Tailored Care Management Provider Manual Addendum:
Healthy Opportunities Pilots Guidance for Providers for Advanced Medical Home Plus/Care Management Agency (AMH+s/CMAs)
June 2024

This document provides guidance to AMH+s/CMAs located in Healthy Opportunities Pilots regions that are participating in the Healthy Opportunities Pilots (HOP) Program. HOP launched for the Tailored Care Management population on May 15, 2024.

Section I: Overview of the Healthy Opportunities Pilots

The Healthy Opportunities Pilots (HOP) presents an unprecedented opportunity to test the impact of providing evidence-based, non-medical interventions to NC Medicaid beneficiaries. In October 2018, the Centers for Medicare & Medicaid Services (CMS) authorized up to $650 million in state and federal Medicaid funding to cover the cost of providing select HOP 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]

HOP allows for NC Medicaid health plans (Standard Plan, Tailored Plans and Local Management Entity/Managed Care Organization (LME/MCOs)), 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 HOP Fee Schedule (Appendix B) to define and price these non-medical interventions. HOP tests whether HOP 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 beneficiaries experiencing certain health needs and social risk factors.

[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.

Most HSOs that deliver HOP services are participating in the health care system for the first time through HOP. While many HSOs traditionally rely on grant funding, in HOP 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 HOP services. These processes seek to build HSO capacity while minimizing burden and ensuring that HSOs are able to effectively participate in HOP.

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

HOP operates in three regions of the state – two in eastern North Carolina and one in western North Carolina. See Appendix A for a map of HOP regions. An organization in each region – called the "HOP Network Lead" –builds and oversees networks of HSOs that deliver HOP services. HOP regions are served by three Tailored Plans / LME/MCOs: Vaya, Trillium and Partners.

The sections below detail the specific roles and responsibilities for AMH+s/CMAs as it relates to HOP care coordination. Participation in HOP is optional for AMH+s/CMAs. An AMH+/CMA that opts into HOP will be known as a Designated HOP Care Coordination Entity[9] and must contract with Tailored Plans / LME/MCOs for the provision of HOP-related care coordination to HOP beneficiaries (see AMH+/CMA HOP Standard Terms and Conditions). As this is a pilot program, the Department will continually review and update entity requirements based on the on-the-ground experience of Designated HOP Care Coordination Entity. To the extent an AMH+ practice or CMA contracts with a Clinically Integrated Network (CIN) or Other Partner, the AMH+ practice or CMA must ensure that the CIN or Other Partner meets all of the applicable Tailored Care Management and HOP requirements for the functions and capabilities that the AMH+ practice or CMA has delegated to the CIN or Other Partner. Applicable Tailored Care Management and HOP requirements are outlined below and in the DHHS-Tailored Plan / LME/MCO Contract.

Section II: Summary of Roles and Responsibilities for HOP

Individuals enrolled in HOP will receive "HOP care coordination" which is 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, further contributing to the delivery of whole person care. Throughout this document, the term care management teams refers to care coordination and/or care management staff that conduct HOP care coordination.

Participation in the HOP program is optional for AMH+s/CMAs:

- **For individuals engaged in Tailored Care Management through an AMH+/CMA that opts into HOP:** the member's assigned care manager will concurrently provide Tailored Care Management and HOP care coordination.

[9] A Designated HOP Care Coordination Entity is a Designated Care Management Entity that is also assuming care coordination responsibilities related to the Healthy Opportunities Pilots.

- **For individuals engaged in Tailored Care Management through an AMH+/CMA that does not opt into HOP:** the member's Tailored Care Management care manager will provide Tailored Care Management and the member's assigned Tailored Plan / LME/MCO will provide HOP care coordination.

In the event that an AMH+/CMA does not opt into HOP, a HOP beneficiary's Tailored Plan / LME-MCO care management/coordination staff will conduct HOP care coordination responsibilities described in this document and must coordinate with the beneficiary's Tailored Care Management care team as needed.

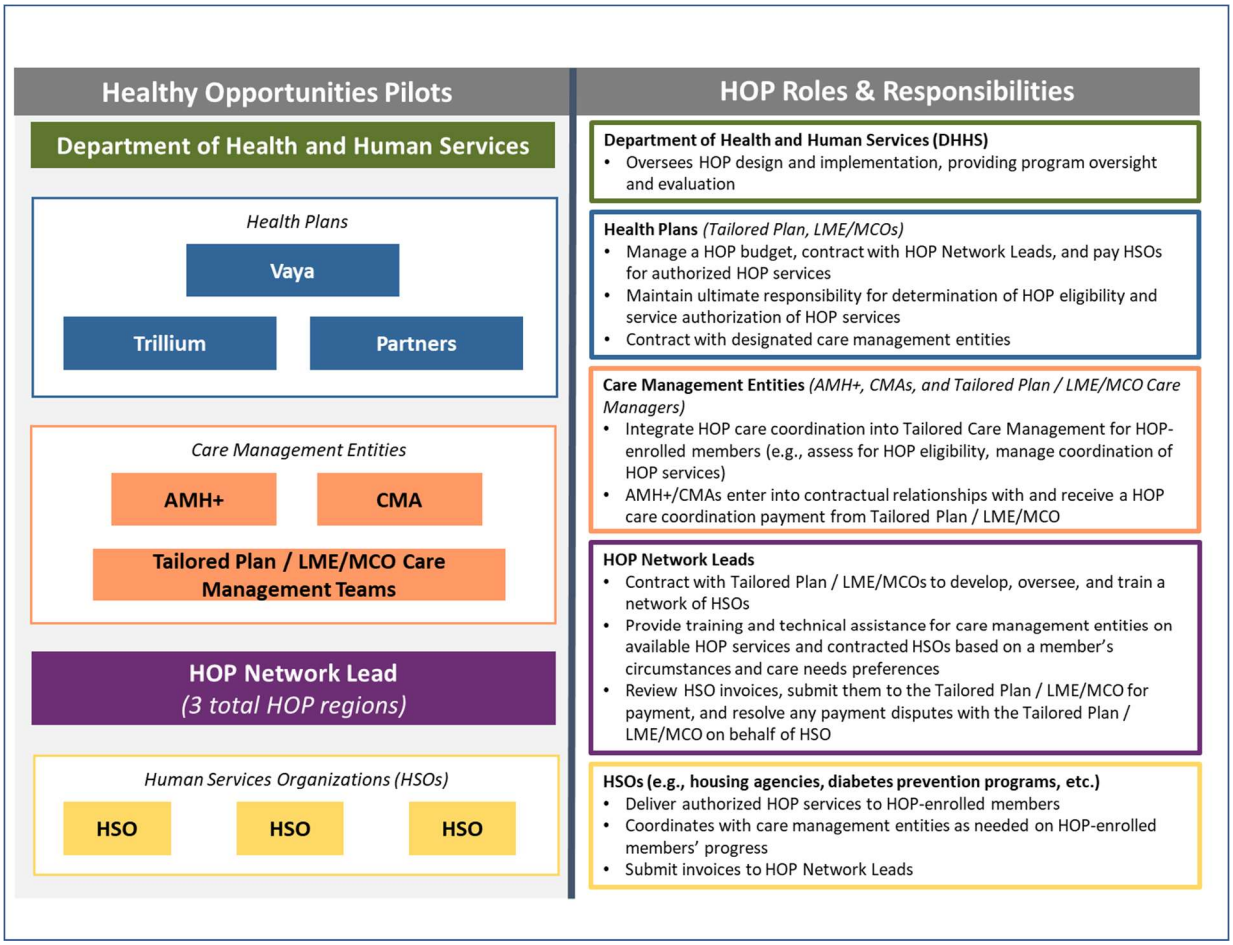
HOP care coordination services, which build on existing Tailored Care Management requirements, include assessing patients' HOP eligibility and specific non-medical needs, and connecting them to appropriate HOP services. Recognizing the added responsibilities that come with HOP participation, AMH+s/CMAs serving as a Designated HOP Care Coordination Entity will receive an additional DHHS-standardized, HOP Care Coordination add-on payment on top of existing Tailored Care Management payments, for each month there is Tailored Care Management engagement with a HOP beneficiary (discussed more in Section V: AMH+/CMA Payment for HOP Responsibilities).

A critical component of implementing HOP is how AMH+s/CMAs will identify and enroll members who are eligible for HOP 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 HOP program, prioritizing the member's seamless and timely experience;
- Utilize a "no wrong door" policy to streamline enrollment into the HOP program regardless of where a member initially seeks care;
- Encourage that care coordination for the HOP program occurs at the local community level;
- Standardize information collected regarding members' HOP eligibility and recommended HOP services using a standard documentation tool called the HOP Eligibility and Service Assessment (PESA);
- Seek to ensure services are allocated across all HOP-eligible populations;
- Minimize the number of member handoffs between Tailored Plans / LME/MCOs and care management entities;
- Standardize the processes and systems as much as possible across Tailored Plans / LME/MCOs to eliminate Designated HOP Care Coordination Entity and HSO burden; and
- Maintain accountability and integrity for the HOP program.

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

Figure 1: Key Roles and Responsibilities for HOP Entities



For some members, Tailored Plans / LME/MCOs will serve as a Designated HOP Care Coordination Entity. In these instances, the Tailored Plan / LME/MCO must provide the same core HOP functions as other Designated HOP Care Coordination Entities and will be compensated through Tailored Plans / LME/MCOs' HOP administrative payments.

Section III, below, further defines HOP care coordination responsibilities.

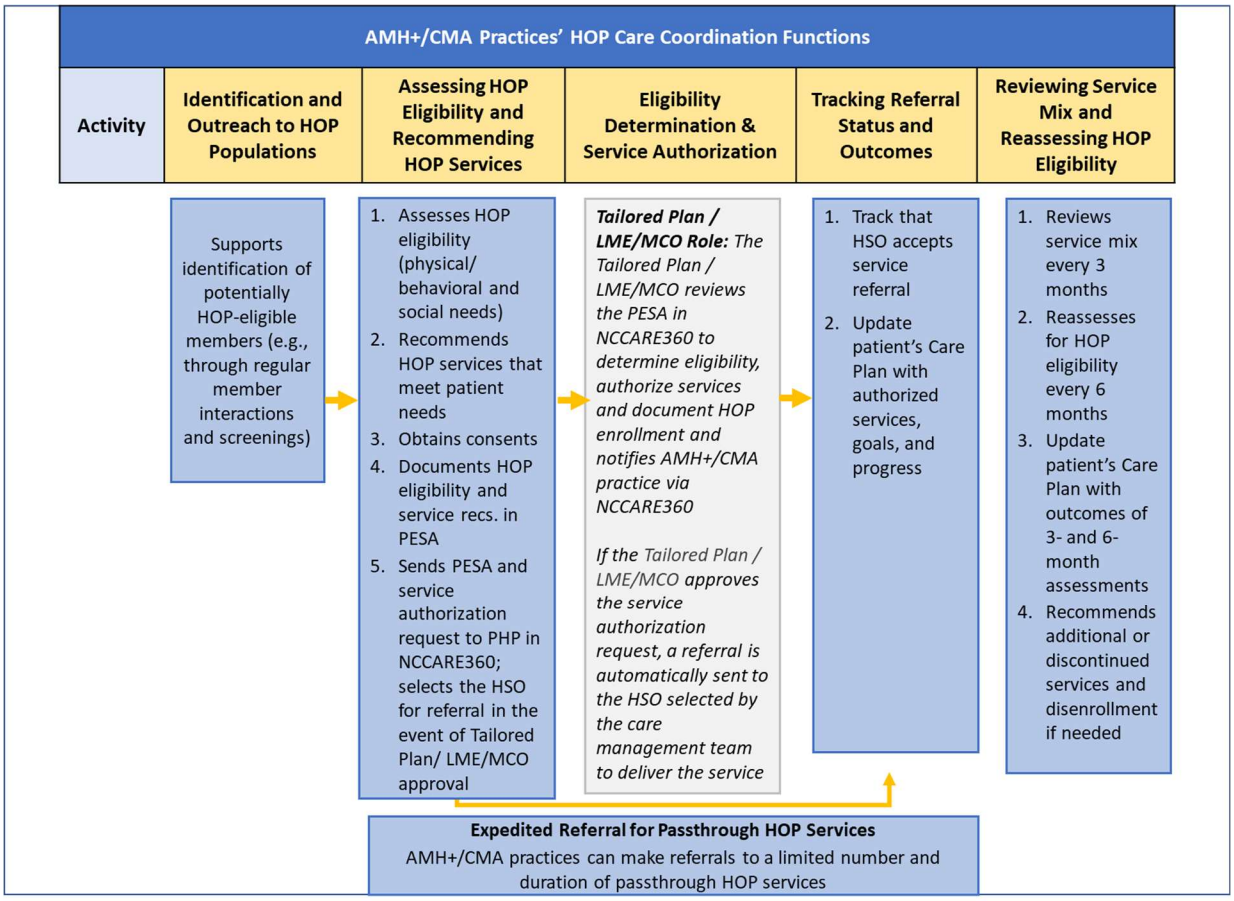
Section III: HOP Care Coordination Responsibilities for AMH+s/CMAs Serving as a Designated HOP Care Coordination Entity

Participating in HOP gives AMH+/CMAs the opportunity to be part of an innovative and nationally recognized initiative. Participating AMH+s/CMAs will integrate their HOP responsibilities into Tailored Care Management workflows, further supporting the vision of whole-person care. Tailored Care Management was designed with the idea that care management should be delivered to members by local community providers, to the maximum extent possible, and the same is true for HOP. While the Department strongly encourages AMH+s/CMAs to participate in HOP, participation is not required. AMH+s/CMAs that choose to participate in HOP are responsible for ensuring HOP care coordination is provided to their members along with Tailored Care Management. In alignment with current AMH+/CMA contracting for care management with Tailored Plans / LME/MCOs, each AMH+/CMA must

have a contract with the Tailored Plan / LME/MCO for HOP-related care coordination activities using the Department-standardized contracting terms and conditions.

Figure 2 outlines the critical HOP care coordination functions that AMH+s/CMAs will perform to participate in HOP and receive HOP care coordination payments.

Figure 2: AMH+s/CMAs' HOP Care Coordination Functions

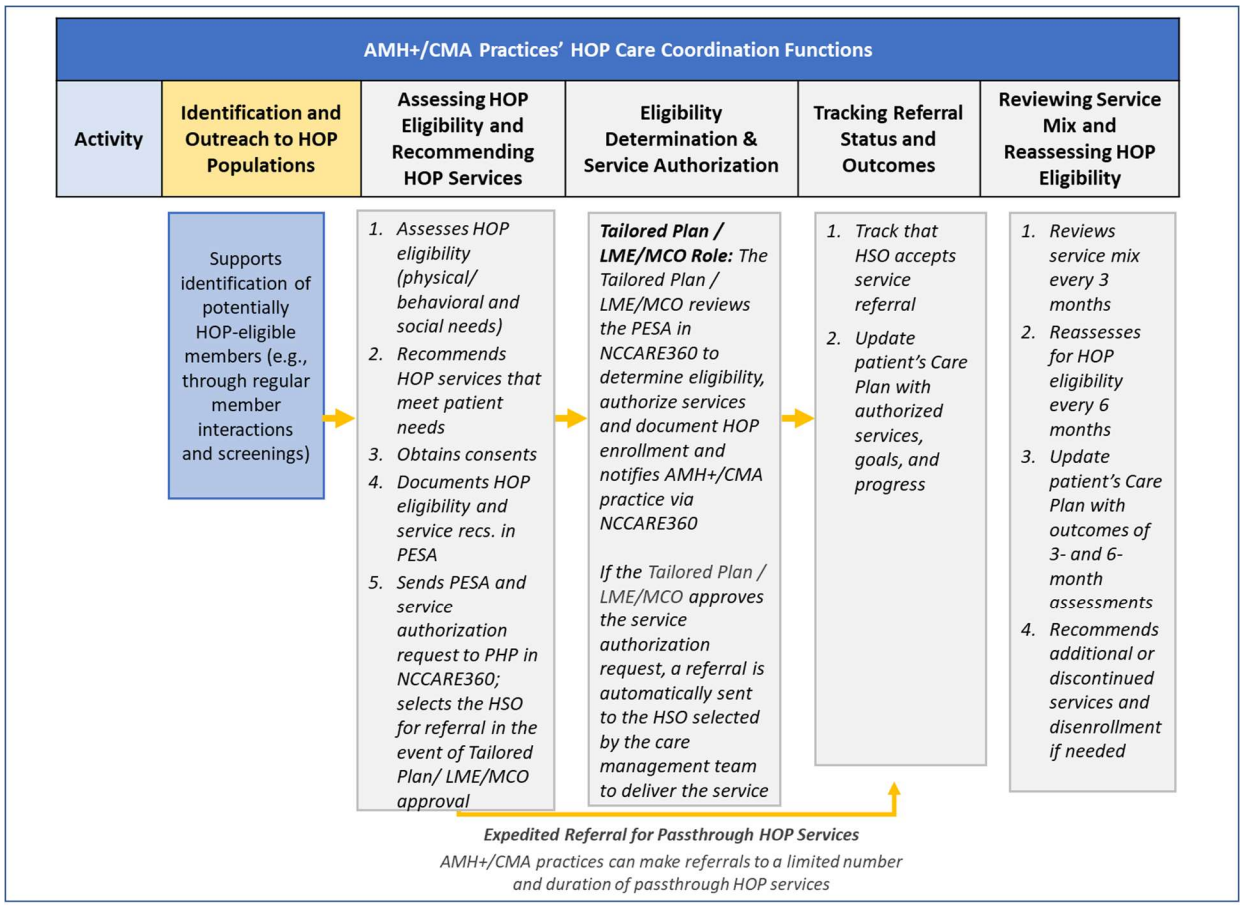


Getting members initially enrolled in HOP and connected to HOP services will require additional effort and activities for AMH+s/CMAs, beyond regular Tailored Care Management delivery. Once members are enrolled in HOP, AMH+s/CMAs will engage with their HOP-enrolled members to review their HOP services as part of ongoing Tailored Care Management (*see Section E. Reviewing HOP Service Mix and Reassessing HOP Eligibility below*).

AMH+s/CMAs should also be aware that members participating in HOP or that may benefit from HOP 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, AMH+s/CMAs participating in HOP must comply with the terms of *Interpersonal Violence-Related Healthy Opportunities Pilots (IPV)-Related Services: Conditions, Requirements, and Standards* attachment in the DHHS-Tailored Plan / LME/MCO contracts.

The below sub-sections provide details on each care coordination activity shown in Figure 2.

A. Identification and Outreach to HOP Populations



The Department launched HOP for the following LME/MCO (and future Tailored Plan) populations eligible for Tailored Care Management beginning May 15, 2024:

- Members engaged in Tailored Care Management,
- Members eligible for Tailored Care Management who have opted out, and
- Members eligible for, but not participating in Tailored Care Management because they are receiving Assertive Community Treatment (ACT)/High Fidelity Wraparound (HFW)

AMH+s/CMAs may identify potentially HOP-eligible members:

- **During engagement into Tailored Care Management (e.g., when completing the initial care management comprehensive assessment) and/or in the course of delivering ongoing Tailored Care Management (e.g., while on the phone or meeting in-person with a member).** During these existing touchpoints, AMH+s/CMAs can utilize the DHHS standardized Healthy Opportunities screening questions or other Social Determinants of Health (SDOH) screening tools approved by the Department, the annual Care Management Comprehensive Assessment, and any data analytics used by the AMH+/CMA as part of existing care management to help identify members that may potentially be eligible for HOP (eligibility criteria for HOP is outlined in the next section).

- **Through a referral from Tailored Plans / LME/MCOs.** At least quarterly, Tailored Plans / LME/MCOs will identify members they think may be eligible for HOP based on Tailored Plan / LME/MCO data. Once identified, the Tailored Plan / LME/MCO will notify each member's AMH+/CMA as part of the Patient Risk List (PRL) transfer if the member already has an assigned AMH+/CMA. Upon being notified by the Tailored Plan / LME/MCO, AMH+s/CMAs should conduct outreach – including at least two documented follow-up attempts if the first is unsuccessful - to the member within three business days to assess for HOP eligibility**.**
- **Through a referral from providers, HSOs, or member self-referral.** Providers and HSOs may also flag members they think may be eligible for HOP, and members (or their family members) may identify themselves as possibly HOP eligible. If the provider, HSO, or member knows who the member's assigned AMH+/CMA is, they may notify the AMH+/CMA, and upon being notified, the AMH+/CMA should conduct outreach, including two follow-up attempts, to the member within three business days to assess for HOP eligibility. If the member's assigned AMH+/CMA is not known to the provider, HSO, or member, they may notify the member's Tailored Plan / LME/MCO in order to flag a potentially HOP eligible member has been identified and should be assessed for HOP eligibility and recommended services. The Tailored Plan / LME/MCO will notify the AMH+/CMA, if applicable, to conduct an assessment of HOP eligibility and recommend appropriate services.

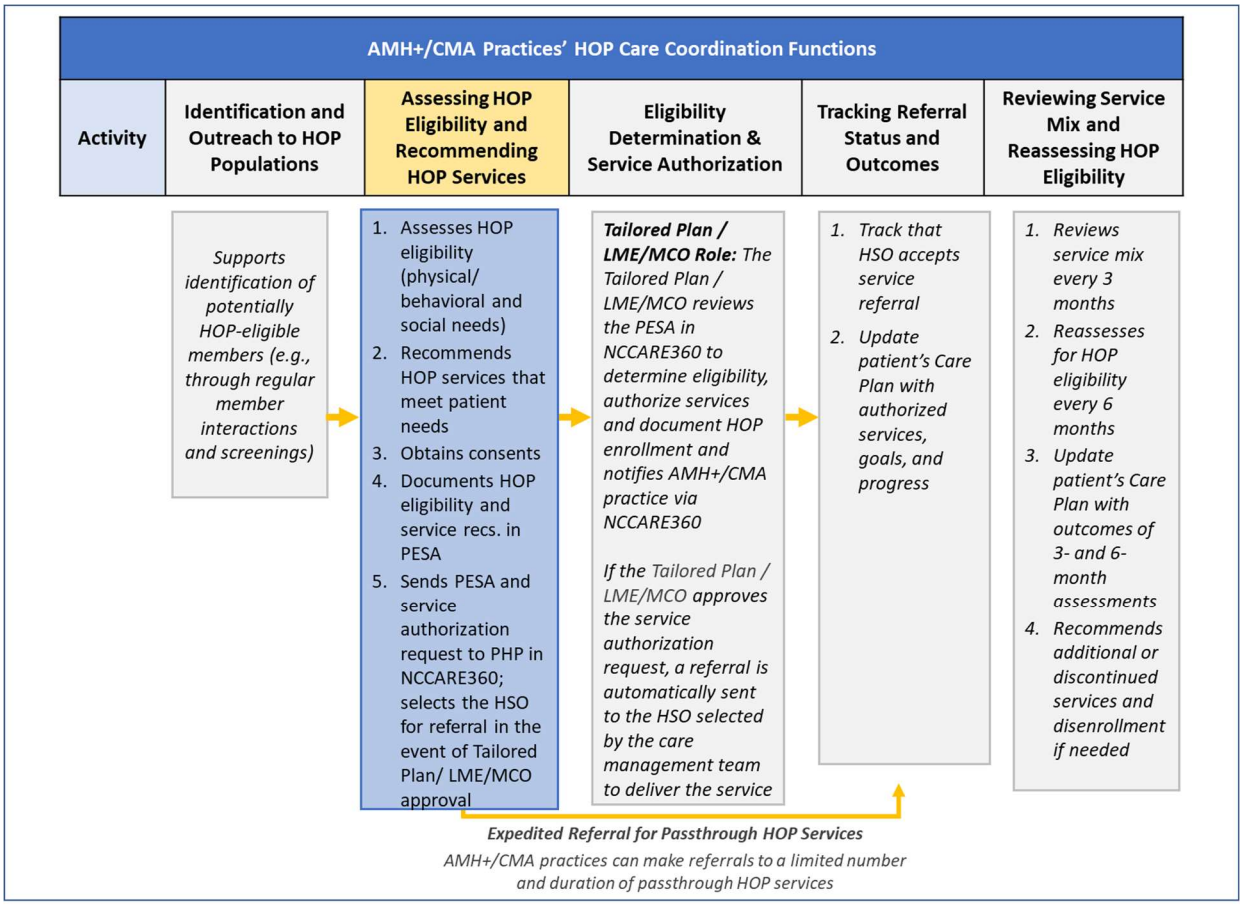
Once an AMH+/CMA has conducted outreach to a member, the AMH+/CMA should document this outreach in the member's Care Plan or Individual Support Plan (ISP) and inform the referring Tailored Plan / LME/MCO provider, or HSO of the outcome of the outreach. If a member not yet engaged in Tailored Care Management is identified as potentially HOP-eligible, the AMH+/CMA should attempt to engage the member in both HOP and Tailored Care Management.

To protect the safety and confidentiality of members who may be experiencing IPV, AMH+s/CMAs are required to record during the initial HOP enrollment, and adhere to in subsequent outreach, instructions from members about how and when to contact them. These instructions should be informed by and specific to each member, and include information about the following:

- Safe methods to contact (phone, text, email, letter),
- Whether it is safe to leave a voicemail,
- Safe days of the week and times to contact,
- Whose contact information is recorded, if not the Member's (i.e., a parent/guardian for minors, a relative or another individual helping to coordinate services), and
- Additional information on how outreach to the Member can be safely conducted (e.g., "when calling, please say you are from the library," or "Client requested to receive all HOP communications from their HSO case manager, Mr. Bob Smith. Please contact the HSO case manager at XXX-XXX-XXXX to coordinate communications with the client.")

Since it is not always possible to know if a member is experiencing IPV, AMH+s/CMAs are required to record and apply these contact instructions for all members. This requirement applies regardless of whether a member is referred to IPV-related services or not.

B. Assessing HOP Eligibility and Recommending HOP Services



Once members that are identified as potentially HOP-eligible (e.g., during initial engagement into Tailored Care Management, in the course of delivering ongoing Tailored Care Management, or through other referral), **AMH+s/CMAs will assess members for HOP eligibility, including health and social risk factor criteria, as described in Section III.B1 below. After assessing HOP eligibility, AMH+s/CMAs will recommend HOP service(s) that best address a member's identified health and social needs as described in Section III.B2.**

B1. Assessing HOP Eligibility: **To assess a member's eligibility for HOP, AMH+s/CMAs need to confirm and document in the HOP eligibility and service assessment (PESA) in NCCARE360 whether the member:**

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

HOP eligibility is determined based on whether the member lives in a HOP region, not on the location of the AMH+/CMA where a member receives care. HOP eligibility for a Medicaid member who is

experiencing homelessness is based on the member's address of record on their Medicaid application. If the member is no longer residing at the address of record, then the care management team should consider the address of the county of Medicaid eligibility that the member initially used to qualify for Medicaid.

Table 1 outlines the detailed physical/behavioral qualifying conditions for the HOP program, and Table 2 outlines qualifying social risk factors for the HOP program. As indicated in Table 1, members eligible for Tailored Care Management meet the HOP health criteria.

Table 1: HOP 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 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, intellectual or developmental disability (I/DD), and traumatic brain injury (TBI). • Meets the clinical eligibility criteria for Tailored Care Management, North Carolina's Health Home benefit (SPA 22-0024) • Repeated incidents of emergency department use (defined as more than four visits per year) or hospital admissions. • Former placement in North Carolina's foster care or kinship placement system. • Previously experienced three or more categories of adverse childhood experiences (ACEs).

Pregnant Women	N/A	• Multifetal gestation • Chronic condition likely to complicate pregnancy, including hypertension and mental illness • Current or recent (month prior to learning of pregnancy) use of drugs or heavy alcohol • Adolescent ≤ 15 years of age • Advanced maternal age, ≥ 40 years of age • Less than one year since last delivery • History of poor birth outcome including: preterm birth, low birth weight, fetal death, neonatal death • Former or current placement in NC's foster care or kinship placement system • Previously experienced or currently experiencing three or more categories of ACEs • I/DD • TBI • Meets the clinical eligibility criteria for Tailored Care Management, North Carolina's Health Home benefit (SPA 22-0024)
Children	0-3	• Neonatal intensive care unit graduate • Neonatal Abstinence Syndrome • Prematurity, defined by births that occur at or before 36 completed weeks gestation • Low birth weight, defined as weighing less than 2,500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit
	0-20	• One or more significant uncontrolled chronic conditions or one or more controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need, including: asthma, diabetes, underweight or overweight/obesity as defined by having a BMI of <5th or >85th percentile for age and gender, developmental delay, cognitive impairment, substance use disorder, behavioral/mental health diagnosis (including a diagnosis under DC: 0-5), attention-deficit/hyperactivity disorder, cancer, autoimmune diseases, learning disorders, intellectual or developmental disability (I/DD), and traumatic brain injury (TBI) • Meets the clinical eligibility criteria for Tailored Care Management, North Carolina's Health Home benefit (SPA 22-0024) • Experiencing or previously experienced three or more categories of adverse childhood experiences (e.g., Psychological, Physical, or Sexual Abuse, or Household dysfunction related to substance abuse, mental illness, parental violence, criminal behavioral in household) • Enrolled or formerly enrolled in North Carolina's foster care or kinship placement system

Table 2: HOP 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 SDOH screening tool.[10,11]
Food insecurity	As defined by the US Department of Agriculture commissioned report on Food Insecurity in America:[12] • 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 SDOH screening tool.[13]
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.[14]
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.[15]

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

To assess whether a member meets the HOP eligibility criteria, AMH+s/CMAs should ask the member questions and review available data/information (e.g., information provided by a Tailored Plan/ LME/MCO on a member's clinical conditions and/or the member's results of the DHHS standardized set of Healthy Opportunities screening questions). Tailored Plans / LME/MCOs have primary responsibility to screen members for unmet health-related resource needs as part of the Care Needs Screening and will share the results of the Care Needs Screenings with a member's AMH+/CMA. AMH+s/CMAs can gather additional information to assess for HOP eligibility either in the course of conducting the Care Management Comprehensive Assessment or through engaging with the member.

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

When submitting a service authorization request for a HOP service(s) in NCCARE360, either for new members identified as potentially HOP-eligible or existing HOP beneficiaries, care coordination must also assess to the best of their ability whether a member is currently obtaining a Medicaid/other service that is duplicative of a HOP service (e.g., identifying duplicative services through the comprehensive care management assessment, through a review of the member's Care Plan/ISP, or member attestation). In the event that care management teams are unsure if a HOP service would be duplicative of an existing Medicaid/other service a member is obtaining, the care manager can flag the potentially duplicative service when sending the Authorization Request in NCCARE360 for that service to the member's Tailored Plan/ LME /MCO by noting the name of the potentially duplicative service in the notes section of the Authorization Request (See the Guidance on Duplicative Medicaid and Healthy Opportunities Pilots Services on the Department's web site for more information).

Table 3: Healthy Opportunities Pilots Services

HOP 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

HOP Services
IPV Case Management Services
Violence Intervention Services
Evidence-Based Parenting Curriculum
Home Visiting Services
Dyadic Therapy
Food
Food and Nutrition Access Case Management Services[16]
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
Linkages to Health-Related Legal Supports

As outlined in the federally-approved Healthy Opportunities Pilots Service Fee Schedule (see HOP web site, under Pilot services)), each HOP 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.

AMH+s/CMAs will be able to access the eligibility criteria for HOP and specific HOP services in the state-standardized tool, the PESA (described in more detail below), available on the NCCARE360 platform.

For example, in order to be considered eligible to receive the Diabetes Prevention Program HOP service, members must meet the following additional service-specific eligibility criteria:

- Be 18 years of age or older,
- Have a BMI ≥ 25,
- Not be pregnant at the time of enrollment

[16] Enrollees engaged in Tailored Care Management are not eligible for the HOP Food and Nutrition Access Case Management Services, as Tailored Care Management provides food and nutrition access support that duplicates the HOP Food and Nutrition Access Case Management Services.

- 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"[17]

To determine if a member meets the service-specific eligibility criteria for the particular HOP service they are recommending for the member, see the HOP Fee Schedule on the HOP web site. AMH+s/CMAs 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 HOP eligibility and services assessment (PESA).

AMH+s/CMAs should also talk to the member about where and how they would like to receive a HOP 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. AMH+s/CMAs will be able to see all HOP-participating HSOs in the NCCARE360 platform.

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

- **Participation in HOP and receipt of HOP services,** including an understanding that HOP 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 HOP** as part of NC 1115 waiver evaluation; and
- **Sharing of personal data, including personal health information, with organizations in the NCCARE360 network, including health plans, Network Leads, and HSOs,** that will be stored and exchanged on NCCARE360**.**

Member consent should be recorded in NCCARE360. AMH+s/CMAs 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). AMH+s/CMAs 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 Tailored Plan / LME/MCO authorizes HOP services or referrals are made to HSOs.

If a member does not give consent, AMH+s/CMAs should explain to the member that he or she will not have HOP services reimbursed by Medicaid. However, the member will continue to receive Tailored Care Management 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 HOP services (see Section F2. Disenrollment from HOP).

B4. Documentation Requirements: **AMH+s/CMAs must document the results of the HOP eligibility assessment, the specific HOP service recommendations, the results of the HOP service-specific eligibility assessment, and the member's HOP consents in NCCARE360 for the member's Tailored Plan**

[17] Available at: https://www.cdc.gov/prediabetes/risktest/index.html

/ LME/MCO. Ultimately, it is the Tailored Plan / LME/MCO – rather than the AMH+/CMA – that determines whether a member is eligible for HOP and authorized to receive specific HOP services. A member will be considered "enrolled" in HOP if they have been authorized for at least one HOP service.

AMH+s/CMAs will document this information for the Tailored Plan / LME/MCO in the PESA on the NCCARE360 platform. All HOP-enrolled members receiving services must have a completed and up-to-date PESA documenting their HOP eligibility criteria as well as eligibility criteria for each HOP service being requested.

AMH+s/CMAs will utilize NCCARE360 to transmit the completed PESA including the enrollment and authorization request to the member's Tailored Plan / LME/MCO that documents the following for service authorization**:**

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

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

Tailored Plans / LME/MCOs will be subject to standardized turnaround times for authorizing HOP services (that vary by service). Tailored Plans / LME/MCOs will document their decision and rationale on HOP eligibility and service authorization in a member's PESA and notify the AMH+/CMA of its decision. For a limited number of low-cost, high-value services, AMH+s/CMAs will be permitted to refer members to 30 days' worth of HOP services without prior approval from Tailored Plans / LME/MCOs (see Section D: Referrals for Passthrough HOP Services)

B.5 Members Receiving Care in Congregate Care Settings

HOP services are generally duplicative of services provided by congregate care and institutional settings (e.g., housing and food). **Members residing or receiving care in a congregate or institutional setting do not meet HOP eligibility criteria based on their access to services within the congregate or institutional setting.**

Upon five days of being notified that a HOP-enrolled member has entered a stay in a congregate care or institutional setting, the member's care management team (at a Tailored Plan / LME/MCO, AMH+, or CMA) must assess the need to continue, suspend, or terminate HOP services.

- If the stay is projected to be longer than 30 days, the care management team or Tailored Plan / LME/MCO should terminate HOP services, and prior to discharge, reassess the member for HOP eligibility and service needs.
- For stays projected to be shorter than 30 days, the care management team or Tailored Plan / LME/MCO should determine which referrals should be closed out in NCCARE360 for the length of the stay. The AMH+/CMA or health plan should send new referrals using NCCARE360 to restart the services post-discharge (e.g., delivery of a healthy food box would no longer be needed and should be closed out for the duration of the stay, whereas telephonic-based housing case management may continue to benefit beneficiary health, depending on the member's circumstances).

For those currently residing in congregate care or institutional settings, the AMH+/CMA or health plan may assess HOP eligibility and service needs prior to discharge/transition so long as service delivery starts upon the return to the community. Congregate/Institutional settings include:

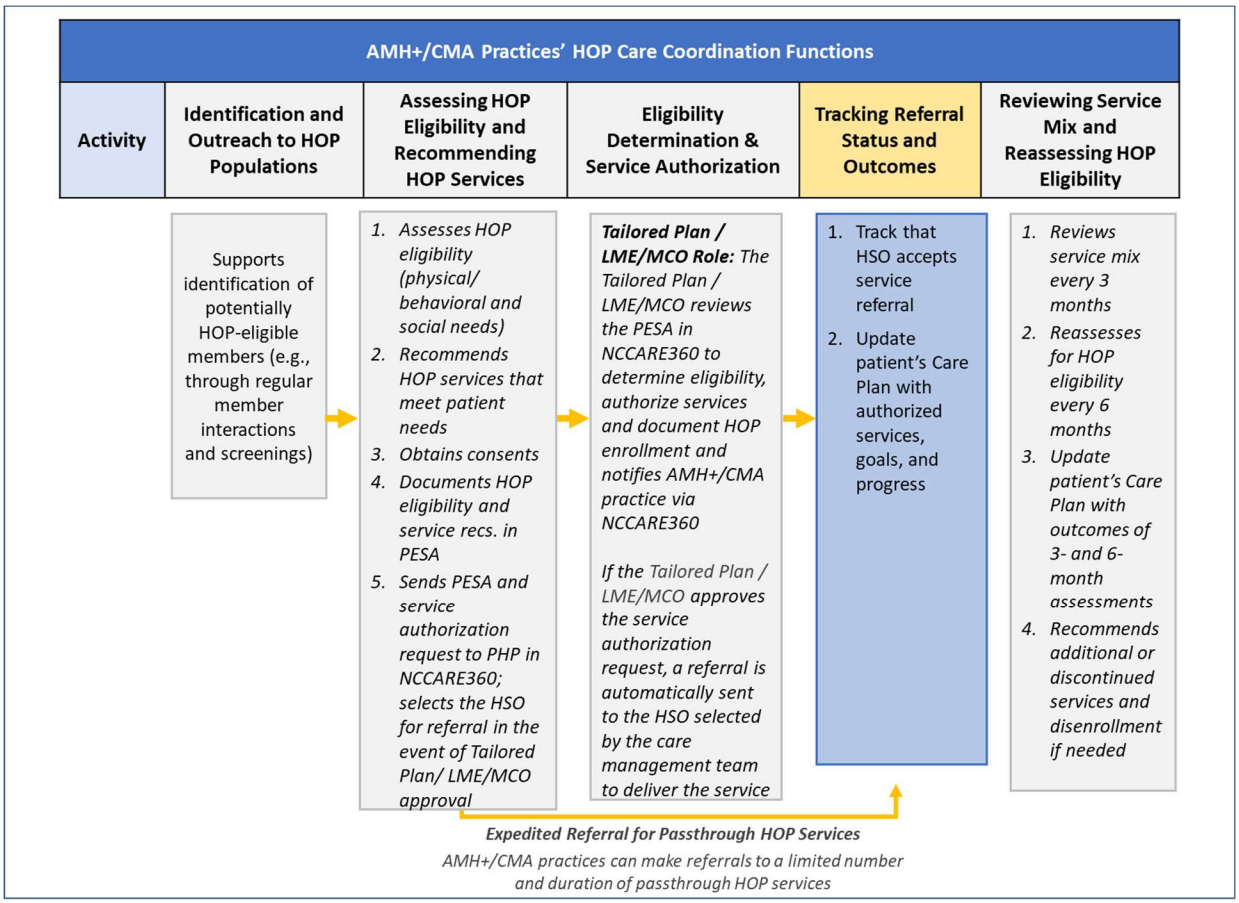
- Residential Treatment Facility Services (including ASAM 3.3 and above and services under Clinical Coverage Policy 8D-2)
- Psychiatric Residential Treatment Facilities (PRTFs)
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)
- Inpatient Psychiatric Hospitals
- Inpatient/Acute Care Hospitals
- Nursing Facilities
- Long-term Care Hospitals
- Group Homes
- Halfway House
- Adult Care Homes
- Family Care Homes
- Alternative Family Living Arrangements

B.6 Making Referrals to HOP Services: AMH+s/CMAs are responsible for referring eligible members to an appropriate HSO through the NCCARE360 platform. The care management team sends the service authorization request to the Tailored Plan / LME/MCO for review. During this step, the care management team also selects the HSO to receive the referral in the event of Tailored Plan/ LME/MCO approval of the service authorization request. If the Tailored Plan/ LME/MCO approves the service authorization request, a referral is automatically sent to the HSO selected by the care management team to deliver the service**.** Tailored Plans / LME/MCOs 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 HOP. Upon Tailored Plan / LME/MCO notification of service authorization, the AMH+/CMA must communicate to the member the authorized HOP services and that an HSO will soon be reaching out to them.

AMH+s/CMAs 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 HOP service. NCCARE360 will have a profile of the HSO including but not limited to: contact information, hours of operation, services offered, and languages spoken. AMH+s/CMAs may also consult with the HOP 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 HOP services that require simultaneous case management, see the HOP Service Fee Schedule on the HOP web site.

C. Tracking Referral Status and Outcomes



C1. Tracking Referral Status and Outcomes: **If the Tailored Plan / LME/MCO approves the service authorization request, a referral is automatically sent to the HSO selected by the care management teams to deliver the service. AMH+s/CMAs 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.** AMH+s/CMAs should reasonably expect HSOs to accept all appropriate service referrals. In limited circumstances, HSOs may reach capacity for how many individuals they can serve. In such circumstances, HSOs are responsible for proactively notifying their HOP Network Lead of limited capacity and indicating that they are not currently accepting referrals in NCCARE360 in order to prevent further referrals that cannot be acted upon. While AMH+s/CMAs must ensure 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.

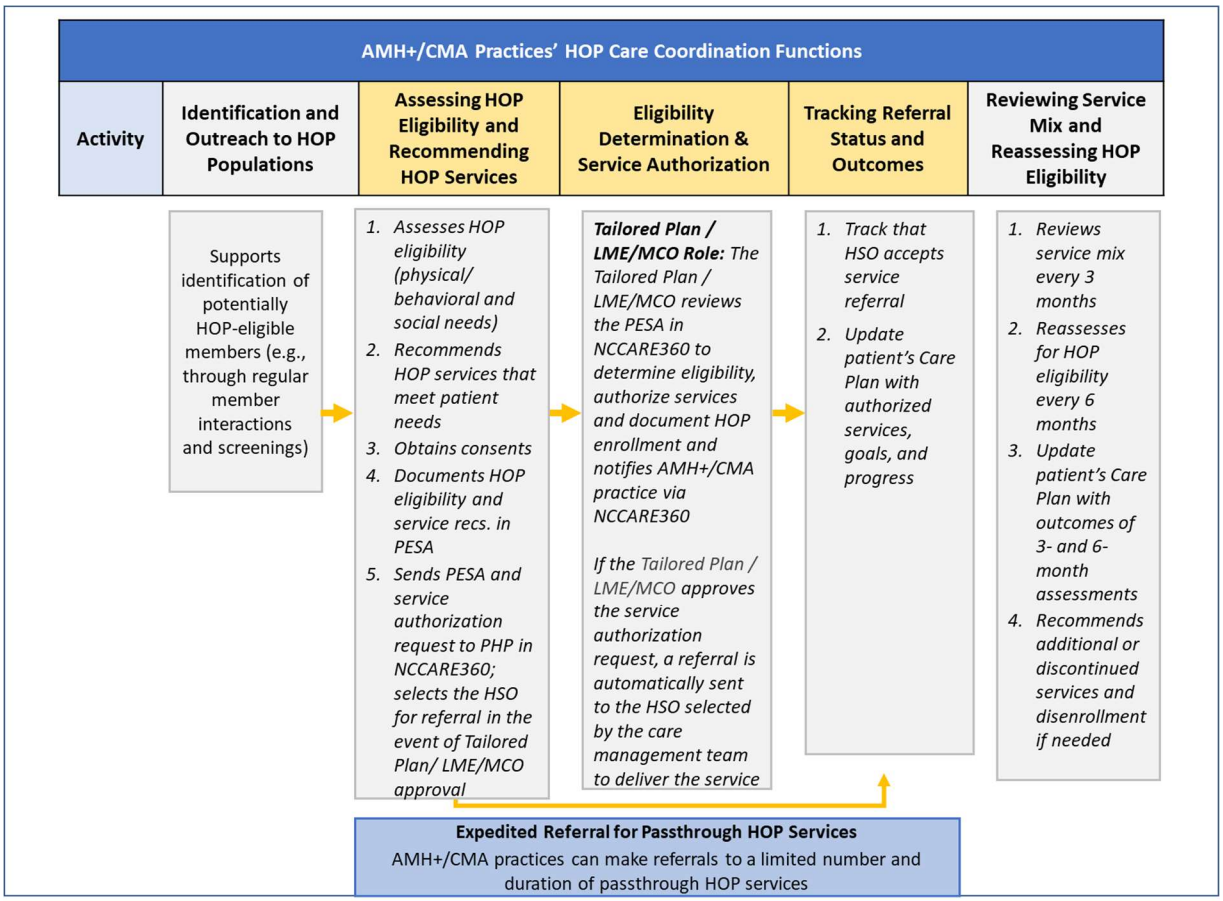
If a referral was sent to a particular HSO and is not accepted within two business days, the AMH+/CMA should contact the HSO to confirm whether it can provide the service. If the HSO does not respond or indicates it does not have capacity, AMH+s/CMAs should escalate the issue to both the Tailored Plan / LME/MCO and the HOP Network Lead, 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, AMH+s/CMAs should escalate the issue to both the Tailored Plan / LME/MCO and the Network Lead, as appropriate. AMH+s/CMAs then need to monitor and track the HOP services delivered and coordinate with the HSO to help assess to what extent the HOP service(s) are meeting their needs.

C2. Documenting HOP Enrollment Status and Authorized HOP Services in Member's Care Plan/ISP: Upon HOP enrollment, AMH+s/CMAs must integrate HOP care coordination activities into Tailored Care Management, as described in this document. For members who were not previously engaged in Tailored Care Management prior to HOP enrollment, the AMH+/CMA will provide both HOP care coordination and Tailored Care Management moving forward.

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

D. Referrals for Passthrough HOP Services



In order to facilitate service delivery and reduce touchpoints with the member, Tailored Plans / LME/MCOs are required to permit AMH+s/CMAs to refer members to passthrough services, a select number of high-value, low-cost HOP services for a 30-day passthrough period without prior Tailored Plan / LME/MCO approval. Tailored Plans / LME/MCOs are required to treat these select HOP services as "pre-approved" for up to 30 days. Passthrough HOP services will be standardized across all Tailored Plans / LME/MCOs 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 AMH+/CMA identifies a potentially HOP-eligible member that is currently engaged in Tailored Care Management or who has been referred to the AMH+/CMA for a HOP assessment, and who would

benefit from one of the passthrough services, the AMH+/CMA obtains required consents, validates HOP eligibility and service-specific eligibility using the PESA in NCCARE360. **The AMH+/CMA may then refer the member to an HSO that delivers the specific passthrough HOP service using NCCARE360 for a period of up to 30 days.** The AMH+/CMA 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/ISP with the passthrough HOP service. The AMH+/CMA tracks the passthrough HOP 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 AMH+/CMA must alert the member's Tailored Plan / LME/MCO 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 HOP and pre-authorized to receive a HOP service for a period of up to 30 days. The Tailored Plan / LME/MCO will then review the PESA to assess the member's eligibility for HOP and the selected service beyond the first 30 days.

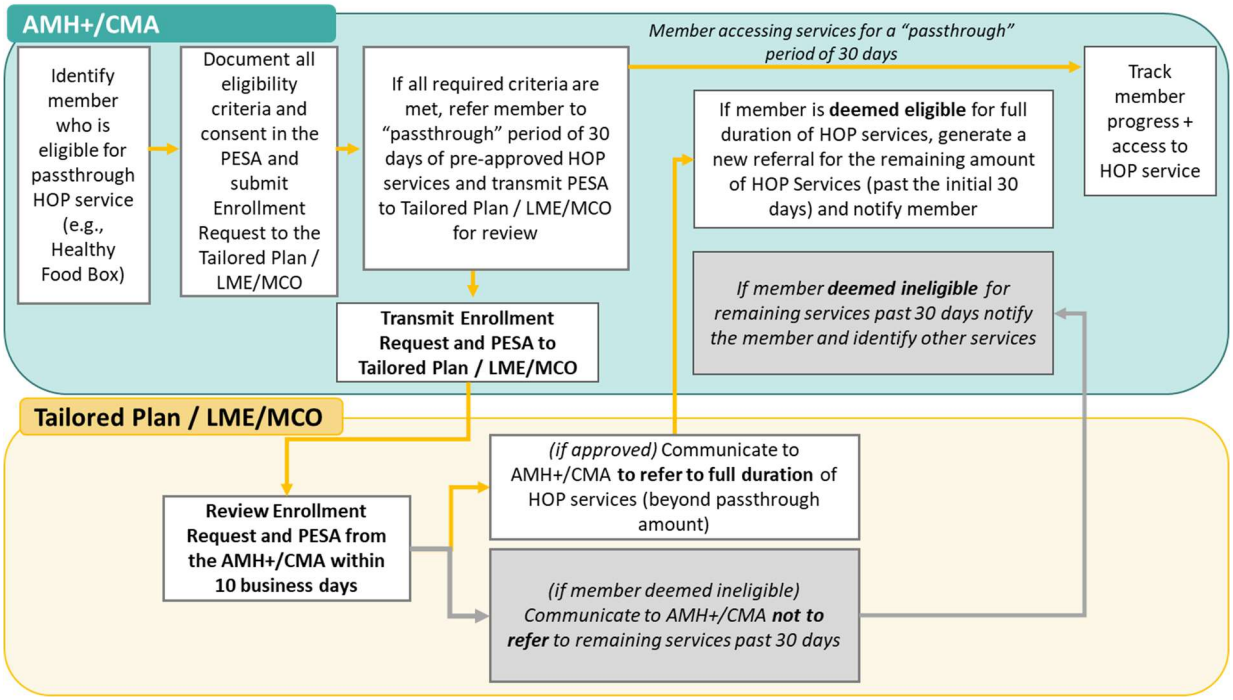
If the Tailored Plan / LME/MCO deems the member eligible for additional services beyond the 30-day passthrough period, the Tailored Plan / LME/MCO will alert the AMH+/CMA through NCCARE360, which then must generate a new referral to the same HSO to extend the HOP services beyond the initial 30 days. The AMH+/CMA must then communicate to the member that they are authorized to receive the full duration of the HOP service and monitors that the HSO accepts the new referral within two business days. The AMH+/CMA will also update the member's Care Plan/ISP, track the additional HOP services delivered to the member, and coordinate with the HSO regarding member progress.

If the Tailored Plan / LME/MCO deems the member ineligible for HOP or the full duration of the recommended service, the Tailored Plan / LME/MCO will alert the AMH+/CMA of its decision. The AMH+/CMA then may not issue another referral for the member for the recommended HOP service. The AMH+/CMA must communicate to the member of the Tailored Plan / LME/MCO's decision and direct the member to other non-HOP services and HSOs to meet their needs.

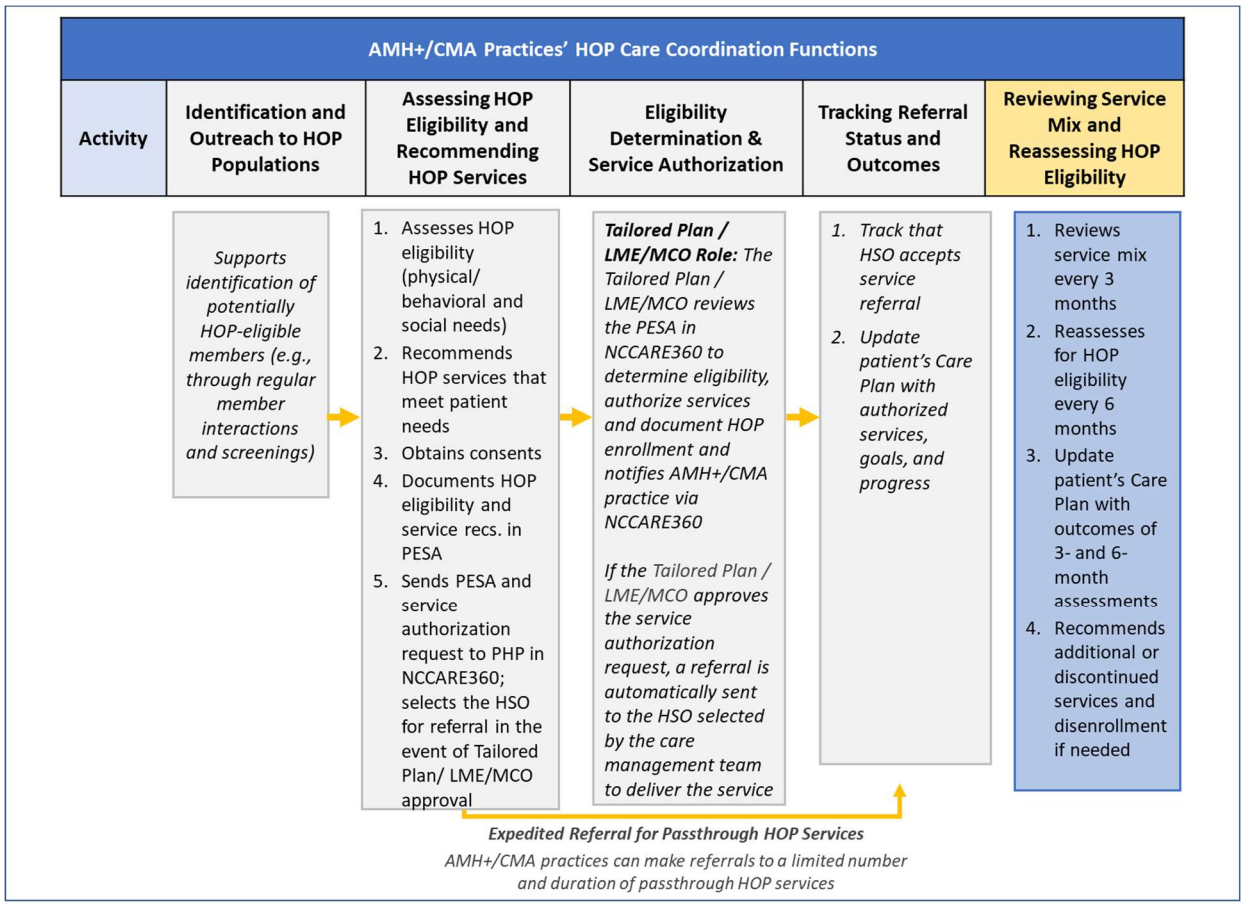
Tailored Plans / LME/MCOs have the ability to discontinue an individual AMH+/CMA's ability to refer members to passthrough services if that practice is found to have a pattern of making referrals for members that are subsequently found to be ineligible for HOP or if the Tailored Plan / LME/MCO runs out of HOP funds.

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

Figure 3: Referrals for Passthrough HOP Services



E. Reviewing HOP Service Mix and Reassessing HOP Eligibility



The HOP program requires AMH+s/CMAs to conduct a three-month assessment of a member's "HOP service mix" to determine if the authorized HOP services are meeting a member's needs. If existing services are not meeting a member's needs, the AMH+/CMA should recommend that the Tailored Plan / LME/MCO add new services and/or discontinue one or more services. **AMH+s/CMAs must also conduct a six-month assessment to reassess members for HOP eligibility (the "eligibility reassessment") in addition to the service mix review.** Care management teams will conduct the HOP service mix review and eligibility reassessment as part of ongoing Tailored Care Management. If an AMH+/CMA identifies that a HOP-enrolled member has met their HOP-related Care Plan/ISP goals in less than three months and no longer requires HOP services, the AMH+/CMA may recommend discontinuing HOP services (see Section F1. Discontinuation of HOP Services).

AMH+s/CMAs must 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 HOP service to which they were referred). AMH+s/CMAs will schedule an in-person, telephonic, or video reassessment with the member (depending on the beneficiary preference). AMH+s/CMAs should schedule a reassessment meeting with HOP-enrolled members within 30 days of the date that members are due for their three- or six-month assessment. AMH+s/CMAs should make at least three contact attempts following the original due date of a three- or six-month assessment. If the member does not respond after three contact attempts,

AMH+s/CMAs must recommend to the Tailored Plan / LME/MCO that the member be disenrolled from HOP (described in detail below).

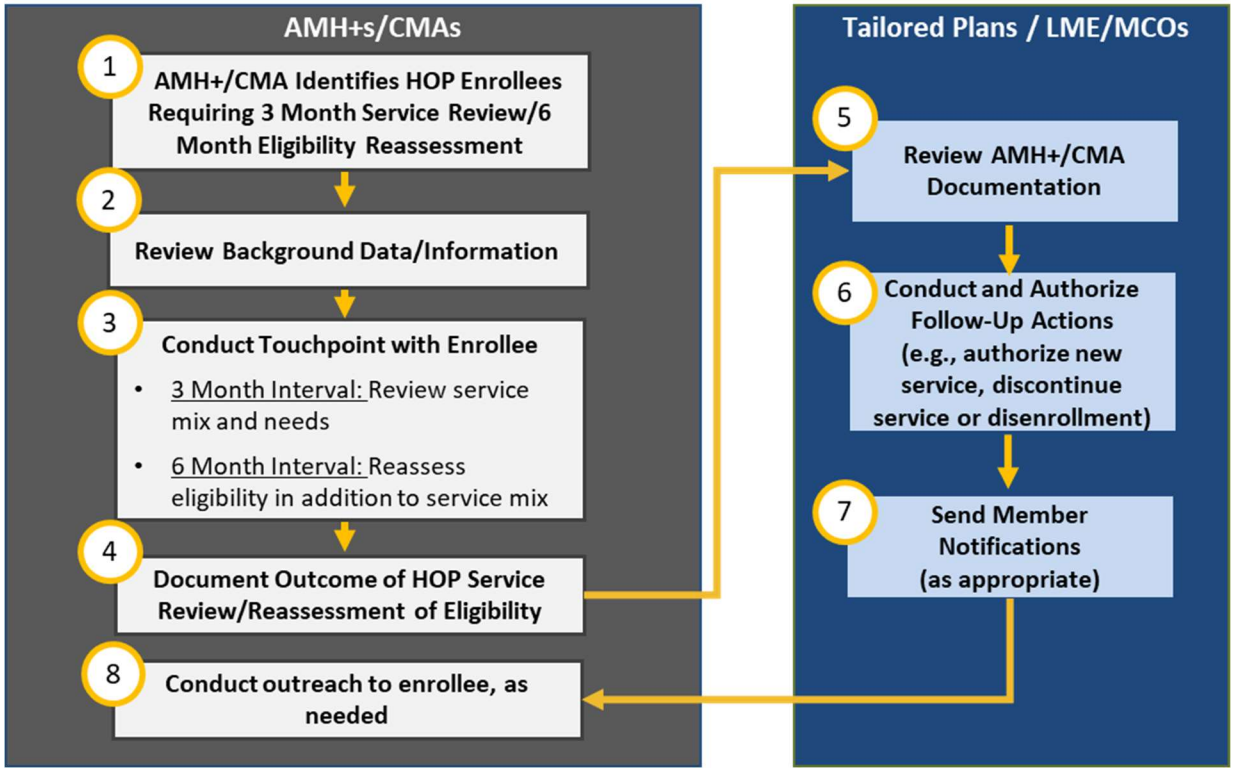
Prior to conducting the three- or six-month assessment, AMH+s/CMAs should review all available data on the member in preparation for the assessment, including, for example:

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

Tailored Plans / LME/MCOs will monitor requirements for HOP service mix reviews and eligibility reassessment through spot audits of member PESAs but will not require additional reporting of AMH+s/CMAs related to reassessments.

Figure 4 provides a summary of the process AMH+s/CMAs will use to conduct three-and six-month assessments.

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

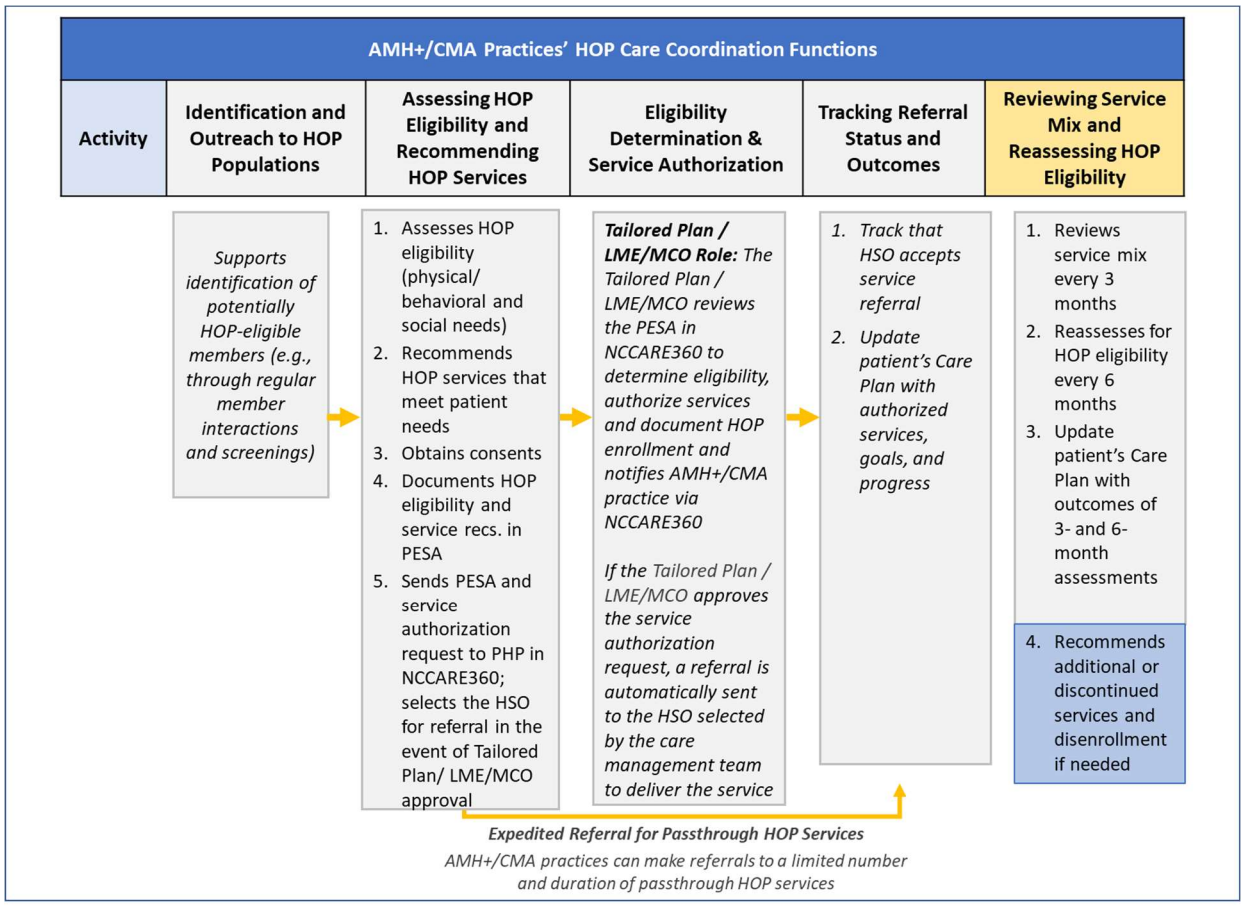


E1. Three-Month Service Mix Review: For each HOP-enrolled member, AMH+s/CMAs must conduct an assessment every three months to discuss the member's current service mix and assess if it is meeting the member's needs. AMH+s/CMAs should use the Department's standardized Healthy Opportunities screening questions and/or other assessments, including those used to originally recommend HOP services, to evaluate if the member needs different HOP services. If a member has no new or changed

needs and requires HOP services to continue, AMH+s/CMAs will document this in the member's Care Plan/ISP. If new or modified services are required due to new or changed needs, AMH+s/CMAs should use the PESA in NCCARE360 to make recommendations for new or modified services and submit the PESA to the Tailored Plan / LME/MCO for service review and authorization. If AMH+s/CMAs decide that a service is no longer needed, they are permitted to discontinue that particular service (see next *Section III.F1. Discontinuation of HOP Services* for additional details). AMH+s/CMAs should document the outcome of the three-month assessment in the member's PESA, including any Tailored Plan / LME/MCO action or decision, and update the member's Care Plan/ISP. The service mix review may occur concurrently with a HOP eligibility reassessment if it is being conducted at the six-month interval (described in *Section III.E2. Six-Month HOP Eligibility Reassessment* below).

***E2. Six-Month HOP Eligibility Reassessment*:** In addition to conducting a HOP service mix review every three months, AMH+s/CMAs must reassess each HOP-enrolled member for their ongoing HOP eligibility every six months. To do so, AMH+s/CMAs should ensure that a HOP-enrolled member still has a qualifying social factor in one of the priority HOP domains and assess the member's underlying health criteria (or new criteria) that makes the member eligible for HOP (e.g., the member requires ongoing HOP services to address the needs that make them eligible for HOP in the first place). When conducting a HOP eligibility reassessment, the AMH+/CMA must also conduct a three-month service mix review. Any changes made to HOP eligibility should be documented in the PESA and transmitted to the Tailored Plan / LME/MCO for review. AMH+s/CMAs should document the outcome of the six-month HOP eligibility reassessment in the member's PESA in NCCARE360, including any Tailored Plan / LME/MCO action or decision, and update the member's Care Plan/ISP. Changes to HOP eligibility status will automatically impact the member's ability to receive HOP services. If the Tailored Plan / LME/MCO finds the member ineligible for HOP, the member's HOP services will be discontinued, and the AMH+/CMA should find new, non-HOP services that meet that member's needs.

F. Discontinuation of HOP Services and Disenrollment from HOP



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

F1. Discontinuation of HOP Services: Discontinuation of HOP services refers to instances when an authorized HOP 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 HOP services. Examples of potential scenarios for discontinuation of HOP services include:

- Current HOP 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).
- The Member has met their HOP-related Care Plan/ISP goals and no longer requires the HOP service (e.g., member has been stably housed for 12 months and no longer requires Housing Navigation, Support and Sustaining Services).
- The Member no longer meets HOP service-specific qualifying criteria (e.g., the member no longer has pre-diabetes and is ineligible for the diabetes prevention program service).

If AMH+s/CMAs identify that a HOP service should be discontinued during a three-month assessment, six-month HOP reassessment, or other regular check-in with a member, AMH+s/CMAs 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 Tailored Plan / LME/MCO via NCCARE360. AMH+s/CMAs 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/ISP. After a HOP service has been discontinued, AMH+s/CMAs need to communicate the decision to the member and provide transition support by identifying other HOP or non-HOP services and programs to meet the member's ongoing needs. If the member requires new or modified HOP services in lieu of the discontinued service, AMH+s/CMAs must submit a HOP service authorization request for the new HOP service to the Tailored Plan / LME/MCO as part of the PESA.

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

- The Member is no longer enrolled in Medicaid.
- The Member no longer lives in a HOP region (regardless of the location of the AMH+/CMA where they receive care).
- The Member is receiving duplicative services or programs that disqualify them from HOP.
- The Member wishes to opt out of HOP.
- The Member is unreachable after three contact attempts.
- The beneficiary transitions to another delivery system that has yet to launch HOP (i.e., transitions to the Tribal Option).

Upon identifying a trigger for HOP disenrollment, AMH+s/CMAs must document information and rationale for HOP disenrollment in a member's PESA and transmit to the Tailored Plan / LME/MCO for verification. If the Tailored Plan / LME/MCO agrees with the AMH+/CMA recommendation, the Tailored Plan / LME/MCO disenrolls the member from HOP. AMH+s/CMAs must close out any open referrals for HOP services in NCCARE360, communicate directly with the HSO(s) regarding the change in status and ensure they do not submit invoices for further HOP services, and update the member's Care Plan/ISP. In the event a member has HOP services that were authorized and started at the time of HOP enrollment (e.g., home modifications) or passthrough services, the AMH+/CMA must coordinate with the HSO to ensure the HOP service is delivered even if the member has since been disenrolled from HOP. After a member has been disenrolled from HOP, the AMH+/CMA needs to communicate the decision to the member and continue to deliver Tailored Care Management, including providing transition supports by identifying non-HOP services, programs and HSOs to meet the needs of the member.

G. Use of NCCARE360 for HOP Responsibilities

To participate in HOP, AMH+s/CMAs must be registered and trained on NCCARE360 for core HOP responsibilities, including:

- Creating the member's profile in NCCARE360 if it does not already exist.
- Obtaining consent for capturing the member's data on NCCARE360, which includes personal health information, and sharing it with organizations in the NCCARE360 network.
- Completing the PESA form, and transmitting it with an Enrollment Request to the Tailored Plan / LME/MCO to review the member's HOP eligibility
- Generating Authorization Requests for HOP services and selecting HSOs to deliver HOP services upon the Authorization Request's approval by the Tailored Plan / LME/MCO.
- Monitoring referrals to HSOs for authorized HOP 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 three-month service mix review and six-month eligibility reassessment.
- Instructing HSOs to close out referrals for services that are no longer needed/authorized
- Prompting disenrollment from HOP if the member is no longer eligible to participate.

AMH+s/CMAs contracted with the Tailored Plan / LME/MCO to provide HOP care coordination must be registered, trained, and actively use NCCARE360 to promote whole-person care.

H. HOP Staffing for AMH+s/CMAs

HOP does not have any additional staffing or licensure requirements separate from Tailored Care Management requirements. For members in Tailored Care Management and HOP, care management teams include:

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

For members in Tailored Care Management and HOP, care management teams should directly supervise care manager extenders that participate in a HOP beneficiary's care team and ensure that they are only performing functions within their training, scope, and abilities.[18] Care management team staff serving HOP beneficiaries, including care manager extenders, must complete required HOP trainings (see *Section III.I. Participation in HOP Convenings/Trainings* below). Care manager extenders can support the following HOP activities, as deemed appropriate by the care management team:

- Perform outreach to, engagement with, as well as follow-up with members
- Assess members for HOP eligibility by using the PESA and recommend HOP services
- Coordinate referrals to HOP services
- Help track that HSOs accept a referral to deliver HOP services, that HSOs initiate that service, and ongoing coordination with HSOs to help assess to what extent HOP services are meeting a member's needs

[18] For more information on qualifications and functions for care manager extenders, see the Department's "Guidance on the Use of Care Manager Extenders in Tailored Care Management."

- Review the service(s) a HOP beneficiary is receiving and reassess for HOP eligibility

I. Participation in HOP Convenings/Trainings

HOP-Related Convenings

There will be regular telephonic or web-based convenings with HOP-participating entities, including AMH+s/CMAs serving as a Designated HOP Care Coordination Entity, to share learnings and best practices as well as at least two in-person convenings per year that include all HOP participating entities (HSOs, Network Leads, Tailored Plans / LME/MCOs, etc.). Specifically, the HOP convenings may:

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

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

AMH+s/CMAs must participate in HOP-related convenings; where applicable, the convening entity will specify the intended audiences for each convening so AMH+s/CMAs can determine who from the practice is best suited to attend.

Training and Technical Assistance

The Department provides HOP-related technical assistance for frontline care management teams via its partnership with the Area Health Education Centers (AHEC). Training materials and forums may include office hours, webinars, training modules, written materials, and targeted, one-on-one training. Trainings cover topics including:

- Assessing eligibility for HOP services
- Choosing appropriate HOP Food, Housing, Transportation, Health Related Legal Supports, Interpersonal Violence Services/Toxic Stress services and understanding the Medical Respite Cross Domain Service
- Tracking beneficiary progress over time, Reviewing Service Mix, and Reassessing HOP Eligibility
- Obtaining HOP consent

Prior to making HOP referrals, all AMH+/CMA care coordinators must complete the following Department-identified trainings related to IPV topics including the provision of IPV-related services, working with IPV survivors, trauma informed care delivery, and protecting privacy and confidentiality:

- Healthy Opportunities Pilots: How Care Managers Can Choose Appropriate Interpersonal Violence Services – Part One
- Healthy Opportunities Pilots: How Care Managers Can Choose Appropriate Interpersonal Violence Services – Part Two

Additionally, general staff (i.e., non-care management staff) at all HOP entities, including AMH+/CMAs, who handle sensitive service data must complete the following training on the importance of privacy, safety, and confidentiality when working with HOP beneficiaries and their data:

- Healthy Opportunities: Sensitive Services for HSOs and HOP Staff; Privacy and Confidentiality for Survivors

The Department may require or recommend additional IPV-related training in the future.

In addition, the HOP Network Leads also provide technical assistance for care coordination entities, including AMH+s/CMAs, on available HOP services and appropriate contracted HSOs based on a member's circumstances and care needs preferences.

The HOP Network Leads will also provide ongoing technical assistance for AMH+s/CMAs, to:

- Address issues related to HOP services and HSO availability/accessibility;
- Support AMH+s/CMAs ability to refer members to contracted HSOs and adhere to HOP responsibilities; and
- Support AMH+s/CMAs' understanding of and familiarity with contracted HSOs and HOP services.

AMH+s/CMAs must participate in both the HOP Network Leads and the Department-led trainings as well as the HOP Network Leads technical assistance; where applicable, the HOP Network Leads and the Department will specify the intended audiences for each training and technical assistance session so AMH+s/CMAs can determine who from the practice is best suited to attend.

J. Supporting HOP-Enrolled Members Transitioning between Designated HOP Care Coordination Entities and/or Health Plans

A transition between care coordination entities, health plans, or service delivery systems entities can pose unique challenges to ensuring service continuity and coordination for members.

HOP-enrolled members enrolled in a Tailored Plan / LME/MCO may experience the transition of care scenarios described below.

- Scenarios where a member remains HOP-eligible:
    - Member transitions to a different health plan in a HOP region,
    - Member transitions to a different Designated HOP Care Coordination Entity participating in HOP, and
    - Member transitions to a different care management organization not participating in HOP[19].
- Scenarios where a member is no longer HOP-eligible:
    - Member transitions to a non-HOP region (i.e., a county within the same health plan or across health plans that is not participating in HOP), and
    - Member transitions to another delivery system that has yet to launch HOP (i.e., transitions to the Tribal Option.

Building off the existing requirements for supporting transitions of care, AMH+s/CMAs and Tailored Plans / LME/MCOs will collaborate to facilitate transitions of care for members when needed. AMH+s/CMAs will be required to do the following for HOP-enrolled members in a transition of care scenario where a member remains HOP-eligible:

- **Coordinate a timely warm handoff, or a transfer of care between Designated HOP Care Coordination Entities** for effective knowledge transfer or to ensure member continuity of care with regards to HOP services;

[19] In this scenario, where a member is engaged in Tailored Care Management through an AMH+/CMA that does not opt into the HOP, the member's assigned care manager will provide Tailored Care Management and the member's assigned Tailored Plan / LME/MCO will provide HOP care coordination.

- **Promote proactive communication** regarding the member's HOP participation/services with the receiving entity (e.g., the Tailored Plan / LME/MCO, a new AMH+/CMA, etc.) prior to transition to coordinate the transfer of care;
- **Establish a follow-up protocol** to communicate with the receiving entity (e.g., the Tailored Plan / LME/MCO, a new AMH+/CMA, etc.) after the member's transition to confirm receipt of the transferred information and to troubleshoot dynamics related to HOP that may have resulted from the transition;
- **Work with the HSO and former Tailored Plan / LME/MCO** to ensure the continued delivery of any current HOP services authorized while the member was still enrolled with the former Tailored Plan / LME/MCO;
- **Use the NCCARE360 functionality** to send the new Designated HOP Care Coordination Entity or Tailored Plan / LME/MCO a summary of services using a Transition of Care Referral Request [See Transition of Care Policy for more detail].
- **Act as the receiving entity in a transition of care (for AMH+s and CMAs), ensure that members are reassessed** for ongoing HOP eligibility and service mix within 90-days of transfer following a transition of care.
- **Close the case if a referral for services has not yet been accepted by the HSO**. The AMH+/CMA must close the case.
- **Contact the HSO to close the case for HOP service for services that were accepted by the HSO and not yet started**. The AMH+/CMA must contact the HSO to close the case for HOP service.

In a transition of care scenario where a member is no longer HOP-eligible, the AMH+/CMA must disenroll the member from HOP, work with the HSO to close the case for the service(s), and coordinate with the HSO to ensure any pending HOP services that were authorized and started at the time of HOP enrollment are delivered (see *Section III.F2. Disenrollment from HOP*).

K. HOP-Related Member and Provider Grievances

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

In addition, AMH+s/CMAs will be permitted to submit HOP-related provider grievances directly to the Tailored Plan / LME/MCO.

Section IV: AMH+/CMA Eligibility Criteria to Participate in HOP

AMH+/CMA Eligibility Criteria to Participate in HOP

To participate in HOP, providers must:

- Be certified with the Department as an AMH+/CMA,
- Be contracted with at least one Tailored Plan / LME/MCO as an AMH+/CMA
- Provide Tailored Care Management to Medicaid -enrolled members in a HOP region, and
- Contract with the Tailored Plan / LME/MCO to assume HOP-related responsibilities using Department-standardized contracting terms and conditions.

If an AMH+/CMA does not participate in HOP, there is no effect on their AMH+/CMA status.

Section V: AMH+/CMA Payment for HOP Responsibilities

HOP-participating AMH+s/CMAs will receive a HOP Care Coordination add-on payment on top of their Tailored Care Management payment. For every month that a HOP beneficiary receives Tailored Care Management engagement, Tailored Plans / LME/MCOs must pay AMH+s/CMAs the HOP Care Coordination "add-on" payment. HOP design seeks to maintain (and not disrupt) current contracting and payment practices. The "add-on" payment will be applied to the regular Tailored Care Management payment for members enrolled in HOP during the billing month. Tailored Plans / LME/MCOs must use the HOP Care Coordination add-on payment rate and payment approach outlined in the HOP Payment Protocol to pay AMH+s/CMAs for HOP-related care coordination and are not permitted to negotiate the rate. The Department reserves the right to modify this payment approach in the future, as needed.

Section VI: Tailored Plan / LME/MCO Oversight of AMH+s/CMAs for HOP Responsibilities

Tailored Plans / LME/MCOs will be responsible for overseeing and monitoring AMH+/CMA compliance with HOP responsibilities but may not put additional requirements on AMH+s/CMAs above and beyond what the Department requires.

Tailored Plans / LME/MCOs are responsible for overseeing and monitoring compliance of each AMH+/CMA contracted to participate in HOP. Tailored Plans / LME/MCOs are not permitted to hold AMH+s/CMAs accountable for requirements that go above and beyond AMH+/CMA HOP requirements described in this document.

Tailored Plans / LME/MCOs have the ability to put an individual AMH+/CMA on a corrective action plan (CAP) if the practice is found to have a pattern of making referrals to HOP passthrough services for members that are subsequently found to be ineligible for HOP (note: the process for HOP-related CAPs is different from Tailored Care Management CAPs). The Tailored Plan / LME/MCO will have the ability to discontinue an individual AMH+/CMA's ability to refer members to passthrough services if that practice continues to have a pattern of making referrals for members that are subsequently found to be ineligible for HOP. Tailored Plans / LME/MCOs should give prior notification to AMH+s/CMAs if they are outliers in referring ineligible members to the program and given a time period to demonstrate improvement.

Section VII: Changes to HOP Participation and Contract Terminations

If a provider loses its certification as an AMH+/CMA, it will also lose its designation as a Designated HOP Care Coordination Entity. Additionally, a Tailored Plan / LME/MCO may terminate a HOP-related contract with an AMH+/CMA, with cause related to HOP performance.

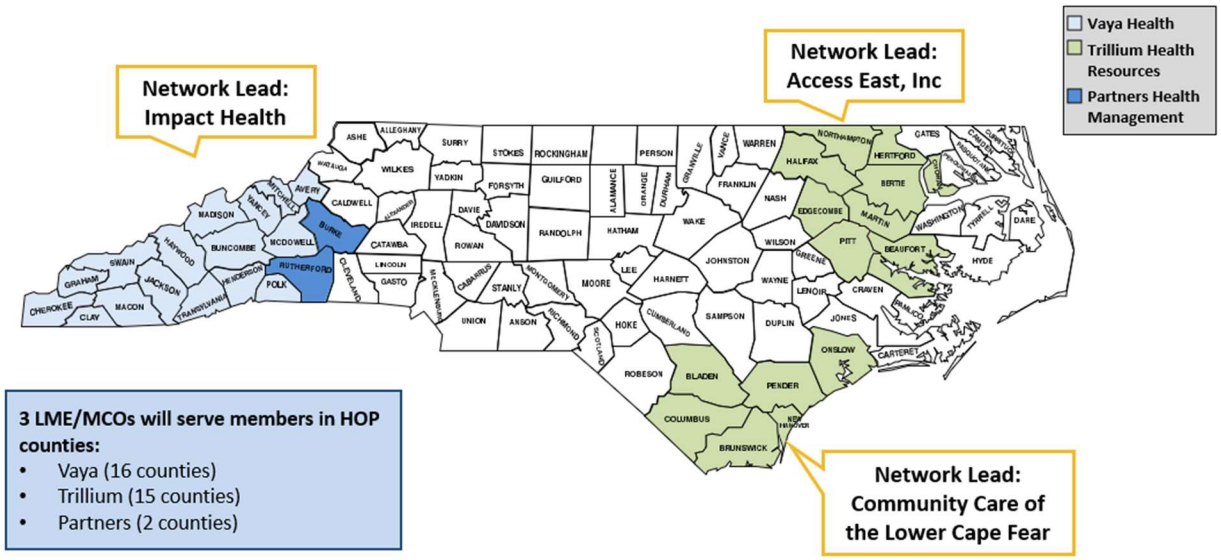
As discussed above in Section VI: Tailored Plan / LME/MCO Oversight of AMH+s/CMAs for HOP Responsibilities, **if a Tailored Plan / LME/MCO determines that an AMH+/CMA is not adequately meeting HOP requirements, it may lose its designation as a Designated HOP Care Coordination Entity and ability to earn HOP care coordination add-on payment for providing HOP care coordination to HOP beneficiaries**. Prior to HOP contract termination with cause related to HOP performance, the Tailored Plan / LME/MCO must notify the AMH+/CMA of the underperformance issues and give the AMH+/CMA 90 business days to remedy any HOP-related underperformance. Once notified, the AMH+/CMA must acknowledge receipt of the notice within three business days and develop and submit a corrective action plan (CAP) to the Tailored Plan / LME/MCO within 15 business days of receiving notice of underperformance. The AMH+/CMA must include in their CAP a "performance improvement plan" that clearly states the steps being taken to rectify underperformance. Tailored Plans / LME/MCOs are required to notify the Department of any HOP-related underperformance and/or CAPs. If the Tailored Plan / LME/MCO moves forward with the termination of a HOP contract because the AMH+/CMA does not remedy its underperformance after 90 business days, the Tailored Plan / LME/MCO will provide written notice to the AMH+/CMA. Upon receiving notice of termination, the Tailored Plan / LME/MCO must notify Unite Us of the terminated contract in order to be removed from the HOP-related components of the NCCARE360 platform (unless contracts with other Tailored Plans / LME/MCOs for HOP care coordination are still active).

In addition, AMH+s/CMAs are permitted to discontinue HOP-related contracts with Tailored Plans / LME/MCOs at any time. AMH+s/CMAs must notify the Department and the Tailored Plan / LME/MCO of its intent to terminate the HOP-related contract, 45 business days before doing so. In addition, AMH+s/CMAs must notify Unite Us of the terminated contract in order to be removed from the HOP-related components of the NCCARE360 platform, unless contracts with other Tailored Plans / LME/MCOs for HOP care coordination are still active. AMH+s/CMAs must notify the Tailored Plan / LME/MCO of the end date of the HOP-portion of its contract and meet data storage and reporting requirements for one calendar year.

For any terminated contracts, the Tailored Plan / LME/MCO must follow all requirements in the HOP Transition of Care Protocol to ensure continuity of care for members, including providing HOP care coordination to HOP beneficiaries from AMH+/CMAs who lose their designation as a Designated HOP Care Coordination Entity.

Appendix A: Awarded Healthy Opportunities Pilots Network Leads

HOP operates in three geographic regions of the state led by Network Leads. HOP regions are served by three Tailored Plans / LME/MCOs: Partners, Trillium, Vaya.



HOP 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

Healthy Opportunities Pilots Fee Schedule		
Service Name	**Unit Of Service/Payment**	**Rate or Cap**
Home Remediation Services	Cost-Based Reimbursement Up to A Cap	Up to $5,000 per year[20]
Home Accessibility and Safety Modifications	Cost-Based Reimbursement Up to A Cap	Up to $10,000 per lifetime of waiver demonstration[21]
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[22] (based on home size) • Security deposit: Up to 110% FMR (based on home size) x2
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

[20] 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.

[21] 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.

[22] 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**

Diabetes Prevention Program	• Four classes (first phase)
	• Three classes (second phase)[23]
		• **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[24]
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[25]

[23] 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.

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

[25] 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.

Healthy Opportunities Pilots Fee Schedule		
Service Name	**Unit Of Service/Payment**	**Rate or Cap**
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

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: o Obtaining necessary personal documentation required for housing applications or programs; o 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: o Coordinating transportation for enrollees to housing-related services necessary to obtain housing (e.g. apartment/home visits). o 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 o 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 Tailored Plan /

	LME/MCO 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	• Enrollee must be receiving at least one of the following Pilot services in order to be eligible for this service: o Housing Navigation, Support and Sustaining Services ▪ 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. o Home Remediation Services o Home Accessibility and Safety Modifications o Holistic High Intensity Enhanced Case Management • 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 Tailored Plan / LME/MCO 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[26] or shelter, or for individuals who are moving from 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 Tailored Plan / LME/MCO 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).

[26] 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.

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 Tailored Plan / LME/MCO 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. • The enrollee's landlord has provided written confirmation that they consent to have the approved home remediation service provided on behalf of the enrollee prior to service delivery. An enrollee who lives in a home where they do not pay rent (e.g.,

	home owned by the enrollee or enrollee's family member) would not be required to provide such written consent. • Prior to service delivery, landlord or enrollee has provided written confirmation that the enrollee can reasonably be expected to remain in the residence for at least six months after the authorized home remediation service. An enrollee who lives in a home where they do not pay rent (e.g., home owned by the enrollee or enrollee's family member) would not be subject to this requirement. • Services are authorized in accordance with Tailored Plan / LME/MCO 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. • The enrollee's landlord has provided written confirmation that they consent to have the approved home accessibility or safety modifications provided on behalf of the enrollee prior to service delivery. An enrollee who lives in a home where they do not pay rent (e.g., home owned by the enrollee or enrollee's family member) would not be required to provide such written consent. • Prior to service delivery, landlord or enrollee has provided written confirmation that the enrollee can reasonably be expected to remain in the residence for at least 12 months after the authorized home accessibility or safety modification service. An

	enrollee who lives in a home where they do not pay rent (e.g., home owned by the enrollee or enrollee's family member) would not be subject to this requirement. • Services are authorized in accordance with Tailored Plan / LME/MCO 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 *(if applicable)*	N/A
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 Tailored Plan / LME/MCO 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 Tailored Plan / LME/MCO 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 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+/CMA. 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 *(if applicable)*	N/A
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 or appropriate dwelling owner or administrator must be willing to enter into an agreement that maintains a satisfactory dwelling and access to needed medical services for the enrollee throughout the duration of the agreement, unless there are appropriate and fair grounds for termination of the agreement. • 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 Tailored Plan / LME/MCO 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.[27] • Services are authorized in accordance with Tailored Plan / LME/MCO 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. • 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.

[27] 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.

	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 Tailored Plan / LME/MCO 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 Tailored Plan / LME/MCO 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 six months are 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 Tailored Plan / LME/MCO 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 Tailored Plan / LME/MCO 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 Tailored Plan / LME/MCO 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)[28] • A Taste of African Heritage (for Kids, Adults) [29] 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 Tailored Plan / LME/MCOs.
Frequency *(if applicable)*	Typically weekly
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.

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

	• Services are authorized in accordance with Tailored Plan / LME/MCO 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.[30]
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"[31]
	• Services are authorized in accordance with Tailored Plan / LME/MCO 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.

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

[31] Available at: https://www.cdc.gov/prediabetes/takethetest/

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, 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 service delivery is included in the service rate.
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)*	Six 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 two months, or
	  ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months
	• Services are authorized in accordance with Tailored Plan / LME/MCO 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 two months, or ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months • Services are authorized in accordance with Tailored Plan / LME/MCO 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 three 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 two 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 Tailored Plan / LME/MCO 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,[32] and adhere to the current Dietary Guidelines for Americans,

[32] Dietary Reference Intakes available at: https://www.nal.usda.gov/fnic/dietary-reference-intakes.

	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)*	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.
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 two months, or ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months • Services are authorized in accordance with Tailored Plan / LME/MCO 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,[34] 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

[33] Most recent version of the Dietary Guidelines for Americans is available at: https://health.gov/dietaryguidelines/2015/guidelines .

[34] Dietary Reference Intakes available at: https://www.nal.usda.gov/fnic/dietary-reference-intakes.

	U.S. Department of Agriculture.[35] 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 two 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.
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 two months, or ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months • Services are authorized in accordance with Tailored Plan / LME/MCO 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

[35] Most recent version of the Dietary Guidelines for Americans is available at: https://health.gov/dietaryguidelines/2015/guidelines .

	nutrition care plan, the preparation and delivery of the prescribed nutrition care regimen, and regular reassessment at least once every three months. Meals must be in accordance with nutritional guidelines established by the National Food Is Medicine Coalition (FIMC) or other appropriate guidelines.[36] 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 two 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.
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 two months, or
	  ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months
	• Services are authorized in accordance with Tailored Plan / LME/MCO 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

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

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 Tailored Plan / LME/MCO 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)[37] • 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 Tailored Plan / LME/MCO:[38] • Repairs to an enrollee's vehicle • Reimbursement for gas mileage, in accordance with North Carolina's Non-Emergency Medical Transportation clinical policy[39] 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	N/A

[37] 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.

[38] 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.

[39] 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.

(if applicable)	
Setting	N/A
Minimum Eligibility Criteria	• Services are authorized in accordance with Tailored Plan / LME/MCO 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
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 three 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 Tailored Plan / LME/MCO 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 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.[40] 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 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 Tailored Plan / LME/MCO 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.

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

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 Tailored Plan / LME/MCO 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.