolina's model could help inform your CCO's social care integration strategies at a regional or local level?

Elizabeth Cuervo Tilson, MD, MPH (she/her)
North Carolina Department of Health and Human Services

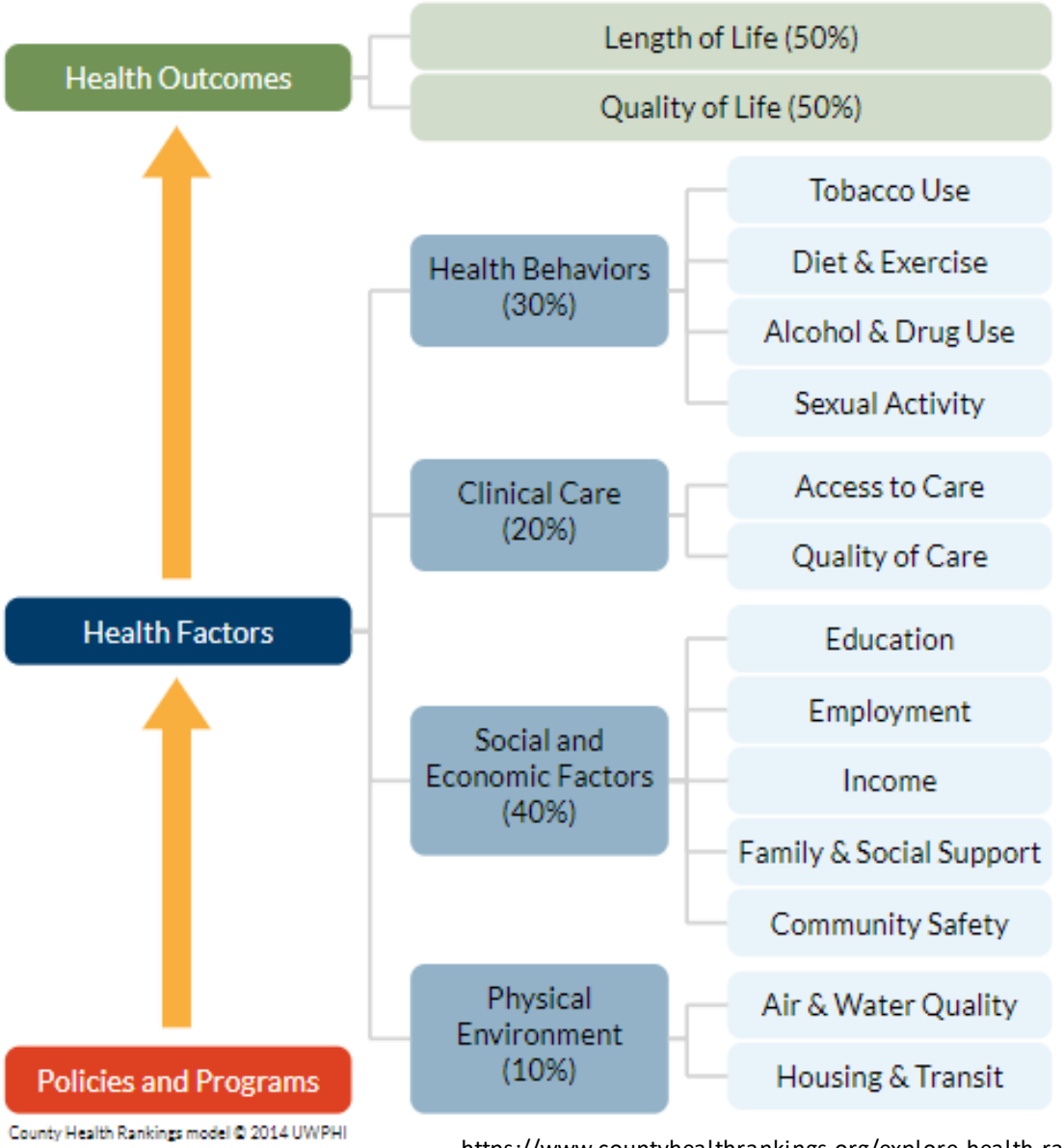


The Opportunity for Health

Elizabeth Cuervo Tilson, MD, MPH
State Health Director
Chief Medical Officer
North Carolina Department of Health and Human Services

We want all people to have an equitable Opportunity for Health

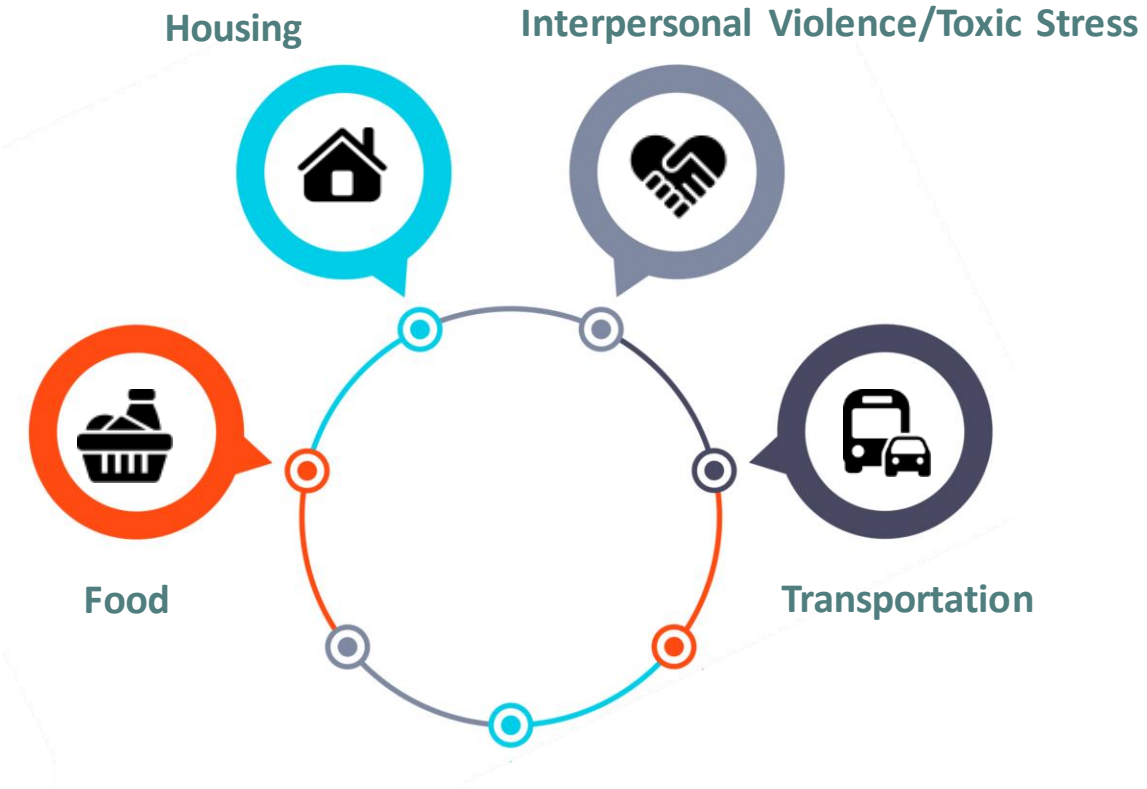
The Factors that Influence Health – Robert Wood Johnson Foundation



https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

Taking Steps to Ensure All North Carolinians have the Opportunity for Health

- Address the "Other 80%"
- Improve whole-person health, safety and well-being of all North Carolinians while being good stewards of resources
- Intentionally, strategically, and pragmatically use health care dollars to "Buy Health"

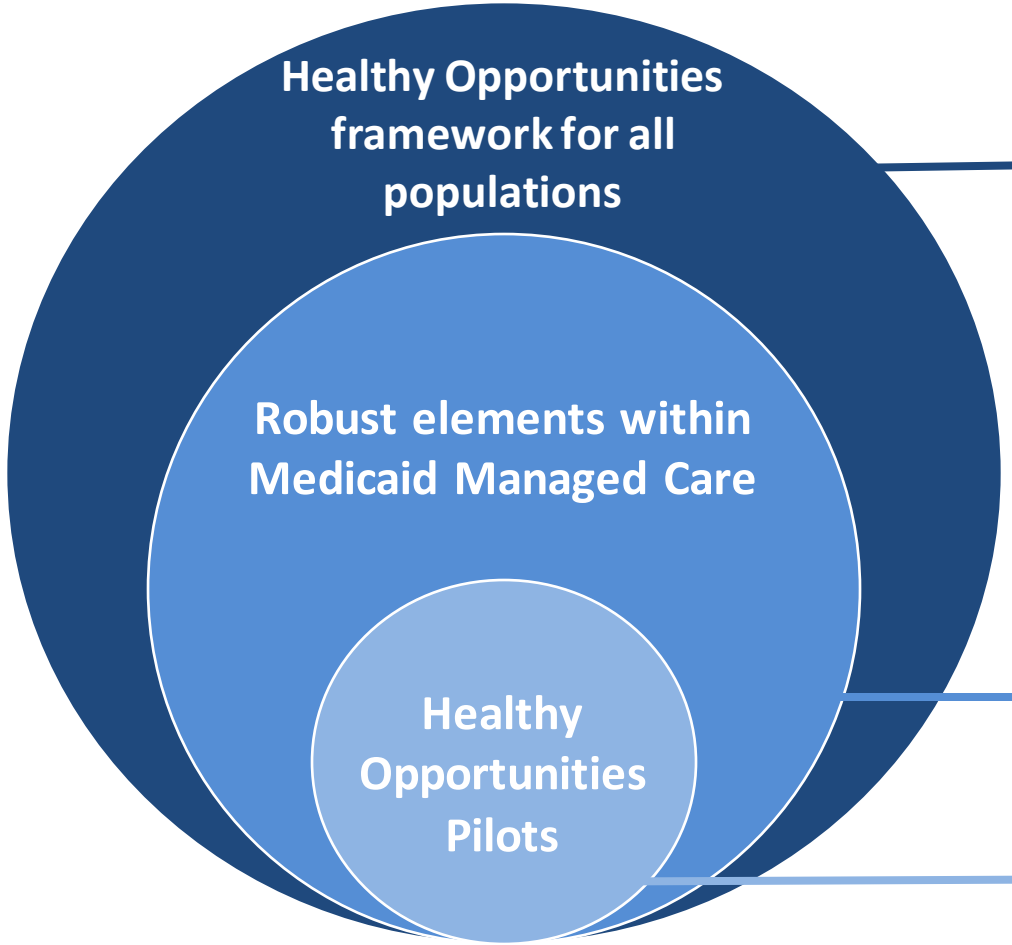


- Drivers of health inequities
- Risk factors for chronic diseases and increase health care costs
- Addressing can improve health and lower health care costs

Building Statewide Multi-components Shared Infrastructure

https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities

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 North Carolina 2030
- Healthy Opportunities "Hot Spot" Map
- Standardized social needs screening
- NCCARE360- Statewide closed loop referral system
- Community Health Workers
- Data linkages, and tailored outreach

Embed shared assets and infrastructure in Medicaid

- Care management
- Quality strategy, Withholds
- Community Investments/Medical Loss Ratio
- Value added services, In-Lieu-of services
- Alternative Payment Models

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

Healthy Opportunities Pilots

All Populations: Standardized Screening Questions

	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?		

Efforts toward Data Standardization

SDOH-related domains and the respective terminologies designated through the Gravity Project.

Use	Standard
Screening/assessment question/answer pairs	LOINC®
Observations	SNOMED CT®
Diagnoses	ICD-10
Goal setting	LOINC
Interventions	SNOMED CT®
Billing	CPT®/HCPCS

All Populations: NCCARE360 Functionalities

FOUNDATION FOR HEALTH LEADERSHIP & INNOVATION
MOVING PEOPLE AND IDEAS INTO ACTION

NCDHHS

- **First statewide network** that unites health care and human services organizations
- A **robust statewide resource directory**
- A **closed loop referral platform** that enables providers to assess for and identify unmet social needs, send and receive secure electronic referrals, securely share client information and track outcomes together
- A **team of dedicated navigators**
- A **community engagement team** working with community-based organizations, social service agencies, health systems, independent providers, and more to create a statewide, coordinated care network
- A **coordinated network** of providers and community-based organizations
- **Enhanced Healthy Opportunity Pilot functionalities** that will allow referral for pilot specific services, enhanced data, invoicing mechanism.

United Way
United Way of North Carolina

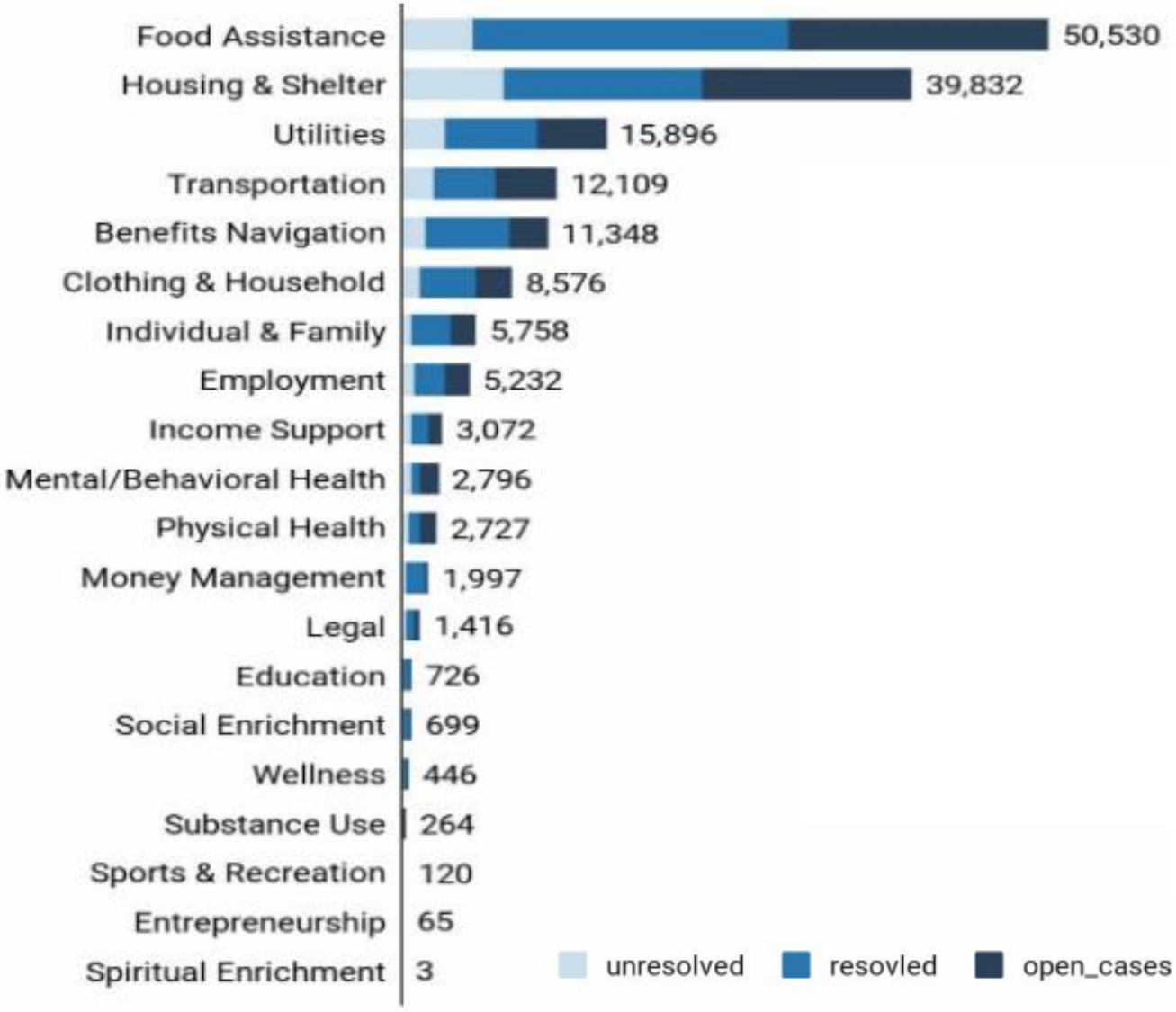
2·1·1
North Carolina

UNITE US

All Populations: NCCARE360 by the numbers

Network Needs Overview

Cases by Service Type (12/1/22-12/31/23)



3,323 in-network partners
55,132 in-network users

155, 916 people
495,599 referrals
~8,000+ referrals per month

Medicaid Managed Care: Pre-Paid Health Plans (PHPs)

Levers to Increase Health-Related Resource Needs (HRRN) Screening

NC Medicaid is encouraging screening for health-related resource needs, and collection of valid data on screening, through a series of mechanisms.

- Contract Requirement
- Quality Measure
- Data Validation
- Withhold Program
- Performance Improvement Projects

Withhold for HRRN Screening

- Rate of Screening for Health-Related Resource Needs is one part of NC Medicaid's Withhold Program

- In Year 1 (2024) of the withhold program, NC is focused on improving the *data* on HRRN screening rates, using a "pay for reporting" measure
  - Submission of validated data will qualify a plan for return of the portion of the withhold associated with this measure

- The PHP with the highest completed screening rate from among those with validated data may qualify for a bonus payment

- NC Medicaid plans to move to a withhold measure based on screening rates (pay for performance) in future years

Medicaid Managed Care: Pre-Paid Health Plans (PHPs)

Incentivizing Investments in the Community

Under a new program that launched in 2023, NC Medicaid's managed care organizations are incentivized to invest in initiatives that **promote health equity** and **address unmet resource needs** in their communities.

- Plans get direct "financial credit" for approved investments
  - Can count toward the numerator of their Medical Loss Ratio
  - Can also be accepted in lieu of remittance related to the risk corridor for excess revenue
  - Can lead to a preference in the auto-enrollment process
- Investments must meet a set of criteria, including but not limited to
  - Partnership with a community-based organization
  - Promoting NC Medicaid's quality strategy
  - Driven by data and community need

Medicaid Managed Care: Pre-Paid Health Plans (PHPs)

NC Medicaid managed care plans are encouraged to address health-related resource needs through Value-Added Services and In-Lieu-of Services

Value-Added Services

- **Health plans offer numerous Value-Added Services**, such as:
  - Boys and Girls Club Membership and other extracurricular support
  - Asthma Navigation and Supplies (e.g. hypoallergenic mattress/pillow covers, air purifiers)
  - High School Equivalency (e.g. GED) preparation and testing
  - Post-discharge home-delivered meals
  - Community transportation and Lyft/Uber gift cards
  - Limited hotel stay while transitioning from an inpatient setting and lacking a safe place to continue recovery
  - Home repair and modification services
  - School supplies
  - Healthy food vouchers

In-Lieu-of Services

- **Health plans have taken limited advantage of In-Lieu-of Services**, but offer services such as:
  - Environmental home modifications, including:
    - Pest extermination
    - Mold remediation
    - Temporary housing and,
    - External physical adaptations
  - Behavioral health urgent care
  - Virtual urgent care
  - Institute for Mental Disease for acute psychiatric care

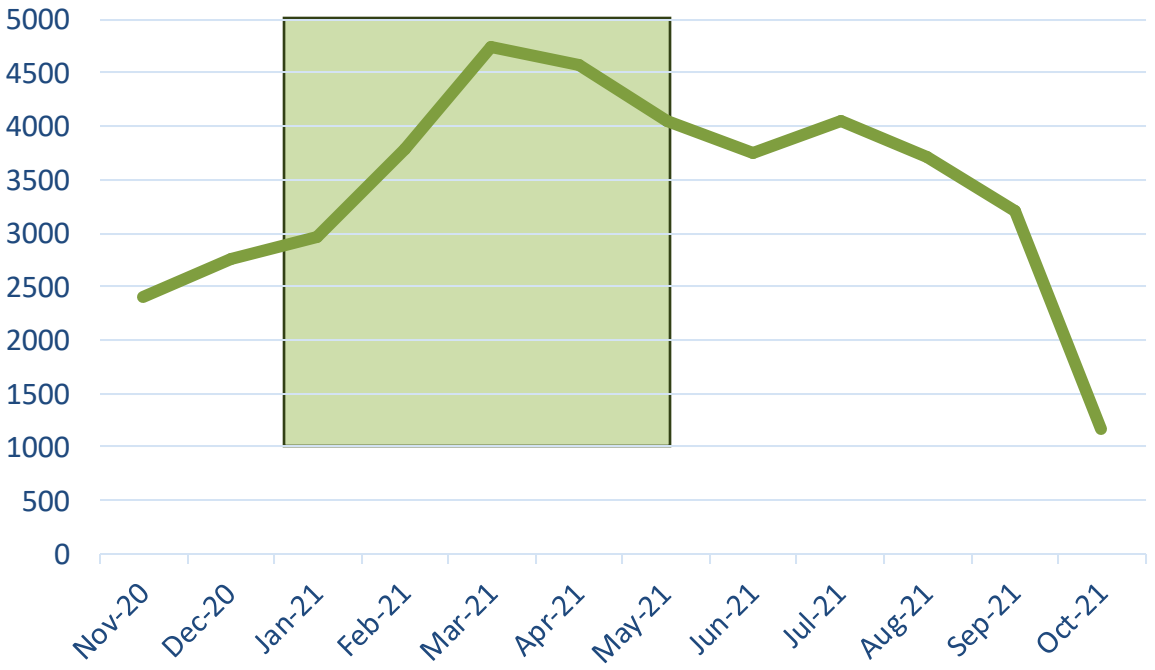
Alternative Payment Models: Providers

Payment for Social Needs Screening and Referral

Healthy Opportunities Screening And Referral Initiative (HOSAR)

- Intended to encourage screenings in advance of managed care launch
- Temporarily paid providers $29-43 per positive screen from Jan 2021 to June 2021
- Providers used a G9919 code to indicate a positive screen and were encouraged to add ICD-10 Z codes indicating patients' resource needs

Select Z Codes Billed During HOSAR



Lessons Learned

- Screening at the provider level increased, but was still limited to a small portion of Medicaid beneficiaries
- Feedback: Pay for negative screens in addition to positive ones
- Additional efforts needed to support providers in screening, intervention, and data sharing

Integrated Care for Kids (InCK) Alternative Payment Model

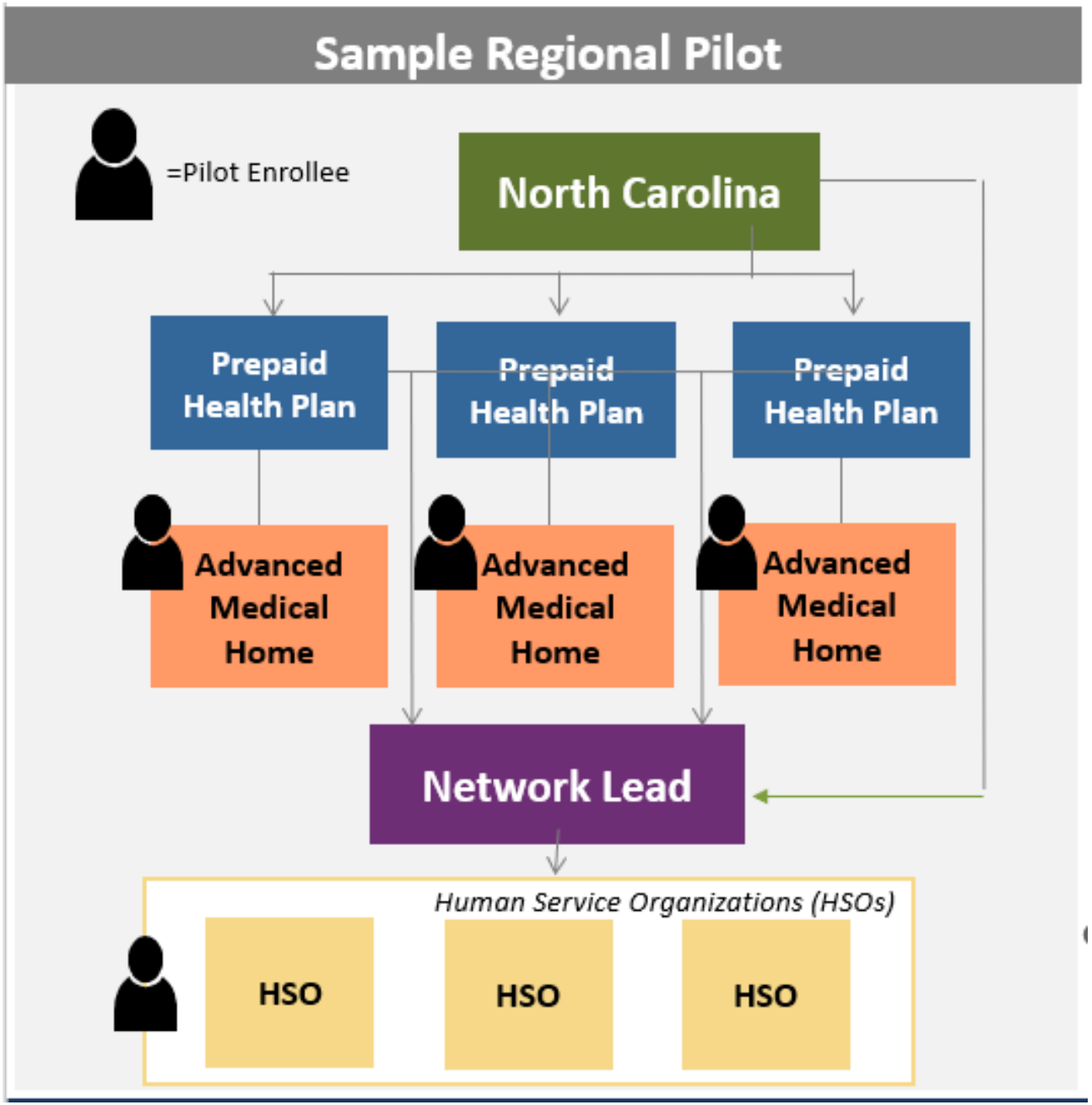
- As part of a CMS/CMMI pilot model, NC Medicaid has partnered with the NC InCK program to launch a new alternative payment model that links **provider incentive payments to more meaningful measures of child well-being**
- **Goal:** Increase resourcing and flexibility for practices to support more whole-child care approaches
- Launched in Jan 2023 and runs through 2026

	NC InCK APM Performance Measures
Cross-sector child well-being metrics	Kindergarten Readiness Promotion Bundle
	Screening for Food Insecurity and Housing Instability
	Cross-Sector, Family-Centered Shared Action Plan
Health care utilization metrics	Screening for Clinical Depression & Follow Up
	Rate of Emergency Department Visits
	Reduction in Disparity in Infant Well-Child Visits

Healthy Opportunity Pilots: 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
- **Pilot Vision and Goals:**
  - Integrate evidence-based, non-medical services into Medicaid to:
    - **Improve health outcomes** for high-risk Medicaid members
    - **Promote health equity** in the communities served by the Pilots
    - **Reduce costs** in North Carolina's Medicaid program
  - **Evaluation:**
    - CMS-approved SMART design (randomized trial) to provide rapid-cycle feedback, concluding in a summative evaluation
    - Ability to create functioning networks, connection to non-medical services; improvement in social risk factors;
    - Which services are highest value & impact for which populations
    - Impacts to community and sectors outside of health care (e.g. enrollment in SNAP and WIC, school attendance)
  - Create **accountable infrastructure**, **sustainable partnerships** and **payment vehicles** that support integrating highest value non-medical services into the Medicaid program sustainably **at scale**

Healthy Opportunity Pilots: Sample Regional Pilot



Healthy Opportunity Pilots: Eligibility

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)*

- **Adults** (e.g., having two or more qualifying chronic conditions)
- **Pregnant Women** (e.g., history of poor birth outcomes such as low birth weight)
- **Children, ages 0-3** (e.g., neonatal intensive care unit graduate)
- **Children 0-20** (e.g., experiencing three or more categories of adverse childhood experiences)

+

✓

At least one Social Risk Factor:
(based on federal and NC criteria)*

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

Meet service specific eligibility criteria, as needed.

* Additional information in Appendix and located here: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf

Healthy Opportunity Pilots: Services

NC DHHS has defined and priced 29 services that can be covered by the Pilot. These services will be reimbursed via fee-for-service (FFS), per-member per-month (PMPM) payments, or cost-based reimbursement up to a cap and include:

Housing

- Housing navigation, support and sustaining services
- Inspection for housing safety and quality
- Housing move-in support
- Essential utility set-up
- Home remediation services
- Home accessibility and safety modifications
- Healthy home goods
- One-time payment for security deposit and first month's rent
- Short-term post hospitalization housing

Food

- Food and nutrition access case management
- Evidence-based group nutrition class
- Diabetes Prevention Program
- Fruit and vegetable prescription
- Healthy food box (pick-up or delivered)
- Healthy meal (pick-up or delivered)
- Medically Tailored Home Delivered Meal

Transportation

- Reimbursement for health-related public or private transportation
- Transportation case management

Interpersonal Safety

- Interpersonal safety case management*
- Violence intervention services*
- Evidence-based parenting curriculum
- Home visiting services
- Dyadic therapy*

Cross-Domain

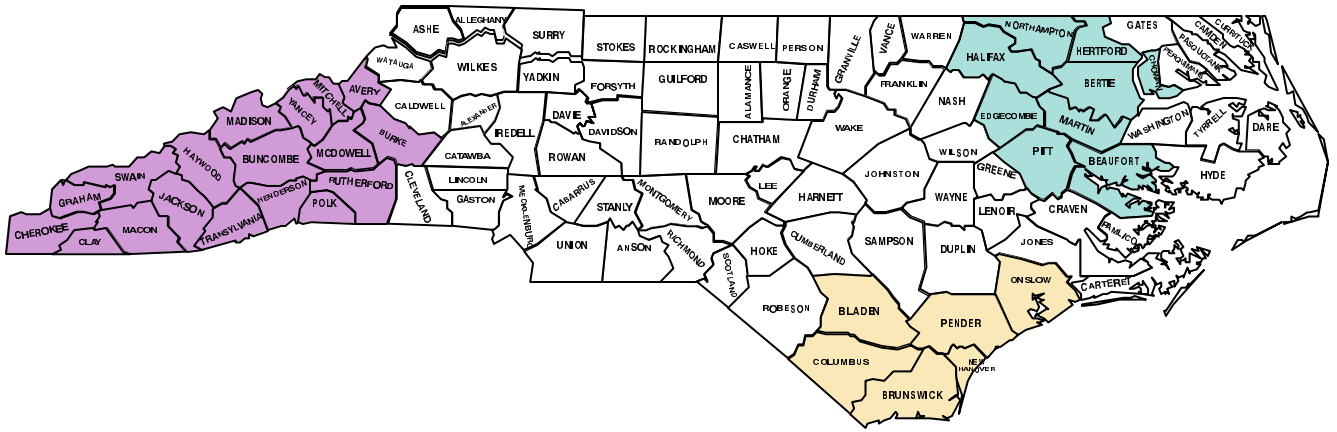
- Holistic high-intensity enhanced case management*
- Medical respite
- Linkages to health-related legal supports*

*Sensitive services will be phased in

Healthy Opportunity Pilots: Regions

Network Leads, Health Plans, and Human Services Organizations will work with communities in three geographic areas of the state to implement the Pilots.

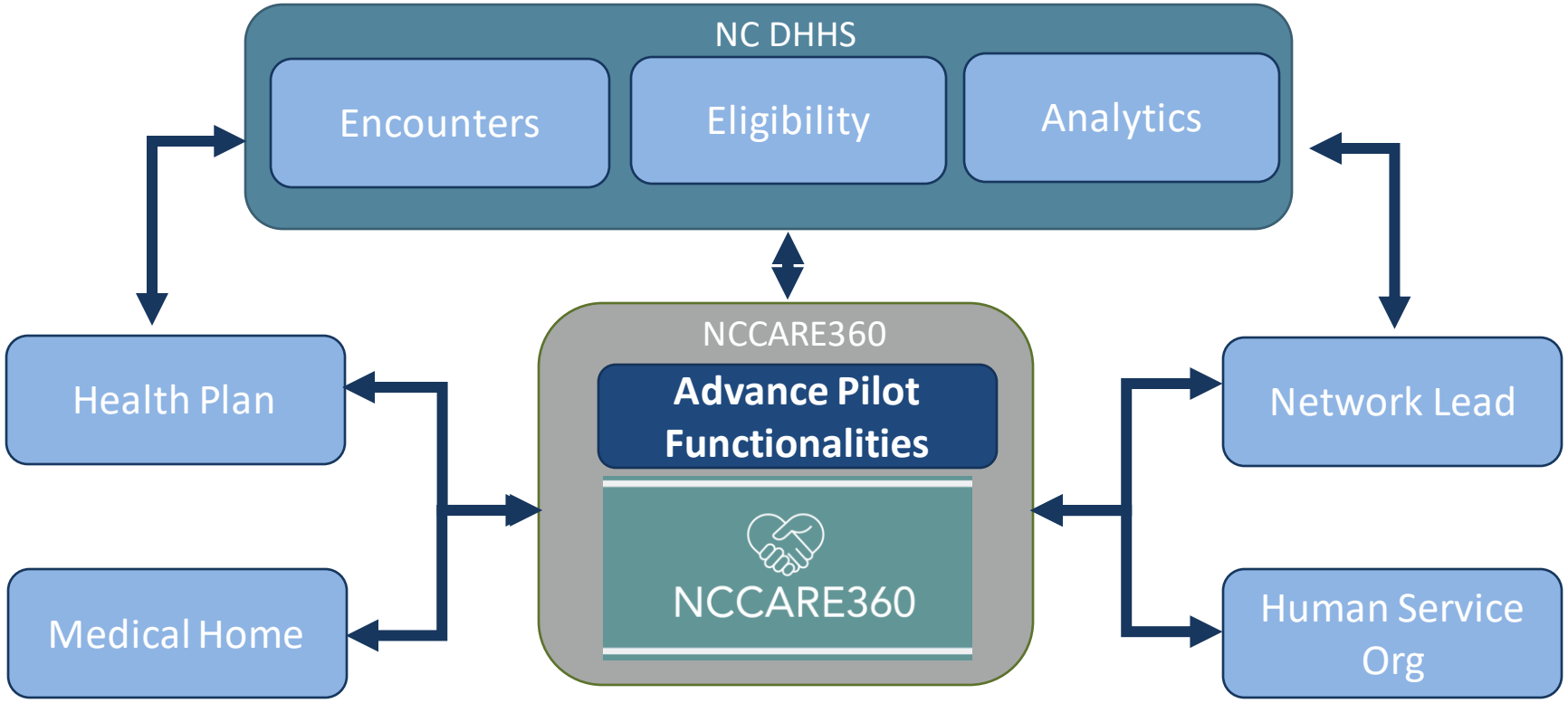
- DHHS awarded **three Network Lead contracts** in May 2021 (one per Pilot region).
- Pilot regions cover 33 (of North Carolina's 100) counties. All 3 regions consist of predominantly **rural areas** and have varying levels of **racial/ethnic diversity**.
- Once fully operational, the Pilots will serve an estimated 13,000-20,000 individuals per month (4-6% of Medicaid enrollees in Pilot regions)



5 Prepaid Health Plans
3 Network Leads
23 Care Management Organizations
150 Human Service Organizations

Healthy Opportunity Pilots: Building on NCCARE360

- Prioritized having one shared technology system for all Pilot Entities to use that would integrate with Health Plans, Providers, and State Systems.
- Built additional functionality into NCCARE360 to support eligibility documentation, enrollment, service authorization, and invoicing processes for the Pilots



Healthy Opportunity Pilots: At Work

Key Metrics

Number of Enrollees	16,610
Percent of Service Authorizations Approved	80%
Number of Services Delivered	208,560
Number of Invoices Submitted	219,350
Percent of Invoices Accepted, Paid, or In Progress	93%
Amount Paid for Service Delivery	**$33,855,500**

*Data through Nov. 30, 2023

Number of HOP Enrollees includes all members enrolled in HOP, beginning March 15, 2022.

Healthy Opportunity Pilots: Value Based Payment Progression

North Carolina implemented value-based payments in the Healthy Opportunities Pilots to incentivize delivery of high-quality services, advancing the evolution of value-based payments each year

- **VBP Period 1 (Implementation): Incentive payments** for health plans and Network Leads tied to meeting operational milestones to prepare for HOP launch, e.g.:
  - *Health Plans*: executing contracts, completing readiness reviews, passing technology testing
  - *Network Leads*: Building an HSO network, distributing capacity building funds, completing readiness reviews
- **VBP Period 2: Incentive payments** for health plans, care management entities, Network Leads, and HSOs tied to meeting performance metrics, e.g.:
  - *Health Plans and CMEs*: Meet a HOP enrollment target, 75% of invoices paid within 45 days
  - *Network Leads and HSOs:* Meet a service delivery target, 75% of invoices submitted within 45 days, develop a sustainability plan
- **VBP Period 3: Incentive payments** tied to meeting performance metrics; **withholds** for health plans and Care Management Entities for exceeding benchmarks associated with addressing Pilot enrollees' unmet resource needs; and **collection of baseline quality measures**
  - *Health Plans and CMEs*: 20% increase in referrals in non-food domains; 90% of HOP enrollees reassessed for needs within 6 months of enrollment; withhold returned if the % of HOP enrollees that received a service to address an unmet need shows an improvement of 5%
  - *Network Leads and HSOs:* % of accepted referrals resulting in a delivery is 95% or higher, meet sustainability plan benchmarks

For more details, see: https://www.medicaid.gov/sites/default/files/2023-09/nc-medicaid-reform-demo-attach-h-appvl-09282023.pdf

Healthy Opportunity Pilots: Results of First Evaluation

Accomplishments

- Major achievement - establishment of the infrastructure necessary for the Pilots to function.
- "This included necessary information technology platforms, the legal and regulatory agreements necessary for the state of North Carolina, prepaid health plans, network leads, human services organizations, and healthcare organizations to collaborate, integrating HSOs into the healthcare ecosystem, and the interpersonal work of making these relationships productive."
- Allowed for large-scale delivery of Pilot services across three regions of the state.
- Keys to success included support for capacity building, facilitating of communication between Plans, Network Leads, and Human Service Organizations, and detailed planning for the complicated logistics of delivery Pilot services to a large number of participants.

- **Recommendations**
  - Continue to accelerate enrollment
  - Ensure high rates of service delivery
  - Collect repeat needs assessments

Healthy Opportunity Pilots: 1115 Waiver Renewal

- Current waiver ends Oct. 31, 2024
- Submitted waiver renewal request to CMS for Nov 2024 – Oct 2029
- Requested changes to HOP:
  - **Expand services statewide**, with ability to procure additional Network Leads to cover new regions and additional capacity building funds for new Network Leads and HSOs
  - **Scale and modify certain existing HOP services** (e.g. 3 meals/day, 6 months rent and mortgage including arrears, firearm safety service and childcare services)
  - **Expand eligibility criteria** (e.g. “at risk of” a chronic condition, all pregnant women, all Tailored Plan members individuals impacted by natural disaster, individuals recently released from incarceration, children/youth who receive adoption assistance)

For more details, see: https://medicaid.ncdhhs.gov/meetings-notices/proposed-program-design/nc-section-1115-demonstration-waiver

Social Needs Screening, Referral, and Service Delivery and Payment – Overall Key Learnings

- Create an ecosystem and shared statewide infrastructure that can support innovation and payment structures across payers, plans, providers, community-based organizations e.g.;
  - Standardized screening questions, data collection, technology infrastructure
  - Network Leads to support community organizations
  - Standardized legal documents
- Invest in Community and Provider Capacity
  - Financial support upfront to community-based organizations
  - Technical Assistance for plans and community-based organizations to interact
  - Investment in community and local community-based organizations
- Make small incremental steps in value-based payment models

Elizabeth Tilson, MD, MPH (she/her)
North Carolina Department of Health and Human Services

Questions?

Next Steps

- **Review New SDOH Metric Guidance Documents!**
  - Latest December SDOH Metric FAQ
  - SDOH Screening & Referral Training Resources; and
  - Written Agreements Guidance Document

★ **All resources can be found on OHA Transformation Center Webpage.**

Upcoming SDOH Metric TA Opportunities

- **Office Hour -** Developing Data Sharing Agreements
  - February 16, 2023, 10 a.m. PST – Registration Link
- **Learning Collaborative** – Social Needs Screening Training & Resources
  - February 29, 2023, 3 p.m. PST – Registration Link
- **Café Connect** – Establishing Data Sharing Approaches and Agreements
  - March 18, 2023, 1 p.m. PST – Registration Link
- Contact **Claire Londagin** (londagin@ohsu.edu) for **1:1 TA**

Upcoming Technical Assistance (TA) Opportunities

Café Connect Event Series

Audience: CCOs, CBOs, & providers

- Hear from experts in the field
- Opportunity for CCOs, CBOs, and providers to engage in dialogue

Upcoming Topic: (Mar 18)
Establishing Data Sharing Approaches and Agreements – **Register Here**

Bi-Monthly Office Hours

Audience: CCO Measure Leads

- Talk through questions with TA providers and other CCOs
- Structured resources on a specific topic area

Upcoming Topic: (Feb 16)
Developing Data Sharing Agreements – **Register Here**

Learning Collaboratives (LCs)

Audience: CCO Measure Leads

- Share strategies and learn from one another
- Topics will center high priority needs and metric must-pass elements

Upcoming Topic: (Feb 29)
Social Needs Screening Training & Resources – **Register Here**

Individualized Technical Assistance

- One-on-one technical assistance is available to all CCO staff responsible for metric implementation
- Support tailored to the needs of individual CCOs
- Contact **Claire Londagin** (londagin@ohsu.edu) for individualized TA

Measure Contacts

Technical Assistance Team

- Anne King, MBA (she/her)
  kinga@ohsu.edu
- Kate Wells, MPH (she/her)
  katemcwells@gmail.com
- Claire Londagin, MPH (she/her)
  londagin@ohsu.edu
- Kristina Giordano (she/her)
  giordank@ohsu.edu

Oregon Health Authority Team

- Rachel Burdon, MPH (she/her)
  Rachel.E.Burdon@oha.oregon.gov
- Katie Howard, MPH (she/they)
  Katie.Howard@oha.oregon.gov

Health-Related Resource Needs Screening Levers

NC Medicaid is encouraging screening for health-related resource needs, and collection of valid data on screening, through a series of mechanisms.

Contract Requirement

- PHPs are contractually required to screen (or make at least three attempts to screen) members for HRRN within 90 days of enrollment.

Quality Measure

- PHPs are measured on three rates related to HRRN screening:
  - 1. At least 3 screening attempts within 90 days of health plan enrollment (contract requirement)
  - 2. Successful screening within 90 days of health plan enrollment
  - 3. Successful screening within the calendar year (withhold measure)

Data Validation

- PHPs report screening data to the Department, but the data has had significant quality issues. The Department now provides quarterly feedback to plans, and the External Quality Review Organization will conduct performance measure validation annually, which includes data validation

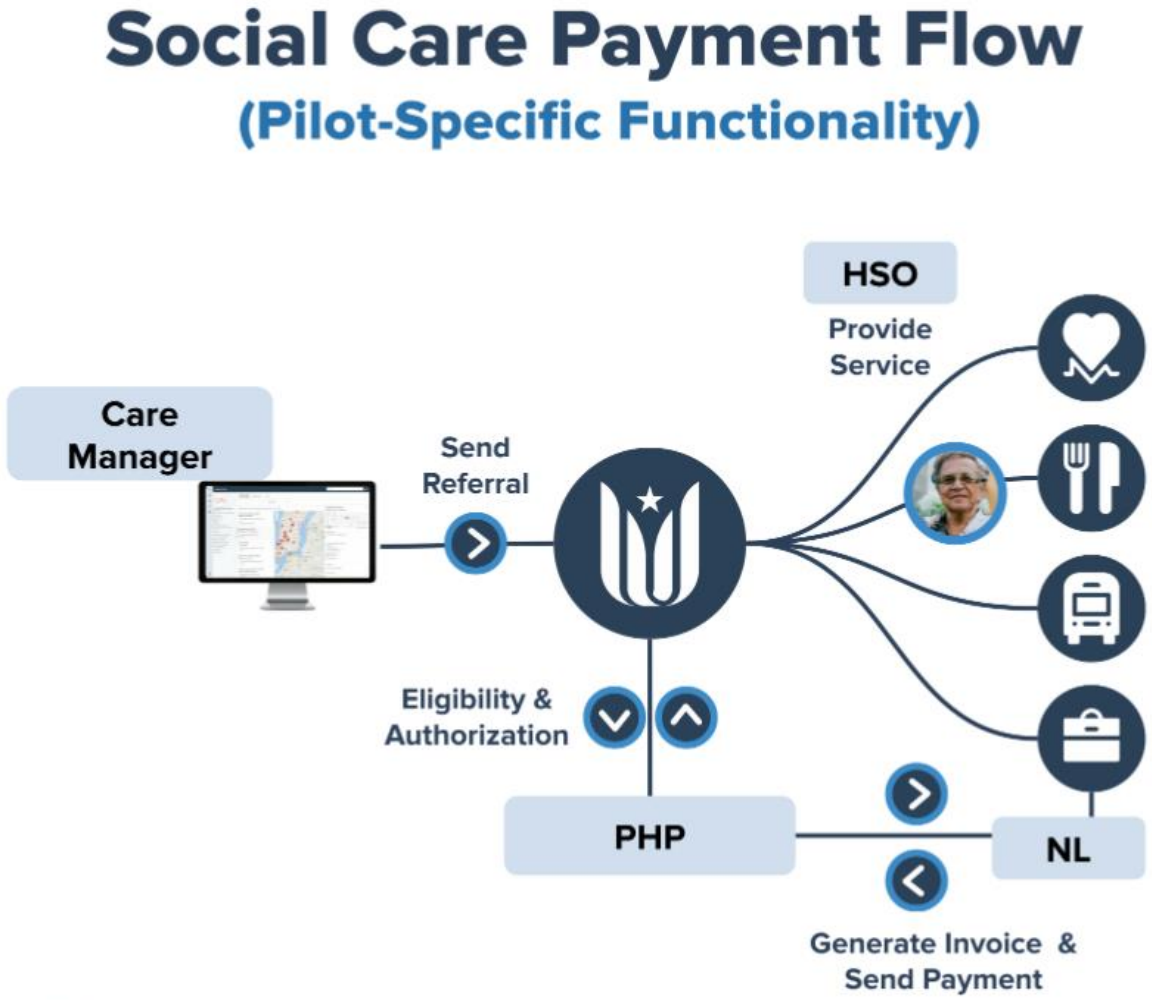
Withhold Program

- Year 1 of withhold program includes an HRRN "pay for reporting" (pay for data quality) measure, with bonus for PHP with highest completed screening rate within the calendar year.

Performance Improvement Projects

- States must require managed care plans to implement performance improvement projects (PIPs). The purpose of these projects is to achieve significant improvement in measurement of quality performance with objective indicators, as well as to generally sustain this improvement over time. Includes Learning Collaboratives, where plans problem solve barriers to improve rates and implement change ideas with the support of the Department's Quality Improvement Team.
- Beginning in 2024, PHPs are required to have a PIP for care needs screening

Workflow Across the Pilot Activities and Entities



Eligibility and Authorization

- Care Manager determines client's eligibility, needed services, and document using the PESA inNCCARE36
- Health Plan (PHP) verifies eligibility and authorized services
- Starting expediting enrollment for first service delivery

Referral Management

- Care Manager sends a referral for a reimbursable service through NCCARE360

Provide Service

- HSO delivers authorized services to client and documents details in NCCARE360

Generate Claim

- HSO automatically generates an invoice for service once the outcome is recorded
- NCCARE360 sends invoice t Network Lead for review and then on to PHP

Send Payment

- PHP receives invoice through NCARE360
- PHP remits payments to HSO outside of NCCARE360

Create Encounter

- PHP creates an encounter for the invoice and payment in NCCARE360 and sends to NCDHHS