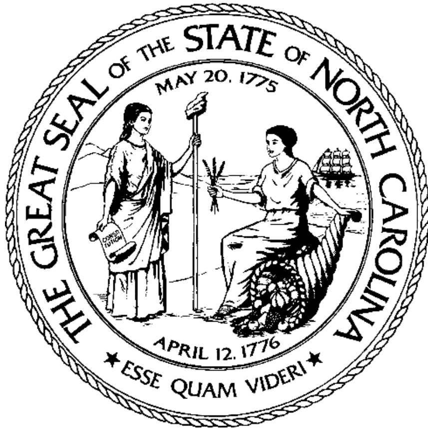


Healthy Opportunities Pilot: LME/MCO, AMH+, CMA Care Manager Training

Deeper Dive on Responsibilities of Frontline Care Management Teams in the Healthy Opportunities Pilot

November 6, 2023

Presenters

Andrea Price-Stogsdill	Leonard Croom
Program Manager, NC Medicaid, Strategy Office: Healthy Opportunities Pilot Program	Population Health Program Lead, NC Medicaid, Quality & Population Health

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

Objectives for Today's Session

Objectives

- Care management teams at LME/MCOs, AMH+s, CMAs understand:
  - The process for enrolling members in HOP and coordinating HOP services
  - Care management team roles and responsibilities for ongoing HOP care management
  - How Tailored Care Management and HOP care management requirements intersect

Reminder: Schedule for HOP Trainings

In the lead up to HOP launch, the Department is hosting live training sessions for care management teams. Care management teams will subsequently complete virtual self-paced trainings that provide a deep dive into HOP services and how to choose appropriate services for members.

HOP Training Topic	Date
Three live sessions hosted by DHHS staff	
• *The Role of Care Management Teams in the Healthy Opportunities Pilot*	*Monday, October 23* *11-11:50 AM ET*
• Deeper Dive on HOP Responsibilities of Frontline Care Managers	**Today's Focus**
• Assessing Member Eligibility for Participation in the Healthy Opportunities Pilot	**Monday, November 20** **11-11:50 AM ET**
Self-paced sessions accessed through online AHEC modules	
• HOP Overview module for Care Managers (**Bundle 1**) • Diversity, Equity, and Inclusion (DEI) – Cultural Humility (**Bundle 1**) • How Care Managers Can Obtain Pilot Consent (**Bundle 1**) • Tracking Enrollee Progress, Reviewing Service Mix, and Reassessing Pilot Eligibility (**Bundle 1**) • How Care Managers Can Choose Appropriate Interpersonal Violence Services (Part 1) (**Bundle 1**) • How Care Managers Can Choose Appropriate Interpersonal Violence Services (Part 2) (**Bundle 1**) • How Care Managers Can Choose Appropriate Transportation Services (**Bundle 2**) • How Care Managers Can Choose Appropriate Food Services (**Bundle 2**) • How Care Managers Can Choose Appropriate Housing Services (**Bundle 2**) • Understanding the Medical Respite Cross Domain Service (**Bundle 2**) • How Care Managers Can Choose Appropriate Toxic Stress Services (**Bundle 2**) • How Care Managers Can Choose Appropriate Health Related Legal Supports (**Bundle 2**)	***Ongoing*** ***Bundle 1: Released October 20th*** ***Bundle 2: To Be Released November 20th***

Recap: Healthy Opportunities Pilot Overview

The Healthy Opportunities Pilot (HOP) will test evidence-based, non-medical interventions designed to reduce costs and improve health outcomes for qualifying Medicaid enrollees.

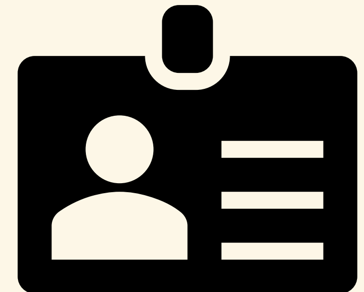
- HOP launched for the Standard Plan population in 2022. **HOP will launch for the following LME/MCO population eligible for Tailored Care Management beginning February 1, 2024:**
  - Members engaged in Tailored Care Management,
  - Members eligible for Tailored Care Management who have opted out, and
  - Members not participating in Tailored Care Management because they are receiving ACT/HFW.
- HOP will operate in **three "HOP regions"** across select counties in the state; 4 LME/MCOs will serve members in HOP regions *(see appendix).*
- HOP services will be offered across **four priority domains:** Housing, Food, Transportation, and Interpersonal Violence.
- **LME/MCO members eligible for Tailored Care Management are likely eligible to participate in HOP;** these members meet the HOP health criteria and must also have a qualifying social risk factor.
- HOP care management will be **integrated into existing Tailored Care Management workflows**.

Today's presentation will highlight how HOP requirements for care management teams intersect with Tailored Care Management.

Context for Today: Care Management Teams Serving LME/MCO Members

Care management teams will be central to the success of HOP by coordinating HOP services and providing care management. For members in Tailored Care Management and HOP, Care management teams include:

- **Supervising Care Manager:** Responsible for overseeing care managers
- **Care Manager:** Leads delivery of integrated, whole-person Tailored Care Management to members as well as HOP care management
- **Care Manager Extender:** Can support care managers in delivering Tailored Care Management and various HOP activities *(see next slide)*



Requirements on Tailored Care Management staffing are detailed in the Tailored Care Management Provider Manual

The Role of Care Management Extenders in HOP

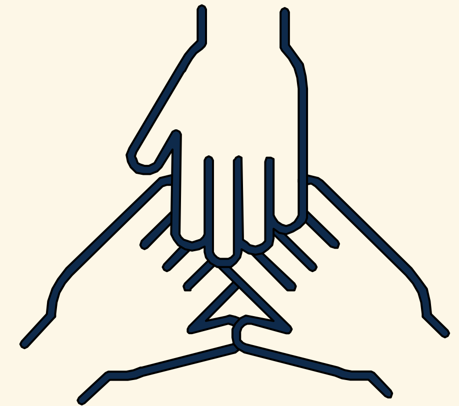
The HOP program does not have any additional staffing or licensure requirements separate from Tailored Care Management requirements.

- A care manager should directly supervise extenders and ensure that they are only performing functions within their training, scope, and abilities. See the Department's "Guidance on the Use of Care Manager Extenders in Tailored Care Management."
- Care manager extenders can support the following HOP activities, as deemed appropriate by the care manager:
  - Perform outreach to, engagement with, as well as follow-up with members
  - Assess members for HOP eligibility by using the PESA and recommend HOP services
  - Coordinate referrals to HOP services
  - Help track that HSOs accept a referral to deliver HOP services, that HSOs initiate that service, and ongoing coordination with HSOs to help assess to what extent HOP services are meeting a member's needs
  - Review the service(s) a HOP enrollee is receiving and reassess for HOP eligibility
- Care manager extenders supporting HOP activities must complete required HOP trainings.

Care Management Team HOP Roles & Responsibilities

Today's training will focus on the following HOP care management responsibilities for care management teams:

- Identification of and Outreach to HOP Populations
- Assessing HOP Eligibility using the "Pilot Eligibility And Service Assessment (PESA)" and Recommending HOP Services
- Eligibility Determination & Service Authorization
- Referral to Authorized Services and Tracking
- Reviewing Service Mix and Reassessing HOP Eligibility

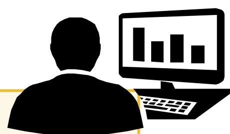


Identifying Potentially HOP Eligible Populations

Identifying Potentially HOP Eligible Populations

Both LME/MCOs and care management teams have requirements related to identifying potentially HOP-eligible members.

LME/MCO Role



- Proactively identify potentially HOP-eligible members by:
  - Leveraging existing population health management capabilities (e.g., Care Needs Screening, risk stratification) and
  - Conducting member education (e.g., direct mail)
- Pass on this information to care managers so that members can be connected to HOP service.
- Notify the member's assigned care manager within 10 days when potentially HOP eligible members are identified.

Care Management Team Role

- Initiate the HOP eligibility assessment and service recommendation process, once notified by LME/MCO of potentially HOP eligible members.
- Build in opportunities for assessing HOP eligibility when engaging with their assigned members (e.g., when conducting the care management comprehensive assessment).

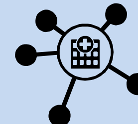
No Wrong Door: Multiple Entry Points into HOP

HOP was designed to have a no wrong door policy. In addition to being proactively identified by an LME/MCO, potentially HOP eligible individuals may be identified via one of the other pathways below.

Provider Referral

Referral from HOP Participating Human Service Organization (HSO)

Referral from Non-HOP Participating HSO



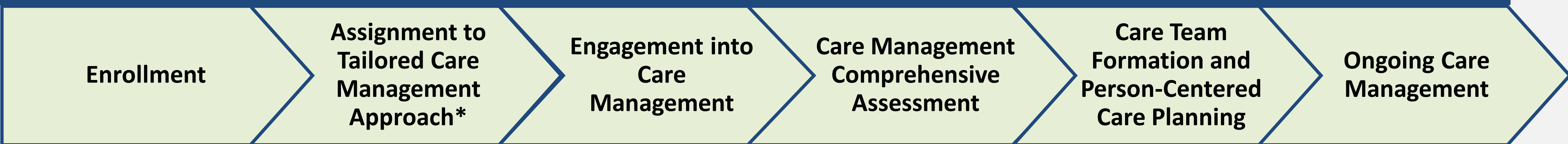
Self/Family Referral

Care Management Teams

Today's Focus

LME/MCOs will ensure there are multiple mechanisms for providers, HSOs, members/families to submit referrals for HOP eligibility to a member's LME/MCO. *When potentially HOP eligible members are identified, LME/MCOs will notify the member's assigned care manager within 3 business days to initiate the HOP eligibility assessment and service recommendation process.*

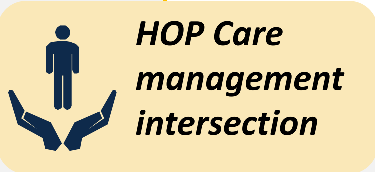
Identifying Potentially HOP Eligible Populations: Intersection with Tailored Care Management



LME/MCOs identify member who may benefit from HOP services

Care management teams may identify potentially HOP eligible individuals

- **During initial engagement into Tailored Care Management,**
- **As part of the care management comprehensive assessment, or**
- **As part of ongoing care management**



*LME/MCO assigns each member who did not express a preference at enrollment to CMA, AMH+, or LME-MCO for care management; that organization assigns member to a specific care manager

Assessing HOP Eligibility and Recommending Needed Services

HOP Eligibility Criteria

Members in LME/MCOs eligible for Tailored Care Management are likely eligible to participate in HOP due to their overlap with the health eligibility criteria. To qualify for HOP services, members must live in a HOP region and have:

Physical/Behavioral Health Criteria:

- Individuals eligible for Tailored Care Management meet the HOP health criteria

At least one Social Risk Factor:

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

Meet service specific eligibility criteria, as needed.

More detail on HOP eligibility criteria available in the appendix.

Pilot Eligibility and Service Assessment (PESA)

Care management teams will use the standardized PESA tool in NCCARE360 to document a member's assessment of HOP eligiblity, service recommendations, and service-specific eligiblity criteria. The PESA is not an additional screening tool, but a documentation tool to facilitate the eligibility determination and service authorization process.

- In HOP regions, care management teams will be responsible for assessing individuals for their HOP eligiblity and recommending HOP services that will meet their needs.
- The PESA pre-populates a list of all eligibility criteria for HOP enrollment and selected service(s) allowing care management teams to check off applicable eligibility criteria for a member.
- All HOP enrollees receiving HOP services must have a completed and up-to-date PESA. A member's PESA will be available to and editable by their care management team and LME/MCO.

The PESA is standardized across all care management entities and is a dynamic tool for care management teams to assess and document essential information related to HOP eligibility and recommended services, including:

- Member contact and identifying information;
- Qualifying health and social needs eligibility criteria;
- Recommended HOP service(s)
- Service-specific eligibility for recommended services, and necessary documentation;
- Member consent to participate in HOP
- Required documentation for specific services (as needed).

Care Management Team Role in Assessing HOP Eligibility and Needed Services

Once a potentially HOP eligible member has been identified, care management teams will assess and document whether an individual meets HOP eligibility criteria and recommend HOP services that meet the individual's need(s).

Care Management Team Role

- Leverage existing contacts to assess and document whether an individual meets HOP eligibility criteria
- Use the standardized Pilot Eligibility and Service Assessment tool (PESA) to document:
  - A member's assessment of HOP eligibility,
  - Recommended HOP service(s) that can best address the member's needs*, and
  - Member meets service-specific eligibility criteria
- Transmit the PESA to the appropriate service authorization team at the member's LME/MCO using NCCARE360

*Virtual self-paced HOP trainings will include information on how care managers can identify and recommend appropriate HOP services.

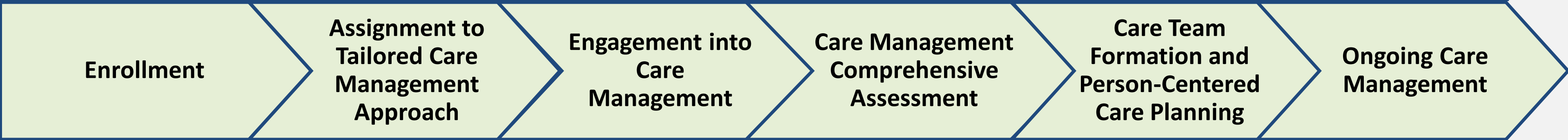
Obtaining HOP Consent

Members must give consent to participate in HOP. The Department has developed a standardized consent form that care management teams must use to obtain member consent: "Consent Form for NC Medicaid Coverage of Healthy Opportunities Pilot Services"

Care Management Team Role

- Obtain member consent using the standardized HOP Consent Form to:
  - Participate in HOP and receive HOP services
  - Consent to have their personal data, including personal health information, be used to evaluate HOP
  - Have their personal data, including personal health information, shared with organizations in the NCCARE360 network, and stored and exchanged on NCCARE360
- Member consent should be recorded in NCCARE360 when completing the PESA (prior to HOP service authorization or submitting HOP service referrals to HSOs).
  - Care management teams may accept electronic or written consent from a member.
- If a member does not give consent, care management teams will explain that the member will not be able to receive HOP services.
  - The member may continue receiving Tailored Care Management and the care management team will refer the member to other, non-HOP, services to meet their needs.

Assessing HOP Eligibility and Needed Services: Intersection with Tailored Care Management



Care management teams may assess members for HOP eligibility and needed services when administering the care management comprehensive assessment or at any other point in ongoing care management.

Eligibility Determination & Service Authorization

Eligibility Determination & Service Authorization

Once care management teams request HOP service authorization via the PESA, LME/MCO administrative/service authorization staff will determine eligibility and authorize HOP services for members. Care management teams must wait for LME/MCO approval before connecting members to recommended services.

LME/MCO Service Authorization Staff Role

- Review a member's PESA to ensure they meet HOP qualifying criteria (e.g., lives in a HOP region) and that the PESA is complete.
  - LME/MCOs are expected to rely on the care management team assessment of whether a member meets the qualifying health and social needs.
- Review and authorize HOP services recommended by a member's care management team.
  - LME/MCOs must follow DHHS standardized timeframes for authorization of all HOP services *(see slides 22-24)*
- Document eligibility determination and service authorization information in the member's PESA and communicate approval/denial to the member's care management team
  - A member will be considered "enrolled" in HOP if they have been authorized for at least one HOP service.

Referral to Passthrough HOP Services

To facilitate service delivery and reduce touchpoints with the member, care management teams are permitted to refer members to a select number of high-value, low-cost HOP services for a 30-days without prior LME/MCO approval.

Passthrough HOP Services

- DHHS has designated 7 services as "passthrough" HOP services. These services and amounts are standardized across Standard Plans and LME/MCOs:

Food Services

- ✓ Fruit and Vegetable Prescription
- ✓ Healthy Food Box (For Pick-Up)
- ✓ Healthy Food Box (Delivered)
- ✓ Healthy Meal (For Pick-Up)
- ✓ Healthy Meal (Home Delivered)

Transportation Services

- ✓ Reimbursement for Health-Related Public Transportation
- ✓ Reimbursement for Health-Related Private Transportation

- Care management teams must send the member consent form to the LME/MCO prior to making a referral to passthrough services.
- Care management teams must still complete the PESA and transmit it to the LME/MCO to confirm authorization decision beyond the first 30 days.

Timelines for HOP Service Authorization: Housing

LME/MCOs will follow DHHS standardized timeframes for authorization of all HOP services. Timeframes for HOP Service Authorization are be standardized across Standard Plans and LME/MCOs.

Domain	HOP Service Name	Timelines for HOP Service Authorization		
		Passthrough; Expedited Referral	3 business days	7 business days or less
Housing Services	Housing Navigation, Support and Sustaining Services		X	
	Inspection for Housing Safety and Quality			X
	Housing Move-In Support			X
	Essential Utility Set-Up		X	
	Home Remediation Services			X
	Home Accessibility and Safety Modifications			X
	Healthy Home Goods			X
	One-Time Payment for Security Deposit and First Month's Rent			X
	Short-Term Post Hospitalization Housing		X	

Timelines for HOP Service Authorization: Food

Domain	HOP Service Name	Timelines for HOP Service Authorization		
		Passthrough; Expedited Referral	3 business days	7 business days or less
Food Services	Food and Nutrition Access Case Management Services			X
	Evidence-Based Group Nutrition Classes			X
	Diabetes Prevention Program			X
	Fruit and Vegetable Prescription	X		
	Healthy Food Box (For Pick-Up)	X		
	Healthy Food Box (Delivered)	X		
	Healthy Meal (For Pick-Up)	X		
	Healthy Meal (Home Delivered)	X		
	Medically Tailored Home Delivered Meal			X

Timelines for HOP Service Authorization: IPV, Transportation and Cross-Domain

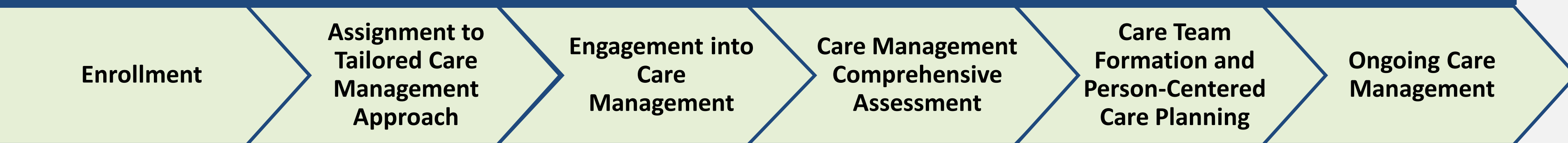
Domain	HOP Service Name	Timelines for HOP Service Authorization		
		Passthrough; Expedited Referral	3 business days	7 business days or less
Interpersonal Violence Services (IPV)*	IPV Case Management Services			X
	Violence Intervention Services			X
	Evidence-Based Parenting Curriculum			X
	Home Visiting Services			X
	Dyadic Therapy			X
Transportation Services	Reimbursement for Health-Related Public Transportation	X		
	Reimbursement for Health-Related Private Transportation	X		
	Transportation PMPM Add-On for Case Management Services			X
Cross-Domain Services	Holistic High Intensity Enhanced Case Management			X
	Medical Respite		X	
	Linkages to Health-Related Legal Supports			X

Key Takeaways: Eligibility Determination & Service Authorization

Key Takeaways

- LME/MCO administrative/service authorization staff will have the ultimate responsibility for determining eligibility and authorizing HOP services for members
- Care management teams must wait for authorization before connecting members to recommended services (except in the case of passthrough HOP services)
- Members are only considered enrolled once they have at least one HOP service authorized
- For select, high-value “passthrough” services, care management teams can refer members directly to an HSO that provides those services after obtaining member consent

Eligibility Determination & Service Authorization: Intersection with Tailored Care Management



LME/MCO Responsibility

LME/MCOs will be responsible for reviewing and evaluating the PESA completed by the care management team to ensure that basic HOP program eligibility criteria, as well as HOP service-level eligibility criteria have been met.

Referral to Authorized Services and Tracking

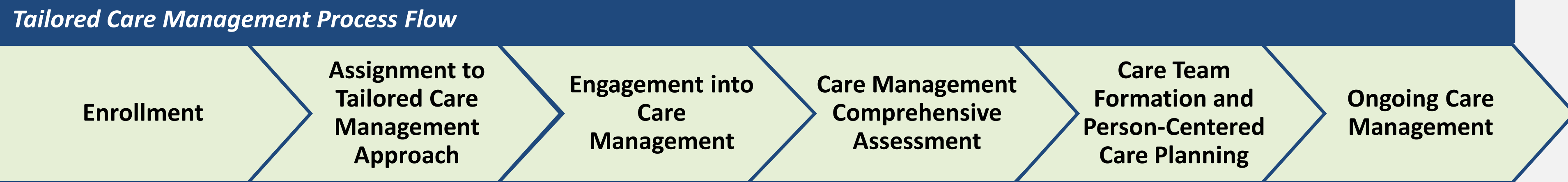
Referral to and Delivery of HOP Services

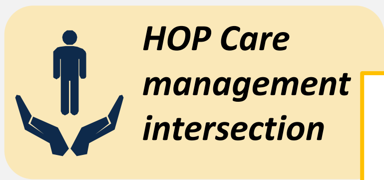
Once the care management team receives authorization from the LME/MCO administrative staff, they will refer members to an appropriate HSO using NCCARE360 and track their progress.

Care Management Teams Role

- Use NCCARE360 to refer members to authorized HOP services within two business days of receiving notice from the LME/MCO
- Communicate to the member HOP services authorized by the LME/MCO
- Use NCCARE360 to monitor that HSOs accept the referral and initiate the service
- Update the enrollee’s Care Plan/ISP when an HSO accepts the referral
- Coordinate with HSOs to help assess to what extent HOP services are meeting their needs

Referral to Authorized Services and Tracking: Intersection with Tailored Care Management





Care management teams will be responsible for referring members with an authorized HOP service to an appropriate HSO and will track their progress as part of ongoing care management.

Service Mix Review and HOP Eligibility Reassessment

Overview of Service Mix Review and Eligibility Reassessment

As required by the federal government, care management teams must 1) assess enrollees every 3 months to ensure HOP services are meeting their needs and 2) reassess enrollees every 6 months for continued HOP eligibility.

Definitions

1. **Service Mix Review (at least every 3 months):** Assessment of HOP services the enrollee is receiving to determine if they are meeting the enrollee's needs. If the current mix of services is not meeting the enrollee's needs, care management teams will recommend modified services.

2. **Eligibility Reassessment (at least every 6 months)**: Reassess the enrollee's eligibility for HOP services based on the qualifying criteria (health and social risk factor criteria) in addition to service mix.

Care management team check-ins with enrollees at the 3-month and 6-month interval after enrollment are **minimum requirements**. Care management teams are expected to discuss and check-in on HOP services in the course of Tailored Care Management contacts.

Key Takeaways: Care Management Team Role in Conducting Service Mix Review and Eligibility Reassessment

Care management teams play an essential role in conducting and documenting the results of the 3- and 6- month HOP reassessments.

Care Management Teams Role

- Schedule, prepare for, and conduct a 3-month service mix assessment and 6-month eligiblity reassessment (in-person, via telephone or via video)
    - **Service Mix Review:** Ask questions to determine if current services are meeting member needs, if ***new/modified*** services are required, or if services should be ***discontinued***
    - **Eligibility Reassessment:** In addition to service mix review, ask questions to confirm the member's eligibility in HOP, or if they should be ***disenrolled***
- Document and transmit outcomes of the 3- and 6- month assessment in the member's PESA and transmit it to the LME/MCO via NCCARE360
- Communicate any changes to the member, update the member's care plan, and generate new referrals via NCCARE360, as needed

LME/MCOs will monitor and validate that care management entities have conducted and documented the service mix review and eligibility reassessment.

Discontinuation of HOP Services and HOP Disenrollment

Care management teams may identify instances where HOP services should be discontinued or when members must be disenrolled from HOP.

Definitions

Discontinuation: One or more of an enrollee's HOP services is discontinued because they are no longer required, available or the enrollee is no longer eligible to receive a previously authorized service. Examples include:

- Current HOP service(s) are not meeting the needs of the member
- Member has met their Care Plan/ISP goals and no longer requires HOP services
- Member no longer meets the service-specific qualifying criteria

Disenrollment: An enrollee is disenrolled from HOP because they are no longer eligible to participate. Examples of potential scenarios for disenrollment from HOP include:

- Member moved out of a HOP region
- Member wishes to opt out of HOP
- Member is unreachable after consistent, monthly outreach efforts for a period of 6 months

Key Takeaways: Discontinuation of HOP Services and HOP Disenrollment

Care management teams will provide a recommendation to LME/MCOs to discontinue HOP services or disenroll members from HOP, as appropriate. Members who have HOP services discontinued or are disenrolled from HOP may continue receiving Tailored Care Management.

Discontinuation of HOP Services

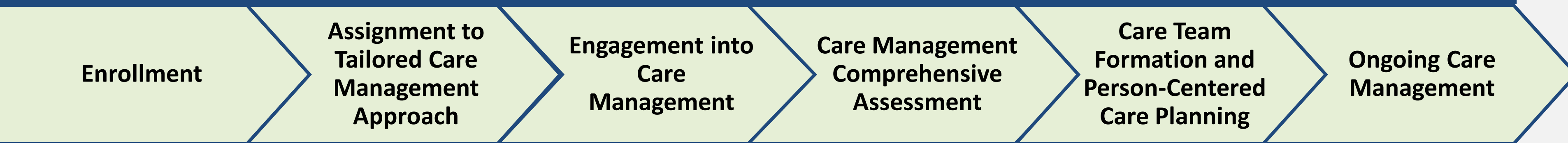
- Upon identifying that a HOP service should be discontinued, care management teams must:
  - Document the service being discontinued and the rationale (e.g., if the service is no longer meeting the member's need) in the member's PESA, and
  - Transmit member's PESA to the member's LME/MCO via NCCARE360 to notify of discontinued service*

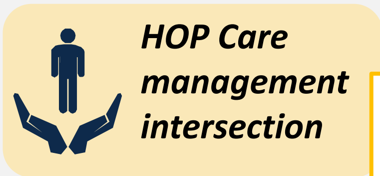
Disenrollment from HOP

- Upon identifying a trigger for HOP disenrollment, care management teams must:
  - Document information and rationale for HOP disenrollment (e.g., member no longer lives in a HOP region) in the member's PESA, and
  - Transmit member's PESA to the member's LME/MCO via NCCARE360 for verification

*If the patient requires new or modified HOP services in lieu of the discontinued service, care management teams must submit a recommended HOP service to the LME/MCO as part of the PESA.

Service Mix Review and HOP Eligibility Reassessment: Intersection with Tailored Care Management

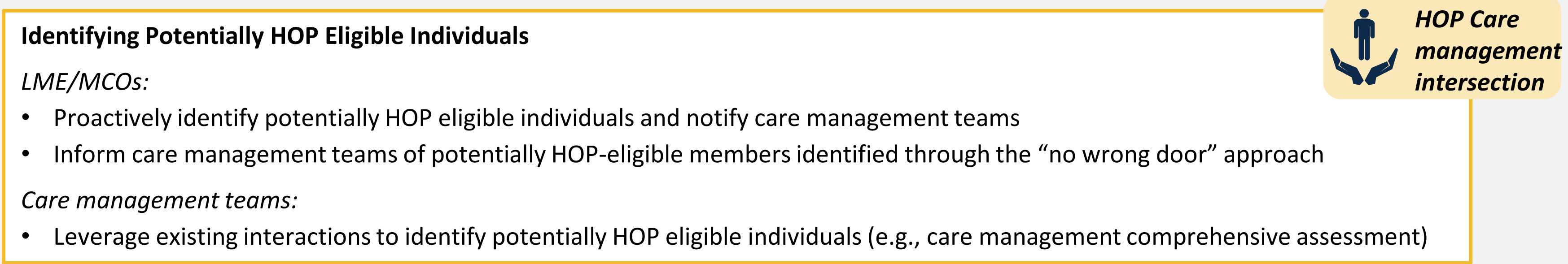




Care management teams will conduct the HOP service mix review and eligibility reassessment as part of ongoing Tailored Care Management and in the course of Tailored Care Management contacts.

Recap: Intersection of HOP and Tailored Care Management

Recap: Intersection of HOP and Tailored Care Management



Identifying Potentially HOP Eligible Individuals

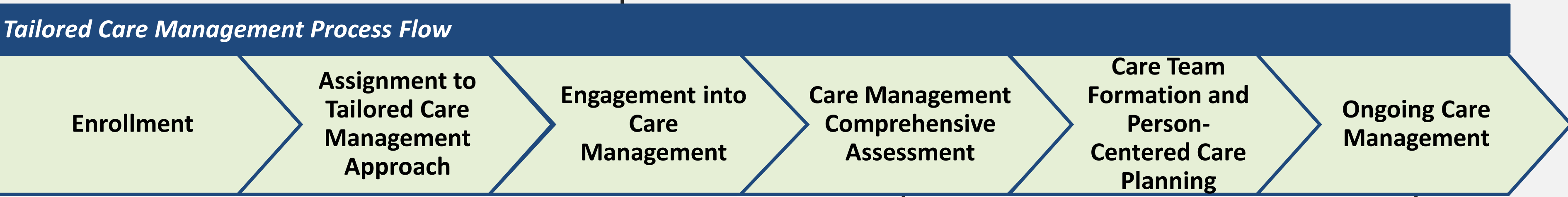
LME/MCOs:

- Proactively identify potentially HOP eligible individuals and notify care management teams
- Inform care management teams of potentially HOP-eligible members identified through the “no wrong door” approach

Care management teams:

- Leverage existing interactions to identify potentially HOP eligible individuals (e.g., care management comprehensive assessment)

HOP Care management intersection



HOP Care management intersection

Assessing HOP Eligibility and Needed Services

- *Care management teams:* Leverage existing contacts with members to assess for HOP eligibility and complete/submit the PESA (e.g., during care management comprehensive assessment)

Eligibility Determination & Service Authorization

- *LME/MCOs*: Review submitted PESAs and conduct HOP service authorization
- *Care management teams*: Conduct expedited referrals ‘pre-approved’ HOP services for eligible members

Referral to Authorized Services and Tracking

- *Care management teams*: Refer members to an appropriate HSO for HOP services and track their progress as part of ongoing care management

Service Mix Review and HOP Eligibility Reassessment

- *Care management teams:* Assess enrollees at least every 3 months to ensure HOP services are meeting their needs and reassess enrollees at least every 6 months for continued HOP eligibility.

Next Steps

Upcoming HOP Care Manager Trainings

Attending live trainings and completing virtual self-paced trainings are required to ensure care management teams can understand and fulfill their HOP responsibilities.

HOP Training Topic	Date
Three live sessions hosted by DHHS staff	
• *The Role of Care Management Teams in the Healthy Opportunities Pilot*	*Monday, November 6* *11-11:50 AM ET*
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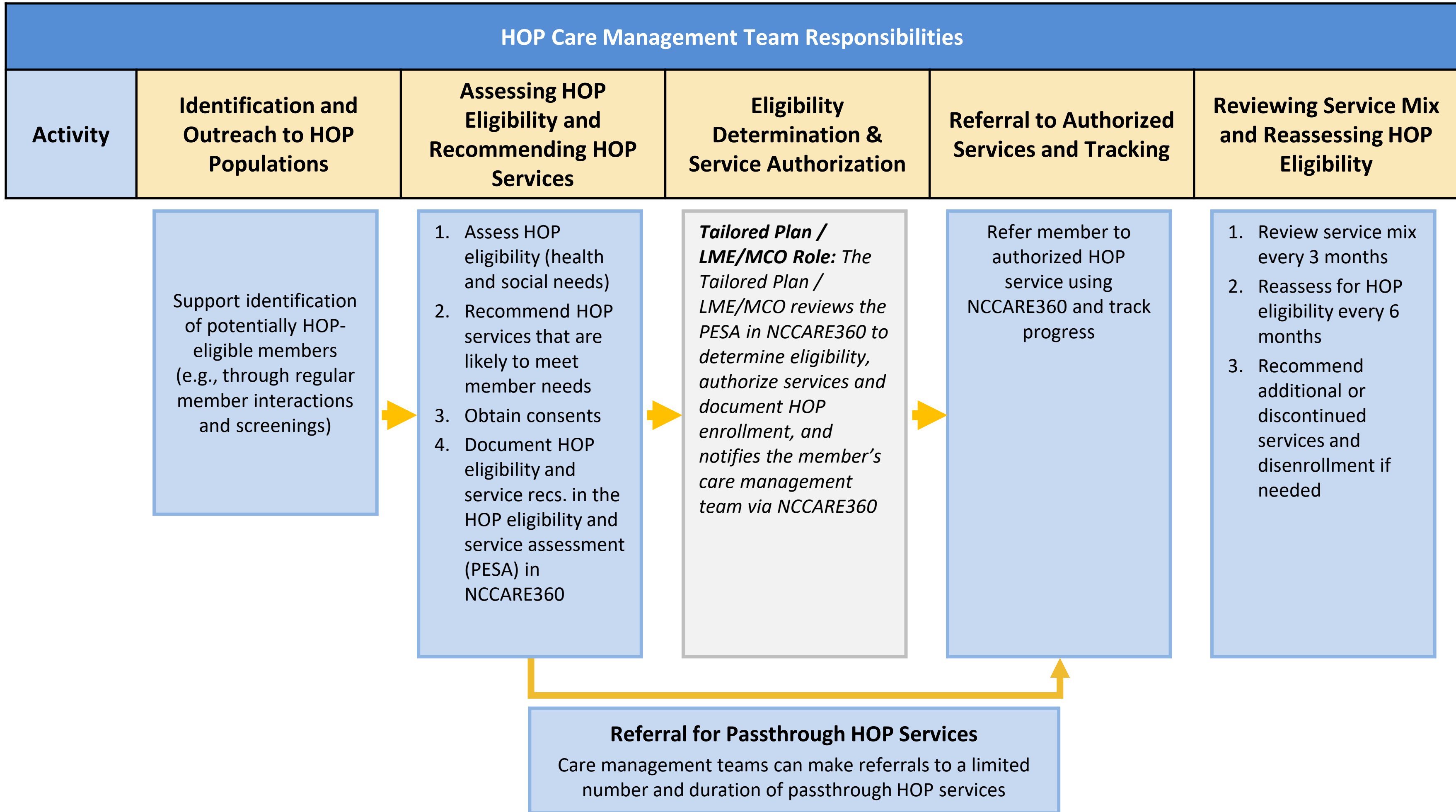
Questions?

Appendix

HOP Care Management Team Responsibilities



Healthy Opportunities Pilot: Qualifying Physical/Behavioral Health Criteria

Population	Age	Physical/Behavioral Health-Based Criteria
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, chronic infectious disease, cancer, autoimmune disorders, chronic liver disease and chronic renal failure, intellectual or developmental disability (I/DD), and traumatic brain injury (TBI). • Meets the clinical eligibility criteria for Tailored Care Management, North Carolina's Health Home benefit (SPA 22-0024) • Repeated incidents of emergency department use (defined as more than four visits per year) or hospital admissions. • Former placement in North Carolina's foster care or kinship placement system. • Previously experienced three or more categories of adverse childhood experiences (ACEs).
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 • Former or current placement in NC's foster care or kinship placement system • Previously experienced or currently experiencing three or more categories of ACEs • Intellectual or developmental disability (I/DD) • Traumatic brain injury (TBI) • Meets the clinical eligibility criteria for Tailored Care Management, North Carolina's Health Home benefit (SPA 22-0024)
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 <5th or >85th percentile for age and gender, developmental delay, cognitive impairment, substance use disorder, behavioral/mental health diagnosis (including a diagnosis under DC: 0-5), attention-deficit/hyperactivity disorder, cancer, autoimmune diseases, learning disorders, intellectual or developmental disability (I/DD), and traumatic brain injury (TBI) • Meets the clinical eligibility criteria for Tailored Care Management, North Carolina's Health Home benefit (SPA 22-0024) • Experiencing or previously experienced 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 or formerly enrolled in North Carolina's foster care or kinship placement system

Healthy Opportunities Pilot Regions

HOP operates in three geographic regions of the state led by Network Leads. As of February 1, 2024, HOP regions will be served by four LME/MCOs: Eastpointe, Partners Trillium, and Vaya.