Learning Community Meeting

April 19, 2022

Focus on Maternity Innovations in North Carolina

Agenda

1. Reintroducing the Maternal Health Hub and Online Portal

2. Focus on North Carolina Innovations
   - Amanda Van Vleet, North Carolina Dept of Health & Human Services
   - Dr. Sherma Morton and Rita Hanson-Bohl, Healthy Blue North Carolina
   - Kelly Crosbie, North Carolina Dept of Health & Human Services

3. Preview of Upcoming Learning Community Meetings

4. Adjourn

MATERNAL HEALTH hub

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Maternal Health Hub Phase 2 Collaboration

With continuing support from the Commonwealth Fund, the Health Care Transformation Task Force will work with the National Birth Equity Collaborative to map out the Learning Community plan for the coming year.

HEALTH CARE TRANSFORMATION TASK FORCE

The Commonwealth Fund

NBEC NATIONAL BIRTH EQUITY COLLABORATIVE

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Maternal Health Hub: Phase 2 Vision

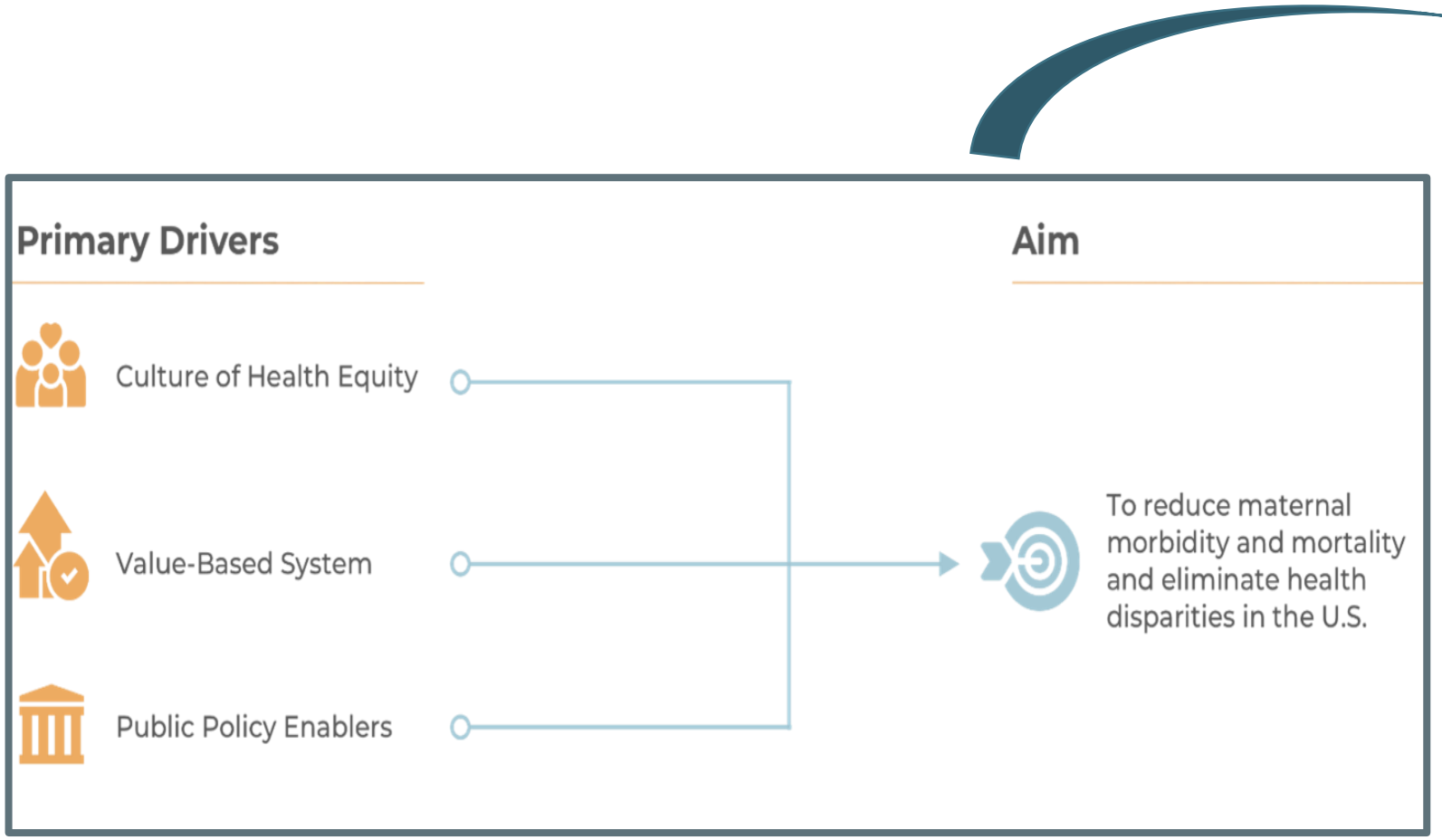
Vision: Public and private sector implementation of value-based payment strategies for maternity care that center health equity and address the need for anti-racist health system transformation for BIPOC birthing people and newborns.

Building on the discussions and output from Phase 1, in Phase 2 the MHH will

- Operate and populate the online repository to share and promote resources;
- Convene the Learning Community to share learnings and develop actionable recommendations for embedding health equity into the design and implementation of maternity value-based payment models; and
- Convey these recommendations to senior leaders at CMS/CMCS/CMMI

MATERNAL HEALTH hub

Maternity Theory of Change Model



The second phase effort will focus on communicating the Hub's learnings and resources to CMS, CMCS, and CMMI

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Phase 2 Learning Community Plan

Integrating Health Equity into Maternity Care Payment Models

- How can payment models be designed to address the challenges associated with social determinants of health and structural racism, with the goal of centering health equity?
- What payment policies and promising practices are successfully addressing health equity by incentivizing equitable access to care?
- How can existing efforts using Medicaid SPAs and waivers be applied to this goal?
- What are states doing to embed health equity and anti-racism policies into MCO contracts?
- How are health care providers creating financial incentives to embed anti-racist care delivery into clinical pathways?

General APM Operational Challenges and Opportunities

- What are the most promising APM levers and strategies states can use to positively impact maternity care outcomes?
- How can advances in understanding the implications of new maternity care models help drive and support additional payment model innovations, both for maternity care, and for early pediatric care?
- What are the opportunities and challenges to expanding Medicaid post-partum coverage to 12 months?

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Phase 2 Learning Community Plan

Data and Infrastructure

- What infrastructure is currently in place, and what new systems will be needed, for payers to develop, and providers to implement, maternity APMs that center the tenets of the community-based maternity model?
- What strategies are available to expand data collection in a way that allows for implementation of a broader set of quality measures, including patient experience measures, and allow them to be stratified by race, ethnicity, and other demographic variables?

Performance Measurement

- What are the most promising measures of health equity related to maternity care, and what data are needed to support the use of these measures?
- What tools exist today to collect patient experience data, and can they be used to assess experiences with maternity care?
- How can data collection and measures be meaningfully implemented into value-based payment models?

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Maternal Health Hub Online Portal

- In between Learning Community meetings, we encourage all members to visit the Maternal Health Hub online portal: www.maternalhealthhub.org
- The Task Force will update the resources section with findings, tools, resources, and reports identified by the Task Force, NBEC, and Learning Community members
- Learning Community members also have access to a discussion forum to dialogue on topics of interest as well as access summaries of previous meetings

To participate in the online forum, log in using the log in information provided to you (sent from anna.kemmerer@hcttf.org) with the subject line "Welcome to the Maternal Health Hub!"

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Maternal Health Hub Online Portal

Forum	Topics	Posts	Last Post
Introductions Use this forum to post an introduction of yourself to the learning community. This could include your organizational affiliation, areas of interest and expertise, and what you are hoping to learn and contribute.	8	24	1 week, 5 days ago Dana Strauss
Phase 1 Learning Community Meetings Materials and notes from each monthly meeting. September Kick-Off and Action Plan (1, 0), First Trimester: Building a Better Business Case for Community-Based Maternity Care (4, 2), Second Trimester: High-Value and Equitable Maternity Care in the Time of COVID-19 (3, 2), Third Trimester: Advancing Alternative Payment Models for Maternity Care (3, 0)	12	16	1 year, 3 months ago Leslie Farrington
Phase 2 Learning Community Meetings Materials and notes from each monthly meeting will be posted here.	1	1	3 weeks, 4 days ago Anna Kemmerer
Culture of Health Equity Fulfilling a culture of health equity requires a systemwide racial and economic justice approach to undo the status quo, with many implications beyond maternity care.	4	5	No Topics
Value-Based System A value-based system of health care prioritizes accountability for quality, health outcomes, and value over volume of care.	6	6	1 year, 8 months ago Carol Sakala
Public Policy Enablers Policy change is critical to address the complex and interconnected public health and social service shortcomings that often contribute to pregnant persons' poor outcomes and widening disparities.	3	3	No Topics
COVID-19 Impact on Maternity Care	1	2	1 year, 9 months ago Josh Traylor

Topic
4/19/22: Spotlight on North Carolina Started by: Anna Kemmerer

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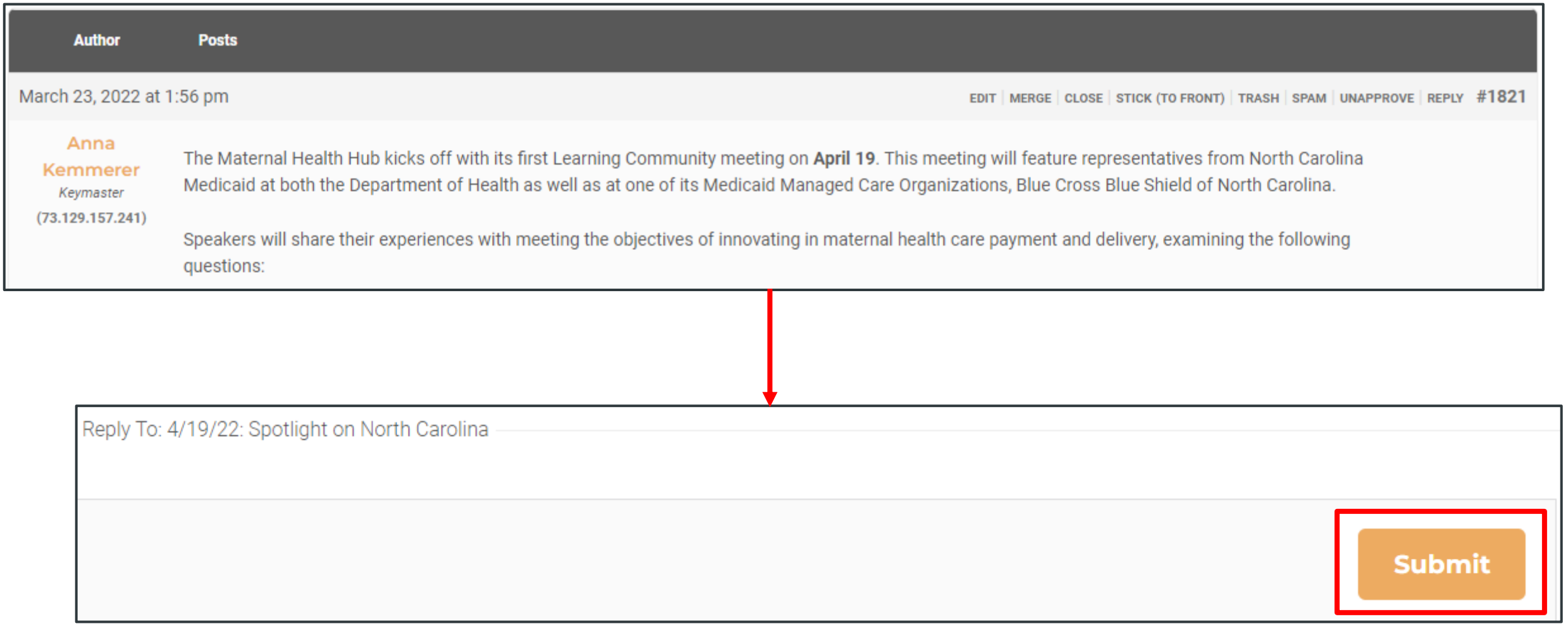
Maternal Health Hub Online Portal



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Focus on North Carolina to gather perspectives on the following questions:

- How can payment models be designed to address the challenges associated with social determinants of health and structural racism, with the goal of centering health equity?
- What payment policies and promising practices are successfully addressing health equity by incentivizing equitable access to care?
- How are Medicaid and State Health Departments embedding policies related to equity, cultural congruence, and anti-racism training, into their MCO contracts?

MATERNAL HEALTH hub

Healthy Opportunities Pilots in NC Medicaid

Amanda Van Vleet, MPH
Associate Director, Innovation
North Carolina Medicaid
Department of Health & Human Services

MATERNAL HEALTH hub





Healthy Opportunities in North Carolina Medicaid

Amanda Van Vleet, MPH
Associate Director, Innovation
NC Medicaid
North Carolina Department of Health and Human Services

April 19, 2022

Healthy Opportunities Pilots: Overview

NC's 1115 Medicaid transformation waiver authorizes **up to $650 million** in state and federal Medicaid funding to establish and operate regional Healthy Opportunities Pilots for five years.

Pilot funds will be used to:

- Pay for **evidence-based, federally-approved, non-medical Pilot services** defined in NC DHHS' Pilot fee schedule
- Establish infrastructure to bridge health and human services providers through **capacity building** in first two years[1]

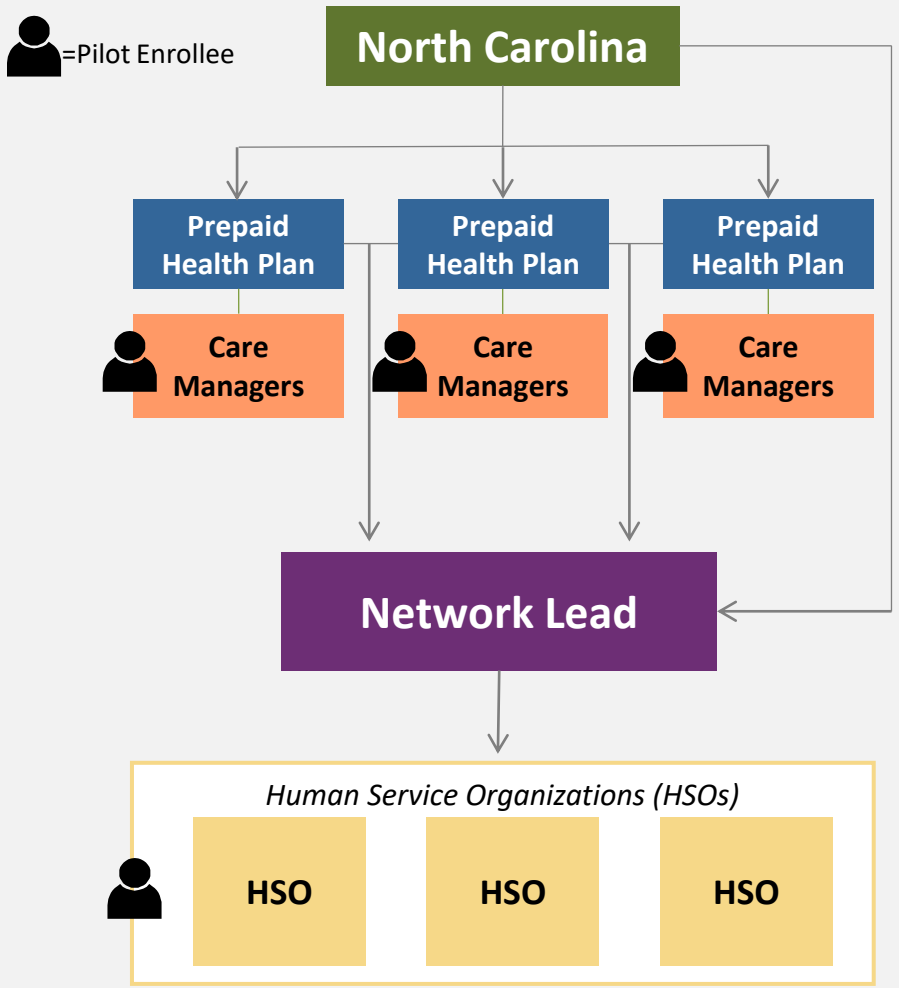
Pilot Vision and Goals:

- Integrate evidence-based, non-medical services into the Medicaid program 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** and identify which services are highest value and impact for which populations
  - NC DHHS and UNC Sheps Center have developed a CMS-approved SMART design (randomized trial) to provide rapid-cycle feedback during the life of the Pilots, 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**.

[1] A small amount of **administrative, care management, and value-based payments** will be made to incentivize Pilot entities to perform optimally

Healthy Opportunities Pilots: Structure

Sample Regional Pilot



Key Entities' Roles in the Pilots

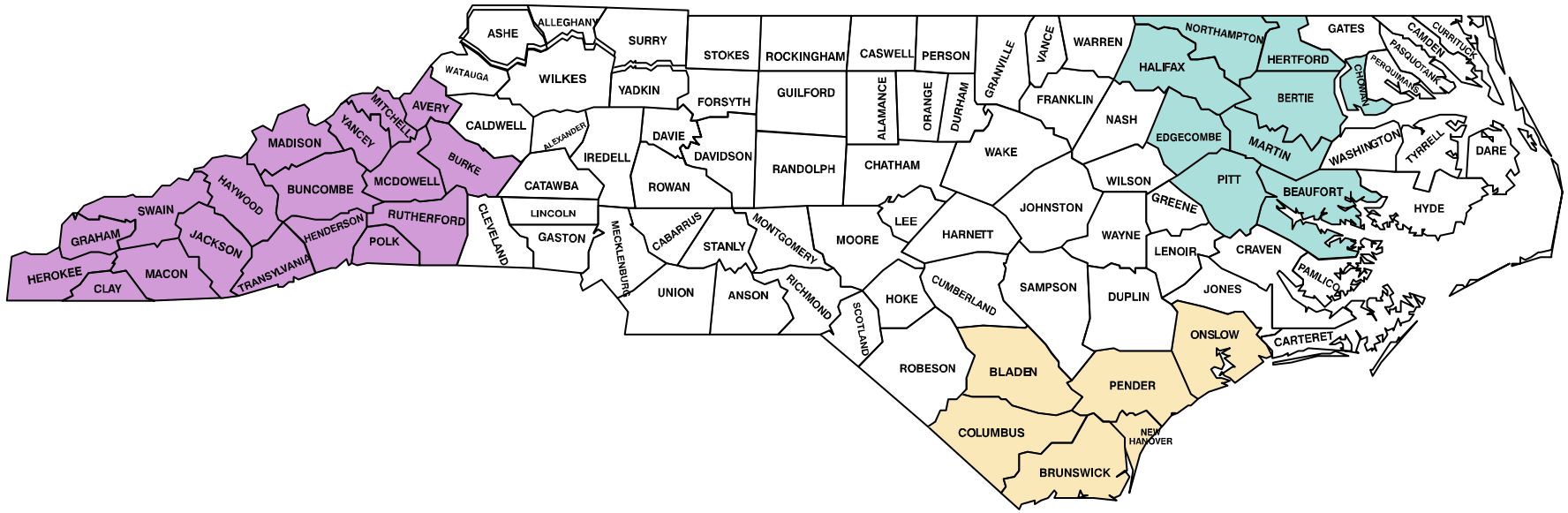
- **Prepaid Health Plans (PHPs):**
  - Approve which of their enrollees qualify for Pilot services and which services they qualify to receive
  - Ensure the provision of integrated care management to Pilot enrollees
  - Manage a Pilot budget and pay HSOs for delivery of Pilot services to their Pilot enrollees
- **Care Managers:**
  - Frontline service providers located at Tier 3 AMHs, LHDs, and PHPs interacting with beneficiaries
  - Assess beneficiary eligibility for Pilot, identify recommended Pilot services, refer Pilot enrollee to a Pilot HSO, and manage coordination of Pilot services, in addition to managing physical and behavioral health needs
  - Track enrollee progress over time
- **Network Leads:**
  - Develop, manage, and oversee a network of HSOs
  - Receive, track and validate invoices from HSOs and work with PHP to ensure accurate invoices are paid
  - Provide support and technical assistance for HSO network
  - Convene Pilot entities to share best practices
- **Human Service Organizations:**
  - Frontline social service providers that contract with the Network Lead to deliver Pilot services to Pilot members
  - Participate in the healthcare delivery system, including submitting invoices and receiving reimbursement for services delivered
  - Support identification of potential Pilot-enrollees by connecting them to their PHP or CM

Healthy Opportunities Pilots: Regions

PHPs, Network Leads, Care Management Entities, and HSOs will work with communities in three geographic areas of the state to implement the Pilots.

Highlights

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



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

Healthy Opportunities Pilots: Eligibility

To qualify for pilot services, Medicaid managed care enrollees in PHPs 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

Healthy Opportunities Pilots: Services

NC DHHS has defined and priced 29 services that can be covered by the Pilot. Services 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 Opportunities Pilots: Building on NCCARE360

NCCARE360 is the nation's first statewide closed-loop referral system that allows key stakeholders to connect individuals with needed community resources

- **NCCARE360 is a telephonic, online and interfaced IT platform, providing:**
  - A robust **statewide resource database** of community-based organizations and social service agencies
  - A **referral platform** that allows health care providers, insurers and human service providers to connect people to resources in their communities. It supports "closed-loop referrals," giving them the ability to track whether individuals accessed the community-based services to which they were referred
- **NC DHHS and Unite Us have worked together to build additional features into NCCARE360** to support eligibility documentation, enrollment, service authorization, and invoicing processes specific to the Pilots

Healthy Opportunities Pilots: Key Implementation Activities

Cross-Cutting Priority: *Increase accountability on health equity as part of Pilot design and implementation.*
DHHS continually working with stakeholders to understand and address feedback.

Developing Pilot Technology Systems

- Built eligibility, enrollment, service authorization, referral, and invoicing technology specific to Pilots in **NCCARE360** (onboarded and trained organizations; conducted end-to-end testing)
- Created and customized a new provider enrollment type for HSOs to easily enroll as Medicaid providers (**MMIS**)
- Developing **claims** and **encounters** technology for non-medical pilot services and **data analytics** systems

Facilitating Operational Readiness

- Developed **model contracts** between health plans, Network Leads, and HSOs
- Assisted health plans **in enrolling HSOs into payment systems**
- Conducted **trainings** and **readiness reviews**

Engaging with Key Stakeholders

- Engagement with **health plans**, **clinically integrated networks**, **Network Leads**, and **HSOs** on Pilot implementation
- Engagement with **Coalition Against Domestic Violence** and **Legal Aid of NC** on interpersonal violence and other sensitive services
- Engaging with stakeholders on **health equity** in pilots

Monitoring and Evaluation

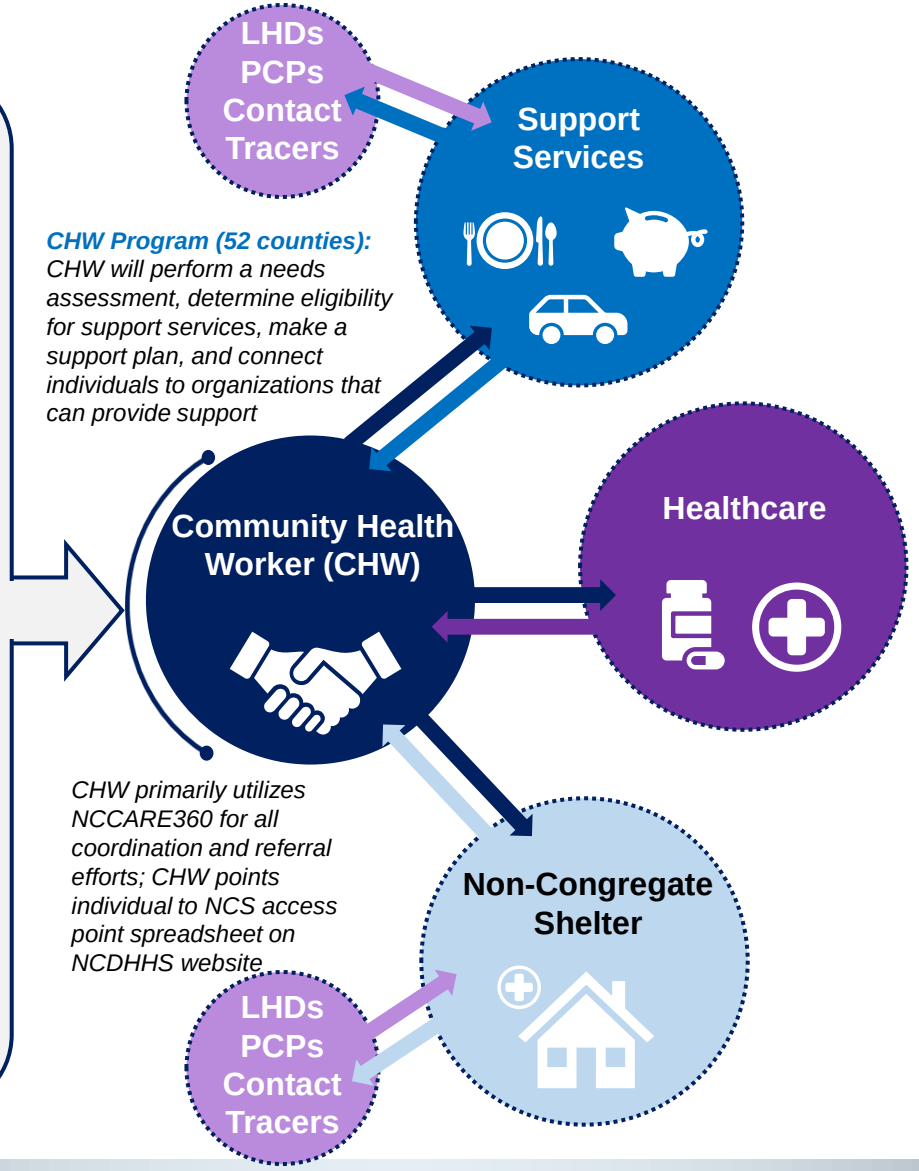
- Implementing **data transfer** capabilities; designing **dashboards and reports**; requesting 1115 waiver extension to June 30, 2026 from CMS
- **Monitoring** equity of HSO networks, HSO network size and availability of services; adequate member enrollment

Early Learnings: COVID-19 Quarantine and Isolation Supports Program

Braided multiple sources of federal CARES Act funding, State Medicaid dollars, & FEMA reimbursement, Aug 2020 – Apr 2021

Individual need is identified in a variety of ways ("No Wrong Door"):

- individual tests positive for COVID-19 and receives instructions from the testing center
- individual is contacted by a Contact Tracer about possible COVID-19 exposure/next steps
- individual reaches out to their Local Health Department about COVID-19 needs
- individual is referred to Q&I supports by their doctor/nurse
- individual has recommendation to isolate as a high-risk individual
- individual is a first-responder or frontline healthcare worker
- individual sees information online and believes they might qualify for services
- individual is waiting on test results to come in



CHW Program (52 counties): *CHW will perform a needs assessment, determine eligibility for support services, make a support plan, and connect individuals to organizations that can provide support*

CHW primarily utilizes NCCARE360 for all coordination and referral efforts; CHW points individual to NCS access point spreadsheet on NCDHHS website

Support Services Program (29 counties; 4 regions): Innovative program to assist individuals in high-risk counties who need access to primary medical care and supports such as food or a relief payment to successfully quarantine or isolate due to COVID-19:

1. **Nutrition assistance**, including home-delivered meals and food boxes
2. **A one-time COVID-19 relief payment** to help supplement lost wages or the inability to look for work while in isolation/quarantine and to be used on basic living expenses
3. **Private transportation** provided in a safe manner to/from testing sites, medical visits, and sites to acquire food
4. **Medication delivery**
5. **COVID-related over-the-counter supplies**, such face masks, hand sanitizers, thermometers, and cleaning supplies
6. **Access to primary medical care** to manage COVID recovery will also be provided through telehealth services through Community Health Workers (CHWs).

Non-Congregate Shelter Program (statewide): Collaborative effort between the State, counties and local partners to secure **non-congregate shelter** for individuals with no other safe place to quarantine, isolate, or social distance due to COVID-19.

2 options for reimbursement:

1. Local partners desiring state-centric coverage through NCEM (required MOA)
2. Local partners seeking direct reimbursement from FEMA

Key Lessons Learned from COVID-19 Quarantine & Isolation Supports Program

- **Capacity of community organizations and network leads is extremely important**
  - Cash reserves and need for up-front funding
  - Staff capacity or partnerships
  - Experience with technology, data monitoring, and reporting

- **Relationships with community members and organizations is key**
  - Trusted members of the community and trusted local organizations were vital in reaching NC residents and achieving equity
  - Existing partnerships enabled the program to launch and scale quickly

- **Need for technical assistance and learning collaboratives**
  - High need for in-depth, one-on-one technical assistance and training
  - Collaborative forums helpful for vendors to share experiences, issues, and lessons learned

- **Simple, user-friendly technology needed** to refer to, and invoice for, specific services

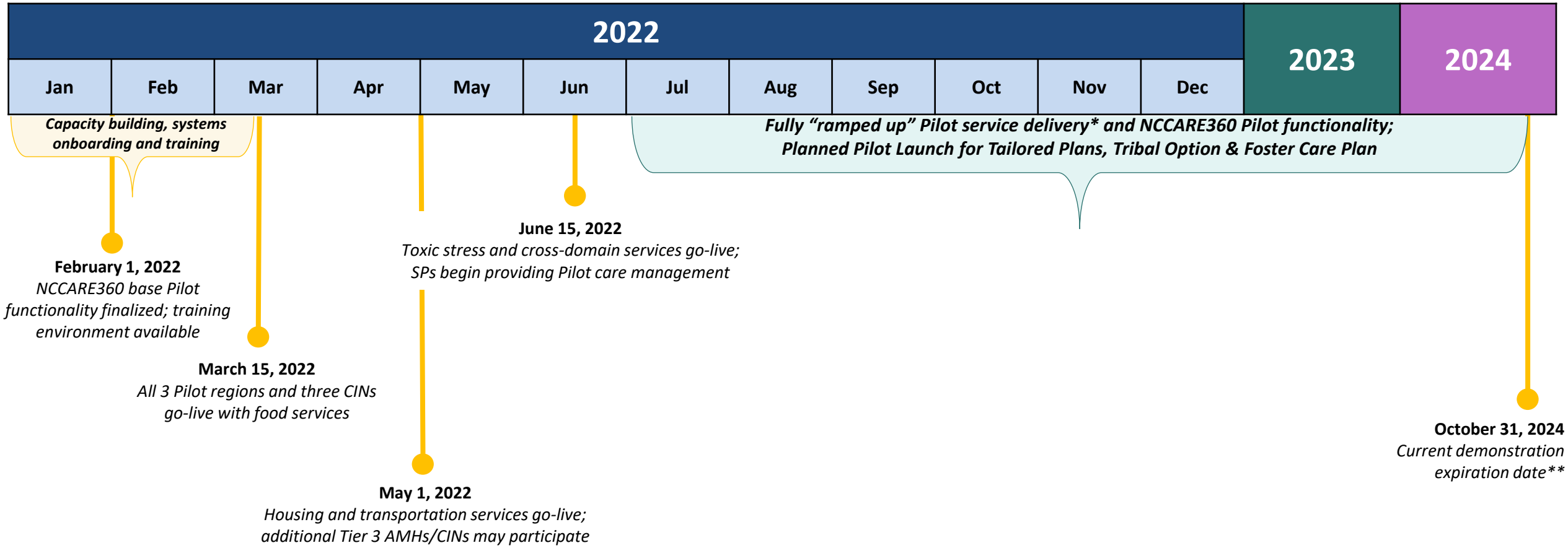
- **Need for the Department to be nimble, iterative, and collaborative**
  - Focus on speed and simplicity
  - Iterated regularly in response to real-time learnings; need for clear communication
  - Simple, streamlined enrollment process amplified enrollment

- **Results**
  - Provided more than 171,000 services to nearly 42,000 households
  - Over 70% of support services were delivered to historically marginalized populations
  - Both clients and CHWs reported positive experiences[1]

[1] https://www.milbank.org/publications/north-carolinas-covid-19-support-services-program-lessons-for-health-policy-programs-to-address-social-needs/

Timeline for Healthy Opportunities Pilot Launch

The Healthy Opportunities Pilots will launch in phases between March 15 and June 15, 2022.



*Timing for launch of interpersonal violence services and other sensitive services is TBD
**Negotiations underway to extend demonstration period to June 30, 2026

Appendix

Context Setting: North Carolina's "Healthy Opportunities" (SDOH) Initiatives

NC DHHS has built shared assets and infrastructure to be used across populations, embedded them in Medicaid, and developed targeted initiatives to build the Healthy Opportunities evidence base.

Shared assets and infrastructure across populations:

- Healthy Opportunities "Hot Spot" Interactive GIS Map
- Standardized Healthy Opportunities Screening Questions
- NCCARE360
- Workforce development / Community Health Worker Initiatives
- COVID-19 Isolation and Quarantine Supports

Cross-divisional work within DHHS and work with external health and human service partners

Medicaid Enrollees | **Medicare Enrollees** | **Commercially-Insured** | **Uninsured**

- **Embed assets and infrastructure in Medicaid** as a base for other payers and initiatives to build on
- **Targeted initiatives to develop evidence base:** Healthy Opportunities Pilots

Today's Focus

Priority Domains for All Healthy Opportunities Initiatives

Pilot Eligibility: Physical/Behavioral Health Criteria

Medicaid members must meet at least one physical/behavioral health criteria and one social risk factor to be eligible for the Pilot program.

Eligibility Category	Age	Physical/Behavioral Health Criteria (at least one, per eligibility category)
Adults	21+	• 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 mental illness, 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 2500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit
	0-20	• 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 85th %ile for age and gender, developmental delay, cognitive 67 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

Pilot Eligibility: Social Risk Factors

Medicaid members must meet at least one physical/behavioral health criteria and one social risk factor to be eligible for the Pilot program.

Risk Factor	Definition
Homelessness and housing insecurity	Homelessness, as defined in U.S. Department of Health and Human Services 42 CFR § 254(h)(5)(A), and housing insecurity, as defined based on questions used to establish housing insecurity in the NC Healthy Opportunities Screening Tool.
Food insecure	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 Or as defined based on questions used to establish food insecurity in the NC Healthy Opportunities Screening Tool.
Transportation insecure	Defined based on questions used to establish transportation insecurities in the NC Healthy Opportunities Screening Tool.
At risk of, witnessing or experiencing interpersonal violence	Defined based on questions used to establish interpersonal violence in the NC Healthy Opportunities Screening Tool.

Pilot-Service Specific Eligibility Criteria (Examples)

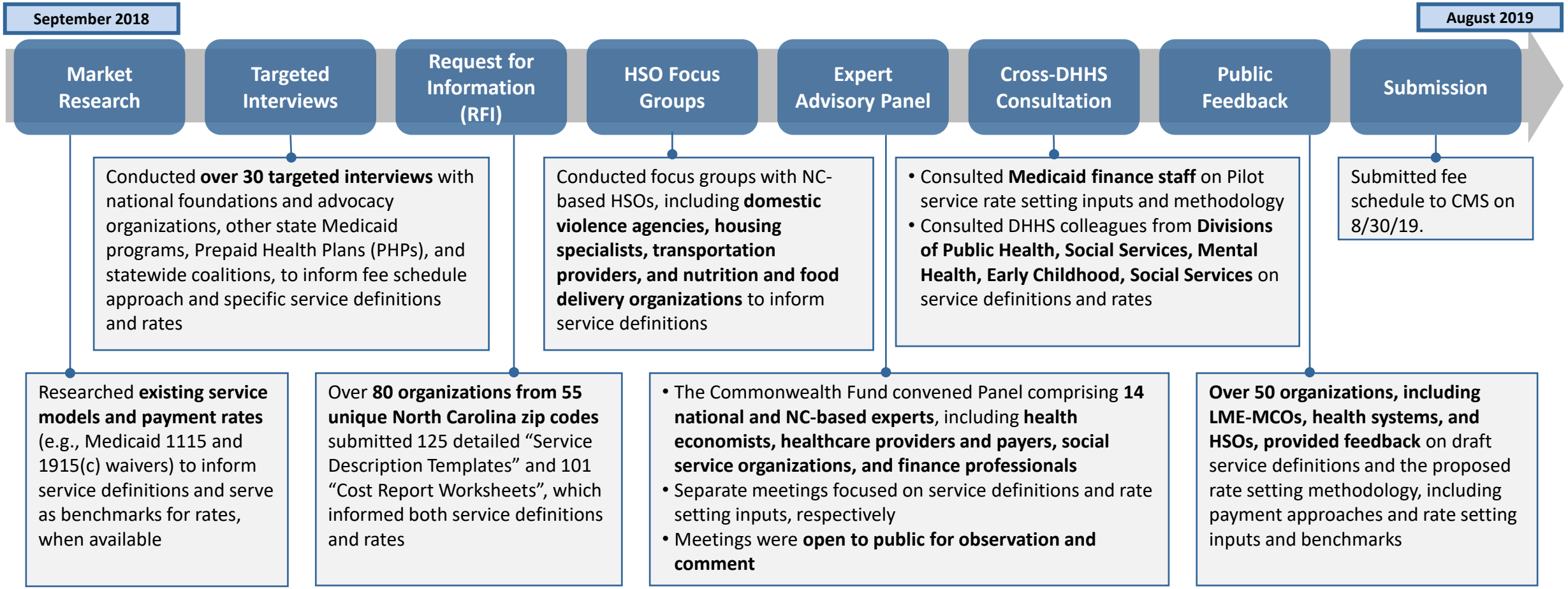
Individuals determined eligible for the Pilot program must also meet eligibility requirements for specific Pilot services, which are documented in the Pilot Service Fee Schedule.

Service	Minimum Eligibility Criteria
Housing Navigation, Support, and Sustaining Services	• Enrollee is assessed to be currently experiencing homelessness, are at risk of homelessness and those whose quality/safety of housing are adversely affecting their health. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollees may not simultaneously receive the Housing Navigation, Support and Sustaining Services and the IPV Case Management Services. Individuals with cooccurring housing and IPV-related needs should receive the Holistic High Intensity Case Management service. • This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Medically Tailored Home Delivered Meals	• Enrollee does not have capacity to shop and cook for self or have adequate social support to meet these needs.
	• Eligible disease states include but are not limited to obesity, failure to thrive, slowed/faltering growth pattern, gestational diabetes, pre-eclampsia, HIV/AIDS, kidney disease, diabetes/pre-diabetes, and heart failure.
	• If potentially eligible for SNAP and/or WIC, the enrollee must either:
	  ○ Be enrolled in SNAP and/or WIC, or
	  ○ Have submitted a SNAP and/or WIC application within the last 2 months, or
	  ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months
	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan.
	• Enrollee is not currently receiving duplicative support through other Pilot services.
	• This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service.
	• Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Healthy Opportunities Pilots Fee Schedule: Overview

North Carolina conducted a rigorous, data-driven, and transparent year-long process to develop the Pilot Service Fee Schedule, informed by feedback from local and national experts and North Carolina constituents.



Healthy Opportunities Pilots Fee Schedule: Sample Service Definition

HSOs must deliver authorized Pilot services to enrolled Members in accordance with the service definitions in the Pilot Fee Schedule

- Service definitions provide additional detail on each Pilot service, including:
  - Service description,
  - Anticipated frequency,
  - Duration,
  - Setting of service delivery, and,
  - Minimum eligibility criteria for receiving the service.
- The service definitions are final as approved by CMS and not subject to change prior to the initial service delivery period.
- The full fee schedule is available here: https://www.ncdhhs.gov/media/14071/open

Home Remediation Services

Category	Information
Service Name	Home Remediation Services
Service Description	Evidence-based home remediation services are coordinated and furnished to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Home remediation services may include for example pest eradication, carpet or mold removal, installation of washable curtains or synthetic blinds to prevent allergens, or lead abatement.
Frequency *(if applicable)*	Enrollees may receive home remediation services at any point at which they meet minimum service eligibility criteria and have not reached the cap.
Duration *(if applicable)*	N/A
Setting	Home remediation services occur in the enrollee's current place of residence or potential residence.
Minimum Eligibility Criteria	• Enrollee must be moving into a new housing unit or must reside in a housing unit that is adversely affecting his/her health or safety. ○ The housing unit may be owned by the enrollee (so long as it is their primary place of residence) or rented. • Landlord has agreed to and provided signed consent for approved home remediation services prior to service delivery (if applicable). • Landlord has agreed to and provided signed consent to keep rent at current rate for a period of twenty-four months after receiving Pilot Home remediation services prior to service delivery (if applicable). • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Healthy Opportunities Pilots Fee Schedule: Pilot Service Rates

The Pilots represent the first time Medicaid funding will systematically pay for health-related social services for a broad subset of Medicaid enrollees. The CMS-approved fee schedule, defines and prices Pilot services. All Pilots will adhere to the fee schedule's rates in their payment practices

	Service Name	Fee Schedule Rate
Housing Services	Housing Navigation, Support and Sustaining Services	$400.26 PMPM
	Inspection for Housing Safety and Quality	Up to $250 per inspection*
	Housing Move-In Support	1-5+ BR: Up to $900- $1,250* per month
	Essential Utility Set-Up	Up to $500 for utility deposits, arrears or reinstatement*
	Home Remediation Services	Up to $5,000 per year*
	Home Accessibility and Safety Modifications	Up to $10,000 per lifetime of waiver demonstration*
	Healthy Home Goods	Up to $2,500 per year*
	One-Time Payment for Security Deposit and First Month's Rent	• First Month's Rent: Up to 110% Fair Market Rent (FMR)* • Security deposit: Up to 110% FMR x2*
	Short-Term Post Hospitalization Housing	• First Month's Rent: Up to 110% Fair Market Rent (FMR)* • Security deposit: Up to 110% FMR x2*

These payment rates include the HSO's costs for delivering the service, as well as the HSO's related administrative costs.

* Indicates cost-based reimbursement up to the fee schedule cap

Healthy Opportunities Pilots Fee Schedule: Pilot Service Rates (cont'd)

	Service Name	Fee Schedule Rate
Food Services	Food and Nutrition Access Case Management Services	15-minute interaction: $13.27
	Evidence-Based Group Nutrition Class	One class: $22.680
	Diabetes Prevention Program	**Phase 1: $275.83** • Completion of 4 classes: $27.38 • Completion of 4 additional classes (8 total): $54.77 • Completion of 4 additional classes (12 total): $68.46 • Completion of 4 additional classes (16 total): $125.22 **Phase 2: $103.44** • Completion of 3 classes: $31.02 • Completion of 3 additional classes (6 total): $72.42
	Fruit and Vegetable Prescription	Up to $210 per month*
	Healthy Food Box (For Pick-Up)	Small box: $89.29 Large box: $142.86
	Healthy Food Box (Delivered)	Small box: $96.79 Large box: $150.36
	Healthy Meal (For Pick-Up)	$7.00 per meal
	Healthy Meal (Home Delivered)	$7.60 per meal
	Medically Tailored Home Delivered Meal	$7.80 per meal

* Indicates cost-based reimbursement up to the fee schedule cap

Healthy Opportunities Pilots Fee Schedule: Pilot Service Rates (cont'd)

	Service Name	Fee Schedule Rate
Interpersonal Violence (IPV) Services	IPV Case Management Services	$221.96 PMPM
	Violence Intervention Services	$168.94 PMPM
	Evidence-Based Parenting Curriculum	One class: $22.60
	Home Visiting Services	One home visit: $67.89
	Dyadic Therapy	$68.25 per occurrence
Transportation Services	Reimbursement for Health-Related Public Transportation	Up to $102 per month*
	Reimbursement for Health-Related Private Transportation	Up to $267 per month*
	Transportation PMPM Add-On for Case Management Services	$71.30 PMPM
Cross-Domain Services	Holistic High Intensity Enhanced Case Management	$501.41 PMPM
	Medical Respite	$206.98 per diem
	Linkages to Health-Related Legal Supports	15-minute interaction: $25.30

* Indicates cost-based reimbursement up to the fee schedule cap

Healthy Opportunities Pilots Evaluation

Key Learning Objectives

- **Evaluate the effectiveness** of select, evidence-based, non-medical interventions and the role of the Network Lead in improving health outcomes and reducing health care costs for high-risk members
- **Leverage evaluation findings** to embed cost-effective interventions that improve health outcomes into the Medicaid program statewide to promote sustainability
- **Support the sustainability** of delivering non-medical services identified as effective through the evaluation, including by strengthening the capabilities of HSOs and partnerships with health care payers and providers

Hypotheses Tested

- Network Leads will enable **effective delivery of Pilot services**
- The Pilot program will increase rates of Medicaid enrollees **screened** for social risk factors and **connected to** services that address these risk factors
- The Pilot program **will improve the qualifying social risk factors, health outcomes, healthcare utilization, and healthcare costs of participants** (overall and by sub-populations)

Evaluation Phases

- **Rapid cycle assessments:** To gain "real-time" insights on whether Pilots are operating as intended, if services are having their intended effects, and what mid-course adjustments need to be made to improve delivery of effective services
- **Summative Evaluation:** To assess the global impact of the Pilots, learn which interventions are effective for specific populations, and plan for incorporation into the Medicaid program

Healthy Blue North Carolina

Sherma Morton, MD FACOG
OBGYN Medical Director
Healthy Blue NC

Rita Hanson-Bohl, MHA, CPC
Director, Network Relations
Healthy Blue NC

MATERNAL HEALTH hub

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Initiatives

Please share some background on the various initiatives being used via Healthy Blue to support improvements in how maternity care is being delivered (this will allow me to bring in several BCBS representatives to share their work)

- **Care management**-Case Management services provided to pregnant women identified as having the highest obstetric risk determined through predictive modeling. Work one on one with members and their families, using behavioral health change science to promote engagement .
  - Members are empowered to exercise their options and access the services appropriate to meet their individual health needs, by using communication, education, and available resources to promote quality cost-effective outcomes and optimize health care benefits.
- **OB consultants** -OB Practice Consultants serve as a positive clinical liaison between OB providers and health plans to promote high quality, cost-effective, evidenced-based care. They offer OB Providers resources, education & support on our maternal/child programs, policies and procedures
- **OB High Risk rounds**- biweekly rounds facilitated by the OBGYN MDR with care management, behavioral health, and nutritionist to assess high- risk members and determine what their current needs and possible future needs are. Also, topic discussion and education of the clinical significance of medical and social issues impacting the member
- **Engaging with Health Departments**

Improvements on how maternity care is delivered

- **The Healthy Blue perinatal program** is a proactive care management program for all expectant mothers in GBD health plans. Depending on the market, the program is known as Taking Care of Baby and Me® (TCOBAM) or New Baby, New Life℠ (NBNL).

- **My Advocate™**-As part of the TCOBAM/NBNL program a service of Change Healthcare, a vendor conducting health-related outreach to pregnant members. interactive programs for maternal health using Change Healthcare's innovative communications platform of automated telephone calls, text message service, web/email and smartphone app.

- **Prenatal Packs-** congratulations flier, an education booklet on Planning a Healthy Pregnancy, and postcards

- **Postpartum Pack**. May vary depending on the health plan/ however, generally contains a congratulations flier, an education booklet on Caring for Your Newborn, and a postcard that the member's doctor can fill out to verify she had a postpartum follow up appointment

Improvements on how maternity care is delivered Continued

- **Diversifying the Breastfeeding/Lactation Support Workforce** to Reduce Breastfeeding Disparities- International Board of lactation consultants-2% of members are African American. Black babies are five times more likely to be offered formula than white babies in a hospital. (Medolac, 2015). In addition, Black families continue to have the lowest breastfeeding imitation and duration rates (CDC,2020). Investing in HBCU training of lactation consultants. First inaugural class was 2021 at NCA&T SU funded by the breastfeeding institute at UNC

- **Utilization of other pilot programs** methodology such as California doula pilot programs (Anthem Doula Pilot, Contra Costa County – Perinatal Equity Initiative Community Based Doula Program) that are currently running to learn from mistakes and successes

Developing Initiatives for Doulas

- Learning the pillars of **emotional support, physical support, advocacy, and informational support**
- **Reinforcing the evidence**: Cochran review (Bohren et al 2017)
  - Patients more likely to have spontaneous vaginal births
  - Less likely to require pain medication or epidurals
  - Less likely to have negative feelings about childbirth
  - Less likely to have instrumented deliveries
  - Labors were shorter by about 40 minutes
  - Babies- less likely to have low Apgar scores at birth
  - Lower postpartum depression in mothers
  - *No* evidence for negative consequences to continuous labor support
- **Promotion of community-based doula organizations** verses private doulas- Trusted members of the community that serve as a bridge for language and cultural gap, Offers Whole-Person Care, Prioritize the postpartum period, Programs built around a reproductive just framework – that includes implicit bias, trauma-informed care training, Peer Support for Doulas -Includes ongoing supervision or mentorship
- **Leaning from currently practicing doula programs** to navigate and diversify care models to incorporate community needs

Challenges for Developing Initiatives for Doulas

- Patient notification and engagement
- Engagement of doula organizations
- Billing mechanisms (doulas cannot bill in NC)
- Reimbursement rate
- Administrative burdens
- Doula certification and standardization
- Value added services
- **Partnership-** engaging and partnering with community-based doula and doula collectives within the region being served to build capacity

Challenges for Developing Initiatives for Doulas

- **Expansion-** engaging and in communication with other groups in region two to partner with HealthyBlue to provide doula services
- **Notify –** notification of value-based initiative available to our members through OB practice managers, doula providers, birth centers and with patients through care managers
- **Engaging and becoming stakeholders in academic research**- Dr. Morton is currently involved with UNC (ACCURE4 MOM) enrolling patients to investigate the effects of doula involvement in High-risk pregnancies.

Value Added Services

- **Value-added services** focused on prenatal care for the at-risk population-
  - **Substance abuse**- UNC Horizons- ensure that each pregnant woman who seeks or is referred for and would benefit from substance use disorder services is given preference in admission to our program.
    - Helping the patient develop an individual treatment plan
  - **Breastfeeding Support Kit –**
    - support kit includes
      an Infant support nursing pillow, washable nursing pads, nursing cover, educational brochures such as Breastfeeding Facts & Myths and How to Breastfeed
  - **Doula Services –**
    - Up to 2 prenatal visits
    - Up to 2 childbirth education classes
    - Labor support
    - Up to 2 postpartum visits

Value Added Services Continued

- **Healthcare Beyond Home Repair and Modification Services-**
  - Healthy Blue will provide up to a $1500 allowance to help support members needing help with home repairs and/or modifications that will allow them to stay or return to their homes

- **Healthcare Beyond Housing Transition Assistance Services –**
  - Healthy Blue will provide up to a $500 allowance to help members experiencing homelessness
    transition into more permanent housing

- **Safe Sleep Kit –**
  - safe sleep kit includes –
    infant sleep guidelines and education, breastfeed facts and myths, how to breast feeding educational materials, halo sleepsack, and Soothie pacifier

Vision for a CMS/CMCS Value Based Payments

- **Utilization of the 12 months of Medicaid covered postpartum care** extension to make an impact of preventative diseases such as hypertension, obesity, and diabetes that are major determinants in pregnancy outcomes
- **Measuring and tracking health equity** relative to key maternal health outcomes
- **The addition of some of the value-added services**
- **Using OB screening questioning** to determine social determinants of Health
- **Certification-** aid in the certification of doulas
- **Engage practices in proposed regions-** Notify of Doula initiative and target high-risk patient population
- **Referrals-** for example: through the provider at first/any prenatal visit postpartum visit, Healthy Blue care manager, or in Initial pregnancy folder
  - Account for how patient was notified to see what method made more of an impact

Vision for a CMS/CMCS Value Based Payments

- **Presence in the community**-Healthy Blue should have a presence in the communities that we serve such as health fairs or the recent OBGYN society meetings.
- **Employ implicit bias training and cultural competence training**
- **Healthy Blue whole health strategy**- with the provision of doula care will address expectant mothers' physical, behavioral, and social needs by centering members.
- **Diversifying the workforce**- through grant funded trainings
- **Supporting doulas programs, birthing centers, and Midwifery**
- **Partnering directly** with community-based organizations (CBOs) to aid in education and utilization of plan benefits.
- **Facilitating and aiding in continued evidence base medicine-** through evaluation, research and collaboration with other research organizations
- **Ultimately, closing the coverage gap for uninsured women of reproductive age to make an impact in birth outcomes affected by preventative diseases**

State Initiatives on Health Equity in Population Health, Quality, and Value-Based Payment

Kelly Crosbie
Chief Quality Officer
North Carolina Medicaid
Department of Health & Human Services

MATERNAL HEALTH hub

Agenda

1. Reintroducing the Maternal Health Hub and Online Portal

2. Focus on North Carolina Innovations
   - Amanda Van Vleet, North Carolina Dept of Health & Human Services
   - Dr. Sherma Morton and Rita Hanson-Bohl, Healthy Blue North Carolina
   - Kelly Crosbie, North Carolina Dept of Health & Human Services

3. Preview of Upcoming Learning Community Meetings

4. Adjourn

MATERNAL HEALTH hub

Upcoming Meetings

May 17: Embedding equity at the health care executive level and in MCO contracts

- Representatives from the University of Pennsylvania Health System and Minnesota State Department of Health are invited to speak

June 21: Post-Partum Care and Coverage in Medicaid

- Louisiana expanded Medicaid postpartum coverage under American Rescue Plan (began 4/1/22)
- Washington State enacted legislation to seek federal approval to expand coverage regardless of changes in income, during the postpartum period

Please share the website (www.maternalhealthhub.org) with your networks and encourage participation in the Learning Community.

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