Tailored Care Management Technical Advisory Group (TAG)

Meeting #22

Tailored Care Management Updates and Healthy Opportunities Pilot Overview

September 22, 2023

Agenda

- Welcome and Roll Call
- Tailored Care Management Updates
  - Provider and Community Engagement Work Group
  - Provider Rate Assumption Survey
  - Tailored Care Management Provider Newsletter
- Healthy Opportunities Pilot Overview
- Public Comments

Welcome and Roll Call

Department of Health and Human Services

Kristen Dubay, MPP	Loul Alvarez, MPA	Regina Manly, MSA	Eumeka Dudley, MHS	Gwendolyn Sherrod, MBA, MHA	Tierra Leach, MS, LCMHC-A, NCC	Tenille Lewis, MA
Chief Population Health Officer	Associate Director, Population Health	Senior Program Manager, Tailored Care Management	Program Lead, Tailored Care Management	Program Lead, Tailored Care Management	Program Specialist, Tailored Care Management	Population Health Coordinator
Contact: Medicaid.TailoredCareMgmt@dhhs.nc.gov						

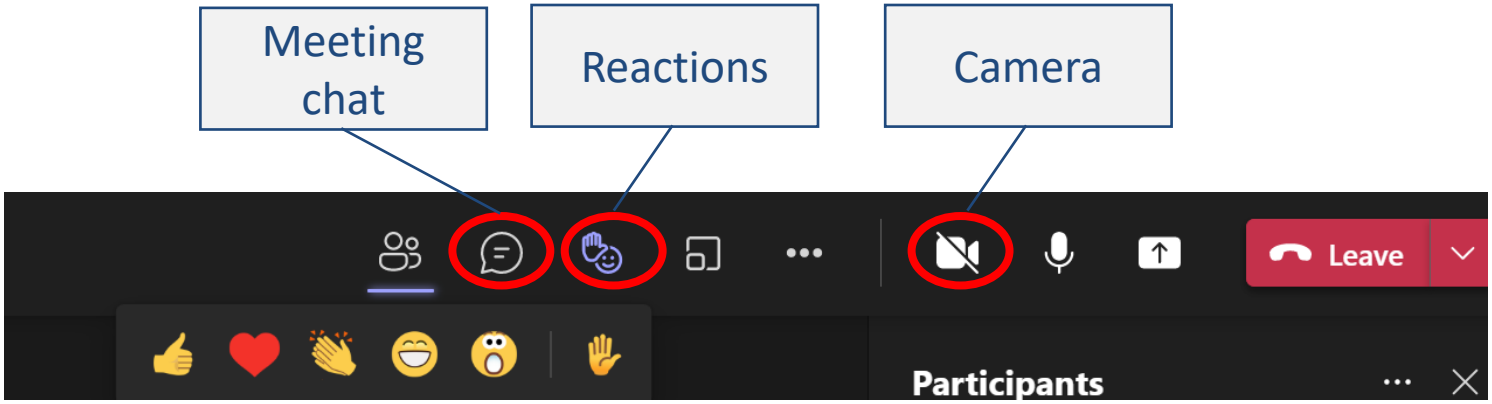
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management TAG Membership

Name	Organization	Stakeholder
Erin Lewis	B&D Integrated Health Services	Provider Representative
Julie Quisenberry	Coastal Horizons Center	Provider Representative
Billy West	Daymark	Provider Representative
Denita Lassiter	Dixon Social Interactive Services	Provider Representative
Ruth Craig	ECU Physicians	Provider Representative
Luevelyn Tillman	Greater Vision Counseling and Consultants	Provider Representative
Keischa Pruden	Integrated Family Services, PLLC	Provider Representative
Haley Huff	Pinnacle Family Services	Provider Representative
Sandy Feutz	RHA	Provider Representative
Lisa Poteat	The Arc of NC	Provider Representative
Eleana McMurry, LCSW	UNC Center for Excellence in Community Mental Health	Provider Representative
Donna Stevenson	Alliance Health	Tailored Plan Awardee
Donetta Wilson	Eastpointe	Tailored Plan Awardee
Lynne Grey	Partners Health Management	Tailored Plan Awardee
Sabrina Russell	Sandhills Center	Tailored Plan Awardee
Cindy Ehlers	Trillium Health Resources	Tailored Plan Awardee
Chris Bishop	Vaya Health	Tailored Plan Awardee
Cindy Lambert	Cherokee Indian Hospital Authority	Tribal Option Representative
Jessica Aguilar	N/A	Consumer Representative
Pamela Corbett	N/A	Consumer Representative
Jonathan Ellis	N/A	Consumer Representative
Alicia Jones	N/A	Consumer Representative

Increasing Engagement

We encourage those who are able to turn on cameras, use reactions in Teams to share opinions on topics discussed, and share questions in the chat.



Tailored Care Management Updates

Update on the TCM Member Education and Community Awareness Workgroup

As previously announced, the Department is launching a Tailored Care Management workgroup to develop a community engagement campaign, which will focus on developing strategies to create greater awareness of Tailored Care Management across potentially eligible members, providers, community organizations, and other stakeholders.

- First workgroup meeting date is being finalized.
- The workgroup will bring periodic updates to the Tailored Care Management TAG to solicit feedback on key activities.
- The Department thanks the following ten organizations for volunteering representatives to serve on the workgroup:
  - Coastal Horizons Center
  - Integrated Family Services
  - Monarch
  - Pivotal Healthcare
  - The Arc of NC
  - Alliance Health
  - Eastpointe
  - Sandhills Center
  - Trillium
  - Vaya Health
  - Autism Society of North Carolina
  - NC Council on Developmental Disabilities
  - Consumer Representative
  - Benchmarks

Provider Rate Assumption Survey

On September 18, 2023, the Department released a survey to collect information on providers' actual time and costs associated with the delivery of Tailored Care Management. Survey results will inform ongoing discussions about potential modifications to the rates and payment approach. Any changes to the rates and payment approach would go into effect after July 2024.

- The deadline for survey responses is **September 29, 2023**.
- Each provider should **complete a single survey**.
- The survey will take approximately **25** minutes to complete and will include the sections noted in the table on the right.

Survey Sections	
Time Spent	• Time spent with members/guardians
Contact	• In-person and telephonic contacts
Engagement	• Time spent to successfully engage members
Panel	• Experience with panel by member acuity and over time
Staff	• Experience with care management teams
Expenses	• Expenses (e.g., software, consultant time for quality checks of data)

We need your feedback!!

Tailored Care Management Provider Newsletter

The Department developed the monthly Tailored Care Management newsletter to keep providers updated on key dates and activities. The Department would like to gather real-time feedback on the monthly provider newsletter sent to Tailored Care Management providers.

- **Poll:** Do you find the monthly newsletter useful? (Yes/No)
- **Open Discussion:** What other ways would you like the Department to share Tailored Care Management updates with you? (open-response)

Please respond in the Microsoft Teams Poll to the 1st question.
We will then have an open discussion for the 2nd question.

Healthy Opportunities Pilot Overview

Healthy Opportunities Pilot Launch for Tailored Care Management Population

- As previously announced, the Healthy Opportunities Pilot ("HOP") will launch for the Medicaid Direct Tailored Care Management-eligible population on February 1, 2024.* (See slide 16 for HOP regions and participating LME/MCOs)
- To date, 29 Advanced Medical Home Plus (AMH+) practices and Care Management Agencies (CMAs) have opted into participating in HOP.
- In preparation for this launch and to increase general awareness of the program, in the following slides, we present:
  - Key HOP background and context
  - An overview of who qualifies to receive HOP services
  - The role of Tailored Care Management in HOP

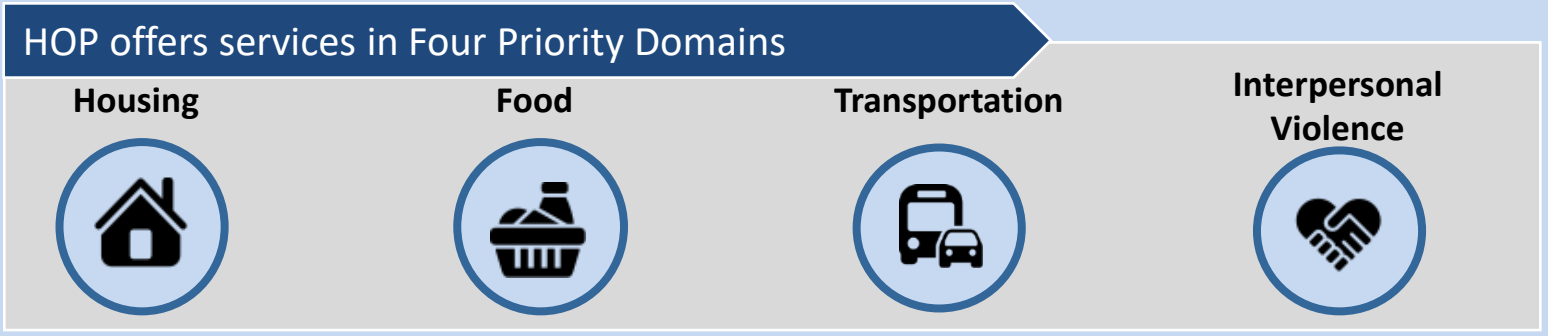
Note: the Department plans to conduct HOP care manager training in October.

** HOP launched for the Standard Plan population in March 2022*

What is the Healthy Opportunities Pilot (HOP)?

HOP is a Department pilot program to test evidence-based, non-medical interventions designed to improve health and reduce healthcare costs for qualifying Medicaid enrollees.

- HOP funds cover the cost of federally-approved, non-medical services in four priority domains and support associated administrative costs



Why Do We Need HOP?

HOP presents a unique opportunity to provide selected evidence-based, non-medical interventions to Medicaid enrollees to address social needs. Tailored Care Management members are likely to meaningfully benefit from HOP services.

- **Social and economic factors have a significant impact** on individuals' and communities' health—driving as much as 80% of health outcomes.
- HOP will help evaluate the effectiveness of non-medical services on health outcomes and costs, with the ultimate goal of **making successful HOP services available statewide** through Medicaid.
- **Tailored Care Management members have among the most substantial healthcare needs** in the Medicaid program and, on average, their care needs are more expensive.
- Tailored Care Management members are also **more likely to struggle with social needs such as homelessness and food insecurity**.

Which Members Can Participate in HOP?

On February 1, 2024, HOP will launch in the three pilot regions for the below groups of Medicaid Direct members.* An AMH+/CMA or LME/MCO will deliver HOP care management to these individuals.**

Groups Launching February 1, 2024	Entity Delivering HOP Care Management
• Assigned to an AMH+/CMA for Tailored Care Management	• For AMH+/CMAs that opt into HOP, AMH+/CMA care management teams will deliver HOP care management • For AMH+/CMAs that do not opt into HOP, LME/MCO care management teams will deliver HOP care management
• Assigned to an LME/MCO for Tailored Care Management • Eligible for Tailored Care Management but have opted out • Not participating in Tailored Care Management because receiving ACT/HFW	• LME/MCO based care management teams will deliver HOP care management

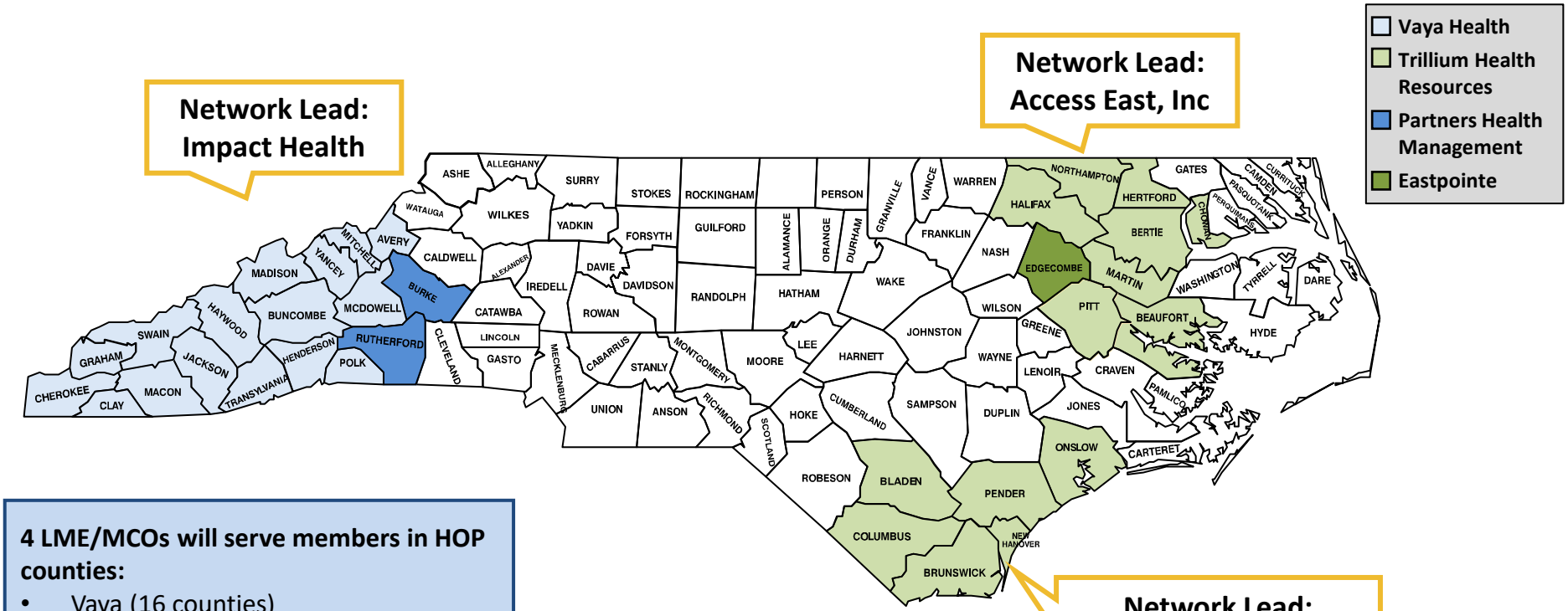
Note: Upon Tailored Plan launch, eligible populations in NC Medicaid Direct will transition to a Tailored Plan and continue to have access to both Tailored Care Management and HOP.

** Medicaid Standard Plan members can also participate in HOP, as of March 2022.*

*** HOP care management includes identifying members' medical and non-medical needs, recommending appropriate services to address non-medical needs and ensuring that members receive these services, conducting "whole person" care management of medical and non-medical health, and re-assessing member's needs and HOP eligibility every 3-6 months.*

Where in North Carolina Does HOP Operate?

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



4 LME/MCOs will serve members in HOP counties:

- Vaya (16 counties)
- Trillium (14 counties)
- Partners (2 counties)
- Eastpointe (1 county)

Who Qualifies for HOP?

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

☑ At least one Physical/Behavioral Health Criteria:

(varies by population)

- **Adults** (e.g., having two or more qualifying chronic conditions, including chronic mental illness, I/DD, and TBI)
- **Pregnant Women** (e.g., history of poor birth outcomes such as low birth weight, condition likely to complicate pregnancy such as hypertension)
- **Children, ages 0-3** (e.g., neonatal intensive care unit graduate)
- **Children 0-20** (e.g., experiencing three or more categories of adverse childhood experiences such as history of abuse and household substance use)

☑ At least one Social Risk Factor:

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

Meet service specific eligibility criteria, as needed.

I/DD = intellectual/developmental disability; TBI = traumatic brain injury

What Services Can Eligible Tailored Care Management Members Receive Through HOP?

HOP will cover the cost of 29 approved services in four priority service domains, plus a cross-domain category. Examples include:

Housing

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

Food

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

Transportation

- Linkages to existing public transit
- Payment for transit to support access to HOP services (e.g., bus passes, taxi vouchers, ride-sharing credits)

Interpersonal Violence

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

Cross-Domain

- Medical respite care
- Linkages to health-related legal supports

See appendix for full list of HOP services and a summary of service definitions

SNAP/WIC= Supplemental Nutrition Assistance Program / Special Supplemental Nutrition Program for Women, Infants, and Children

What are the Key HOP Entities and their Roles?

Care Management Teams, LME/MCOs, Network Leads, and Human Service Organizations will work to implement HOP.

Care Management Teams

- Frontline care management teams, based at an LME/MCO or AMH+/CMA, interacting with members
- Assess member eligibility for HOP and coordinate HOP services as part of ongoing care management, in addition to managing physical, behavioral health, TBI and I/DD needs
- Coordinate HOP services and track enrollee progress as part of Care Plan/Individual Support Plan (ISP) development and monitoring

LME/MCOs

- Maintain accountability for HOP administration and budget
- Approve which members qualify for HOP services and which services they qualify to receive—based on care management team recommendations
- Pay for HOP services delivered by HSOs

Network Leads (NLs)

- Organizations that serve as the essential connection between LME/MCOs and HSOs
- Develop, manage, and oversee a network of HSOs
- Provide support and technical assistance for HSO network
- Convene HOP entities to share best practices

Human Service Organizations (HSOs)

- Frontline social service providers that contract with the Network Lead and deliver authorized HOP services to HOP enrollees
- Coordinate with care management teams on the delivery of HOP service to enrollees

What is NCCARE360?

NCCARE360 is a statewide resource and referral platform that allows key stakeholders to connect individuals with needed community resources.

- **NCCARE360 is a telephonic, online and interfaced IT platform, providing:**
  - A robust **statewide resource database** of community-based organizations and social service agencies
  - A **referral platform** that allows health care providers, insurers and human service providers to connect people to resources in their communities. It supports "closed-loop referrals," giving them the ability to track whether individuals accessed the community-based services to which they were referred
  - **Additional features** to support eligibility, enrollment and invoicing processes specific to HOP
- Care management teams will use NCCARE360 to generate referrals for HOP services, and track enrollee progress over time

How Does HOP Care Management Intersect with Tailored Care Management?

"HOP care management" will be in addition and complementary to Tailored Care Management.

- Tailored Care Management already includes responsibilities related to addressing unmet health-related resource needs (e.g., referrals to needed social services).
- HOP provides additional structure and resources to support care management teams in addressing the social needs of members.
- HOP care management will be integrated into Tailored Care Management workflows and includes the following activities*
  - Identification of and outreach to HOP populations
  - Assessing HOP eligibility and recommending HOP services
  - Eligibility determination & service authorization (LME/MCO role)
  - Referral to authorized services and tracking
  - Ongoing "whole person health" (medial and non-medical) care management
  - Reviewing service mix every 3 months and reassessing eligibility every 6 months

NOTE: HOP does not have any additional staffing or licensure requirements separate from Tailored Care Management requirements. Care management teams may include care manager supervisors, care managers & care manager extenders

**If a member's AMH+/CMA does not opt into HOP, LME/MCO will deliver HOP care management, coordinating with the AMH+/CMA care manager as needed.*

How will AMH+s/CMAs be Paid for HOP Care Management?

HOP-participating AMH+s/CMAs will receive a HOP care management add-on payment on top of the Tailored Care Management monthly payment for HOP enrollees.

- **The process to bill for HOP care management has been built into the existing billing and contracting structures for Tailored Care Management.**
- **For every month that an AMH+/CMA delivers a qualifying Tailored Care Management contact to a HOP enrollee, the AMH+/CMA will add a modifier to the TCM billing code sent to the LME/MCO. The LME/MCO will pay the AMH+/CMA a HOP Care Management add-on payment of $80.41**. The "add-on" payment will be paid in addition to the regular Tailored Care Management payment for members enrolled in HOP during the billing month.
- **LME/MCOs must pass on the HOP care management add-on payment in full to HOP-participating AMH+s/CMAs.** LME/MCOs are not permitted to further negotiate the rate with AMH+s/CMAs.

Questions?

Public Comments

Tailored Care Management TAG Meeting Cadence

Tailored Care Management TAG meetings will generally take place the fourth Friday of every month from 3:30-4:30 pm ET.

Upcoming 2023 Meeting:

October 27

Previous Meetings:

- **Meeting #1:** Friday, October 29, 2021 (presentation, minutes)
- **Meeting #2:** Friday, November 19, 2021 (presentation, minutes)
- **Meeting #3:** Friday, December 17, 2021 (presentation, minutes)
- **Meeting #4:** Friday, January 28, 2022 (presentation, minutes)
- **Meeting #5:** Friday, February 25, 2022 (presentation, minutes)
- **Meeting #6:** Friday, March 25, 2022 (presentation, minutes)
- **Meeting #7:** Friday, June 3, 2022 (presentation, minutes)
- **Meeting #8:** Friday, June 24, 2022 (presentation, minutes)
- **Meeting #9:** Friday, July 22, 2022 (presentation, minutes)
- **Meeting #10:** Friday, August 26, 2022 (presentation, minutes)
- **Meeting #11:** Friday, September 23, 2022 (presentation, minutes)
- **Meeting #12:** Thursday, October 27, 2022 (presentation, minutes)
- **Meeting #13:** Friday, November 18, 2022 (presentation, minutes)
- **Meeting #14:** Friday, December 16, 2022 (presentation, minutes)
- **Meeting #15:** Friday, February 24, 2023 (presentation, minutes)
- **Meeting #16:** Friday, March 24, 2023 (presentation, minutes)
- **Meeting #17:** Friday, April 28, 2023 (presentation, minutes)
- **Meeting #18:** Friday, May 26, 2023 (presentation, minutes)
- **Meeting #19:** Friday, June 23, 2023 (presentation, minutes)
- **Meeting #20:** Friday, July 28, 2023 (presentation, minutes)
- **Meeting #21:** Friday, August 25, 2023 (presentation, minutes)

Healthy Opportunities Pilot Appendix

HOP Care Management Team Responsibilities

HOP Care Management Team Responsibilities					
Activity	**Identification and Outreach to HOP Populations**	**Assessing HOP Eligibility and Recommending HOP Services**	**Eligibility Determination & Service Authorization**	**Referral to Authorized Services and Tracking**	**Reviewing Service Mix and Reassessing HOP Eligibility**
	Support identification of potentially HOP-eligible members (e.g., through regular member interactions and screenings)	1. Assess HOP eligibility (health and social needs) 2. Recommend HOP services that are likely to meet member needs 3. Obtain consents 4. Document HOP eligibility and service recs. in the HOP eligibility and service assessment (PESA) in NCCARE360	***Tailored Plan / LME/MCO Role:*** *The Tailored Plan / LME/MCO reviews the PESA in NCCARE360 to determine eligibility, authorize services and document HOP enrollment, and notifies the member's care management team via NCCARE360*	Refer member to authorized HOP service using NCCARE360 and track progress	1. Review service mix every 3 months 2. Reassess for HOP eligibility every 6 months 3. Recommend additional or discontinued services and disenrollment if needed

Expedited Referral for Pre-Approved HOP Services

Care management teams can expedite referral to a limited number and duration of pre-approved HOP services

Care management teams will also support transitions of care if a member switches health plans

Healthy Opportunities Pilot: Qualifying Physical/Behavioral Health Criteria

Population	Age	Physical/Behavioral Health-Based Criteria
Adults	21+	• 2 or more chronic conditions. Chronic conditions that qualify an individual for HOP 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

Qualifying criteria includes I/DD and TBI

HOP Services: Housing

Domain	HOP Service Name	Service Definition Summary
Housing Services	Housing Navigation, Support and Sustaining Services	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).
	Inspection for Housing Safety and Quality	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.
	Housing Move-In Support	Non-recurring set-up expenses (e.g., moving expenses required to occupy and utilize the housing, discrete goods to support an enrollee's transition to stable housing as part of this service).
	Essential Utility Set-Up	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
	Home Remediation Services	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.
	Home Accessibility and Safety Modifications	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).
	Healthy Home Goods	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).
	One-Time Payment for Security Deposit and First Month's Rent	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
	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 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.

HOP Services: Food

Domain	HOP Service Name	Service Definition Summary
Food Services	Food and Nutrition Access Case Management Services	Provision of one-on-one case management and/or educational services to assist an enrollee in addressing food insecurity. May include 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
	Evidence-Based Group Nutrition Classes	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.
	Diabetes Prevention Program	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.
	Fruit and Vegetable Prescription	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.
	Healthy Food Box (For Pick-Up)	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.
	Healthy Food Box (Delivered)	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.
	Healthy Meal (For Pick-Up)	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.
	Healthy Meal (Home Delivered)	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.
	Medically Tailored Home Delivered Meal	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

HOP Services: Interpersonal Violence Services (IPV)

Domain	HOP Service Name	Service Definition Summary
Interpersonal Violence Services (IPV)	IPV Case Management Services	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, etc.
	Violence Intervention Services	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.
	Evidence-Based Parenting Curriculum	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.
	Home Visiting Services	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.
	Dyadic Therapy	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 HOP 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 HOP enrolled child should but is not required to receive Medicaid covered behavioral health or dyadic therapy services as a complement to this HOP service.

HOP Services: Transportation and Cross-Domain Services

Domain	HOP Service Name	Service Definition Summary
Transportation Services	Reimbursement for Health-Related Public Transportation	Provision of health-related transportation for qualifying HOP enrollees through vouchers for public transportation. This service may be furnished to transport HOP enrollees to non-medical services that promote community engagement, health and well-being.
	Reimbursement for Health-Related Private Transportation	Provision of private health-related transportation for qualifying HOP 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) • Account credits for taxis or ridesharing mobile applications for transportation
	Transportation PMPM Add-On for Case Management Services	Reimbursement for coordination and provision of transportation for HOP 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
Cross-Domain Services	Holistic High Intensity Enhanced Case Management	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
	Medical Respite	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.
	Linkages to Health-Related Legal Supports	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.