Healthy Opportunities Pilots Guidance for Local Health Departments Delivering Care Management for At-Risk Children (CMARC) and Care Management for High-Risk Pregnancies (CMHRP)

Section I: Overview of Pilots

North Carolina's transition to Medicaid managed care includes the launch of the Healthy Opportunities Pilots ("the Pilots") in 2022. The Pilots present an unprecedented opportunity to test the impact of providing evidence-based, non-medical interventions to Medicaid enrollees. In October 2018, the Centers for Medicare and Medicaid Services (CMS) authorized up to $650 million in state and federal Medicaid funding to cover the cost of providing select Pilot services that address non-medical drivers of health in four priority domains: housing, food, transportation, and interpersonal violence/toxic stress. While access to high-quality medical care is critical, research shows that up to 80 percent of a person's health is determined by social and environmental factors and the behaviors that emerge as a result.[1] A substantial body of research has established that having an unmet resource need – including experiencing housing instability,[2] food insecurity,[3] unmet transportation needs,[4] and interpersonal violence or toxic stress[5,6] – can significantly and negatively impact health and well-being, as well as increase health care utilization and costs.[7,8]

The Pilots allow for North Carolina's Medicaid managed care plans ("Prepaid Health Plans (PHPs)"), providers, and community-based organizations to have the tools, infrastructure, and financing to integrate non-medical services, such as medically tailored home delivered meals or short-term post hospitalization housing, that are directly linked to health outcomes into the delivery of care. The Department has developed the Healthy Opportunities Pilots Fee Schedule (Appendix B) to define and price these non-medical interventions. The Pilots test whether Pilot services, which are delivered by local community-based organizations and social services agencies called human service organizations (HSOs), can improve health outcomes and/or reduce health care costs for Medicaid managed care enrollees experiencing certain health needs and social risk factors.

Most Human Service Organizations (HSOs) that deliver Pilot services are participating in the health care system for the first time through the Pilots. While many HSOs traditionally rely on grant funding, in the

[1] Booske, B.C., Athens, J.K., Kindig, D. A., et al. Different Perspectives for Assigning Weights to Determinants of Health. University of Wisconsin Population Health Institute. February 2010
[2] A. Simon, et al. "HUD Housing Assistance Associated with Lower Uninsurance Rates and Unmet Medical Need." Health Affairs, June 2017
[3] A.Coleman-Jensen, et al., Household Food Security in the United States in 2012, Economic Research Report No. 155 (Sept. 2013); Food Res. & Action Ctr., Food Hardship in America 2012 (Feb. 2013).
[4] S. Syed, B. Gerber, L. Sharp. "Traveling Towards Disease: Transportation Barriers to Health Care Access." Journal of Community Health. October, 2013.
[5] H. Resnick, R. Acierno, D. Kilpatrick. "Health Impact of Interpersonal Violence: Medical and Mental Health Outcomes." Journal of Behavioral Medicine, 1997.
[6] V. Felitti, et al. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults—The Adverse Childhood Experiences Study." American Journal of Preventive Medicine. May 1998.
[7] B. C. Booske, J. K. Athens, D. A. Kindig et al., Different Perspectives for Assigning Weights to Determinants of Health (University of Wisconsin Population Health Institute, Feb. 2010).
[8] L. M. Gottlieb, A. Quiñones-Rivera, R. Manchanda et al., "States' Influences on Medicaid Investments to Address Patients' Social Needs," American Journal of Preventive Medicine, Jan. 2017 52(1):31–37.

Pilots they operate as Medicaid providers by invoicing for delivered services based on a fee schedule. To operationalize the fundamental shift in business processes for these organizations, infrastructure and procedures have been put in place to assist HSOs in invoicing and paying for Pilot services. These processes seek to build HSO capacity while minimizing burden and ensuring that HSOs can effectively participate in the Pilots.

Recognizing that North Carolina is breaking new ground with the Pilots, the Department of Health and Human Services ("the Department") is rigorously evaluating the Pilots to assess their effectiveness and identify key elements, including successful services, that could be continued on an ongoing basis and extended statewide in the Medicaid program.

The Pilots operate in three regions of the state – two in eastern North Carolina and one in western North Carolina. See Appendix A for a map of the Pilot regions. An organization in each region – called the "Healthy Opportunities Network Lead" – builds and oversees networks of HSOs that deliver Pilot services.

The purpose of this document is to provide guidance to Local Health Departments (LHDs) on how they can participate in the Pilots as Designated Pilot Care Management Entities.[9] The Department understands LHDs may be contracted to serve in other roles (e.g., an LHD also serves Pilot enrollees as an AMH Tier 3 or as a Pilot HSO) and has provided additional information in this document on responsibilities for LHDs in these scenarios (see Section VII: LHDs with Multiple Pilot-Related Roles and Responsibilities below).

The sections below detail the specific roles and responsibilities for LHDs as they relate to Pilot care management. LHDs serving as Designated Pilot Care Management Entities must contract with PHPs for the provision of Pilot-related care management to Pilot enrollees. As this is a pilot program, the Department will continually review and update entity requirements based on the on the ground experience of Designated Pilot Care Management Entities.

Section II: Summary of Roles and Responsibilities for Pilots

Foundational to North Carolina's Medicaid managed care program, which includes both Standard Plans and Behavioral Health and Intellectual/Developmental Disability Tailored Plans (BH I/DD Tailored Plans), is local care management integrated with primary care where personal interaction is possible. North Carolina's Standard Plans, which launched on July 1, 2021, are required to contract with LHDs for the provision of Care Management for At-Risk Children (CMARC) and Care Management for High-Risk Pregnancies (CMHRP) for the first three years of managed care.

Mirroring the Department's approach to care management for high-risk pregnant women and at-risk children, it is also critical to the Pilot program that Pilot care management—which is offered in addition to the broader care management responsibilities under North Carolina's CMARC and CMHRP programs[10] — is delivered by LHDs. Pilot care management services, which build on existing CMARC and CMHRP care management requirements, include assessing members' Pilot eligibility and specific non-medical

[9] A Designated Pilot Care Management Entity refers to the entity that is assuming care management responsibilities specifically related to the Healthy Opportunities Pilot.
[10] For a complete list of LHD care management responsibilities, refer to the LHD Program Guide: Management of High-Risk Pregnancies and At-Risk Children in Managed Care

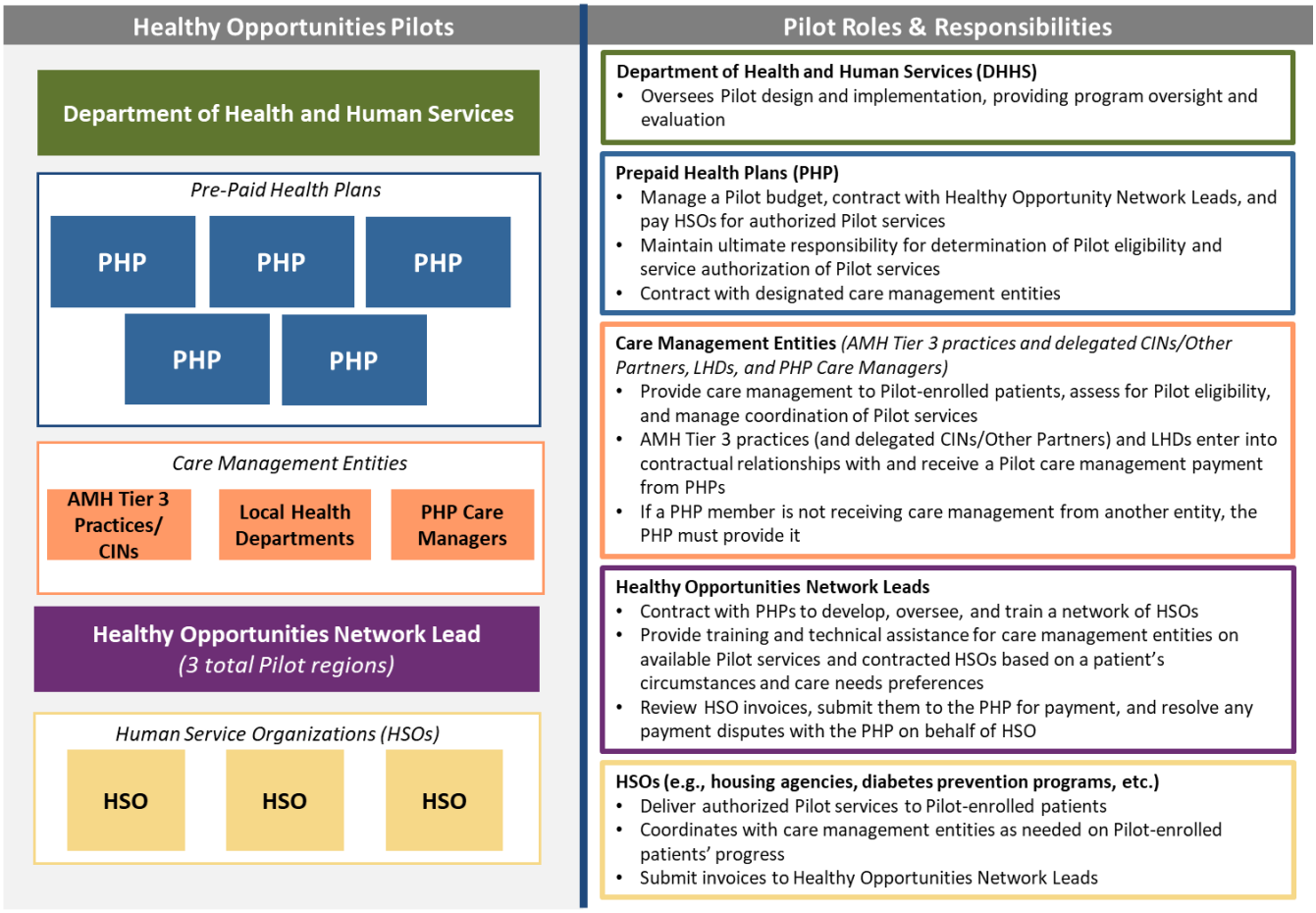
needs and connecting them to appropriate Pilot services. Recognizing the added responsibilities that come with Pilot participation, LHDs serving as Designated Pilot Care Management Entities will receive an additional, DHHS-standardized, Pilot Care Management per member per month (PMPM) payment, on top of existing CMARC and CMHRP payments, for each Medicaid enrollee assigned to a Pilot-participating LHD regardless of Pilot enrollment at Pilot launch (discussed more in Section V: LHD Payment for Pilot Responsibilities).

A critical component of implementing the Pilots is how PHPs and local care management entities, including LHDs, will work together to identify and enroll members who are eligible for Pilot services, connect those individuals to such services, and ensure ongoing whole person care management. The Department has developed the following overarching goals for these processes:

- Place Medicaid members at the center of the Pilot program, prioritizing the member's seamless and timely experience;
- Utilize a "no wrong door" policy to streamline enrollment into the Pilot program regardless of where a member initially seeks care;
- Encourage that care management for the Pilot program occurs at the local community level;
- Standardize information collected regarding members' Pilot eligibility and recommended Pilot services using a standard documentation tool called the Pilot Eligibility and Service Assessment (PESA);
- Seek to ensure services are allocated across all Pilot-eligible member populations;
- Minimize the number of member handoffs between PHPs and care management entities;
- Standardize the processes and systems as much as possible across PHPs to eliminate Designated Pilot Care Management Entity and HSO burden; and
- Maintain accountability and integrity for the Pilot program.

Figure 1 describes the key roles and responsibilities for each Pilot entity and provides an overview of how the entities interact with one another.

Figure 1: Key Roles and Responsibilities for Pilot Entities



This document provides specific guidance for how LHDs can participate in the Pilots as a Designated Pilot Care Management Entity (see Section VII: LHDs with Multiple Pilot-Related Roles and Responsibilities for additional information for LHDs that are also contracted as AMH Tier 3 practices).

PHPs will be required to provide the same core Pilot functions as Designated Pilot Care Management Entities for members who are receiving CMARC/CMHRP by an LHD that is not providing Pilot care management and will be compensated through PHPs' Pilot administrative payments.

Section III, below, further defines Pilot care management responsibilities.

Section III: Pilot Care Management Responsibilities for LHDs Serving as a Designated Pilot Care Management Entity

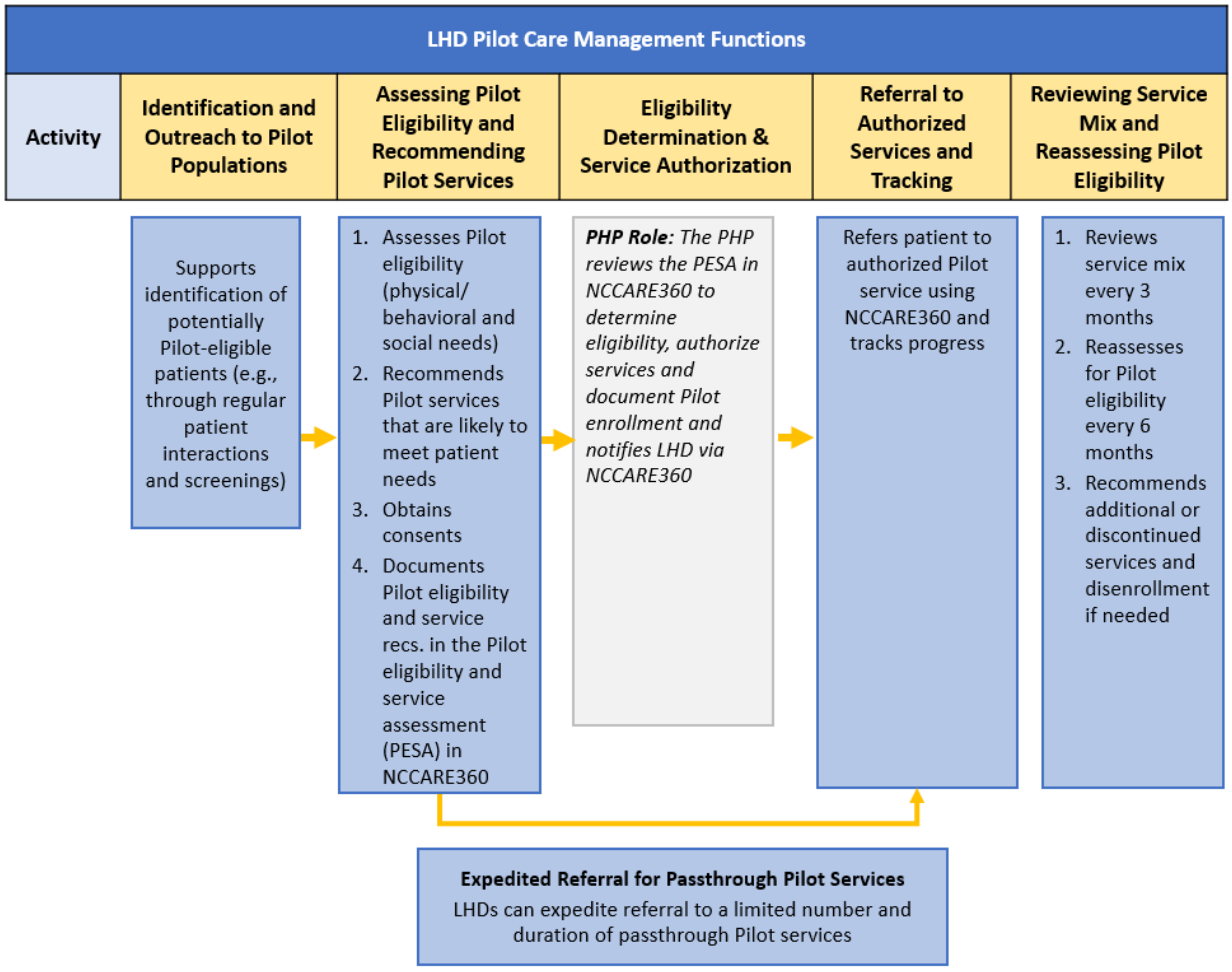
Participating in the Pilots as a Designated Pilot Care Management Entity gives LHDs the opportunity to be part of an innovative and nationally recognized initiative that will shape North Carolina's Medicaid program. Participating LHDs will integrate their Pilot responsibilities into clinical care, further supporting the vision of whole-person care. Additionally, given that Pilot eligibility criteria significantly overlaps with CMARC and CMHRP eligibility criteria, LHDs are uniquely positioned to identify individuals who may be Pilot-eligible and connect them to needed services.

The cornerstone of North Carolina's Medicaid Transformation is that care management is delivered to members locally, and the same is true for the Pilots. While the Department strongly encourages LHDs located in Pilot regions to participate in the Pilots, participation is not required. LHDs that choose to participate in the Pilots are responsible for ensuring Pilot care management is provided to their members; Pilot responsibilities may be integrated into existing CMARC and CMHRP care management processes and existing workflows.

In alignment with current LHD contracting for CMARC and CMHRP each LHD must have a contract with each PHP for which it will perform Pilot-related care management activities.

Figure 2 outlines the critical Pilot care management functions that LHDs will perform to participate in the Pilots and receive Pilot care management payments.

Figure 2: LHDs' Pilot Care Management Functions

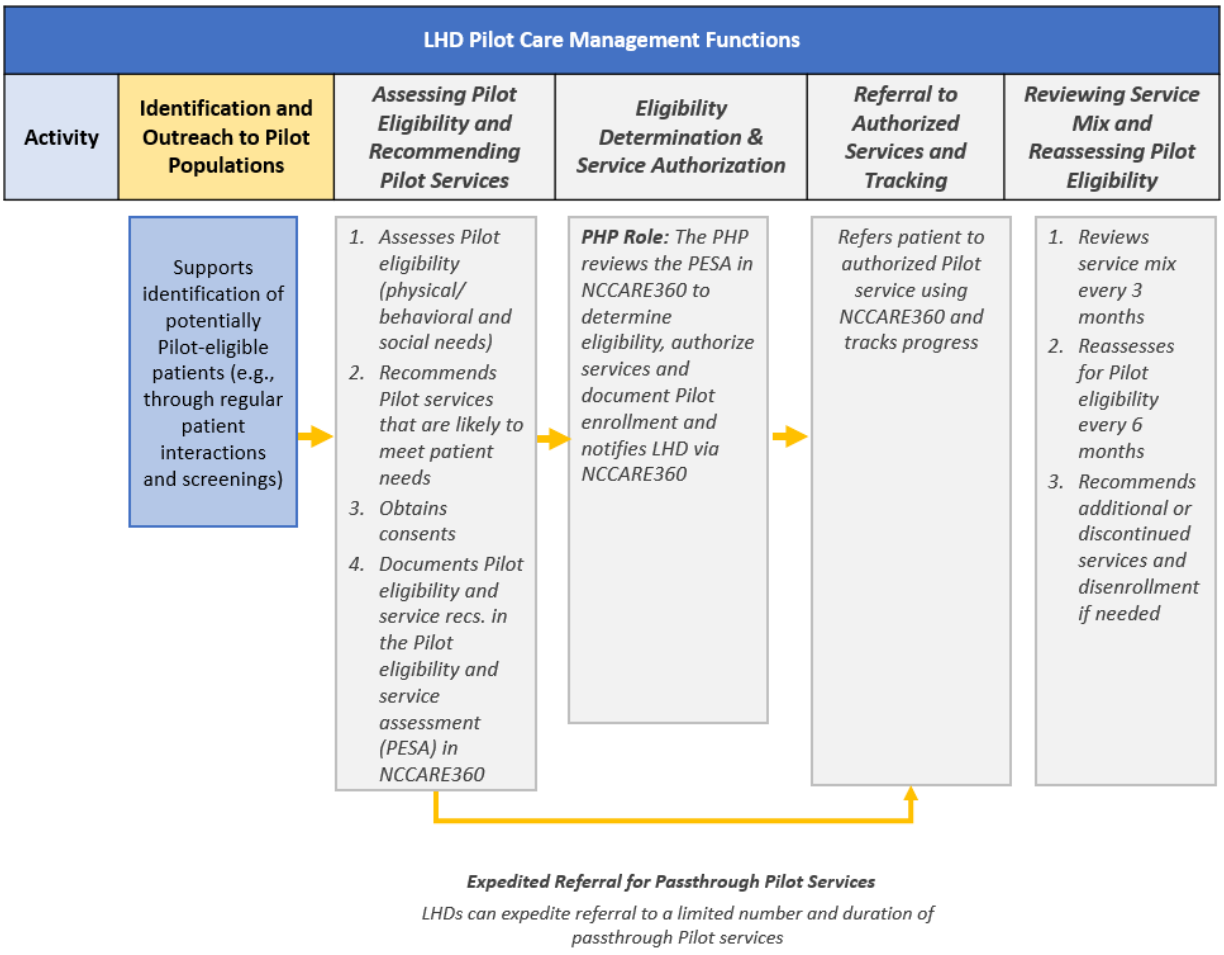


Getting members initially enrolled in the Pilots and connected to Pilot services will require a higher level of effort. Once members are enrolled in the Pilots, LHDs will have a minimum requirement of engaging with their Pilot-enrolled members every three months to review their Pilot services (described in more detail below in Section E: Reviewing Pilot Service Mix and Reassessing Pilot Eligibility); some Pilot-enrolled members will require more frequent and intensive engagement and coordination.

In addition, LHDs should be aware that members participating in the Pilots or that may benefit from Pilot services may have certain highly sensitive needs, such as those related to interpersonal violence (IPV). To protect the safety and security of members who may be eligible for or may receive (or who are receiving) IPV-related services, and to safeguard the privacy and security IPV-related data, LHDs participating in the Healthy Opportunities Pilots must comply with the terms of *Interpersonal Violence-Related Healthy Opportunities Pilots (IPV)-Related Services: Conditions, Requirements, and Standards* attachment in the DHHS-Standard Plan contract.

The below sub-sections discuss each care management activity in the graphic in greater detail.

A. Identification and Outreach to Pilot Populations



LHDs should build in opportunities to identify potentially Pilot-eligible members during existing touchpoints with members who have been identified for CMARC or CMHRP services, have been referred by the PHP, HSOs or by themselves/families, or are currently receiving CMARC or CMHRP services. LHDs may identify other members that are not currently receiving CMARC or CMHRP that may benefit from Pilot services. These touchpoints may occur during regular care visits, care manager check-ins, throughout pregnancy and the postpartum period, at transitions of care, and when a member's circumstances or needs change significantly (e.g., a member has been diagnosed with a chronic condition).

During these existing touchpoints, LHDs can utilize the DHHS standardized Healthy Opportunities screening questions, the existing CMARC Screening Tool, the existing CMHRP Screening Tool, other SDOH screening tools, and any data analytics used by the LHD for existing care management to help identify members that may potentially be eligible for the Pilot (eligibility criteria for the Pilot is outlined in the Section IV: LHD Eligibility Criteria to Participate in the Pilots for Pilot Participation).

LHDs are expected to conduct outreach to any members receiving CMHRP/CMARC that PHPs, providers, or HSOs flag as also being potentially Pilot eligible.

Providers and HSOs may also flag members they think may be eligible for the Pilots, and members (or their family members) may identify themselves as possibly Pilot eligible. If the provider, HSO, or member knows who the member's assigned LHD is, they may notify the LHD and upon being notified, the LHD should make best efforts to conduct outreach, including two follow-up attempts if needed, to the member within three business days to assess for Pilot eligibility. LHDs will not face penalties if outreach attempts take longer than three business days. If the member's assigned LHD is not known to the provider, HSO, or member, they may notify the member's PHP in order to flag a potentially Pilot eligible member has been identified and should be assessed for Pilot eligibility and recommended services. The PHP will notify the LHD, if applicable, to conduct an assessment of Pilot eligibility and recommend appropriate services. Once an LHD has conducted outreach to a member, the LHD should document this outreach in the member's Care Plan or in the member record, as appropriate based on whether the member has an existing Care Plan, and is encouraged to inform the referring entity of the outcome of the outreach through existing communication channels. LHDs will not face penalties if they are unable to reach members following outreach attempts.

The Pilots do not require a specific avenue for communication with the member. LHDs may communicate with the member using existing workflows and preferences for communication (e.g., phone, in-person, video, etc.).

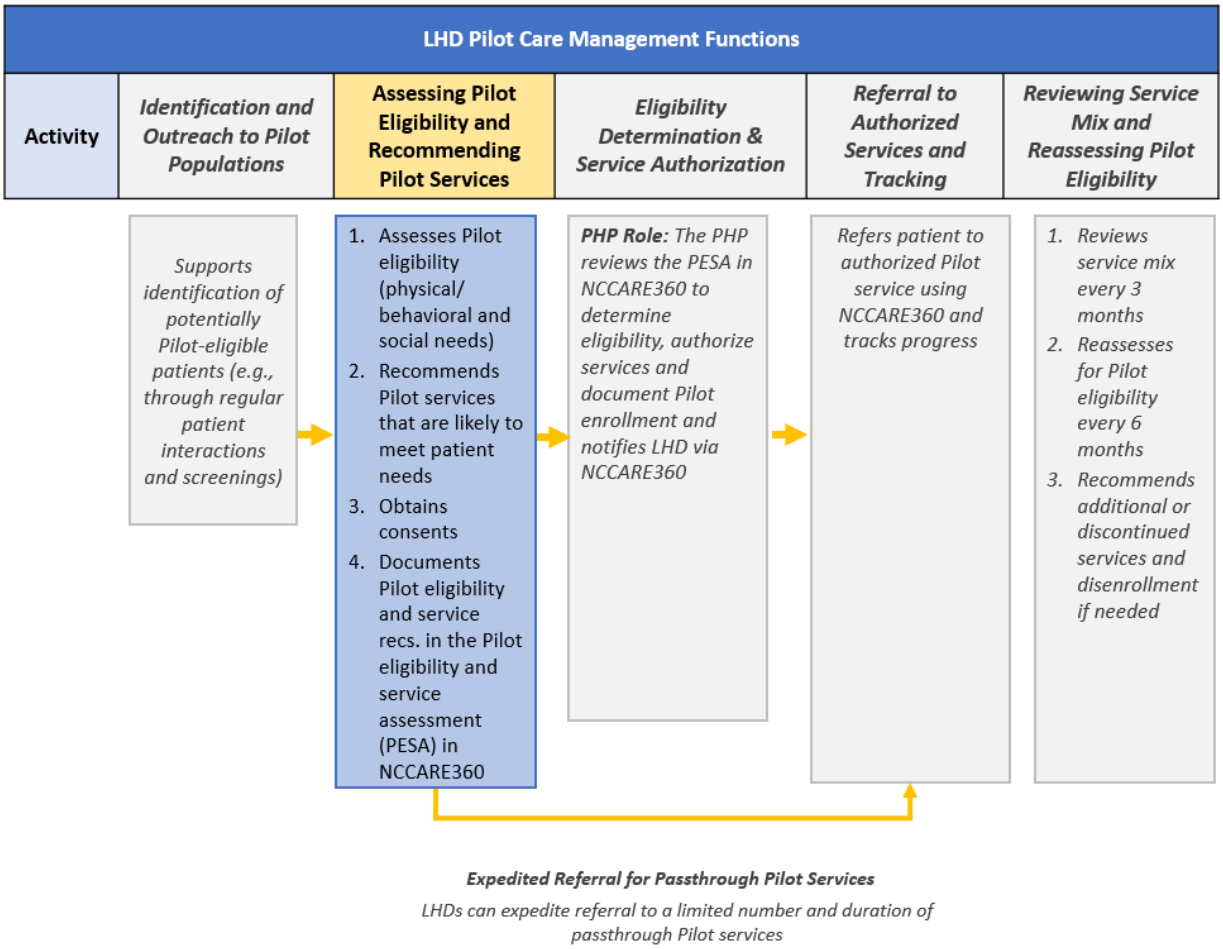
When enrolling a member in the Pilot or prior to conducting outreach to a Pilot enrollee, LHDs must obtain from and record in NCCARE360 for each member assigned to them:

- Whether the member opts-in or opts-out of Pilot-specific non-essential communications (as recorded during their initial Pilot assessment and as amended from time to time thereafter in the Member's sole discretion),
- Preferred dates or days of the week for being contacted, time of day at which to be contacted, and modality of contact (e.g., calls vs. texts, use of voicemail, email, postal mail, etc.),
- Whether any other days of the week, times of day, or modalities for contact must not be used, and,

- Whether it is acceptable to leave a message for the member using their preferred modality of contact.

LHDs must review these contact requirements prior to, and adhere to such preferences when, conducting any Pilot outreach to a member.

B. Assessing Pilot Eligibility and Recommending Pilot Services



B1. Assessing Pilot Eligibility: **To assess a member's eligibility for the Pilots, LHDs need to confirm and document in the Pilot eligibility and service assessment (PESA) in NCCARE360 whether the member:**

- Lives in a Pilot region;
- Is enrolled in Medicaid managed care;
- Meets at least one qualifying physical/behavioral health criterion; and
- Has at least one qualifying social risk factor.

Pilot eligibility is determined based on whether the member lives in a Pilot region, not on the location of the LHD where a member receives care. Table 1 outlines the detailed physical/behavioral qualifying conditions for the Pilot program, and Table 2 outlines qualifying social risk factors for the Pilot program.

Table 1: Pilot Physical/Behavioral Health-Based Criteria

Population	Age	Physical/Behavioral Health-Based Criteria (must meet at least one 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, 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. • 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
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, and learning disorders • 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

Table 2: Pilot Social Risk Factors

Risk Factor	Definition
Homelessness or housing insecurity	Homelessness, as defined in 42 C.F.R. § 254b(h)(5)(A), or housing insecurity, as defined based on the principles in the questions used to establish housing insecurity in the Accountable Health Communities Health Related Screening Tool or based on responses to the North Carolina Social Determinants of Health (SDOH) screening tool.[11,12]

[11] The Accountable Health Communities Health-Related Social Needs Screening Tool. Available https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf.
[12] North Carolina's SDOH Screening Questions. Available: https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions.

Food insecurity	As defined by the US Department of Agriculture commissioned report on Food Insecurity in America:[13] • 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 food insecure as defined based on the principles in the questions used to establish food insecurity in the North Carolina Social Determinants of Health (SDOH) screening tool.[14]
Transportation insecurity	Defined based on the principles in the questions used to establish transportation insecurities in the Accountable Health Communities Health Related Screening Tool or based on responses to the North Carolina SDOH screening tool.[15]
At risk of, witnessing, or experiencing interpersonal violence	Defined based on the principles in the questions used to establish interpersonal violence in the Accountable Health Communities Health Related Screening Tool or the North Carolina SDOH screening tool.[6]

To assess whether a member meets the Pilot eligibility criteria, LHDs should ask the member questions and review available data/information (e.g., information provided by a PHP on a member's clinical conditions and/or the member's results of the DHHS standardized set of Healthy Opportunities screening questions). PHPs have primary responsibility to screen members for unmet health-related resource needs as part of the Care Needs Screening. If a PHP has not already completed the DHHS standardized set of Healthy Opportunities screening questions for the member, LHDs should conduct this screening as part of the Pilot eligibility assessment.

B2. Recommending Pilot Services: **After assessing a member's eligibility for the Pilots, LHDs should recommend which specific Pilot service(s) would best address the member's physical/behavioral health and social needs from a list of federally-approved services outlined in Table 3.** Pilot services fall

[13] USDA Economic Research Service [Internet]. Washington: USDA Economic Research Service; [updated 2017 Nov 27]. Definitions of Food Insecurity; [updated 2017 Oct 4; cited 2017 Nov 27]. Available from: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security/

[14] North Carolina SDOH Screening Tool. Available: https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

[15] *Ibid*

[6] *Ibid*.

into one of four priority domains: housing, food, transportation, and interpersonal safety/toxic stress. In some cases, a member may require more than one service—either in one domain (e.g., a member requires two housing services) or spanning multiple domains (e.g., a member who requires a food and transportation service).

Table 3: Healthy Opportunities Pilots Services

Pilot Services
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
Interpersonal Violence / Toxic Stress
IPV Case Management Services
Violence Intervention Services
Evidence-Based Parenting Curriculum
Home Visiting Services
Dyadic Therapy
Food
Food and Nutrition Access Case Management Services
Evidence-Based Group Nutrition Class
Diabetes Prevention Program
Fruit and Vegetable Prescription
Healthy Food Box (For Pick-Up)
Healthy Food Box (Delivered)
Healthy Meal (For Pick-Up)
Healthy Meal (Home Delivered)
Medically Tailored Home Delivered Meal
Transportation
Reimbursement for Health-Related Public Transportation
Reimbursement for Health-Related Private Transportation
Transportation PMPM Add-On for Case Management Services
Cross-Domain
Holistic High Intensity Enhanced Case Management
Medical Respite

Pilot Services
Linkages to Health-Related Legal Supports

As outlined in the federally-approved Healthy Opportunities Pilot Service Fee Schedule (see Appendix B), each Pilot service has a specific unit of service, service rate, service description, anticipated frequency, duration, setting of service delivery, and minimum eligibility criteria for receiving the specific service.

LHDs will be able to access the eligibility criteria for the Pilots and specific Pilot services in the state-standardized tool called the "Pilot Eligibility and Service Assessment," or the "PESA" (described in more detail below), available on the NCCARE360 platform.

For example, in order to be considered eligible to receive the Evidence-Based Group Nutrition Class Pilot service, members must meet the following additional service-specific eligibility criteria:

- Have a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high risk pregnancy.

To determine if a member meets the service-specific eligibility criteria for the particular Pilot service they are recommending for the member (see Appendix B), LHDs will need to ask the member questions and gather and review available data/information to evaluate whether the member is qualified to receive the service, and document that service in the Pilot eligibility and services assessment (PESA).

LHDs should also talk to the member about where and how they would like to receive a Pilot service. For example, the member might already have a relationship with an HSO that offers the service or only be able to use an HSO that offers evening hours. LHDs will be able to see all Pilot-participating HSOs in the NCCARE360 platform (See Section VII: LHDs with Multiple Pilot-Related Roles and Responsibilities below for more information for LHDs who are also contracted as Pilot HSOs).

B3. Obtaining Pilot Consents: Members must give consent to participate in the Pilots. **LHDs will be responsible for obtaining member consent** using the DHHS-standardized 'Consent Form for NC Medicaid Coverage of Healthy Opportunities Pilot Services' **for the following activities:**

- **Participation in the Pilots and receipt of Pilot services,** including an understanding that Pilot services are not an entitlement and may be revoked at any time;
- **Sharing of personal data, including personal health information**, that will be used to **evaluate the Pilots** as part of North Carolina's 1115 waiver evaluation; and
- **Sharing of personal data, including personal health information, with organizations in the NCCARE360 network,** that will be stored and exchanged on NCCARE360**.**

Member consent should be recorded in NCCARE360. LHDs are permitted to accept electronic or written consent from a member. Written consents should be stored by attaching them to the member's PESA in NCCARE360 (described in more detail below). LHDs must also give an electronic or hard copy of the

consent to the member, if requested by the member. Consent must be obtained before a PHP authorizes Pilot services or referrals are made to HSOs.

If a member does not give consent, LHDs should explain to the member that he or she will not have Pilot services reimbursed by Medicaid. However, the member will continue to receive CMARC/CMHRP as appropriate to find other non-medical services that meet the member's need. If a member revokes consent, consent is revoked going forward, and the member must be disenrolled from Pilot services (see Section F2. Disenrollment from the Pilots).

B4. Documentation Requirements: **LHDs must document the results of the Pilot eligibility assessment, the specific Pilot service recommendations, the results of the Pilot service-specific eligibility assessment, and the member's Pilot consents in NCCARE360 for the member's PHP.** Ultimately, it is the PHP – rather than the LHD – that determines whether a member is eligible for the Pilots and is authorized to receive specific Pilot services.

LHDs will document this information for the PHP in a standardized tool called the PESA on the NCCARE360 platform. All Pilot-enrolled members receiving services must have a completed and up-to-date PESA documenting their Pilot eligibility criteria as well as eligibility criteria for each Pilot service being requested.

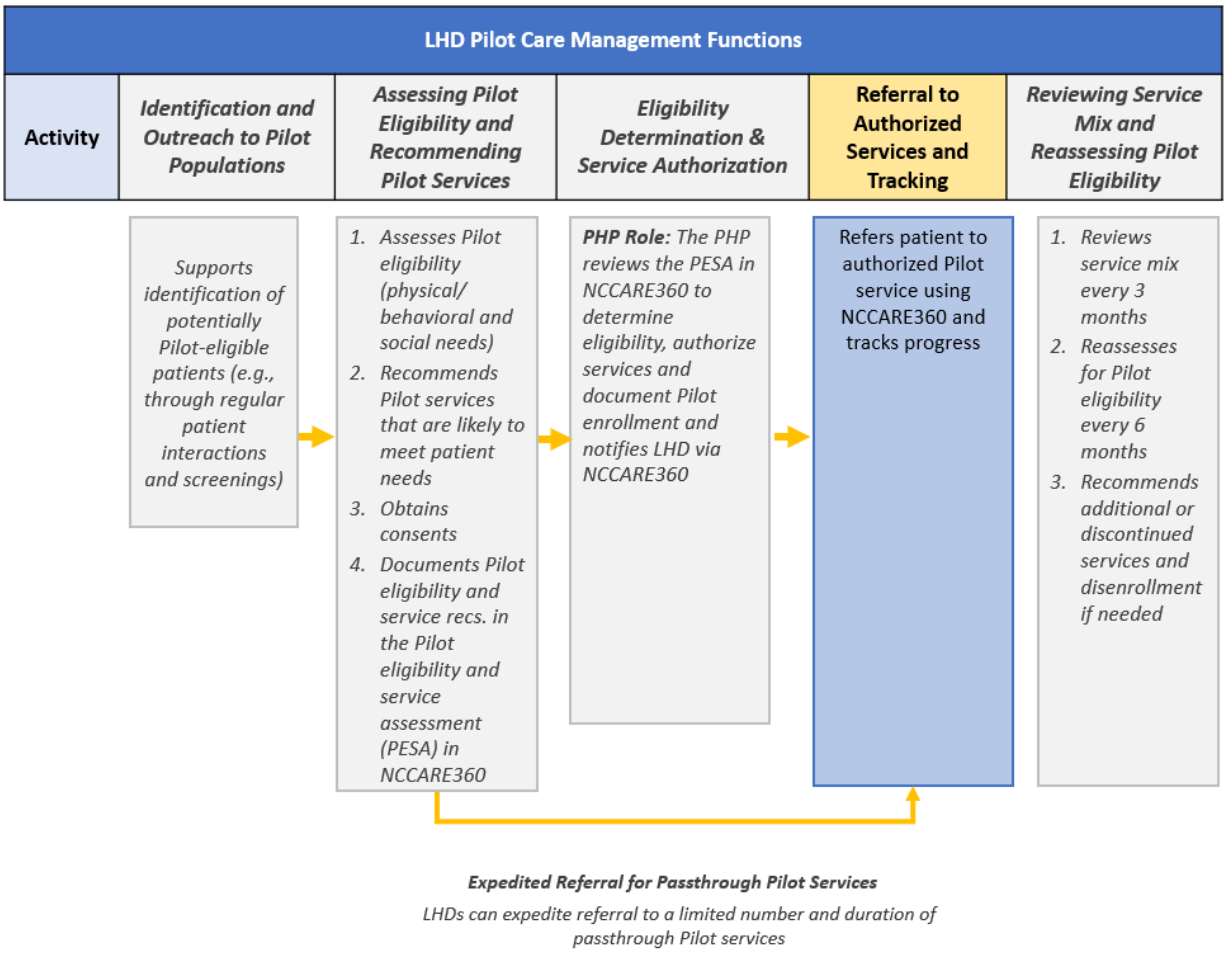
LHDs will utilize NCCARE360 to transmit the completed PESA including the enrollment and authorization request to the member's PHP that documents the following for service authorization:

- Member contact information (including address to ensure they live in a Pilot region);
- CMARC or CMHRP care manager of record;
- Physical and social risk factors supporting Pilot eligibility;
- Recommended Pilot services;
- Service-specific eligibility criteria for recommended services;
- Indication of consent for 1) Pilot participation, 2) Pilot evaluation, and 3) validation of consent to share personal information using NCCARE360; and
- Additional rationale or documentation for specific services (as needed).

LHDs are responsible for completing the PESA during the initial Pilot assessment and updating it any time there is a change to a member's service needs or Pilot eligibility. If the PHP requires additional eligibility information (e.g., if information in the PESA is missing or incomplete), the PHP may contact the LHD to obtain it. LHDs should work collaboratively with PHPs to fill out any incomplete information. PHPs will not be permitted to require LHDs to submit anything beyond what is required to determine Pilot eligibility and authorize appropriate services, and only PHPs and LHDs will be able to view and make changes to a member's PESA.

PHPs will be subject to standardized turnaround times for authorizing Pilot services (that vary by service). PHPs will document their decision and rationale on Pilot eligibility and service authorization in a member's PESA and notify the LHD of its decision. Over time, the Department intends to integrate these notifications into NCCARE360. For a limited number of low-cost, high-value services, LHDs will be permitted to refer members to 30 days' worth of Pilot services without prior approval from PHPs (see Section D: Expedited Referrals for Passthrough Pilot Services for additional information).

C. Referral to Authorized Pilot Services and Tracking



C1. Making Referrals to Pilot Services: **LHDs are responsible for referring eligible members to an appropriate HSO through the NCCARE360 platform. Once a PHP has authorized a Pilot service for a member, the LHD must submit an electronic referral for the service in NCCARE360 within two business days of receiving PHP authorization.** PHPs will monitor receipt of invoices from HSOs to ensure that referrals are occurring and services are being delivered in a timely manner. NCCARE360 will clearly indicate which HSOs are participating in the Pilots. Upon PHP notification of service authorization, the LHD must communicate to the member the authorized Pilot services and that an HSO will soon be reaching out to them.

LHDs may target a referral to a particular HSO (for example, if a member has an existing relationship with that HSO) or send the referral to all relevant HSOs that are available to provide the Pilot service. NCCARE360 will have a profile of the HSO including but not limited to: contact information, hours of operation, services offered, and languages spoken. LHDs may also consult with the Healthy Opportunities Network Lead as needed to assist in identifying appropriate HSOs.

Referrals for services that require simultaneous case management will be noted in the PESA in NCCARE360 (e.g., in order to receive the "one-time payment for security deposit and first month's rent" service, a member must also receive ongoing housing case management) and will include a separate

referral to an HSO case management service if the member does not already have an established HSO case management service. For a list of Pilot services that require simultaneous case management, see Healthy Opportunities Pilot Service Fee Schedule in Appendix B.

C2. Tracking Referral Status and Outcomes: **Once a referral is sent, LHDs should follow-up with the HSO if the referral is not accepted within two business days of the referral being sent via NCCARE360 and elevate the issue to the appropriate Network Lead as necessary to ensure the individual can access services.** LHDs should reasonably expect HSOs to accept all appropriate service referrals. While LHDs must verify HSOs accept individual referrals submitted for their members in a timely manner, Network Leads will hold primary responsibility for monitoring referral acceptance from HSOs across their network. Network Leads also hold primary responsibility to ensure HSO network adequacy within their corresponding Pilot region.

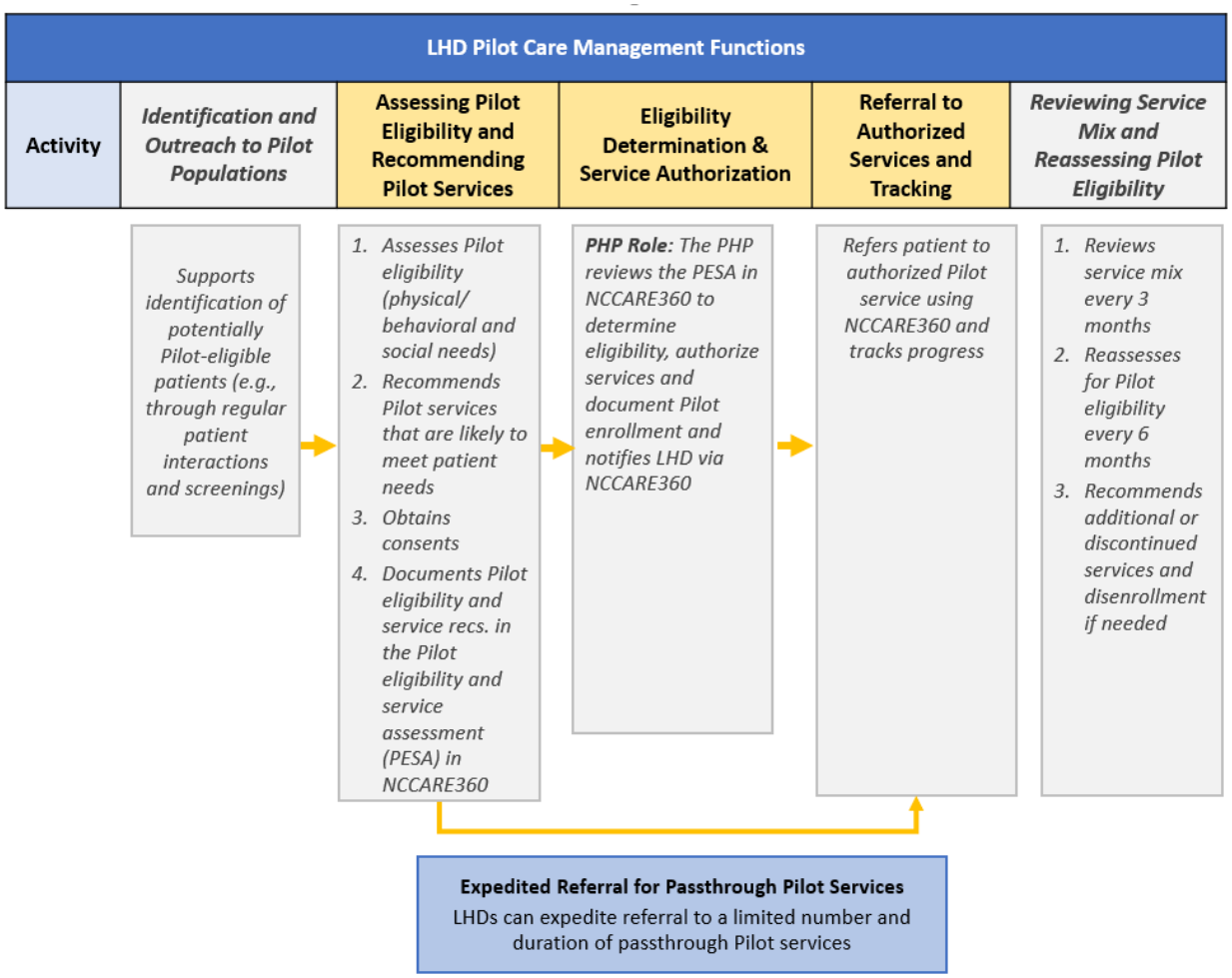
If a referral was sent to a particular HSO and is not accepted within two business days, the LHD should contact the HSO to confirm whether it can provide the service. If the HSO does not respond or indicates it does not have capacity, LHDs should escalate the issue to both the PHP and the NL, as appropriate, and send the referral to another HSO.

Similarly, if a referral was sent to all relevant HSOs and is not accepted within two business days, LHDs should escalate the issue to both the PHP and the NL, as appropriate. LHDs then need to monitor and track the Pilot services delivered and coordinate with the HSO to help assess to what extent the Pilot service(s) are meeting their needs. LHDs will not face penalties in the event there is no appropriate HSO or HSO with capacity to provide a member with an authorized Pilot service. In the event there are no HSOs to deliver Pilot services in a region, LHDs may still refer members to other non-Pilot community resources to receive non-Pilot services that meet their needs.

C3. Documenting Pilot Enrollment Status and Authorized Pilot Services in Member's Care Plan:
Upon Pilot enrollment, LHDs must initiate care management to the member, if the member is not already receiving care management and continue providing care management if the member is already receiving it.

For Pilot-enrolled members, LHDs must include in the member's Care Plan information on Pilot enrollment status, authorized Pilot services and Pilot-related needs. LHDs will regularly update member's Care Plan when an HSO accepts a referral for an authorized Pilot service, throughout the time the member is receiving Pilot services, and after a member's three-month Pilot service mix review and six-month Pilot eligibility reassessment (discussed more below).

D. Expedited Referrals for Passthrough Pilot Services



In order to expedite service delivery and reduce touchpoints with the member, PHPs are required to permit LHDs to refer members to passthrough services, a select number of high-value, low-cost Pilot services for a 30-day passthrough period without prior PHP approval. PHPs are required to treat these select Pilot services as "pre-approved" for up to 30 days. Passthrough Pilot services are standardized across all PHPs and include:

- Fruit and Vegetable Prescription
- Healthy Food Box (For Pick-Up)
- Healthy Food Box (Delivered)
- Healthy Meal (For Pick-Up)
- Healthy Meal (Home Delivered)
- Reimbursement for Health-Related Public Transportation
- Reimbursement for Health-Related Private Transportation

The Department may expand this list over time.

After an LHD identifies a potentially Pilot-eligible member that is currently in care management or who has been referred to the LHD for a Pilot assessment, who would benefit from one of the passthrough services, the LHD obtains required consents, validates Pilot eligibility and service-specific eligibility using the PESA in NCCARE360. **The LHD may then refer the member to an HSO that delivers the specific passthrough Pilot service using NCCARE360 for a period of up to 30 days.** The LHD monitors via NCCARE360 that the referral is accepted by an HSO within two business days and then creates or updates the member's Care Plan with the passthrough Pilot service. The LHD tracks the passthrough Pilot service delivered to the member and coordinates with the HSO to track member progress.

At the same time that it submits an electronic referral on NCCARE360 for a passthrough service, the LHD must alert the member's PHP by sending the completed PESA in NCCARE360. The PESA will include a recommendation for the proposed duration of the service (which may exceed the initial 30-day period) and the member will be provisionally enrolled in the Pilots and pre-authorized to receive a Pilot service for a period of up to 30 days. The PHP will then review the PESA to assess the member's eligibility for the Pilots and the selected service beyond the first 30 days.

If the PHP deems the member eligible for additional services beyond the 30-day passthrough period, the PHP will alert the LHD, which then must generate a new referral to the same HSO to extend the Pilot services beyond the initial 30 days. The LHD must then communicate to the member that they are authorized to receive the full duration of the Pilot service and monitors that the HSO accepts the new referral within two business days. The LHD will also update the member's Care Plan, track the additional Pilot services delivered to the member, and coordinate with the HSO regarding member progress.

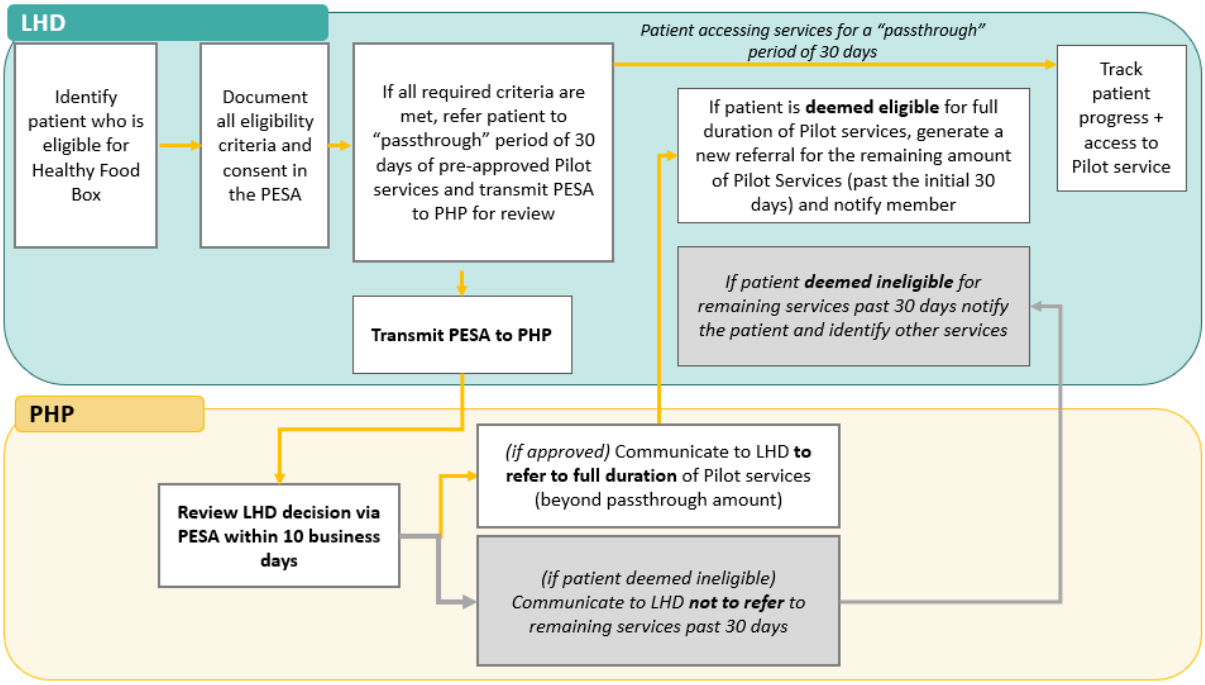
If the PHP deems the member ineligible for the Pilots or the full duration of the recommended service, the PHP will alert the LHD of its decision. The LHD then may not issue another referral for the member for the recommended Pilot service. The LHD must communicate to the member of the PHP's decision and direct the member to other non-Pilot services and HSOs to meet their needs.

PHPs have the ability to discontinue an individual LHD's ability to refer members to passthrough services if that LHD is found to have a pattern of making expedited referrals for members that are subsequently found to be ineligible for the Pilots or in the unlikely event the PHP runs out of Pilot funds[16].

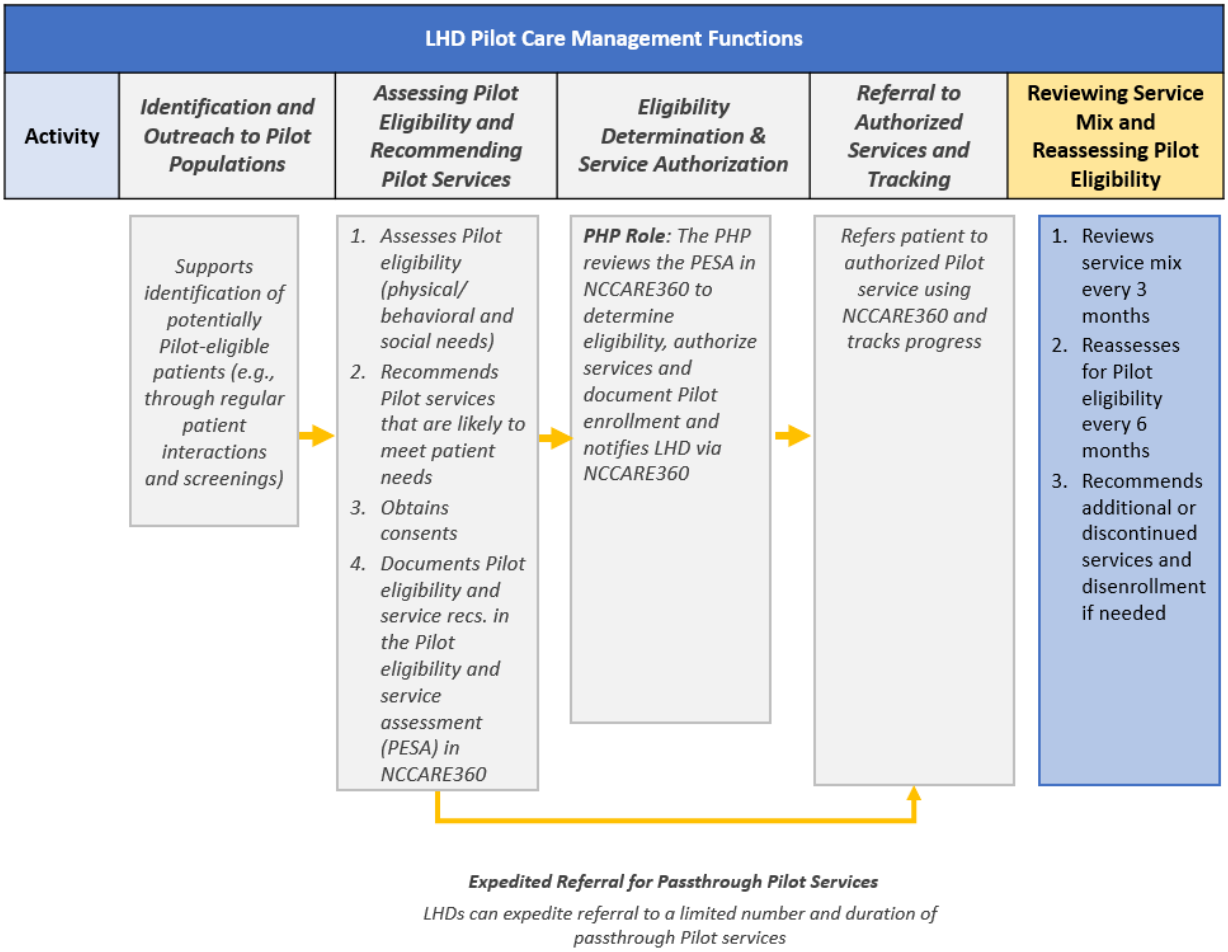
Note: the LHD should receive prior notification that they are outliers in referring ineligible members to the program and given a time period to demonstrate improvement.

[16] LHDs will be given significant (more than 60 days) notice in the event a PHP runs out or is likely to run out of Pilot funds.

Figure 3: Expedited Referrals for Passthrough Pilot Services



E. Reviewing Pilot Service Mix and Reassessing Pilot Eligibility



The Pilot program requires LHDs to conduct a three-month assessment of a member's Pilot service mix to determine if the authorized Pilot services are meeting a member's needs. If not, the LHD should modify the existing service mix, recommend to the PHP adding new services, and/or discontinue one or more services. **Pilot-enrolled members must also have a six-month assessment where they are assessed for Pilot eligibility (eligibility reassessment) based on the qualifying criteria (physical/behavioral health criteria and social risk factor) in addition to the service mix review.** Reassessment at the three- and six-month intervals after enrollment are the minimum requirements for member contact but should not replace regular care team check-ins with members to understand how Pilot services are meeting the member's needs. If an LHD identifies that a Pilot-enrolled member has met their Care Plan goals in less than 3 months and no longer requires Pilot services, the LHD may recommend discontinuing Pilot services (see Section F1. Discontinuation of Pilot Services).

LHDs must identify members requiring a three-month assessment (service mix review) and six-month assessment (Pilot eligibility reassessment), and identify members that are due for a three- or six-month assessment based on their date of enrollment (i.e., not from when the member accessed the Pilot service to which they were referred). LHDs will schedule an in-person, telephonic, or video reassessment

with (depending on the LHD's chosen modality and enrollee preference). LHDs should then schedule a reassessment meeting with Pilot-enrolled members within 30 days. LHDs should make reassessment attempts at least monthly following the original due date of a three- or six-month assessment. If the member does not respond by the next six-month interval, LHDs must recommend to the PHP that the member be disenrolled from the Pilots (described in detail below).

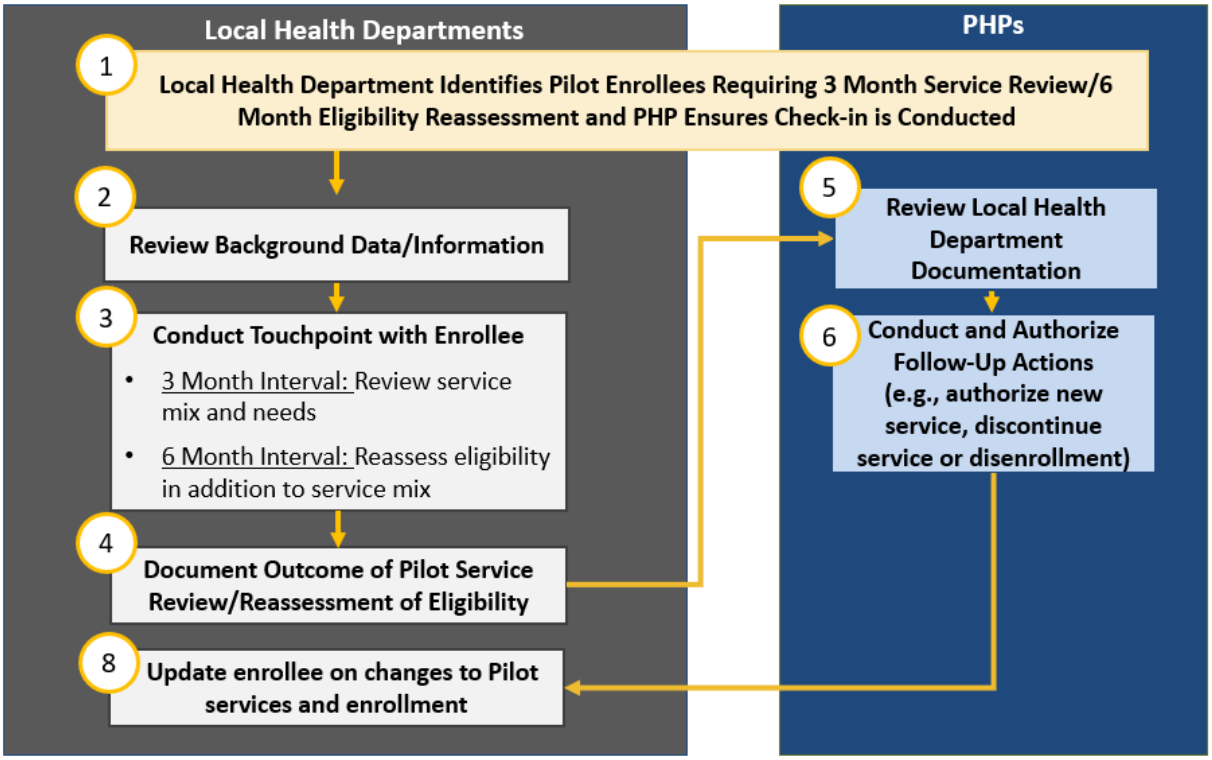
Prior to conducting the three- or six-month assessment, LHDs should review all available data on the member in preparation for the assessment, including, for example:

- The member's Care Plan, including current and previously authorized Pilot services, status updates and overarching goals;
- Care team notes from prior assessments;
- Outcomes of referred Pilot services in NCCARE360 and any subsequent information provided by HSO staff to the care team; and,
- Data provided by the PHP related to health care activities.

PHPs will monitor requirements for Pilot service mix reviews and eligibility reassessment through spot audits of member PESAs, but will not require additional reporting of LHDs related to reassessments.

Figure 4 provides a summary of the process LHDs will use to conduct three-and six-month assessments.

Figure 4: Reviewing Pilot Service Mix and Reassessing Eligibility: High-Level Process Flow

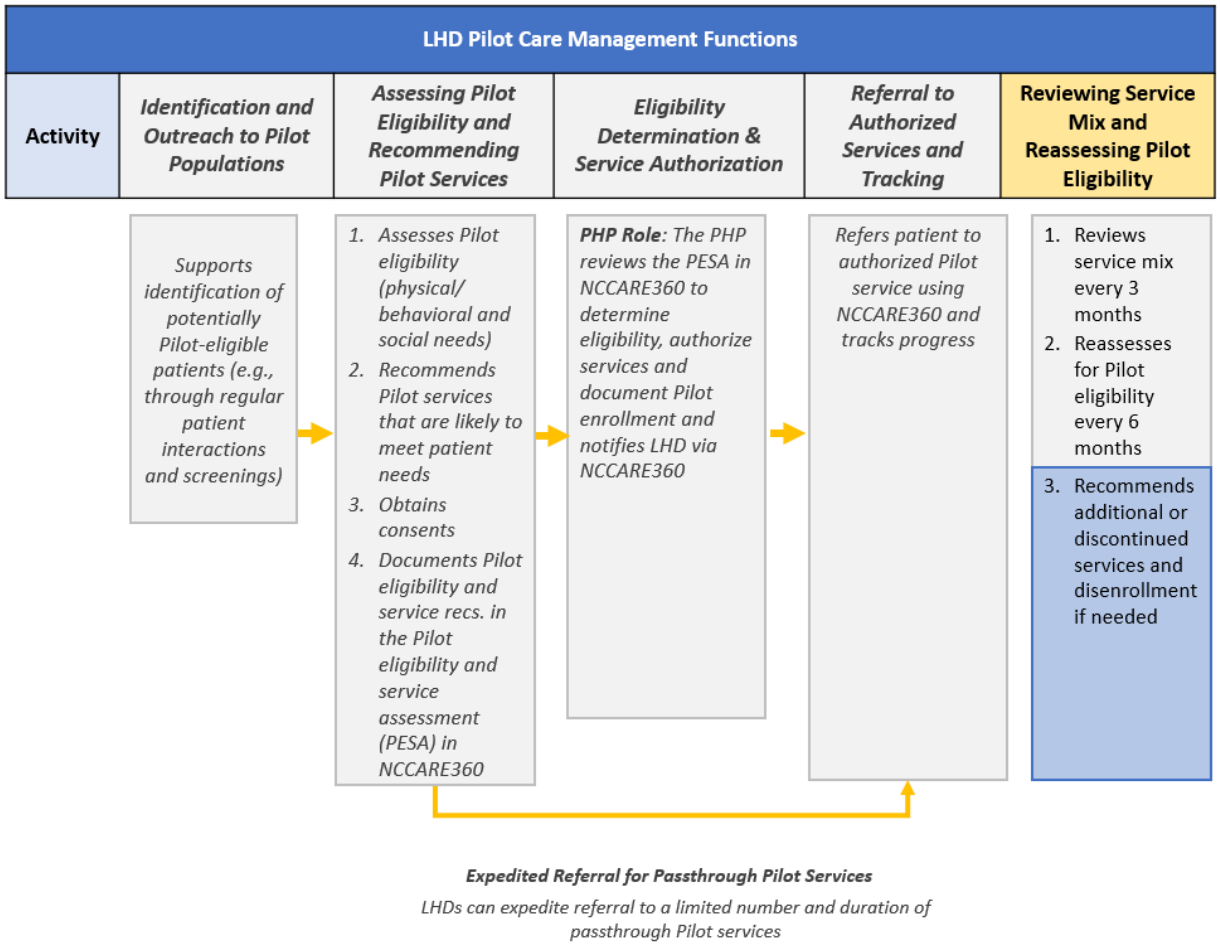


E1. Three-Month Service Mix Review: For each Pilot-enrolled member, LHDs must facilitate an assessment every three months to discuss the member's current service mix and assess if it is meeting the member's needs. LHDs should use the Department's standardized Healthy Opportunities screening questions and/or other assessments, including those used to originally recommend Pilot services, to evaluate if the member needs different Pilot services. The service mix review may occur concurrently with a Pilot eligibility reassessment if it is being conducted at the six-month interval (described in the next section). If a member has no new or changed needs and requires Pilot services to continue, LHDs will document this in the member's Care Plan. If new or modified services are required due to new or changed needs, LHDs should use the PESA in NCCARE360 to make recommendations for new or modified services and submit the PESA to the PHP for review and authorization. If LHDs decide that a service is no longer needed, they are permitted to discontinue that particular service (see next section for additional details). LHDs should document the outcome of the three-month assessment in the member's PESA, including any PHP action or decision, and update the member's Care Plan.

***E2. Six-Month Pilot Eligibility Reassessment*:** In addition to conducting a Pilot service mix review every three months, LHDs must reassess each Pilot-enrolled member for their ongoing Pilot eligibility every six months. To do so, LHDs should ensure that a Pilot-enrolled member still has a qualifying social factor in one of the priority Healthy Opportunities domains and assess the member's underlying physical/behavioral health criteria (or new criteria) that makes the member eligible for the Pilots (e.g., the member requires ongoing Pilot services to address the needs that make them eligible for the Pilots in the first place). The Pilot eligibility reassessment will always be conducted concurrently with a three-month service mix review. Any changes made to Pilot eligibility should be documented in the PESA and transmitted to the PHP for review. LHDs should document the outcome of the six-month Pilot eligibility

reassessment in the member's PESA in NCCARE360, including any PHP action or decision, and update the member's Care Plan. Changes to Pilot eligibility status will automatically impact the member's ability to receive Pilot services. If the PHP finds the member ineligible for the Pilots, the member's Pilot services will be discontinued, and the LHD should find new, non-Pilot services that meet that member's needs.

F. Discontinuation of Pilot Services and Disenrollment from Pilots



Members' needs and circumstances will change over the course of their Pilot participation. For this reason, there are some circumstances in which a member's Pilot services should be discontinued, and other circumstances where the member should be disenrolled from the Pilots.

F1. Discontinuation of Pilot Services: Discontinuation of Pilot services refers to instances when an authorized Pilot service should be stopped. Discontinuation of a service does not necessarily mean that an individual is ineligible to receive other or modified amounts/intensity of existing Pilot services. Examples of potential scenarios for discontinuation of Pilot services include:

- Current Pilot service(s) are not meeting the needs of the member (e.g., the member no longer requires support with their housing needs, but indicates that he hasn't been able to purchase enough food in the past month and may require a Healthy Food Box).
- Member has met their Care Plan goals and no longer requires the Pilot service (e.g., member has been stably housed for 12 months and no longer requires Housing Navigation, Support and Sustaining Services).
- Member no longer meets the service-specific qualifying criteria (e.g., the member no longer has pre-diabetes and is ineligible for the diabetes prevention program service).

If LHDs identify that a Pilot service should be discontinued during a three-month assessment, six-month Pilot reassessment, or other regular check-in with a member, LHDs should document that the service is to be discontinued and the rationale (e.g., if the service is no longer meeting the member's need) for doing so in a member's PESA and notify the PHP via NCCARE360. LHDs must then close out any open referrals for the discontinued service(s) in NCCARE360, communicate directly with the HSO(s) regarding the change in status, and update the member's Care Plan. After a Pilot service has been discontinued, LHDs need to communicate the decision to the member and provide transition support by identifying other Pilot and non-Pilot services and programs to meet the member's ongoing needs. If the member requires new or modified Pilot services in lieu of the discontinued service, LHDs must submit a recommended Pilot service to the PHP as part of the PESA.

F2. Disenrollment from the Pilots: Pilot disenrollment refers to instances where a member is no longer eligible to participate in the Pilots and should no longer receive Pilot services. Examples of potential scenarios for disenrollment from the Pilots include:

- Member is no longer enrolled in Managed Care (see Section I. Supporting Pilot-Enrolled Members Transitioning between Designated Pilot Care Management Entities and/or PHPs below).
- Member no longer lives in a Pilot region (regardless of the location of the LHD where they receive care).
- Member is receiving duplicative services or programs that disqualify them from Pilots (e.g., Innovations Waiver services).
- Member wishes to opt out of the Pilots.
- Member is unreachable after consistent, monthly outreach efforts by the LHD for a period of 6 months.

Upon identifying a trigger for Pilot disenrollment, LHDs must document information and rationale for Pilot disenrollment in a member's PESA and transmit to the PHP for verification. If the PHP agrees with the LHD recommendation, the PHP disenrolls the member from the Pilots, LHDs must close out any open referrals for Pilot services in NCCARE360, communicate directly with the HSO(s) regarding the change in status and ensure they do not submit invoices for further Pilot services, and update the member's Care Plan. In the event a member has Pilot services that were authorized and started at the time of Pilot enrollment (e.g., home modifications) or passthrough services, the LHD must coordinate with the HSO to ensure the Pilot service is delivered even if the member has since been disenrolled from the Pilots. After a member has been disenrolled from the Pilots, the LHD needs to communicate the decision to the member and provide transition support by identifying non-Pilot services, programs and HSOs to meet the needs of the member.

G. Use of NCCARE360 for Pilot Responsibilities

To participate in the Pilots as a Designated Pilot Care Management Entity, LHDs must be registered and trained on NCCARE360 for core Pilot responsibilities including:

- Developing the member's record and profile in NCCARE360 if it does not already exist.
- Obtaining consent for sharing members' personal data, including personal health information, with organizations in the NCCARE360 network.

- Completing the PESA documentation, transmitting it to the PHP for review, and reviewing PHP decisions on eligibility and service authorization.
- Generating referrals to HSOs for authorized Pilot services.
- Monitoring referrals to HSOs for authorized Pilot services to ensure they are accepted by the HSO and communicating with the HSO on member progress as needed.
- Using the PESA to conduct the 3-month and 6-month assessment.
- Instructing HSOs to close out referrals for services that are no longer needed/authorized
- Prompting disenrollment from the Pilots if the member is no longer eligible to participate.

H. Participation in Pilot Convenings/Trainings

Pilot-Related Convenings

There will be regular telephonic or web-based convenings with Pilot-participating entities, including LHDs serving as a Designated Pilot Care Management Entity, to share learnings and best practices as well as at least two in-person convenings per year that include all Pilot participating entities (HSOs, NLs, PHPs, etc.). Specifically, the Healthy Opportunities convenings may:

- Solicit information about implementation barriers and best practices and identify areas where training and/or technical assistance would support effective Pilot implementation;
- Review Pilot-related policies and procedures; and
- Strengthen relationships between Pilot-participating entities.

The Department will also hold learning collaboratives designed to share best practices across Pilot regions.

LHDs must participate in Pilot-related convenings; where applicable, the convening entity will specify the intended audiences for each convening so LHDs can determine who from the LHD is best suited to attend.

Training and Technical Assistance

The Department provides Pilot-related technical assistance for frontline care managers performing Pilot care management functions via its partnership with the Area Health Education Centers (AHEC). Training materials and forums may include webinars, written materials, and targeted, one-on-one training. Trainings will cover topics including, for example:

- Assessing eligibility for Pilot services
- Deep-dive on recommending services in the various Pilot domains
- Tracking enrollee progress over time
- Obtaining Pilot consent

In addition, all LHDs will complete specific training related to topics such as: provision of IPV-related services, working with IPV survivors, trauma informed care delivery, IPV-related data, and privacy and security of sensitive data, each of which will be provided by or approved in advance by the Department and each of which is intended to be completed prior to outreach for Pilot assessment.

Finally, the Healthy Opportunities Network Leads provide technical assistance for Designated Pilot Care Management Entities, including LHDs, on available Pilot services and choosing an appropriate HSO based on a member's circumstances and care needs preferences.

The Healthy Opportunities Network Leads will also provide ongoing technical assistance for LHDs, to:

- Address issues related to Pilot services and HSO availability/accessibility;
- Support LHDs' ability to refer members to contracted HSOs and adhere to Pilot responsibilities; and
- Support LHDs' understanding of and familiarity with contracted HSOs and Plot services.

LHDs must participate in both the Healthy Opportunities Network Leads and the Department-led trainings as well as the Healthy Opportunities Networks Leads technical assistance; where applicable. The Healthy Opportunities Network Leads and the Department will specify the intended audiences for each training and technical assistance session so LHDs can determine who from the LHD is best suited to attend.

I. Supporting Pilot-Enrolled Members Transitioning between Care Management Entities and/or PHPs

A member's transition between service delivery systems, including between PHPs and care management entities can pose unique challenges to ensuring service continuity and coordination. LHDs are expected to support Pilot-related activities during transitions of care including by doing the following for Pilot enrollees they are providing care management for:

- **Coordinate a timely warm handoff, or a transfer of care between care management entities and/or PHPs** for effective knowledge transfer or to ensure member continuity of care with regards to Pilot services;
- **Promote proactive communication** regarding the member's Pilot participation/services with the receiving entity (e.g., the PHP, a new care management entity, etc.) prior to transition to coordinate the transfer of care;
- **Establish a follow-up protocol** to communicate with the receiving entity (e.g., the PHP, a new care management entity etc.) after the member's transition to confirm receipt of the transferred information and to troubleshoot dynamics related to the Pilots that may have resulted from the transition;
- **Work with the HSO and former PHP** to ensure the continued delivery of any current Pilot services authorized while the member was still enrolled with the former PHP;
- **Use the NCCARE360 functionality** to send the new Designated Pilot Care Management Entity or PHP a summary of services using a Transition of Care Referral Request [See Transition of Care Policy for more detail].
- **For LHDs acting as the receiving entity in a transition of care, ensure that members are reassessed** for ongoing Pilot eligibility and service mix within 90-days of transfer following a transition of care.
- **In the case that a referral for services has not yet been accepted by the HSO**, the LHD must close the case.
- **For services that were accepted by the HSO and not yet started**, the LHD must contact the HSO to close the case for the Pilot service.

In order to be eligible to receive Pilot Services, members must be enrolled in a PHP. If a member transitioning to Medicaid Direct or has been retroactively disenrolled from managed care, the LHD must disenroll the member from the Pilots and work with the HSO to close the case for the service(s) (see F2. Disenrollment from the Pilots).

In addition, some members may discontinue or complete CMARC/CMHRP while they are still receiving Pilot services (e.g., a member completes CMHRP 60 days postpartum). In the event the member maintains eligibility for the Pilots, but is no longer participating in CMARC/CMHRP, the LHD must notify the member's PHP. The PHP will ensure the member can continue required, ongoing care management and coordination of Pilot services through either the PHP or an AMH Tier 3/CIN.

In the event an LHD is unable to continue providing a Pilot-enrolled member with CMARC/CMHRP and Pilot care management (e.g., due to capacity issues), LHDs should follow the existing guidance for transferring members for CMARC/CMHRP. Members should be transferred to another LHD to continue CMARC/CMHRP; if the member's new LHD does not provide Pilot care management, the LHD must notify the member's PHP and transition the member to receive ongoing Pilot care management through the PHP (i.e., members will receive CMARC/CMHRP from an LHD and Pilot care management from their PHP).

J. Pilot-Related Member and Provider Issues and Grievances

Pilot services have been approved as part of the State's 1115 waiver and are separate from North Carolina's Medicaid managed care benefit package available statewide to Medicaid members. For this reason, Medicaid members are not entitled to receive Pilot services, and traditional Medicaid managed care "appeals" processes do not apply to adverse determinations made about Pilot services/eligibility. However, to keep the member at the center of the Pilot experience, LHDs will support the tracking and resolution of Pilot-related issues and grievances submitted by members. LHDs must submit any Pilot-related member issues/grievances to the PHP. Further, for any member issues/grievances that involve the LHD, LHDs will be required to resolve those issues in a timely manner.

In addition, LHDs will be permitted to submit Pilot-related provider issues and grievances directly to the PHP.

Section IV: LHD Eligibility Criteria to Participate in the Pilots for Pilot Participation

LHD Eligibility Criteria to Participate in the Pilots

To participate in the Pilots, LHDs must:

- Be contracted with at least one PHP as an LHD
- Provide CMARC and/or CMHRP to Medicaid managed care-enrolled members in a Pilot region (note—LHDs may only provide Pilot-related care management for enrollees of PHPs for which it is contracted as an LHD), and
- Contract with the PHP to assume Pilot-related responsibilities using Department-standardized contracting terms and conditions

If an LHD does not participate in the Pilots, there is no effect on their contract for the provision CMARC/CMHRP.

Section V: LHD Payment for Pilot Responsibilities

Following Pilot service delivery launch of LHDs as Pilot care management entities in 2023, LHDs that are contracted with one or more PHPs to provide Pilot care management services will receive Pilot care management payments from the PHPs. Pilot care management payments are not negotiated. Instead, DHHS will require PHPs to pay LHDs serving as a Designated Pilot Care Management Entity additional, DHHS-standardized, Pilot Care Management per member per month (PMPM) payment for each

Medicaid member eligible for CMARC or CMHRP in the three Pilot regions regardless of their Pilot enrollment. The Pilot Care Management PMPM payment is separate and on top of existing payments for CMARC and CMHRP.

Pilot design seeks to maintain (and not disrupt) current contracting and payment practices. Given that relationships between PHPs and LHDs are unique, entities are encouraged to continue their existing processes for Pilot care management payments. PHPs must use the Pilot care management rates and payment approach outlined in the Healthy Opportunities Pilots Payment Protocol to pay LHDs for Pilot-related care management, and are not permitted to further negotiate rates. The Department reserves the right to modify this payment approach in the future, including to require that PHPs pay contracted LHDs based on actual Pilot enrollment, rather than attributed population. LHDs will be given appropriate notice in the event of a change to the Pilot payment approach.

LHDs that are also AMH Tier 3 practices will receive Pilot Care Management payments for both the CMARC/CMHRP population and AMH Tier 3 attributed members (See Section VII. LHDs with Multiple Pilot-Related Roles and Responsibilities for additional details about the LHDs that are also contracted as AMH Tier 3 practices).

In addition to receiving Pilot care management payments, Pilot-participating LHDs will be eligible to participate in the Pilot VBP program described further in the Department's Pilot VBP protocols and guidance.

Section VI: PHP Oversight of LHDs for Pilot Responsibilities

Aligned with oversight of CMARC and CMHRP, PHPs will be responsible for overseeing and monitoring LHD compliance with Pilot responsibilities. However, PHPs may not put additional requirements on Designated Pilot Care Management Entities above and beyond what the Department requires.

Under the existing CMARC/CMHRP program guidance/requirements, PHPs are responsible for overseeing and monitoring compliance of each contracted LHD, including compliance with the "Healthy Opportunities Pilots Standard Terms and Conditions for PHP Contracts with LHDs Serving as a Designated Pilot Care Management Entity" (Pilot Standard Terms and Conditions). PHPs are not permitted to hold LHDs accountable for requirements that go above and beyond the CMARC/CMHRP requirements and Pilot Standard Terms and Conditions. For LHDs, a separate process has been developed to address areas of underperformance, should they arise.[17] In these cases, PHPs will intervene and initiate action in one of two pathways: a standardized Corrective Action Plan (CAP) (most likely) or immediate termination (rare).

Similar to requirements in the CMARC/CMHRP programs, PHPs will have the ability to put an LHD on a CAP if the LHD is found to have a pattern of Pilot-related underperformance, defined as noncompliance with the Pilot Standard Terms and Conditions. The Pilot-related CAP process aligns with what currently exists for CMARC and CMHRP. PHPs are required to provide written notice detailing Pilot-related underperformance to the LHD and must notify the Department within 45 business days. The LHD is

[17] For additional information see LHD Program Guide: Management of High-Risk Pregnancies and At-Risk Children in Managed Care. Available at: https://files.nc.gov/ncdma/documents/Transformation/caremanagement/Program-Guide-for-Care-Management-of-High--Risk-Pregnancies-and-At-Risk-Children-in-Managed-Care-2.0.pdf

required to submit a CAP within 15 business days of receiving notice of underperformance. Once the CAP is approved by the PHP, the LHD has 90 days to implement and demonstrate improved performance. In addition, the PHP will also have the ability to discontinue an individual LHD's ability to refer members to passthrough services if that LHD continues to have a pattern of making expedited referrals for members that are subsequently found to be ineligible for the Pilots. PHPs should give prior notification to LHDs who are outliers in referring ineligible members to Pilot passthrough and will be given a time period to demonstrate improvement.

The PHP may terminate a contract with an LHD for instances of fraud, waste and abuse or for failure to improve performance against a CAP in the specified timeframe. PHPs must provide notice to the LHD and the Department prior to terminating any Pilot-related contract with an LHD. Termination of a Pilot-related contract has no impact on the LHD's contract for CMARC/CMHRP or on Pilot-related contracts with other PHPs (except in circumstances where an LHD is serving as a Designated Pilot Care Management Entity and a Pilot HSO, as described below). Once a Pilot-related contract has been terminated, the LHD will stop receiving Pilot care management payments and must work with the PHP to ensure that Pilot enrollees are able to continue receiving the authorized Pilot services and Pilot-related care management from another source (e.g., the PHP). LHDs may opt out of the Pilot program at any time, but must provide a minimum of 45 days' notice to the Department and the PHP before doing so. Under all circumstances the LHD must also notify Unite Us of the terminated contract in order to be removed from the Pilot-related components of the NCCARE360 platform. For any terminated contracts, the PHP must follow all requirements in the Pilot Transition of Care Protocol to ensure continuity of care for members.

Section VII: LHDs with Multiple Pilot-Related Roles and Responsibilities

LHDs may serve multiple roles in the Pilots, including:

- Providing Pilot-related care management for CMARC/CMHRP populations;
- Contracting as an AMH Tier 3 practice and providing Pilot-related care management to attributed members (in addition to the CMARC/CMHRP population);
- Serving as a Pilot HSO in addition to providing Pilot-related care management.

The remainder of this section details requirements for how LHDs can serve multiple Pilot-related roles and responsibilities.

LHDs Certified as a Tier 3 Advanced Medical Home

LHDs that are dually certified as an AMH Tier 3 practice can provide Pilot-related care management responsibilities for both their CMARC/CMHRP population and members attributed to their AMH Tier 3 practice. Such LHDs must maintain separate Pilot-related contracts with each PHP—a contract for the CMARC/CMHRP population and a contract for AMH Tier 3 attributed members. Termination of one Pilot-related contract does not affect the status of any other Pilot-related contract. LHDs will receive Pilot-care management payments for the CMARC/CMHRP population. These payments will have no impact on other Pilot-related payments that the LHD is contracted to receive.

LHDs Contracted as a Pilot HSO

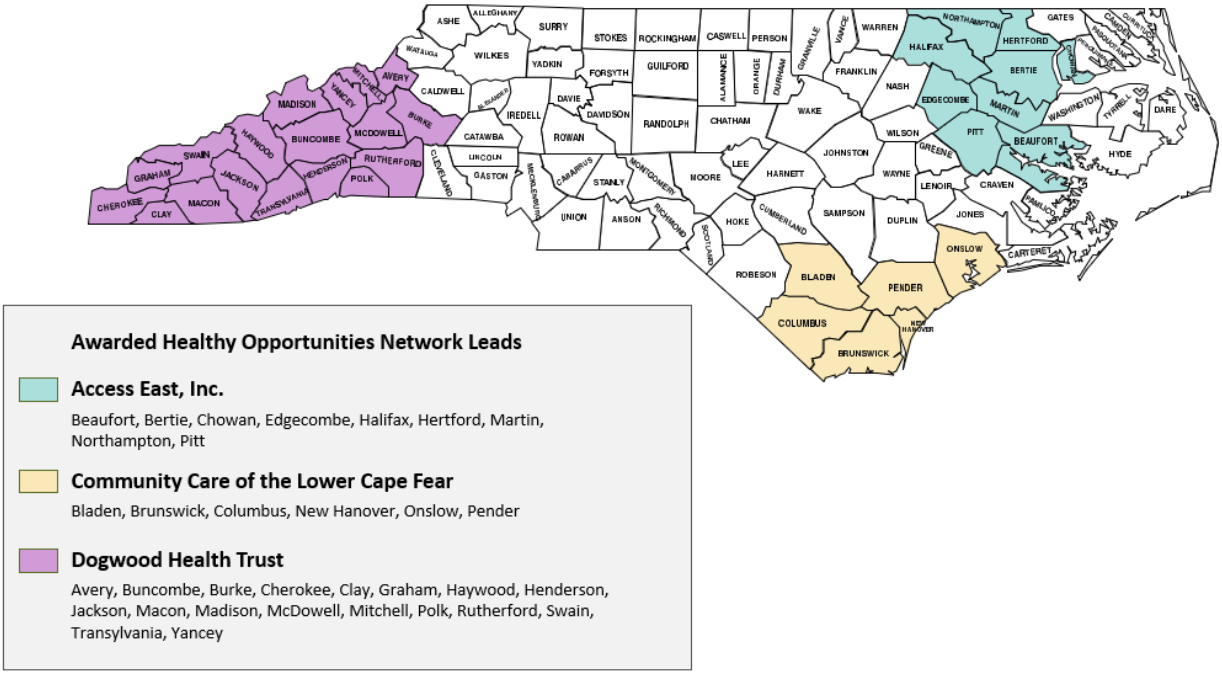
Some LHDs may have the expertise to deliver authorized Pilot services to Pilot enrollees (e.g., healthy food boxes). LHDs are permitted to provide Pilot-related care management and deliver Pilot services to

enrollees. In order to do so, LHDs must maintain separate Pilot-related contracts related to operating as an HSO and as a Designated Pilot Care Management Entity: 1) a contract with the PHP for Pilot-related care management and 2) a contract with the appropriate Network Lead for the delivery of agreed upon Pilot services. Termination of one contract does not impact the status of any other Pilot-related contract.

LHDs are only permitted to deliver Pilot services, including passthrough services, to their own members when appropriate, and when there is no Pilot HSO in the region that would better meet their needs. LHDs are required to individually assess each member to ensure that there is no other HSO in the region that would be preferrable to receiving the service from the LHD itself. In such circumstances, LHDs must notify the appropriate PHP when transmitting the PESA that the member will be receiving Pilot services from their organization. There are no restrictions on which Pilot services may be delivered by the LHD (e.g., passthrough services). The PHP will monitor for instances of fraud, waste and abuse and patterns of underperformance. The PHP will also monitor patterns of referrals from the LHD to themselves to ensure member needs would not be better met by other HSOs. Confirmed instances of fraud, waste or abuse may result in one or more Pilot contract terminations, as described above.

Appendices

Appendix A: Awarded Healthy Opportunities Network Leads



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

Dogwood Health Trust

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

Appendix B: Healthy Opportunities Pilots Fee Schedule

Pilot Service Rates

Healthy Opportunities Pilots Fee Schedule		
Service Name	**Unit Of Service/Payment**	**Rate or Cap**
Housing		
Housing Navigation, Support and Sustaining Services	PMPM	$400.26
Inspection for Housing Safety and Quality	Cost-Based Reimbursement Up to A Cap	Up to $250 per inspection
Housing Move-In Support	Cost-Based Reimbursement Up to A Cap	• 1 BR: Up to $900 per month • 2 BR: Up to $1,050 per month • 3 BR: Up to $1,150 per month • 4 BR: Up to $1,200 per month • 5+ BR: Up to $1,250 per month
Essential Utility Set-Up	Cost-Based Reimbursement Up to A Cap	• Up to $500 for utility deposits • Up to $500 for reinstatement utility payment • Up to $500 for utility arrears
Home Remediation Services	Cost-Based Reimbursement Up to A Cap	Up to $5,000 per year[18]
Home Accessibility and Safety Modifications	Cost-Based Reimbursement Up to A Cap	Up to $10,000 per lifetime of waiver demonstration[19]
Healthy Home Goods	Cost-Based Reimbursement Up to A Cap	Up to $2,500 per year
One-Time Payment for Security Deposit and First Month's Rent	Cost-Based Reimbursement Up to A Cap	• First month's rent: Up to 110% FMR[20] (based on home size) • Security deposit: Up to 110% FMR (based on home size) x2

[18] The HSO that coordinates the contractors to deliver the Home Remediation Service will receive $125 per Home Remediation Service project that costs no more than $1,250 and will receive $250 per Home Remediation Service project that costs between $1,250 and $5,000.

[19] The HSO that coordinates the contractors to deliver the Home Accessibility and Safety Modification will receive $250 per Home Accessibility Modification project that costs no more than $2,500 and will receive $500 per Home Accessibility and Safety Modification project that costs between $2,500 and $10,000.

[20] Fair Market Rent (FMR) standards as established by the U.S. Department of Housing and Urban Development, available here: https://www.huduser.gov/portal/datasets/fmr.html#2022

Healthy Opportunities Pilots Fee Schedule		
Service Name	**Unit Of Service/Payment**	**Rate or Cap**
Short-Term Post Hospitalization Housing	Cost-Based Reimbursement Up to A Cap	• First month's rent: Up to 110% FMR (based on home size) • Security deposit: Up to 110% FMR (based on home size) x2
Interpersonal Violence / Toxic Stress		
IPV Case Management Services	PMPM	$221.96
Violence Intervention Services	PMPM	$168.94
Evidence-Based Parenting Curriculum	One class	$22.60
Home Visiting Services	One home visit	$67.89
Dyadic Therapy	Per occurrence	$68.25
Food		
Food and Nutrition Access Case Management Services	15 minute interaction	$13.27
Evidence-Based Group Nutrition Class	One class	$22.80

Diabetes Prevention Program	• Four classes (first phase)
	• Three classes (second phase)[21]
		• **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	Cost-Based Reimbursement Up to A Cap	Up to $210 per month[22]

[21] The Centers for Disease Control and Prevention recognized Diabetes Prevention Program is offered in two phases, including a minimum of 16 classes in Phase 1 and 6 classes in Phase 2. The DPP program is paid for in allocations so HSOs that participate in the Pilot are able to receive pro-rated payments as enrollees complete four classes.

[22] The HSO that coordinates the Fruit and Vegetable Prescription service will receive $5.25 per person served in a given month.

Healthy Opportunities Pilots Fee Schedule		
Service Name	**Unit Of Service/Payment**	**Rate or Cap**
Healthy Food Box (For Pick-Up)	One food box	• Small box: $89.29 • Large box: $142.86
Healthy Food Box (Delivered)	One food box	• Small box: $96.79 • Large box: $150.36
Healthy Meal (For Pick-Up)	One meal	$7.00
Healthy Meal (Home Delivered)	One meal	$7.60
Medically Tailored Home Delivered Meal	One meal	$7.80
Transportation		
Reimbursement for Health-Related Public Transportation	Cost-Based Reimbursement Up to A Cap	Up to $102 per month
Reimbursement for Health-Related Private Transportation	Cost-Based Reimbursement Up to A Cap	Up to $267 per month[23]
Transportation PMPM Add-On for Case Management Services	PMPM	$71.30
Cross-Domain		
Holistic High Intensity Enhanced Case Management	PMPM	$501.41
Medical Respite	Per diem	$206.98
Linkages to Health-Related Legal Supports	15 minute interaction	$25.30

[23] Repairs to a Pilot Enrollee's car may be deemed an allowable, cost-effective alternative to private transportation by the Enrollee's Prepaid Health Plan. Reimbursement for this service may not exceed six months of capped private transportation services.

Housing Services

Housing Navigation, Support and Sustaining Services

Category	Information
Service Name	Housing Navigation, Support and Sustaining Services

Service Description	Provision of one-to-one case management and/or educational services to prepare an enrollee for stable, long-term housing (e.g., identifying housing preferences and developing a housing support plan), and to support an enrollee in maintaining stable, long-term housing (e.g., development of independent living skills, ongoing monitoring and updating of housing support plan). Activities may include:
	Housing Navigation and Support
	• Assisting the enrollee to identify housing preferences and needs.
	• Connecting the enrollee to social services to help with finding housing necessary to support meeting medical care needs.
	• Assisting the enrollee to select adequate housing and complete a housing application, including by:
	  ○ Obtaining necessary personal documentation required for housing applications or programs;
	  ○ Supporting with background checks and other required paperwork associated with a housing application
	• Assisting the enrollee to develop a housing support and crisis plan to support living independently in their own home.
	• Assisting the enrollee to develop a housing stability plan and support the follow through and achievement of the goals defined in the plan.
	• Assisting to complete reasonable accommodation requests.
	• Identifying vendor(s) for and coordinating housing inspection, housing move-in, remediation and accessibility services.
	• Assisting with budgeting and providing financial counseling for housing/living expenses (including coordination of payment for first month's rent and short-term post hospitalization rental payments).
	• Providing financial literacy education and on budget basics and locating community-based consumer credit counseling bureaus
	• Coordinating other Pilot housing-related services, including:
	  ○ Coordinating transportation for enrollees to housing-related services necessary to obtain housing (e.g. apartment/home visits).
	  ○ Coordinating the enrollee's move into stable housing including by assisting with the following:
	  ▪ Logistics of the move (e.g., arranging for moving company or truck rental);
	  ▪ Utility set-up and reinstatement;
	  ▪ Obtaining furniture/commodities to support stable housing
	  ○ Referral to legal support to address needs related to finding and maintaining stable housing.
	Tenancy Sustaining Services

	• Assisting the enrollee in revising housing support/crisis plan. • Assisting the enrollee to develop a housing stability plan and support the follow through and achievement of the goals defined in the plan, including assistance applying to related programs to ensure safe and stable housing (e.g., Social Security Income and weatherization programs), or assuring assistance is received from the enrollee's Medicaid care manager. • Assisting the enrollee with completing additional or new reasonable accommodation requests. • Supporting the enrollee in the development of independent living skills. • Connecting the enrollee to education/training on tenants' and landlords' role, rights and responsibilities. • Assisting the enrollee in reducing risk of eviction with conflict resolution skills. • Coordinating other Pilot housing-related services, including: o Assisting the enrollee to complete annual or interim housing re-certifications. o Coordinating transportation for enrollees to housing-related services necessary to sustain housing. o Referral to legal support to address needs related to finding and maintaining stable housing. Activities listed above may occur without the Pilot enrollee present. For homeless enrollees, all services must align with a Housing First approach to increase access to housing, maximize housing stability and prevent returns to homelessness. The HSO has the option to partner with other organizations to ensure it is able to provide all activities described as part of this service. If desired by the HSO, the Lead Pilot Entity can facilitate partnerships of this kind.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	On average, individuals require 6-18 months of case management services to become stably housed but individual needs will vary and may continue beyond the 18 month timeframe. Service duration would persist until services are no longer needed, as determined in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	• The majority of sessions with enrollees should be in-person, in a setting desired by the individual. In-person meetings will, on average occur for the first 3 months of service. • Case managers may only utilize telephonic contacts if appropriate. • Some sessions may be "off-site," (e.g., at potential housing locations).
Minimum Eligibility Criteria	• 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 co-occurring 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.

Inspection for Housing Safety and Quality

Category	Information
Service Name	Inspection for Housing Safety and Quality
Service Description	A housing safety and quality inspection by a certified professional includes assessment of potential home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Inspections may assess the habitability and/or environmental safety of an enrollee's current or future dwelling. Inspections may include: • Inspection of building interior and living spaces for the following: o Adequate space for individual/family moving in; o Suitable indoor air quality and ventilation; o Adequate and safe water supply; o Sanitary facilities, including kitchen, bathroom and living spaces o Adequate electricity and thermal environment (e.g. window condition) and absence of electrical hazards; o Potential lead exposure; o Conditions that may affect health (e.g. presence of chemical irritants, dust, mold, pests); o Conditions that may affect safety. • Inspection of building exterior and neighborhood for the following: o Suitable neighborhood safety and building security; o Condition of building foundation and exterior, including building accessibility; and, o Condition of equipment for heating, cooling/ventilation and plumbing. Inspector must communicate inspection findings to the care or case manager working with the enrollee to ensure referrals to appropriate organizations for additional home remediation and/or modifications, if necessary.

	This service can cover Housing Quality Standards (HQS) inspections upon move-in to a new residence, or other inspections to identify sub-standard housing that impacts an enrollee's health and safety. This service covers failed inspections and re-inspections. Each housing inspection does not need to include all activities listed in this service description. Service providers should only execute the necessary components of a housing safety and quality inspection as required based on an enrollee's circumstances. Costs for services provided must be commensurate with a vendor's scope of activities.
Frequency *(if applicable)*	• Enrollees may receive ad hoc assessments to identify housing quality, accessibility and safety issues at time of indication as needed when that current housing may be adversely affecting health or safety. • Housing Quality Standards (HQS) inspections must occur at enrollee move-in to new place of residence if enrollee will receive "One-Time Payment for Security Deposit" and First Month's Rent or "Short Term Post Hospitalization Housing" services.
Duration *(if applicable)*	Approximately one hour.
Setting	Housing inspection should occur in the enrollee's current place of residence or potential residence.
Minimum Eligibility Criteria	• Inspections may be conducted for individuals who are moving into new housing units (e.g., HQS Inspection) or for individuals who are currently in housing that may be adversely affecting their health or safety. • 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. • 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.

Housing Move-In Support

Category	Information
Service Name	Housing Move-In Support

Service Description	Housing move-in support services are non-recurring set-up expenses. Allowable expenses include but are not limited to the following: • Moving expenses required to occupy and utilize the housing (e.g., moving service to transport an individual's belongings from current location to new housing/apartment unit, delivery of furniture, etc.) • Discrete goods to support an enrollee's transition to stable housing as part of this service. These may include, for example: o Essential furnishings (e.g., mattresses and beds, dressers, dining table and chairs); o Bedding (e.g., sheets, pillowcases and pillows); o Basic kitchen utensils and dishes; o Bathroom supplies (e.g., shower curtains and towels); o Cribs; o Cleaning supplies. This service shall not cover used mattresses, cloth, upholstered furniture, or other used goods that may pose a health risk to enrollees.
Frequency *(if applicable)*	Enrollees that meet minimum service eligibility criteria may receive housing move-in support services when they move into a housing/apartment unit for the first time or move from their current place of residence to a new place of residence. This service may be utilized more than once per year, so long as overall spending remains below the annual cap.
Duration *(if applicable)*	N/A
Setting	Variable. Many housing move-in support services will occur in the enrollee's current place of residence or potential residence. Some discrete goods may be given to an enrollee in a location outside the home, including an HSO site or clinical setting.
Minimum Eligibility Criteria	• Enrollee must be receiving Housing Navigation, Support and Sustaining Services or Holistic High Intensity Enhanced Case Management. o Enrollees receiving services substantially similar to Housing Navigation, Supports and Sustaining Services through a different funding source (e.g. Medicaid State Plan, a 1915(c) waiver service, or Housing and Urban Development grant) may still receive this Pilot service if deemed eligible. The provider delivering the substantially similar service must coordinate with the enrollee's Medicaid care manager (if applicable) to determine the necessity of the Pilot service and ensure appropriate documentation in the enrollee's care plan. • Housing move-in support services are available for individuals who are moving into housing from homelessness[24] or shelter, or for individuals who are moving from

[24] The Healthy Opportunities Pilots define homelessness by the U.S. Department of Health and Human Services (HHS) definition from Section 330 of the Public Health Service Act (42 U.S.C., 254b) and HRSA/Bureau of Primary Health Care Program Assistance Letter 88-12, Health Care for the Homeless Principles of Practice, available at: https://www.nhchc.org/faq/official-definition-homelessness/.

	their current housing to a new place of residence due to one or more of the reasons listed under "Minimum Eligibility Criteria."
	• Enrollee is moving into housing/apartment unit due to one or more of the following reasons:
	  ○ Transitioning from homelessness or shelter to stable housing;
	  ○ Addressing the sequelae of an abusive relationship
	  ○ Evicted or at risk of eviction from current housing;
	  ○ Current housing is deemed unhealthy, unsafe or uninhabitable by a certified inspector;
	  ○ Displaced from prior residence due to occurrence of a natural disaster.
	• This Pilot service is furnished only to the extent that the enrollee is unable to meet such expense or when the services cannot be reasonably obtained from other sources.
	• 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.
	• 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.

Essential Utility Set-Up

Category	**Information**
Service Name	Essential Utility Set-Up
Service Description	The Essential Utility Set Up service is a non-recurring payment to: • Provide non-refundable, utility set-up costs for utilities essential for habitable housing. • Resolve arrears related to unpaid utility bills and cover non-refundable utility set-up costs to restart the service if it has been discontinued in a Pilot enrollee's home, putting the individual at risk of homelessness or otherwise adversely impacting their health (e.g., in cases when medication must be stored in a refrigerator). This service may be used in association with essential home utilities that have been discontinued (e.g., initial payments to activate heating, electricity, water, and gas).
Frequency *(if applicable)*	Enrollees may receive this service at any point at which they meet service minimum eligibility criteria and have not reached the cap.
Duration *(if applicable)*	N/A
Setting	• An enrollee's home • Utility vendor's office
Minimum Eligibility Criteria	• Enrollee must require service either when moving into a new residence or because essential home utilities have been discontinued or were never activated at move-in and will adversely impact occupants' health if not restored.

	• Enrollee demonstrates a reasonable plan, created in coordination with care manager or case manager, to cover future, ongoing payments for utilities. • This Pilot service is furnished only to the extent that the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. • 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. • 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.

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.

Home Accessibility and Safety Modifications

Category	Information
Service Name	Home Accessibility and Safety Modifications

Service Description	Evidence-based home accessibility and safety modifications 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 accessibility modifications are adjustments to homes that need to be made in order to allow for enrollee mobility, enable independent and safe living and accommodate medical equipment and supplies. Home modifications should improve the accessibility and safety of housing (e.g., installation of entrance ramps, hand-held shower controls, non-slip surfaces, grab bars in bathtubs, installation of locks and/or other security measures, and reparation of cracks in floor).
Frequency *(if applicable)*	Enrollees may receive home accessibility modifications at any point at which they meet minimum eligibility criteria and have not reached the cap.
Duration *(if applicable)*	N/A
Setting	Home accessibility and safety services will 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 accessibility or safety modifications 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 approved home accessibility or safety modification 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 Home Goods

Category	**Information**
Service Name	Healthy Home Goods
Service Description	Healthy-related home goods are furnished to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Home-related goods that may be covered include, for example, discrete items related to reducing environmental triggers in the home (e.g., a "Breathe Easy at Home Kit" with EPA-vacuum, air filter, green cleaning supplies, hypoallergenic mattress or pillow covers and non-toxic pest control supplies). Healthy Home Goods do not alter the physical structure of an enrollee's housing unit.
Frequency *(if applicable)*	Enrollees may receive healthy home goods when there are health or safety issues adversely affecting their health or safety.
Duration	N/A

(if applicable)	
Setting	Variable. Many times, goods will be given to an enrollee inside the home. Some goods (e.g., air filters) may be given to an enrollee in a location outside the home, including an HSO site or a clinical setting.
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. • 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.

One-Time Payment for Security Deposit and First Month's Rent

Category	Information
Service Name	One-Time Payment for Security Deposit and First Month's Rent
Service Description	Provision of a one-time payment for an enrollee's security deposit and first month's rent to secure affordable and safe housing that meet's the enrollee's needs. All units that enrollees move into through this Pilot service must: • Pass a Housing Quality Standards (HQS) inspection • Meet fair market rent and reasonableness check • Meet a debarment check For homeless enrollees, all services provided must align with a Housing First approach to increase access to housing, maximize housing stability and prevent returns to homelessness.
Frequency *(if applicable)*	Once per enrollee over the lifetime of the demonstration
Duration *(if applicable)*	N/A
Setting	N/A
Minimum Eligibility Criteria	• Enrollee must be receiving Housing Navigation, Support and Sustaining Services or Holistic High Intensity Enhanced Case Management. ○ Enrollees receiving services substantially similar to Housing Navigation, Supports and Sustaining Services through a different funding source (e.g. Medicaid State Plan, a 1915(c) waiver service, or Housing and Urban Development grant) may still receive this Pilot service if deemed eligible. The provider delivering the substantially similar service must coordinate with the enrollee's Medicaid care manager (if applicable) to determine the necessity of the Pilot service and ensure appropriate documentation in the enrollee's care plan. • Enrollee must receive assistance with developing a reasonable plan to address future ability to pay rent through a housing stability plan.

	• Housing unit must pass a Housing Quality Standards (HQS) inspection prior to move-in or, in certain circumstances, a habitability inspection performed by the case manager or other staff. If a habitability inspection is performed, an HQS inspection must be scheduled immediately following move-in. • Landlord must be willing to enter into a lease agreement that maintains a satisfactory dwelling for the enrollee throughout the duration of the lease, unless there are appropriate and fair grounds for eviction. • This pilot service is provided only to the extent that the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. • 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.

Short-Term Post Hospitalization Housing

Category	Information
Service Name	Short-Term Post Hospitalization Housing
Service Description	Post-hospitalization housing for short-term period, not to exceed six [6] months, due to individual's imminent homelessness at discharge from inpatient hospitalization. Housing should provide enrollees with a safe space to recuperate and perform activities of daily living while receiving ongoing medical care as needed and will be limited to housing in a private or shared housing unit. Short-Term Post Hospitalization Housing setting should promote independent living and transition to a permanent housing solution. Services may not be provided in a congregate setting, as defined by the Department. Allowable units for short-term post-hospitalization housing must provide the following for enrollees: • Access to a clean, healthy environment that allows enrollees to perform activities of daily living; • Access to a private or semi-private, independent room with a personal bed for the entire day; • Ability to receive onsite or easily accessible medical and case management services, as needed. Coordination of this service should begin prior to hospital discharge by a medical professional or AMH Tier 3 practice. The referral to Short-Term Post Hospitalization Housing should come from a member of the individual's care team. For homeless enrollees, all services provided must align with a Housing First approach to increase access to housing, maximize housing stability and prevent returns to homelessness.
Frequency	N/A

(if applicable)	
Duration *(if applicable)*	Up to six months, contingent on determination of continued Pilot eligibility
Setting	Coordination should begin prior to hospital discharge. Services may not be provided in a congregate setting.
Minimum Eligibility Criteria	• Enrollee must receive Housing Navigation, Support and Sustaining Services or Holistic High Intensity Enhanced Case Management in tandem with this service. ○ Enrollees receiving services substantially similar to Housing Navigation, Supports and Sustaining Services through a different funding source (e.g. Medicaid State Plan, a 1915(c) waiver service, or Housing and Urban Development grant) may still receive this Pilot service if deemed eligible. The provider delivering the substantially similar service must coordinate with the enrollee's Medicaid care manager (if applicable) to determine the necessity of the Pilot service and ensure appropriate documentation in the enrollee's care plan. • Enrollee is imminently homeless post-inpatient hospitalization. • Enrollee must receive assistance with developing a reasonable plan to address future ability to pay rent through a housing stability plan. • Housing unit must pass a Housing Quality Standards (HQS) inspection prior to move-in or, in certain circumstances, a habitability inspection performed by the case manager or other staff. If a habitability inspection is performed, an HQS inspection must be scheduled immediately following move-in. • Landlord must be willing to enter into a lease agreement that maintains a satisfactory dwelling for the enrollee throughout the duration of the lease, unless there are appropriate and fair grounds for eviction. • This Pilot service is provided only to the extent that the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. • 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. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Interpersonal Violence / Toxic Stress Services

IPV Case Management Services

Category	Information
Service Name	IPV Case Management Services
Service Description	This service covers a set of activities that aim to support an individual in addressing sequelae of an abusive relationship. These activities may include: • Ongoing safety planning/management

	• Assistance with transition-related needs, including activities such as obtaining a new phone number, updating mailing addresses, school arrangements to minimize disruption of school schedule • Linkages to child care and after-school programs and community engagement activities • Linkages to community-based social service and mental health agencies with IPV experience, including trauma-informed mental health services for family members affected by domestic violence, including witnessing domestic violence • Referral to legal support to address needs such as obtaining orders of protection, negotiating child custody agreements, or removing legal barriers to obtaining new housing (excluding legal representation) • Referral to and provision of domestic violence shelter or emergency shelter, if safe and appropriate permanent housing is not immediately available, or, in lieu of shelter, activities to ensure safety in own home • Coordination with a housing service provider if additional expertise is required • Coordination of transportation for the enrollee that is necessary to meet the goals of the IPV Case Management service • Informal or peer counseling and advocacy related to enrollees' needs and concerns. These may include accompanying the recipient to appointments, providing support during periods of anxiety or emotional distress, or encouraging constructive parenting activities and self-care. Activities listed above may occur without the Pilot enrollee present. The HSO has the option to partner with other organizations to ensure it is able to provide all activities described as part of this service. If desired by the HSO, the Lead Pilot Entity can facilitate partnerships of this kind.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	Service duration would persist until services are no longer needed as determined in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	Various settings are appropriate, including at a shelter, home of the enrollee or home of friend or relative, supportive housing, clinical or hospital setting, enrollee's residence, HSO site, or other community setting deemed safe and sufficiently private but accessible to the enrollee.
Minimum Eligibility Criteria	• Enrollee requires ongoing engagement.[25] • 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.

[25] This service is not intended for single or highly intermittent cases often handled through crisis hotlines. The pre-authorized three month interval is designed to address the unpredictable needs and engagement level for those with a sustained relationship with a human services organization.

	• Enrollees may not simultaneously receive the Housing Navigation, Support and Sustaining Services and the IPV Case Management Services. Individuals with co-occurring housing and IPV-related needs should receive the Holistic High Intensity Case Management service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Violence Intervention Services

Category	Information
Service Name	Violence Intervention Services
Service Description	This service covers the delivery of services to support individuals who are at risk for being involved in community violence (i.e., violence that does not occur in a family context). Individuals may be identified based on being the victim of a previous act of crime, membership in a group of peers who are at risk, or based on other criteria. Once identified, Peer Support Specialists and case managers provide: • Individualized psychosocial education related to de-escalation skills and alternative approaches to conflict resolution • Linkages to housing, food, education, employment opportunities, and after-school programs and community engagement activities. Peer Support Specialists are expected to conduct regular outreach to their mentees, to maintain situational awareness of their mentees' milieu, and to travel to conflict scenes where their mentees may be involved in order to provide in-person de-escalation support. Activities listed above may occur without the Pilot enrollee present. The service should be informed by an evidence-based program such as (but not limited to) Cure Violence.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	Service duration would persist until services are no longer needed as determined in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	Various settings are appropriate, including at an individual's home, school, HSO site, or other community setting deemed safe and sufficiently private but accessible to the enrollee.
Minimum Eligibility Criteria	• Individual must have experienced violent injury or be determined as at risk for experiencing significant violence by a case manager or by violence intervention prevention program staff members (with case manager concurrence) • Individual must be community-dwelling (i.e., not incarcerated). • 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.

Evidence-Based Parenting Curriculum

Note: North Carolina has priced one approved curriculum, and will finalize a full list of allowable curricula and associated prices after selection of Pilot regions.

Category	Information
Service Name	Evidence-Based Parenting Classes
Service Description	Evidence-based parenting curricula are meant to provide: • Group and one-on-one instruction from a trained facilitator • Written and audiovisual materials to support learning • Additional services to promote attendance and focus during classes Evidence-based parenting classes are offered to families that may be at risk of disruption due to parental stress or difficulty coping with parenting challenges, or child behavioral or health issues. These services are also appropriate for newly reunited families following foster care/out of home placement or parental incarceration. This service description outlines one approved curriculum: Incredible Years (Parent) – Preschool/School. This service should be delivered in a trauma-informed, developmentally appropriate, and culturally relevant manner.
Frequency *(if applicable)*	N/A
Duration *(if applicable)*	18-20 sessions, typically lasting 2-2.5 hours each.
Setting	Services may be provided in a classroom setting or may involve limited visits to recipients' homes.
Minimum Eligibility Criteria	• 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.

Home Visiting Services

Note: North Carolina has priced one approved curriculum, and will finalize a full list of allowable curricula and associated prices after selection of Pilot regions.

Category	Information
Service Name	Home Visiting Services
Service Description	Home Visiting services are meant to provide: • One-one observation, instruction and support from a trained case manager who may be a licensed clinician • Written and/or audiovisual materials to support learning

	Evidence-based home visiting services are offered to families that may be at risk of disruption due to parental stress or difficulty coping with parenting challenges, or child behavioral or health issues. These services are also appropriate for newly reunited families following foster care/out of home placement or parental incarceration. This service description outlines one approved curriculum: Parents As Teachers. This service should be delivered in a trauma-informed, developmentally appropriate, and culturally relevant manner.
Frequency *(if applicable)*	N/A
Duration *(if applicable)*	• Families with one or no high-needs characteristics should get at least 12 home visits annually • Families with two or more high-needs characteristics should receive at least 24 home visits annually • Home visits last approximately 60 minutes • Home visits provided beyond 6 months are is contingent on determination of continued Pilot eligibility
Setting	Various settings are appropriate, including at an individual's home, school, HSO site, or other community setting deemed safe and sufficiently private but accessible to the enrollee.
Minimum Eligibility Criteria	• 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.

Dyadic Therapy Services

Category	**Information**
Service Name	Dyadic Therapy Services
Service Description	This service covers the delivery of dyadic therapy to benefit a child/adolescent at risk for or with an attachment disorder, a behavioral or conduct disorder, a mood disorder, an obsessive-compulsive disorder, post-traumatic stress disorder, or as a diagnostic tool to assess for the presence of these disorders. This service only covers therapy provided to the parent or caregiver of a Pilot enrolled child to address the parent's or caregiver's behavioral health challenges that are negatively contributing to the child's well-being. This is not a group-based therapy. Sessions are limited to the parent(s) or caregiver(s) of the child/adolescent. Treatments are based on evidence-based therapeutic principles (for example, trauma-focused cognitive-behavioral therapy). When appropriate, the Pilot enrolled child should but is not required to receive Medicaid-covered behavioral health or dyadic therapy services as a complement to this Pilot service. This service aims to support families in addressing the sequelae of adverse childhood experiences and toxic stress that may contribute to adverse health outcomes.

Frequency *(if applicable)*	As needed
Duration *(if applicable)*	As needed, contingent on determination of continued Pilot eligibility
Setting	Services may be delivered in a range of locations, including but not limited to at a provider's location or in the recipient's home.
Minimum Eligibility Criteria	• The covered individual is 21 years old or younger • The parent or caregiver recipient of this service cannot be eligible to receive this service as a Medicaid covered service. • The covered individual is at risk for or has a disorder listed above that can be addressed through dyadic therapy directed at the covered individual's parent or caregiver, delivered together or separately, that is not otherwise covered under Medicaid. • 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 program.

Food Services

Food and Nutrition Access Case Management Services

Category	Information
Service Name	Food and Nutrition Access Case Management Services

Service Description	Provision of one-on-one case management and/or educational services to assist an enrollee in addressing food insecurity. Activities may include:
	• Assisting an individual in accessing school meals or summer lunch programs, including but not limited to:
	  ○ Helping to identify programs for which the individual is eligible
	  ○ Helping to fill out and track applications
	  ○ Working with child's school guidance counselor or other staff to arrange services
	• Assisting an individual in accessing other community-based food and nutrition resources, such as food pantries, farmers market voucher programs, cooking classes, Child and Adult Care Food programs, or other, including but not limited to:
	  ○ Helping to identify resources that are accessible and appropriate for the individual
	  ○ Accompanying individual to community sites to ensure resources are accessed
	• Advising enrollee on transportation-related barriers to accessing community food resources

	It is the Department's expectation that Medicaid care managers will assist all eligible individuals to enroll in SNAP and WIC and secure their enrollment through existing SNAP and WIC assistance resources. Food and Nutrition Access Case Managers will address more complex and specialized needs. However, if under exceptional circumstances a Food and Nutrition Access Case Manager identifies an individual for whom all other forms of assistance have been ineffective, they are permitted to assist the individual with completing enrollment, including activities such as addressing documentation challenges or contacting staff at a local SNAP or WIC agency to resolve issues, or otherwise.
Frequency *(if applicable)*	Ad hoc sessions as needed. It is estimated that on average individuals will not receive more than two to three sessions with a case manager.
Duration *(if applicable)*	N/A
Setting	• May be offered: ○ At a community setting (e.g. community center, health care clinic, Federally Qualified Health Center (FQHC), food pantry, food bank) ○ At an enrollee's home (for home-bound individuals) ○ Via telephone or other modes of direct communication
Minimum Eligibility Criteria	• 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. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Evidence-Based Group Nutrition Class

Category	**Information**
Service Name	Evidence-Based Group Nutrition Class
Service Description	This service covers the provision of an evidence-based or evidence-informed nutrition related course to a group of individuals. The purpose of the course is to provide hands-on, interactive lessons to enrollees, on topics including but not limited to: • Increasing fruit and vegetable consumption • Preparing healthy, balanced meals • Growing food in a garden • Stretching food dollars and maximizing food resources Facilitators may choose from evidence-based curricula, such as: • Cooking Matters (for Kids, Teens, Adults)[26] • A Taste of African Heritage (for Kids, Adults) [27] For curricula not outlined above, an organization must follow an evidence-based curricula that is approved by DHHS, in consultation with the Lead Pilot Entity and PHPs.
Frequency	Typically weekly

[26] More information on Cooking Matters available at: http://cookingmatters.org/node/2215
[27] More information on A Taste Of African Heritage available at: https://oldwayspt.org/programs/african-heritage-health/atoah-community-cooking-classes

(if applicable)	
Duration *(if applicable)*	Typically six weeks
Setting	Classes may be offered in a variety of community settings, including but not limited to health clinics, schools, YMCAs, Head Start centers, community gardens, or community kitchens.
Minimum Eligibility Criteria	• Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high risk pregnancy. • 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.

Diabetes Prevention Program

Category	Information
Service Name	Diabetes Prevention Program
Service Description	Provision of the CDC-recognized "Diabetes Prevention Program" (DPP), which is a healthy living course delivered to a group of individuals by a trained lifestyle coach designed to prevent or delay type 2 diabetes. The program focuses on healthy eating and physical activity for those with prediabetes. The program must comply with CDC Diabetes Prevention Program Standards and Operating Procedures.[28]
Frequency *(if applicable)*	Minimum of 16 sessions in Phase I; Minimum of 6 sessions in Phase II, according to CDC Standards and Operating Procedures.
Duration *(if applicable)*	Typically one year, contingent on determination of continued Pilot eligibility
Setting	Intervention is offered at a community setting, clinical setting, or online, as part of the approved DPP curriculum.

Minimum Eligibility Criteria	• Enrollee must:
	  ○ Be 18 years of age or older,
	  ○ Have a BMI ≥ 25 (≥23 if Asian),
	  ○ Not be pregnant at the time of enrollment
	  ○ Not have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment,
	  ○ Have one of the following:
	  ▪ A blood test result in the prediabetes range within the past year, or
	  ▪ A previous clinical diagnosis of gestational diabetes, or,
	  ▪ A screening result of high risk for type 2 diabetes through the "Prediabetes Risk Test"[29]
	• 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.

Fruit and Vegetable Prescription

Category	Information
Service Name	Fruit and Vegetable Prescription
Service Description	Food voucher to be used by an enrollee with a diet or nutrition-related chronic illness to purchase fruits and vegetables from a participating food retailer. Participating food retailers must sell an adequate supply of WIC-eligible fruits and vegetables (i.e., fresh,

[28] CDC Diabetes Prevention Program Standards and Operating Procedures, available at: https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf
[29] Available at: https://www.cdc.gov/prediabetes/takethetest/

	frozen, canned without any added fats, salt, or sugar). Food retailers may include but are not limited to: • Grocery stores • Farmers markets • Mobile markets • Community-supported agriculture (CSA) programs • Corner stores A voucher transaction may be facilitated manually or electronically, depending on the most appropriate method for a given food retail setting. The cost associated with coordinating the provision of services are included.
Frequency *(if applicable)*	One voucher per enrollee. Each voucher will have a duration as defined by the HSO providing it. For example, some HSOs may offer a monthly voucher while others may offer a weekly voucher.
Duration *(if applicable)*	6 months (on average), contingent on determination of continued Pilot eligibility
Setting	Enrollees spend vouchers at food retailers. Human service organizations administer and coordinate the service in a variety of settings: engaging with enrollees in the community (e.g. health care and community-based settings) to explain the service, administering food retailer reimbursements and other administrative functions from their office, and potentially meeting with food retailers in the field.
Minimum Eligibility Criteria	• Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high-risk pregnancy. • 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 federal, state, or locally-funded programs.

Healthy Food Box (For Pick-Up)

Category	**Information**
Service Name	Healthy Food Box (For Pick-Up)
Service Description	A healthy food box for pick-up consists of an assortment of nutritious foods provided to an enrollee in a community setting, aimed at promoting improved nutrition for the service recipient. It is designed to supplement the daily food needs for food-insecure

	individuals with diet or nutrition-related chronic illness. This service does not constitute a full nutritional regimen (three meals per day per person). Healthy food boxes should be furnished using a client choice model when possible and should be provided alongside nutrition education materials related to topics including but not limited to healthy eating and cooking instructions.
Frequency *(if applicable)*	Typically weekly
Duration *(if applicable)*	On average, this service is delivered for 3 months. Service would continue until services are no longer needed as indicated in an individual's person-centered care plan.
Setting	• Food is sourced and warehoused by a central food bank, and then delivered to community settings by the food bank. • Food is offered for pick-up by the enrollee in a community setting, for example at a food pantry, community center, or a health clinic.
Minimum Eligibility Criteria	• Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high-risk pregnancy. • 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 federal, state, or locally-funded programs.

Healthy Food Box (Delivered)

Category	**Information**
Service Name	Healthy Food Box (Home Delivered)
Service Description	A healthy food box for delivery consists of an assortment of nutritious foods that is delivered to an enrollee's home, aimed at promoting improved nutrition for the service recipient. It is designed to supplement the daily food needs for food-insecure individuals with diet or nutrition-related chronic illness. This service does not constitute a full nutritional regimen (three meals per day per person). Healthy food boxes should be provided alongside nutrition education materials related to topics including but not limited to healthy eating and cooking instructions.
Frequency *(if applicable)*	Typically weekly

Duration *(if applicable)*	On average, this service is delivered for 3 months. Service would continue until services are no longer needed as indicated in an individual's person-centered care plan.
Setting	• Food is sourced and warehoused by a central food bank. • Food boxes are delivered to enrollee's home.
Minimum Eligibility Criteria	• Enrollee does not have capacity to shop for self or get to food distribution site or have adequate social support to meet these needs. • Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high-risk pregnancy. • 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 • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs. • 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.

Healthy Meal (For Pick-Up)

Category	Information
Service Name	Healthy Meal (For Pick-Up)
Service Description	A healthy meal for pick-up consists of a frozen or shelf stable meal that is provided to an enrollee in a community setting, aimed at promoting improved nutrition for the service recipient. This service includes preparation and dissemination of the meal. Meals must provide at least one-third of the recommended Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences,[30] and adhere to the current Dietary Guidelines for Americans, issued by the Secretaries of the U.S. Department of Health and Human Services and the U.S. Department of Agriculture.[31] Meals may be tailored to meet cultural preferences and specific medical needs. This service does not constitute a full nutritional regimen (three meals per day per person).
Frequency *(if applicable)*	Frequency of meal services will differ based on the severity of the individual's needs.
Duration *(if applicable)*	Service would continue until services are no longer needed as indicated in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.

[30] Dietary Reference Intakes available at: https://www.nal.usda.gov/fnic/dietary-reference-intakes.
[31] Most recent version of the Dietary Guidelines for Americans is available at: https://health.gov/dietaryguidelines/2015/guidelines/.

Setting	• Meals are offered for pick-up in a community setting, for example at a food pantry, community center, or a health clinic.
Minimum Eligibility Criteria	• Enrollee does not have capacity to shop and cook for self or have adequate social support to meet these needs. • Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high risk pregnancy. • 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 federal, state, or locally-funded programs.

Healthy Meal (Home Delivered)

Category	**Information**
Service Name	Healthy Meal (Home Delivered)
Service Description	A healthy, home-delivered meal consists of a hot, cold, or frozen meal that is delivered to an enrollee's home, aimed at promoting improved nutrition for the service recipient. This service includes preparation and delivery of the meal. Meals must provide at least one-third of the recommended Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences,[32] and adhere to the current Dietary Guidelines for Americans, issued by the Secretaries of the U.S. Department of Health and Human Services and the U.S. Department of Agriculture.[33] Meals may be tailored to meet cultural preferences and specific medical needs. This service does not constitute a full nutritional regimen (three meals per day per person).
Frequency *(if applicable)*	Meal delivery services for enrollees requiring this service will differ based on the severity of the individual's needs. On average, individuals receive 2 meals per day (or 14 meals per week).
Duration *(if applicable)*	Service would continue until services are no longer needed as indicated in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.

[32] Dietary Reference Intakes available at: https://www.nal.usda.gov/fnic/dietary-reference-intakes.
[33] Most recent version of the Dietary Guidelines for Americans is available at: https://health.gov/dietaryguidelines/2015/guidelines/.

Setting	Meals are delivered to enrollee's home.
Minimum Eligibility Criteria	• Enrollee does not have capacity to shop and cook for self or have adequate social support to meet these needs. • Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high risk pregnancy. • 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. • 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 Meal

Category	**Information**
Service Name	Medically Tailored Home Delivered Meal
Service Description	Home delivered meal which is medically tailored for a specific disease or condition. This service includes an initial evaluation with a Registered Dietitian Nutritionist (RD/RDN) or Licensed Dietitian Nutritionist (LDN) to assess and develop a medically-appropriate nutrition care plan, the preparation and delivery of the prescribed nutrition care regimen, and regular reassessment at least once every 3 months. Meals must be in accordance with nutritional guidelines established by the National Food Is Medicine Coalition (FIMC) or other appropriate guidelines.[34] Meals may be tailored to meet cultural preferences. For health conditions not outlined in the Food Is Medicine Coalition standards above, an organization must follow a widely recognized nutrition guideline approved by the LPE. This service does not constitute a full nutritional regimen (three meals per day per person).
Frequency *(if applicable)*	Meal delivery services for enrollees requiring this service will differ based on the severity of the individual's needs. On average, individuals receive 2 meals per day (or 14 meals per week).
Duration *(if applicable)*	Service would continue until services are no longer needed as indicated in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.

[34] FIMC standards available at: https://static1.squarespace.com/static/580a7cb9e3df2806e84bb687/t/5ca66566e5e5f01ac91a9ab4/1554408806530/FIMC+Nutriton+Standards-Final.pdf.

Setting	• Nutrition assessment is conducted in person, in a clinic environment, the enrollee's home, or telephonically as appropriate. • Meals are delivered to enrollee's home.
Minimum Eligibility Criteria	• 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.

Transportation Services

Reimbursement for Health-Related Public Transportation

Category	Information
Service Name	Reimbursement for Health-Related Public Transportation
Service Description	Provision of health-related transportation for qualifying Pilot enrollees through vouchers for public transportation. This service may be furnished to transport Pilot enrollees to non-medical services that promote community engagement, health and well-being. The service may include transportation to locations indicated in an enrollee's care plan that may include, for example: • Grocery stores/farmer's markets; • Job interview(s) and/or place of work; • Places for recreation related to health and wellness (e.g., public parks and/or gyms); • Group parenting classes/childcare locations; • Health and wellness-related educational events; • Places of worship, services and other meetings for community support; • Locations where other approved Pilot services are delivered.

	Pilot transportation services will not replace non-emergency medical transportation as required in Medicaid.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	N/A
Setting	N/A
Minimum Eligibility Criteria	• Family, neighbors and friends are unable to assist with transportation • Public transportation is available in the enrollee's community. • Service is only available for enrollees who do not have access to their own or a family vehicle. • 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. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Reimbursement for Health-Related Private Transportation

Category	**Information**
Service Name	Reimbursement for Health-Related Private Transportation
Service Description	Provision of private health-related transportation for qualifying Pilot enrollees through one or more of the following services: • Community transportation options (e.g., local organization that organizes and provides transportation on a volunteer or paid basis) • Direct transportation by a professional, private or semi-private transportation vendor (e.g., shuttle bus company or privately operated wheelchair-accessible transport)[35] • Account credits for taxis or ridesharing mobile applications for transportation Private transportation services may be utilized in areas where public transportation is not an available and/or not an efficient option (e.g., in rural areas). The following services may be deemed allowable, cost-effective alternatives to private transportation by a Pilot enrollee's Prepaid Health Plan (PHP):[36] • Repairs to an enrollee's vehicle

[35] An organization providing non-emergency medical transportation in North Carolina is permitted to provide this Pilot service. However, the organization will only receive reimbursement when an individual is transported in accordance with the Pilot service requirements, including that the service is furnished to transport Pilot enrollees to non-medical services that promote community engagement, health and well-being.

[36] Repairs to a enrollee's vehicle and reimbursement for gas mileage may be particularly likely to be cost-effective alternatives in rural areas of North Carolina but may also applicable in other areas of the State with limited public transportation.

	• Reimbursement for gas mileage, in accordance with North Carolina's Non-Emergency Medical Transportation clinical policy[37] This service may be furnished to transport Pilot enrollees to non-medical services that promote community engagement, health and well-being. The service may include transportation to locations indicated in an enrollee's care plan that may include, for example: • Grocery stores/farmer's markets; • Job interview(s) and/or place of work; • Places for recreation related to health and wellness (e.g. public parks and/or gyms); • Group parenting classes/childcare locations; • Health and wellness-related educational events; • Places of worship, services and other meetings for community support; • Locations where other approved Pilot services are delivered. Pilot transportation services will not replace non-emergency medical transportation as required in Medicaid.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	N/A
Setting	N/A
Minimum Eligibility Criteria	• 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. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Transportation PMPM Add-On for Case Management Services

Category	Information
Service Name	Transportation PMPM Add-On for Case Management Services

[37] Reimbursement for gas mileage must be in accordance with North Carolina's Non-Emergency Medical Transportation (NEMT) Policy, available at: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NC/NC-18-011.pdf.

Service Description	Reimbursement for coordination and provision of transportation for Pilot enrollees provided by an organization delivering one or more of the following case management services: • Housing Navigation, Support and Sustaining Services • IPV Case Management • Holistic High Intensity Enhanced Case Management This service is for transportation needed to meet the goals of each of the case management services listed above. Transportation must be to and from appointments related to identified case management goals. For example, an organization providing Housing Navigation, Support and Sustaining Services may transport an individual to potential housing sites. An organization providing IPV case management may transport an individual to peer support groups and sessions. Transportation will be managed or directly provided by a case manager or other HSO staff member. Allowable forms of transportation include, for example: • Use of HSO-owned vehicle or contracted transportation vendor; • Use of personal car by HSO case manager or other staff member; • Vouchers for public transportation; • Account credits for taxis/ridesharing mobile applications for transportation (in areas without access to public transportation. Organizations that provide case management may elect to either receive this PMPM add-on to cover their costs of providing and managing enrollees' transportation, or may use the "Reimbursement for Health-Related Transportation" services—public or private—to receive reimbursement for costs related to enrollees' transportation (e.g., paying for an enrollee's bus voucher). Organizations will have the opportunity to opt in or out of the PMPM add-on annually. Organizations that have opted in for the PMPM add-on may not separately bill for "Reimbursement for Health-Related Transportation" services.

Cross-Domain Services

Holistic High Intensity Enhanced Case Management

Category	Information
Service Name	Holistic High Intensity Enhanced Case Management
Service Description	Provision of one-to-one case management and/or educational services to address co-occurring needs related to housing insecurity and interpersonal violence/toxic stress, and as needed transportation and food insecurities. Activities may include those outlined in the following three service definitions: • Housing Navigation, Support and Sustaining Services • Food and Nutrition Access Case Management Services • IPV Case Management Services Note that case management related to transportation needs are included in the services referenced above.

	Activities listed above may occur without the Pilot enrollee present. The HSO has the option to partner with other organizations to ensure it is able to provide all activities described as part of this service. If desired by the HSO, the Lead Pilot Entity can facilitate partnerships of this kind.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	Service duration would persist until services are no longer needed as determined in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	• Most sessions with enrollees should be in-person, in a setting desired by the individual. In-person meetings will, on average occur for the first 3 months of service. • Case managers may only utilize telephonic contacts if deemed appropriate. • Some sessions may be "off-site," (e.g., at potential housing locations).
Minimum Eligibility Criteria	• Enrollee must concurrently require both Housing Navigation, Support and Sustaining Services and IPV Case Management services. • 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. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Medical Respite

Category	Information
Service Name	Medical Respite Care
Service Description	A short-term, specialized program focused on individuals who are homeless or imminently homeless, have recently been discharged from a hospital setting and require continuous access to medical care. Medical respite services include comprehensive residential care that provides the enrollee the opportunity to rest in a stable setting while enabling access to hospital, medical, and social services that assist in completing their recuperation. Medical respite provides a stable setting and certain services for individuals who are too ill or frail to recover from a physical illness/injury while living in a place not suitable for human habitation, but are not ill enough to be in a hospital. Medical respite services should include, at a minimum: **Short-Term Post-Hospitalization Housing:** Post-hospitalization housing for short-term period, not to exceed six [6] months, due to individual's imminent homelessness at discharge. Housing should provide enrollees with a safe space to recuperate and perform activities of daily living while receiving ongoing medical care as needed and will be limited to housing in a private or shared housing unit. Short-Term Post Hospitalization Housing setting should promote independent living and

transition to a permanent housing solution. Services may not be provided in a congregate setting, as defined by the Department.

Allowable units for short-term post-hospitalization housing must provide the following for enrollees:

- Access to a clean, healthy environment that allows enrollees to perform activities of daily living;
- Access to a private or semi-private, independent room with a personal bed for the entire day;
- Ability to receive onsite or easily accessible medical and case management services, as needed.

Coordination of this service should begin prior to hospital discharge by a medical professional or team member. The referral to medical respite should come from a member of the individual's care team.

For homeless enrollees, all services provided must align with a Housing First approach to increase access to housing, maximize housing stability and prevent returns to homelessness.

Medically Tailored Meal *(delivered to residential setting)*
Home delivered meal which is medically tailored for a specific disease or condition. This service includes an initial evaluation with a Registered Dietitian Nutritionist (RD/RDN) or Licensed Dietitian Nutritionist (LDN) to assess and develop a medically-appropriate nutrition care plan, as well as the preparation and delivery of the prescribed nutrition care regimen.

Meals must be in accordance with nutritional guidelines established by the National Food Is Medicine Coalition (FIMC) or other appropriate guidelines.[38] Meals may be tailored to meet cultural preferences. For health conditions not outlined in the Food Is Medicine Coalition standards above, an organization must follow a widely recognized nutrition guideline approved by the LPE. This service does not constitute a full nutritional regimen (three meals per day per person).

Transportation Services
Provision of private/semi-private transportation services, reimbursement for public transportation and reimbursement for private transportation (e.g., taxis and ridesharing apps—only in areas where public transportation is unavailable) for the enrollee receiving medical respite care to social services that promote community engagement, health and well-being. *Refer to service definitions for Reimbursement for Health-Related Public*

[38] FIMC Standards available at: https://static1.squarespace.com/static/580a7cb9e3df2806e84bb687/t/5ca66566e5e5f01ac91a9ab4/1554408806530/FIMC+Nutriton+Standards-Final.pdf.

	Transportation and Reimbursement for Health-Related Private Transportation for further service description detail. Medical respite program staff are required to check-in regularly with the individual's Medicaid care manager to coordinate physical, behavioral and social needs.
Frequency *(if applicable)*	N/A
Duration *(if applicable)*	Up to six months, contingent on determination of continued Pilot eligibility.
Setting	• The majority of the services will occur in the allowable short-term post-hospitalization housing settings described in the service description. • Some services will occur outside of the residential setting (e.g., transportation to wellness-related activities/events, site visits to potential housing options).
Minimum Eligibility Criteria	• Individuals who are homeless or imminently homeless, have recently been discharged from a hospital setting and require continuous access to medical care. • Enrollee should remain in Medical Respite only as long as it is indicated as necessary by a healthcare professional. • Enrollee requires access to comprehensive medical care post-hospitalization • Enrollee requires intensive, in-person case management to recuperate and heal post-hospitalization. • 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. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Linkages to Health-Related Legal Supports

Category	**Information**
Service Name	Linkages to Health-Related Legal Supports
Service Description	This service will assist enrollees with a specific matter with legal implications that influences their ability to secure and/or maintain healthy and safe housing and mitigate or eliminate exposure to interpersonal violence or toxic stress. This service may cover, for example: • Assessing an enrollee to identify legal issues that, if addressed, could help to secure or maintain healthy and safe housing and mitigate or eliminate exposure to interpersonal violence or toxic stress, including by reviewing information such as specific facts, documents (e.g., leases, notices, and letters), laws, and programmatic rules relevant to an enrollee's current or potential legal problem; • Helping enrollees understand their legal rights related to maintaining healthy and safe housing and mitigating or eliminating exposure to interpersonal violence or toxic stress (e.g., explaining rights related to landlord/tenant disputes, explaining the purpose of an order of protection and the process for obtaining one);

	• Identifying potential legal options, resources, tools and strategies that may help an enrollee to secure or maintain healthy and safe housing and mitigate or eliminate exposure to interpersonal violence or toxic stress (e.g., providing self-advocacy instructions, removing a former partner's debts from credit rating); • Providing advice to enrollees about relevant laws and course(s) of action and, as appropriate, helping an enrollee prepare "pro se" (without counsel) documents. This service is meant to address the needs of an individual who requires legal expertise, as opposed to the more general support that can be offered by a care manager, case manager or peer advocate. The care manager or case manager coordinating this service must clearly identify the scope of the authorized health-related legal support within the enrollee's care plan. This service is limited to providing advice and counsel to enrollees and does not include "legal representation," such as making contact with or negotiating with an enrollee's potential adverse party (e.g., landlord, abuser, creditor, or employer) or representing an enrollee in litigation, administrative proceedings, or alternative dispute proceedings. After issues are identified and potential strategies reviewed with an enrollee, the service provider is expected to connect the enrollee to an organization or individual that can provide legal representation and/or additional legal support with non-Pilot resources.
Frequency *(if applicable)*	As needed when minimum eligibility criteria are met
Duration *(if applicable)*	Services are provided in short sessions that generally total no more than 10 hours.
Setting	Various settings are appropriate. Services described above may be provided via telephone or other modes of direct communication (with or without the Pilot enrollee present) or in person, as appropriate, including, for example, the home of the enrollee, another HSO site, or other places convenient to the enrollee.
Minimum Eligibility Criteria	• Service does not cover legal representation. • 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. • The enrollee's Medicaid care manager or HSO case manager is responsible for clearly defining the scope of the authorized health-related legal support services. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.