Updated Healthy Opportunities Pilots Fee Schedule [Guidance Version]
March 31, 2022

The Healthy Opportunities Pilots Fee Schedule originally posted in December, 2019 has been updated to reflect the most recent data on wages, inflation, employee related expenses and updates to rates for similar services offered by other Department programs. The Fee Schedule may continue to be updated in the future based on DHHS experience implementing the Pilots and any feedback from CMS.

***This version is not part of the model contracts. This version is meant to provide additional guidance by reincorporating information about frequency, duration, setting, and minimum eligibility criteria for each service, where applicable, from the prior version of the fee schedule. This guidance should be considered alongside additional training that will be provided by the Department. ***

Healthy Opportunities Pilots Fee Schedule		
Service Name	**Unit Of Service/Payment**	**Rate or Cap**
Housing		
Housing Navigation, Support and Sustaining Services	PMPM	$400.26
Inspection for Housing Safety and Quality	Cost-Based Reimbursement Up to A Cap	Up to $250 per inspection
Housing Move-In Support	Cost-Based Reimbursement Up to A Cap	• 1 BR: Up to $900 per month • 2 BR: Up to $1,050 per month • 3 BR: Up to $1,150 per month • 4 BR: Up to $1,200 per month • 5+ BR: Up to $1,250 per month
Essential Utility Set-Up	Cost-Based Reimbursement Up to A Cap	• Up to $500 for utility deposits • Up to $500 for reinstatement utility payment • Up to $500 for utility arrears
Home Remediation Services	Cost-Based Reimbursement Up to A Cap	Up to $5,000 per year[1]

[1] 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.

Healthy Opportunities Pilots Fee Schedule		
Service Name	**Unit Of Service/Payment**	**Rate or Cap**
Home Accessibility and Safety Modifications	Cost-Based Reimbursement Up to A Cap	Up to $10,000 per lifetime of waiver demonstration[2]
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[3] (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

Diabetes Prevention Program	• Four classes (first phase)	• **Phase 1: $275.83**
		  • Completion of 4 classes: $27.38
		  • Completion of 4 additional classes (8 total): $54.77

[2] 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.

[3] 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**

	• Three classes (second phase)[4]	• 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[5]
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[6]

[4] 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 payed for in allocations so HSOs that participate in the Pilot are able to receive pro-rated payments as enrollees complete four classes.

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

[6] 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

Pilot Service Descriptions

Housing Services

Housing Navigation, Support and Sustaining Services

Category	Information
Service Name	Housing Navigation, Support and Sustaining Services

Service Description	Provision of one-to-one case management and/or educational services to prepare an enrollee for stable, long-term housing (e.g., identifying housing preferences and developing a housing support plan), and to support an enrollee in maintaining stable, long-term housing (e.g., development of independent living skills, ongoing monitoring and updating of housing support plan). Activities may include:
	Housing Navigation and Support
	• Assisting the enrollee to identify housing preferences and needs.
	• Connecting the enrollee to social services to help with finding housing necessary to support meeting medical care needs.
	• Assisting the enrollee to select adequate housing and complete a housing application, including by:
	  ○ Obtaining necessary personal documentation required for housing applications or programs;
	  ○ Supporting with background checks and other required paperwork associated with a housing application
	• Assisting the enrollee to develop a housing support and crisis plan to support living independently in their own home.
	• Assisting the enrollee to develop a housing stability plan and support the follow through and achievement of the goals defined in the plan.
	• Assisting to complete reasonable accommodation requests.

	• Identifying vendor(s) for and coordinating housing inspection, housing move-in, remediation and accessibility services.
	• Assisting with budgeting and providing financial counseling for housing/living expenses (including coordination of payment for first month's rent and short-term post hospitalization rental payments).
	• Providing financial literacy education and on budget basics and locating community based consumer credit counseling bureaus
	• Coordinating other Pilot housing-related services, including:
	  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 PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollees may not simultaneously receive the Housing Navigation, Support and Sustaining Services and the IPV Case Management Services. Individuals with co-occurring housing and IPV-related needs should receive the Holistic High Intensity Case Management service. • This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Inspection for Housing Safety and Quality

Category	Information
Service Name	Inspection for Housing Safety and Quality

Service Description	A housing safety and quality inspection by a certified professional includes assessment of potential home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Inspections may assess the habitability and/or environmental safety of an enrollee's current or future dwelling. Inspections may include:
	• Inspection of building interior and living spaces for the following:
	  ○ Adequate space for individual/family moving in;
	  ○ Suitable indoor air quality and ventilation;
	  ○ Adequate and safe water supply;
	  ○ Sanitary facilities, including kitchen, bathroom and living spaces
	  ○ Adequate electricity and thermal environment (e.g. window condition) and absence of electrical hazards;
	  ○ Potential lead exposure;
	  ○ Conditions that may affect health (e.g. presence of chemical irritants, dust, mold, pests);
	  ○ Conditions that may affect safety.
	• Inspection of building exterior and neighborhood for the following:
	  ○ Suitable neighborhood safety and building security;
	  ○ Condition of building foundation and exterior, including building accessibility; and,
	  ○ Condition of equipment for heating, cooling/ventilation and plumbing.
	
	Inspector must communicate inspection findings to the care or case manager working with the enrollee to ensure referrals to appropriate organizations for additional home remediation and/or modifications, if necessary.
	
	This service can cover Housing Quality Standards (HQS) inspections upon move-in to a new residence, or other inspections to identify sub-standard housing that impacts an enrollee's health and safety.
	
	This service covers failed inspections and re-inspections.
	
	Each housing inspection does not need to include all activities listed in this service description. Service providers should only execute the necessary components of a housing safety and quality inspection as required based on an enrollee's circumstances. Costs for services provided must be commensurate with a vendor's scope of activities.

Frequency *(if applicable)*	• Enrollees may receive ad hoc assessments to identify housing quality, accessibility and safety issues at time of indication as needed when that current housing may be adversely affecting health or safety.

	• Housing Quality Standards (HQS) inspections must occur at enrollee move-in to new place of residence if enrollee will receive "One-Time Payment for Security Deposit" and First Month's Rent or "Short Term Post Hospitalization Housing" services.
Duration *(if applicable)*	Approximately one hour.
Setting	Housing inspection should occur in the enrollee's current place of residence or potential residence.
Minimum Eligibility Criteria	• Inspections may be conducted for individuals who are moving into new housing units (e.g., HQS Inspection) or for individuals who are currently in housing that may be adversely affecting their health or safety. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Housing Move-In Support

Category	**Information**
Service Name	Housing Move-In Support

Service Description	Housing move-in support services are non-recurring set-up expenses. Allowable expenses include but are not limited to the following:
	• Moving expenses required to occupy and utilize the housing (e.g., moving service to transport an individual's belongings from current location to new housing/apartment unit, delivery of furniture, etc.)
	• Discrete goods to support an enrollee's transition to stable housing as part of this service. These may include, for example:
	  ○ Essential furnishings (e.g., mattresses and beds, dressers, dining table and chairs);
	  ○ Bedding (e.g., sheets, pillowcases and pillows);
	  ○ Basic kitchen utensils and dishes;
	  ○ Bathroom supplies (e.g., shower curtains and towels);
	  ○ Cribs;
	  ○ 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.
	  ○ 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[7] 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.

[7] 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/.

	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Essential Utility Set-Up

Category	Information
Service Name	Essential Utility Set-Up
Service Description	The Essential Utility Set Up service is a non-recurring payment to: • Provide non-refundable, utility set-up costs for utilities essential for habitable housing. • Resolve arrears related to unpaid utility bills and cover non-refundable utility set-up costs to restart the service if it has been discontinued in a Pilot enrollee's home, putting the individual at risk of homelessness or otherwise adversely impacting their health (e.g., in cases when medication must be stored in a refrigerator). This service may be used in association with essential home utilities that have been discontinued (e.g., initial payments to activate heating, electricity, water, and gas).
Frequency *(if applicable)*	Enrollees may receive this service at any point at which they meet service minimum eligibility criteria and have not reached the cap.
Duration *(if applicable)*	N/A
Setting	• An enrollee's home • Utility vendor's office
Minimum Eligibility Criteria	• Enrollee must require service either when moving into a new residence or because essential home utilities have been discontinued or were never activated at move-in and will adversely impact occupants' health if not restored. • Enrollee demonstrates a reasonable plan, created in coordination with care manager or case manager, to cover future, ongoing payments for utilities. • This Pilot service is furnished only to the extent that the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Home Remediation Services

Category	Information
Service Name	Home Remediation Services
Service Description	Evidence-based home remediation services are coordinated and furnished to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Home remediation services may

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

Home Accessibility and Safety Modifications

Category	**Information**
Service Name	Home Accessibility and Safety Modifications
Service Description	Evidence-based home accessibility and safety modifications are coordinated and furnished to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Home accessibility modifications are adjustments to homes that need to be made in order to allow for enrollee mobility, enable independent and safe living and accommodate medical equipment and supplies. Home modifications should improve the accessibility and safety of housing (e.g., installation of entrance ramps, hand-held shower controls, non-slip surfaces, grab bars in bathtubs, installation of locks and/or other security measures, and reparation of cracks in floor).
Frequency *(if applicable)*	Enrollees may receive home accessibility modifications at any point at which they meet minimum eligibility criteria and have not reached the cap.
Duration *(if applicable)*	N/A

Setting	Home accessibility and safety services will occur in the enrollee's current place of residence or potential residence.
Minimum Eligibility Criteria	• Enrollee must be moving into a new housing unit or must reside in a housing unit that is adversely affecting his/her health or safety. ○ The housing unit may be owned by the enrollee (so long as it is their primary place of residence) or rented. • Landlord has agreed to and provided signed consent for approved home accessibility or safety modifications prior to service delivery (if applicable). • Landlord has agreed to and provided signed consent to keep rent at current rate for a period of twenty-four months after approved home accessibility or safety modification prior to service delivery (if applicable). • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Healthy Home Goods

Category	**Information**
Service Name	Healthy Home Goods
Service Description	Healthy-related home goods are furnished to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Home-related goods that may be covered include, for example, discrete items related to reducing environmental triggers in the home (e.g., a "Breathe Easy at Home Kit" with EPA-vacuum, air filter, green cleaning supplies, hypoallergenic mattress or pillow covers and non-toxic pest control supplies). Healthy Home Goods do not alter the physical structure of an enrollee's housing unit.
Frequency *(if applicable)*	Enrollees may receive healthy home goods when there are health or safety issues adversely affecting their health or safety.
Duration *(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 PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

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

Category	Information
Service Name	One-Time Payment for Security Deposit and First Month's Rent
Service Description	Provision of a one-time payment for an enrollee's security deposit and first month's rent to secure affordable and safe housing that meet's the enrollee's needs. All units that enrollees move into through this Pilot service must: • Pass a Housing Quality Standards (HQS) inspection • Meet fair market rent and reasonableness check • Meet a debarment check For homeless enrollees, all services provided must align with a Housing First approach to increase access to housing, maximize housing stability and prevent returns to homelessness.
Frequency *(if applicable)*	Once per enrollee over the lifetime of the demonstration
Duration *(if applicable)*	N/A
Setting	N/A
Minimum Eligibility Criteria	• Enrollee must be receiving Housing Navigation, Support and Sustaining Services or Holistic High Intensity Enhanced Case Management. ○ Enrollees receiving services substantially similar to Housing Navigation, Supports and Sustaining Services through a different funding source (e.g. Medicaid State Plan, a 1915(c) waiver service, or Housing and Urban Development grant) may still receive this Pilot service if deemed eligible. The provider delivering the substantially similar service must coordinate with the enrollee's Medicaid care manager (if applicable) to determine the necessity of the Pilot service and ensure appropriate documentation in the enrollee's care plan. • Enrollee must receive assistance with developing a reasonable plan to address future ability to pay rent through a housing stability plan. • Housing unit must pass a Housing Quality Standards (HQS) inspection prior to move-in or, in certain circumstances, a habitability inspection performed by the case manager or other staff. If a habitability inspection is performed, an HQS inspection must be scheduled immediately following move-in. • Landlord must be willing to enter into a lease agreement that maintains a satisfactory dwelling for the enrollee throughout the duration of the lease, unless there are appropriate and fair grounds for eviction. • This pilot service is provided only to the extent that the enrollee is unable to meet such expense or when the services cannot be obtained from other sources.

	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Short-Term Post Hospitalization Housing

Category	Information
Service Name	Short-Term Post Hospitalization Housing
Service Description	Post-hospitalization housing for short-term period, not to exceed six [6] months, due to individual's imminent homelessness at discharge from inpatient hospitalization. Housing should provide enrollees with a safe space to recuperate and perform activities of daily living while receiving ongoing medical care as needed and will be limited to housing in a private or shared housing unit. Short-Term Post Hospitalization Housing setting should promote independent living and transition to a permanent housing solution. Services may not be provided in a congregate setting, as defined by the Department. Allowable units for short-term post-hospitalization housing must provide the following for enrollees: • Access to a clean, healthy environment that allows enrollees to perform activities of daily living; • Access to a private or semi-private, independent room with a personal bed for the entire day; • Ability to receive onsite or easily accessible medical and case management services, as needed. Coordination of this service should begin prior to hospital discharge by a medical professional or care team member. 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 must be willing to enter into a lease agreement that maintains a satisfactory dwelling for the enrollee throughout the duration of the lease, unless there are appropriate and fair grounds for eviction. • This Pilot service is provided only to the extent that the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Interpersonal Violence / Toxic Stress Services

IPV Case Management Services

Category	Information
Service Name	IPV Case Management Services
Service Description	This service covers a set of activities that aim to support an individual in addressing sequelae of an abusive relationship. These activities may include: • Ongoing safety planning/management • Assistance with transition-related needs, including activities such as obtaining a new phone number, updating mailing addresses, school arrangements to minimize disruption of school schedule

	• Linkages to child care and after-school programs and community engagement activities • Linkages to community-based social service and mental health agencies with IPV experience, including trauma-informed mental health services for family members affected by domestic violence, including witnessing domestic violence • Referral to legal support to address needs such as obtaining orders of protection, negotiating child custody agreements, or removing legal barriers to obtaining new housing (excluding legal representation) • Referral to and provision of domestic violence shelter or emergency shelter, if safe and appropriate permanent housing is not immediately available, or, in lieu of shelter, activities to ensure safety in own home • Coordination with a housing service provider if additional expertise is required • Coordination of transportation for the enrollee that is necessary to meet the goals of the IPV Case Management service • Informal or peer counseling and advocacy related to enrollees' needs and concerns. These may include accompanying the recipient to appointments, providing support during periods of anxiety or emotional distress, or encouraging constructive parenting activities and self-care. Activities listed above may occur without the Pilot enrollee present. The HSO has the option to partner with other organizations to ensure it is able to provide all activities described as part of this service. If desired by the HSO, the Lead Pilot Entity can facilitate partnerships of this kind.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	Service duration would persist until services are no longer needed as determined in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	Various settings are appropriate, including at a shelter, home of the enrollee or home of friend or relative, supportive housing, clinical or hospital setting, enrollee's residence, HSO site, or other community setting deemed safe and sufficiently private but accessible to the enrollee.
Minimum Eligibility Criteria	• Enrollee requires ongoing engagement.[8] • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan.

[8] 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.

	• 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. Peer Support Specialists are expected to conduct regular outreach to their mentees, to maintain situational awareness of their mentees' milieu, and to travel to conflict scenes where their mentees may be involved in order to provide in-person de-escalation support. Activities listed above may occur without the Pilot enrollee present. The service should be informed by an evidence-based program such as (but not limited to) Cure Violence.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	Service duration would persist until services are no longer needed as determined in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.

Setting	Various settings are appropriate, including at an individual's home, school, HSO site, or other community setting deemed safe and sufficiently private but accessible to the enrollee.
Minimum Eligibility Criteria	• Individual must have experienced violent injury or be determined as at risk for experiencing significant violence by a case manager or by violence intervention prevention program staff members (with case manager concurrence) • Individual must be community-dwelling (i.e., not incarcerated). • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Evidence-Based Parenting Curriculum

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

Category	**Information**
Service Name	Evidence-Based Parenting Classes
Service Description	Evidence-based parenting curricula are meant to provide: • Group and one-on-one instruction from a trained facilitator • Written and audiovisual materials to support learning • Additional services to promote attendance and focus during classes Evidence-based parenting classes are offered to families that may be at risk of disruption due to parental stress or difficulty coping with parenting challenges, or child behavioral or health issues. These services are also appropriate for newly reunited families following foster care/out of home placement or parental incarceration. This service description outlines one approved curriculum: Incredible Years (Parent) – Preschool/School. This service should be delivered in a trauma-informed, developmentally appropriate, and culturally relevant manner.
Frequency *(if applicable)*	N/A
Duration *(if applicable)*	18-20 sessions, typically lasting 2-2.5 hours each.
Setting	Services may be provided in a classroom setting or may involve limited visits to recipients' homes.
Minimum Eligibility Criteria	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Home Visiting Services

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

Category	Information
Service Name	Home Visiting Services
Service Description	Home Visiting services are meant to provide: • One-one observation, instruction and support from a trained case manager who may be a licensed clinician • Written and/or audiovisual materials to support learning Evidence-based home visiting services are offered to families that may be at risk of disruption due to parental stress or difficulty coping with parenting challenges, or child behavioral or health issues. These services are also appropriate for newly reunited families following foster care/out of home placement or parental incarceration. This service description outlines one approved curriculum: Parents As Teachers. This service should be delivered in a trauma-informed, developmentally appropriate, and culturally relevant manner.
Frequency *(if applicable)*	N/A
Duration *(if applicable)*	• Families with one or no high-needs characteristics should get at least 12 home visits annually • Families with two or more high-needs characteristics should receive at least 24 home visits annually • Home visits last approximately 60 minutes • Home visits provided beyond 6 months are is contingent on determination of continued Pilot eligibility
Setting	Various settings are appropriate, including at an individual's home, school, HSO site, or other community setting deemed safe and sufficiently private but accessible to the enrollee.
Minimum Eligibility Criteria	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Dyadic Therapy Services

Category	Information
Service Name	Dyadic Therapy Services

Service Description	This service covers the delivery of dyadic therapy to benefit a child/adolescent at risk for or with an attachment disorder, a behavioral or conduct disorder, a mood disorder, an obsessive-compulsive disorder, post-traumatic stress disorder, or as a diagnostic tool to assess for the presence of these disorders. This service only covers therapy provided to the parent or caregiver of a Pilot enrolled child to address the parent's or caregiver's behavioral health challenges that are negatively contributing to the child's well-being. This is not a group-based therapy. Sessions are limited to the parent(s) or caregiver(s) of the child/adolescent. Treatments are based on evidence-based therapeutic principles (for example, trauma-focused cognitive-behavioral therapy). When appropriate, the Pilot enrolled child should but is not required to receive Medicaid-covered behavioral health or dyadic therapy services as a complement to this Pilot service. This service aims to support families in addressing the sequelae of adverse childhood experiences and toxic stress that may contribute to adverse health outcomes.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	As needed, contingent on determination of continued Pilot eligibility
Setting	Services may be delivered in a range of locations, including but not limited to at a provider's location or in the recipient's home.
Minimum Eligibility Criteria	• The covered individual is 21 years old or younger • The parent or caregiver recipient of this service cannot be eligible to receive this service as a Medicaid covered service. • The covered individual is at risk for or has a disorder listed above that can be addressed through dyadic therapy directed at the covered individual's parent or caregiver, delivered together or separately, that is not otherwise covered under Medicaid. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded program.

Food Services

Food and Nutrition Access Case Management Services

Category	Information
Service Name	Food and Nutrition Access Case Management Services
Service Description	Provision of one-on-one case management and/or educational services to assist an enrollee in addressing food insecurity. Activities may include: • Assisting an individual in accessing school meals or summer lunch programs, including but not limited to:

	○ Helping to identify programs for which the individual is eligible ○ Helping to fill out and track applications ○ Working with child's school guidance counselor or other staff to arrange services • Assisting an individual in accessing other community-based food and nutrition resources, such as food pantries, farmers market voucher programs, cooking classes, Child and Adult Care Food programs, or other, including but not limited to: ○ Helping to identify resources that are accessible and appropriate for the individual ○ Accompanying individual to community sites to ensure resources are accessed • Advising enrollee on transportation-related barriers to accessing community food resources It is the Department's expectation that Medicaid care managers will assist all eligible individuals to enroll in SNAP and WIC and secure their enrollment through existing SNAP and WIC assistance resources. Food and Nutrition Access Case Managers will address more complex and specialized needs. However, if under exceptional circumstances a Food and Nutrition Access Case Manager identifies an individual for whom all other forms of assistance have been ineffective, they are permitted to assist the individual with completing enrollment, including activities such as addressing documentation challenges or contacting staff at a local SNAP or WIC agency to resolve issues, or otherwise.
Frequency *(if applicable)*	Ad hoc sessions as needed. It is estimated that on average individuals will not receive more than two to three sessions with a case manager.
Duration *(if applicable)*	N/A
Setting	• May be offered: ○ At a community setting (e.g. community center, health care clinic, Federally Qualified Health Center (FQHC), food pantry, food bank) ○ At an enrollee's home (for home-bound individuals) ○ Via telephone or other modes of direct communication
Minimum Eligibility Criteria	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Evidence-Based Group Nutrition Class

Category	Information
Service Name	Evidence-Based Group Nutrition Class
Service Description	This service covers the provision of an evidence-based or evidence-informed nutrition related course to a group of individuals. The purpose of the course is to provide hands-on, interactive lessons to enrollees, on topics including but not limited to: • Increasing fruit and vegetable consumption • Preparing healthy, balanced meals • Growing food in a garden • Stretching food dollars and maximizing food resources Facilitators may choose from evidence-based curricula, such as: • Cooking Matters (for Kids, Teens, Adults)[9] • A Taste of African Heritage (for Kids, Adults) [10] For curricula not outlined above, an organization must follow an evidence-based curricula that is approved by DHHS, in consultation with the Lead Pilot Entity and PHPs.
Frequency *(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. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

[9] More information on Cooking Matters available at: http://cookingmatters.org/node/2215

[10] More information on A Taste Of African Heritage available at: https://oldwayspt.org/programs/african-heritage-health/atoah-community-cooking-classes

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.[11]
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"[12]
	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan.
	• Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Fruit and Vegetable Prescription

Category	Information
Service Name	Fruit and Vegetable Prescription

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

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

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 the provision of services are included.
Frequency *(if applicable)*	One voucher per enrollee. Each voucher will have a duration as defined by the HSO providing it. For example, some HSOs may offer a monthly voucher while others may offer a weekly voucher.
Duration *(if applicable)*	6 months (on average), contingent on determination of continued Pilot eligibility
Setting	Enrollees spend vouchers at food retailers. Human service organizations administer and coordinate the service in a variety of settings: engaging with enrollees in the community (e.g. health care and community-based settings) to explain the service, administering food retailer reimbursements and other administrative functions from their office, and potentially meeting with food retailers in the field.
Minimum Eligibility Criteria	• Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high risk pregnancy. • If potentially eligible for SNAP and/or WIC, the enrollee must either: ○ Be enrolled in SNAP and/or WIC, or ○ Have submitted a SNAP and/or WIC application within the last 2 months, or ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Healthy Food Box (For Pick-Up)

Category	Information
Service Name	Healthy Food Box (For Pick-Up)

Service Description	A healthy food box for pick-up consists of an assortment of nutritious foods provided to an enrollee in a community setting, aimed at promoting improved nutrition for the service recipient. It is designed to supplement the daily food needs for food-insecure individuals with diet or nutrition-related chronic illness. This service does not constitute a full nutritional regimen (three meals per day per person). Healthy food boxes should be furnished using a client choice model when possible and should be provided alongside nutrition education materials related to topics including but not limited to healthy eating and cooking instructions.
Frequency *(if applicable)*	Typically weekly
Duration *(if applicable)*	On average, this service is delivered for 3 months. Service would continue until services are no longer needed as indicated in an individual's person-centered care plan.
Setting	• Food is sourced and warehoused by a central food bank, and then delivered to community settings by the food bank. • Food is offered for pick-up by the enrollee in a community setting, for example at a food pantry, community center, or a health clinic.
Minimum Eligibility Criteria	• Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high risk pregnancy. • If potentially eligible for SNAP and/or WIC, the enrollee must either: ○ Be enrolled in SNAP and/or WIC, or ○ Have submitted a SNAP and/or WIC application within the last 2 months, or ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Healthy Food Box (Delivered)

Category	**Information**
Service Name	Healthy Food Box (Home Delivered)
Service Description	A healthy food box for delivery consists of an assortment of nutritious foods that is delivered to an enrollee's home, aimed at promoting improved nutrition for the service recipient. It is designed to supplement the daily food needs for food-insecure individuals

	with diet or nutrition-related chronic illness. This service does not constitute a full nutritional regimen (three meals per day per person). Healthy food boxes should be provided alongside nutrition education materials related to topics including but not limited to healthy eating and cooking instructions.
Frequency *(if applicable)*	Typically weekly
Duration *(if applicable)*	On average, this service is delivered for 3 months. Service would continue until services are no longer needed as indicated in an individual's person-centered care plan.
Setting	• Food is sourced and warehoused by a central food bank. • Food boxes are delivered to enrollee's home.
Minimum Eligibility Criteria	• Enrollee does not have capacity to shop for self or get to food distribution site or have adequate social support to meet these needs. • Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high risk pregnancy. • If potentially eligible for SNAP and/or WIC, the enrollee must either: ○ Be enrolled in SNAP and/or WIC, or ○ Have submitted a SNAP and/or WIC application within the last 2 months, or ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months • • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan.

Healthy Meal (For Pick-Up)

Category	Information
Service Name	Healthy Meal (For Pick-Up)
Service Description	A healthy meal for pick-up consists of a frozen or shelf stable meal that is provided to an enrollee in a community setting, aimed at promoting improved nutrition for the service recipient. This service includes preparation and dissemination of the meal. Meals must provide at least one-third of the recommended Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National

	Academy of Sciences,[13] and adhere to the current Dietary Guidelines for Americans, issued by the Secretaries of the U.S. Department of Health and Human Services and the U.S. Department of Agriculture.[14] 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 2 months, or ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Healthy Meal (Home Delivered)

Category	Information
Service Name	Healthy Meal (Home Delivered)

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

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

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,[15] and adhere to the current Dietary Guidelines for Americans, issued by the Secretaries of the U.S. Department of Health and Human Services and the U.S. Department of Agriculture.[16] Meals may be tailored to meet cultural preferences and specific medical needs. This service does not constitute a full nutritional regimen (three meals per day per person).
Frequency *(if applicable)*	Meal delivery services for enrollees requiring this service will differ based on the severity of the individual's needs. On average, individuals receive 2 meals per day (or 14 meals per week).
Duration *(if applicable)*	Service would continue until services are no longer needed as indicated in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	Meals are delivered to enrollee's home.

Minimum Eligibility Criteria	• Enrollee does not have capacity to shop and cook for self or have adequate social support to meet these needs.
	• Enrollee has a diet or nutrition-related chronic illness, including but not limited to underweight, overweight/obesity, nutritional deficiencies, prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high risk pregnancy.
	• If potentially eligible for SNAP and/or WIC, the enrollee must either:
	  ○ Be enrolled in SNAP and/or WIC, or
	  ○ Have submitted a SNAP and/or WIC application within the last 2 months, or
	  ○ Have been determined ineligible for SNAP and/or WIC within the past 12 months
	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan.
	• This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service.
	• Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Medically Tailored Home Delivered Meal

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

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

Category	Information
Service Name	Medically Tailored Home Delivered Meal
Service Description	Home delivered meal which is medically tailored for a specific disease or condition. This service includes an initial evaluation with a Registered Dietitian Nutritionist (RD/RDN) or Licensed Dietitian Nutritionist (LDN) to assess and develop a medically-appropriate nutrition care plan, the preparation and delivery of the prescribed nutrition care regimen, and regular reassessment at least once every 3 months. Meals must be in accordance with nutritional guidelines established by the National Food Is Medicine Coalition (FIMC) or other appropriate guidelines.[17] Meals may be tailored to meet cultural preferences. For health conditions not outlined in the Food Is Medicine Coalition standards above, an organization must follow a widely recognized nutrition guideline approved by the LPE. This service does not constitute a full nutritional regimen (three meals per day per person).
Frequency *(if applicable)*	Meal delivery services for enrollees requiring this service will differ based on the severity of the individual's needs. On average, individuals receive 2 meals per day (or 14 meals per week).
Duration *(if applicable)*	Service would continue until services are no longer needed as indicated in an individual's person-centered care plan, contingent on determination of continued Pilot eligibility.
Setting	• Nutrition assessment is conducted in person, in a clinic environment, the enrollee's home, or telephonically as appropriate. • Meals are delivered to enrollee's home.

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

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

	• Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Transportation Services

Reimbursement for Health-Related Public Transportation

Category	Information
Service Name	Reimbursement for Health-Related Public Transportation
Service Description	Provision of health-related transportation for qualifying Pilot enrollees through vouchers for public transportation. This service may be furnished to transport Pilot enrollees to non-medical services that promote community engagement, health and well-being. The service may include transportation to locations indicated in an enrollee's care plan that may include, for example: • Grocery stores/farmer's markets; • Job interview(s) and/or place of work; • Places for recreation related to health and wellness (e.g., public parks and/or gyms); • Group parenting classes/childcare locations; • Health and wellness-related educational events; • Places of worship, services and other meetings for community support; • Locations where other approved Pilot services are delivered. Pilot transportation services will not replace non-emergency medical transportation as required in Medicaid.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	N/A
Setting	N/A
Minimum Eligibility Criteria	• Family, neighbors and friends are unable to assist with transportation • Public transportation is available in the enrollee's community. • Service is only available for enrollees who do not have access to their own or a family vehicle. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Reimbursement for Health-Related Private Transportation

Category	Information
Service Name	Reimbursement for Health-Related Private Transportation
Service Description	Provision of private health-related transportation for qualifying Pilot enrollees through one or more of the following services: • Community transportation options (e.g., local organization that organizes and provides transportation on a volunteer or paid basis) • Direct transportation by a professional, private or semi-private transportation vendor (e.g., shuttle bus company or privately operated wheelchair-accessible transport)[18] • Account credits for taxis or ridesharing mobile applications for transportation Private transportation services may be utilized in areas where public transportation is not an available and/or not an efficient option (e.g., in rural areas). The following services may be deemed allowable, cost-effective alternatives to private transportation by a Pilot enrollee's Prepaid Health Plan (PHP):[19] • Repairs to an enrollee's vehicle • Reimbursement for gas mileage, in accordance with North Carolina's Non-Emergency Medical Transportation clinical policy[20] 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;

[18] 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.

[19] 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.

[20] 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.

	• Health and wellness-related educational events; • Places of worship, services and other meetings for community support; • Locations where other approved Pilot services are delivered. Pilot transportation services will not replace non-emergency medical transportation as required in Medicaid.
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	N/A
Setting	N/A
Minimum Eligibility Criteria	• Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Transportation PMPM Add-On for Case Management Services

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

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

Cross-Domain Services

Holistic High Intensity Enhanced Case Management

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

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

Medical Respite

Category	**Information**
Service Name	Medical Respite Care
Service Description	A short-term, specialized program focused on individuals who are homeless or imminently homeless, have recently been discharged from a hospital setting and require continuous access to medical care. Medical respite services include comprehensive residential care that provides the enrollee the opportunity to rest in a stable setting while enabling access to hospital, medical, and social services that assist in completing their recuperation. Medical respite provides a stable setting and certain services for individuals who are too ill or frail to recover from a physical illness/injury while living in a place not suitable for human habitation, but are not ill enough to be in a hospital. Medical respite services should include, at a minimum: **Short-Term Post-Hospitalization Housing:**

	Post-hospitalization housing for short-term period, not to exceed six [6] months, due to individual's imminent homelessness at discharge. Housing should provide enrollees with a safe space to recuperate and perform activities of daily living while receiving ongoing medical care as needed and will be limited to housing in a private or shared housing unit. Short-Term Post Hospitalization Housing setting should promote independent living and transition to a permanent housing solution. Services may not be provided in a congregate setting, as defined by the Department. Allowable units for short-term post-hospitalization housing must provide the following for enrollees: • Access to a clean, healthy environment that allows enrollees to perform activities of daily living; • Access to a private or semi-private, independent room with a personal bed for the entire day; • Ability to receive onsite or easily accessible medical and case management services, as needed. Coordination of this service should begin prior to hospital discharge by a medical professional or team member. The referral to medical respite should come from a member of the individual's care team. For homeless enrollees, all services provided must align with a Housing First approach to increase access to housing, maximize housing stability and prevent returns to homelessness. **Medically Tailored Meal *(delivered to residential setting)*** Home delivered meal which is medically tailored for a specific disease or condition. This service includes an initial evaluation with a Registered Dietitian Nutritionist (RD/RDN) or Licensed Dietitian Nutritionist (LDN) to assess and develop a medically-appropriate nutrition care plan, as well as the preparation and delivery of the prescribed nutrition care regimen. Meals must be in accordance with nutritional guidelines established by the National Food Is Medicine Coalition (FIMC) or other appropriate guidelines.[21] 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

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

	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 PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Linkages to Health-Related Legal Supports

Category	Information
Service Name	Linkages to Health-Related Legal Supports
Service Description	This service will assist enrollees with a specific matter with legal implications that influences their ability to secure and/or maintain healthy and safe housing and mitigate

	or eliminate exposure to interpersonal violence or toxic stress. This service may cover, for example: • Assessing an enrollee to identify legal issues that, if addressed, could help to secure or maintain healthy and safe housing and mitigate or eliminate exposure to interpersonal violence or toxic stress, including by reviewing information such as specific facts, documents (e.g., leases, notices, and letters), laws, and programmatic rules relevant to an enrollee's current or potential legal problem; • Helping enrollees understand their legal rights related to maintaining healthy and safe housing and mitigating or eliminating exposure to interpersonal violence or toxic stress (e.g., explaining rights related to landlord/tenant disputes, explaining the purpose of an order of protection and the process for obtaining one); • Identifying potential legal options, resources, tools and strategies that may help an enrollee to secure or maintain healthy and safe housing and mitigate or eliminate exposure to interpersonal violence or toxic stress (e.g., providing self-advocacy instructions, removing a former partner's debts from credit rating); • Providing advice to enrollees about relevant laws and course(s) of action and, as appropriate, helping an enrollee prepare "pro se" (without counsel) documents. This service is meant to address the needs of an individual who requires legal expertise, as opposed to the more general support that can be offered by a care manager, case manager or peer advocate. The care manager or case manager coordinating this service must clearly identify the scope of the authorized health-related legal support within the enrollee's care plan. This service is limited to providing advice and counsel to enrollees and does not include "legal representation," such as making contact with or negotiating with an enrollee's potential adverse party (e.g., landlord, abuser, creditor, or employer) or representing an enrollee in litigation, administrative proceedings, or alternative dispute proceedings. After issues are identified and potential strategies reviewed with an enrollee, the service provider is expected to connect the enrollee to an organization or individual that can provide legal representation and/or additional legal support with non-Pilot resources.
Frequency *(if applicable)*	As needed when minimum eligibility criteria are met
Duration *(if applicable)*	Services are provided in short sessions that generally total no more than 10 hours.

Setting	Various settings are appropriate. Services described above may be provided via telephone or other modes of direct communication (with or without the Pilot enrollee present) or in person, as appropriate, including, for example, the home of the enrollee, another HSO site, or other places convenient to the enrollee.
Minimum Eligibility Criteria	• Service does not cover legal representation. • Services are authorized in accordance with PHP authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • The enrollee's Medicaid care manager or HSO case manager is responsible for clearly defining the scope of the authorized health-related legal support services. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

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