

Pilot Eligibility Service Assessment (PESA) Companion Guide

This document is meant to serve as a companion guide to, and a resource for, completing the Pilot Eligibility Service Assessment (PESA). The Department recommends that individual(s) completing the PESA reference this guidance document when completing the physical/behavioral health needs, social needs and Pilot service selection portions of the PESA.

Section A: Physical or Behavioral Health Needs Definitions

Section A provides information on how North Carolina defines Pilot-qualifying physical or behavioral health needs by Pilot eligibility category. This information will support decision-making in choosing the right Pilot-qualifying physical/behavioral health risk factor that best matches the member's health status. Individual(s) completing the PESA should use their best judgment when choosing appropriate physical/behavioral risk factors based on the information available to them.

Pregnant Women

Less than one year since last delivery: enrollee has given birth within the last 12 months

History of poor birth outcome during previous pregnancy: includes preterm birth (baby is born before 36 weeks of pregnancy), low birth weight (less than 2500 grams or 5 pounds, 8 ounces at birth), fetal death (spontaneous death of a fetus at any time during pregnancy), neonatal death (baby died during the first 28 days of life)

Multifetal gestation: pregnant with twins, triplets, etc.

Chronic condition likely to complicate pregnancy: this includes but is not limited to hypertension and mental illness

Current or recent (month prior to learning of pregnancy) use of drugs or heavy alcohol: use of drugs or heavy alcohol, considered 8 drinks or more per week

Adolescent less than or equal to 15 years of age: member is 15 years of age or younger

Advanced maternal age: member is 40 years of age or older

Experiencing or previously experienced three or more categories of adverse childhood experiences: the member is experiencing or previously experienced traumatic childhood events for example psychological, physical, or sexual abuse, or household dysfunction related to substance abuse, mental illness, parental violence, or criminal behavior in household

Enrolled or formerly enrolled in North Carolina's foster care or kinship placement system: the member is enrolled or was previously enrolled in foster care or kinship placement system. Kinship placement means the member is placed with close relatives rather than an unrelated caregiver

Children Ages 0 – 3

Neonatal intensive care unit (NICU) graduate: infants that spend time in the NICU after birth and are ultimately discharged to their caregiver

Neonatal Abstinence Syndrome: infant experiencing withdrawal from certain drugs they have been exposed to in the womb before birth

Prematurity: births that occur at or before 36 completed weeks gestation

Low birth weight: weighing less than 2500 grams or 5 pounds 8 ounces upon birth

Positive maternal depression screen at an infant well-visit: receiving a positive screen for maternal depression during a screening at an infant well-visit

One or more significant uncontrolled or controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need, including: asthma, diabetes, underweight or overweight/obesity (BMI of <5th or >85th percentile for age & gender), developmental delay (for example autism, Down syndrome, cerebral palsy, etc.), cognitive impairment, substance use disorder, behavioral/mental health diagnosis attention deficit/hyperactivity disorder, and learning disorders (for example dyslexia, attention deficit hyperactivity disorder, etc.)

Experiencing or previously experienced three or more categories of adverse childhood experiences: the member is experiencing or previously experienced traumatic childhood events for example psychological, physical, or sexual abuse, or household dysfunction related to substance abuse, mental illness, parental violence, or criminal behavior in household

Enrolled or formerly enrolled in North Carolina's foster care or kinship placement system: the member is enrolled or was previously enrolled in foster care or kinship placement system, meaning member is placed with close relatives rather than an unrelated caregiver

Children Ages 4 – 20

One or more significant uncontrolled or controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need, including: asthma, diabetes, underweight or overweight/obesity (BMI of <5th or >85th percentile for age & gender), developmental delay (for example autism, Down syndrome, cerebral palsy, etc.), cognitive impairment, substance use disorder, behavioral/mental health diagnosis attention deficit/hyperactivity disorder, and learning disorders (for example dyslexia, attention deficit hyperactivity disorder, etc.)

Experiencing or previously experienced three or more categories of adverse childhood experiences: the member is experiencing or previously experienced traumatic childhood events for example psychological, physical, or sexual abuse, or household dysfunction related to substance abuse, mental illness, parental violence, or criminal behavior in household

Enrolled or formerly enrolled in North Carolina's foster care or kinship placement system: the member is enrolled or was previously enrolled in foster care or kinship placement system, meaning member is placed with close relatives rather than an unrelated caregiver

Adults (21+)

Chronic Conditions (for adults): conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living. See below for examples of Pilot-qualifying conditions for members 21+. This is not intended to serve as an exhaustive list, but provides the care manager with additional guidance when identifying Pilot-qualifying chronic conditions.

- **Autoimmune disorders:** examples include, but are not limited to rheumatoid arthritis, lupus, Crohn's disease, celiac disease, psoriasis and scleroderma
- **BMI Over 25:** body Mass Index (BMI) is a person's weight in pounds divided by the square of height in feet
- **Blindness:** the state or condition of being unable to see because of injury, disease, or a congenital condition
- **Cancer:** examples include breast cancer, prostate cancer, lung cancer, pancreatic cancer

- **Chronic cardiovascular disease:** examples include heart disease such as coronary artery disease, and arrhythmias and sequelae of cardiovascular disease such as stroke and congestive heart failure
- **Chronic pulmonary disease:** examples include COPD, emphysema, chronic bronchitis
- **Congenital anomalies:** examples include birth defects or congenital disorders; heart defects, neural tube defects and Down syndrome
- **Chronic disease of the alimentary system:** examples include gastroesophageal reflux disease, irritable bowel syndrome, and hiatal hernia
- **Substance use disorder:** a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications
- **Chronic endocrine conditions:** examples include diabetes, Cushing's disease and hyperthyroidism/hypothyroidism
- **Cognitive conditions:** examples include dementia, intellectual and developmental disabilities, ADHD, and traumatic brain injury
- **Chronic liver disease:** examples include alcoholic liver disease, hepatitis B and C, and hemochromatosis
- **Chronic renal failure (kidney disease):** examples include glomerulonephritis and polycystic kidney disease
- **Chronic musculoskeletal conditions:** examples include arthritis and osteoporosis
- **Chronic mental illness:** examples include depression, anxiety disorders, bipolar disorder
- **Chronic neurological disease:** examples include Alzheimer's, Parkinson's, ALS/Lou Gehrig's, multiple sclerosis
- **Chronic infectious disease:** examples include infection with human immunodeficiency virus (HIV) and tuberculosis (TB)

Five or more emergency department visits or hospital admissions in the last year: during the past 12 months the member has gone to the hospital emergency department and/or been admitted to the hospital five or more times.

Previously experienced three or more categories of adverse childhood experiences: the member is experiencing or previously experienced traumatic childhood events for example psychological, physical, or sexual abuse, or household dysfunction related to substance abuse, mental illness, parental violence, or criminal behavior in household

Formerly enrolled in North Carolina's foster care or kinship placement system: the member was previously enrolled in foster care or kinship placement system (kinship placement means member is placed with close relatives rather than an unrelated caregiver)

Section B: Social Needs

Section B provides information on how North Carolina defines Pilot-qualifying social needs. This information will support decision-making in choosing the right Pilot-qualifying social need(s) that best match the member's experience. Individual(s) completing the PESA should use their best judgment when selecting a social risk factor based on the information available to them and on conversations with the member.

Social Needs	Criteria
Food	The member meets the social risk factor criteria for food if they attest to one or more of the following:

	<ul style="list-style-type: none"> • Member does not have access to sufficient food/food of adequate quality • Member is experiencing reduced food quality, variety, reduced food intake and/or disrupted eating patterns (e.g., parents with enough food to feed their children but who do not have enough food themselves) • Member is worried their food will run out and they will be unable to get more
Housing	<p>The member meets the social risk factor criteria for housing if they attest to one or more of the following:</p> <ul style="list-style-type: none"> • Member is at risk of losing their housing (e.g., is at risk of being evicted, has insufficient resources to attain or maintain stable housing, is living in an overcrowded environment, spending the bulk of household resources on housing, has moved frequently because of economic reasons, etc.) or is currently homeless • Member has stayed outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else’s home (e.g., couch surfing) in the last 12 months • Member has been unable to get utilities such as water, electricity, heat, gas, etc. • Member’s home is unsafe and or adversely affecting their health (e.g., mold or pests are present; ramps or grip bars are not present, but are necessary to safely live in the home)
Transportation	<p>The member meets the social risk factor criteria for transportation if they attest to one or more of the following:</p> <ul style="list-style-type: none"> • Member indicates that lack of transportation has kept member from essential activities of daily living (e.g., going to the grocery store, work, childcare, school, etc.)
Interpersonal Violence/Toxic Stress	<p>The member meets the social risk factor criteria for interpersonal violence and toxic stress if they attest to one or more of the following:</p> <ul style="list-style-type: none"> • Member feels physically or emotionally unsafe where they currently live • Member has been hit, slapped, kicked, physically hurt by anyone, been humiliated or emotionally abused by anyone in last 12 months. • Member reports experiencing adverse childhood experiences, parental stress, difficulty coping with parenting challenges, child behavioral or health issues, or other factors that contribute to and/or exacerbate toxic stress

Section C: High-Level Descriptions of Pilot Services and Service-Specific Eligibility Criteria

The section below is intended to provide individual(s) completing the PESA with a quick reference guide for service-specific eligibility criteria. Individual(s) completing the PESA should refer to the [Pilot Fee Schedule](#) for full service descriptions and detailed service-specific eligibility criteria.

Pilot services that are high-value, low-cost are eligible as Passthrough Services, which are select Pilot services that Pilot Enrollees may be referred to for a 30-day period without prior Health Plan authorization. Health Plan authorization is required to extend coverage of these services beyond the initial 30-day period. If a service is offered as both a passthrough and non-passthrough service, the

recommendation is that the member be referred to the passthrough version of the service first, and then the non-passthrough version of the service if additional services are needed beyond 30 days.

All services have the following minimum eligibility criteria. See table below for additional service specific minimum eligibility criteria.

- Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.
- Services are or will be indicated in the enrollee's person-centered care plan.

Service Name	Service Description	Minimum Eligibility Criteria	Service Frequency/Duration
Housing Services			
Housing Navigation, Support and Sustaining Services	One-on-one case management or educational services to prepare an enrollee for stable, long-term housing and to support enrollee in maintaining stable, long-term housing	<ul style="list-style-type: none"> • 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. • 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 Pilot services or eligible for substantially similar Medicaid-covered service. 	<ul style="list-style-type: none"> • Frequency: as needed • Duration: 6 – 18 months (on average) but services may persist until services are no longer needed
Inspection for Housing Safety and Quality	A housing safety and quality inspection by a certified professional includes assessment of potential home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety	<ul style="list-style-type: none"> • Enrollees must be receiving at least one of the following Pilot services in order to be eligible for this service: Housing Navigation, Support and Sustaining Services, Home Remediation Services, Home Accessibility and Safety Modifications, 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 • Enrollee is not currently eligible for substantially similar Medicaid covered service. 	<ul style="list-style-type: none"> • Frequency: enrollees may receive ad hoc assessments 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

			<p>First Month's Rent or "Short Term Post Hospitalization Housing" services.</p> <ul style="list-style-type: none"> • Duration: 1 hour
Housing Move-In Support	Provision of expenses for moving-related costs and essential goods such as essential furnishings, beddings, kitchen appliances, crib, bathroom supplies, and cleaning supplies	<ul style="list-style-type: none"> • Enrollee must be receiving Housing Navigation, Support and Sustaining Services or Holistic High Intensity Enhanced Case Management. • Housing move-in support services are available for individuals who are moving into housing from homelessness 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. 	<ul style="list-style-type: none"> • Frequency: upon 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 • Duration: N/A

		<ul style="list-style-type: none"> • Enrollee is not currently eligible for substantially similar Medicaid-covered service. 	
Essential Utility Set-Up	A non-recurring payment to provide utility set-up costs for utilities essential for habitable housing and resolve unpaid bills related to unpaid utility costs and set-up	<ul style="list-style-type: none"> • Enrollee must require service either when moving into a new residence or because essential home utilities will be imminently discontinued, 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. • Enrollee is not currently eligible for substantially similar Medicaid-covered service. • 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. 	<ul style="list-style-type: none"> • Frequency: at any point at which enrollee meets service minimum eligibility criteria and have not reached the cap • Duration: N/A
Home Remediation Services	Coordinated and furnished services to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety including pest eradication, carpet or mold removal, installation of washable curtains or synthetic blinds to prevent allergens, or lead abatement	<ul style="list-style-type: none"> • 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 signed consent to have the approved home remediation services prior to service delivery. An enrollee who lives in a home where they do not pay rent (e.g., home 	<ul style="list-style-type: none"> • Frequency: at any point at which enrollee meets service minimum eligibility criteria and have not reached the cap • Duration: N/A

<p>Home Accessibility and Safety Modifications</p>	<p>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, nonslip surfaces, grab bars in bathtubs, installation of locks and/or other security measures, and reparation of cracks in floor)</p>	<p>owned by the enrollee or enrollee’s family member) would not be required to provide such written consent.</p> <ul style="list-style-type: none"> • 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 6 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. 	
<p>Healthy Home Goods</p>	<p>Furnished services to eliminate known home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety including discrete items related to reducing environmental triggers in the home such as “Breathe Easy at Home Kit” with EPA-vacuum, air filter, green cleaning supplies, hypoallergenic mattress or</p>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Frequency: when there are health or safety issues adversely affecting enrollee health or safety. • Duration: N/A

	pillow covers and non-toxic pest control supplies		
One-Time Payment for Security Deposit and First Month's Rent	One-time payment for an enrollee's security deposit and first month's rent to secure affordable and safe housing that meets the enrollee's needs	<ul style="list-style-type: none"> • Enrollee must be receiving Housing Navigation, Support and Sustaining Services or Holistic High Intensity Enhanced Case Management. • 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. 	<ul style="list-style-type: none"> • Frequency: N/A • Duration: N/A
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 from inpatient hospitalization	<ul style="list-style-type: none"> • Enrollee must be receiving Housing Navigation, Support and Sustaining Services or Holistic High Intensity Enhanced Case Management. • Enrollee is imminently homeless post-inpatient hospitalization. 	<ul style="list-style-type: none"> • Frequency: N/A • Duration: up to 6 months

		<ul style="list-style-type: none"> • 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. • Enrollee must receive assistance with developing a reasonable plan to address future ability to pay rent through a housing stability plan • 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 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. • Enrollee is not currently receiving duplicative support through other Pilot services. 	
Food Services			
Food and Nutrition Access Case Management Services	One-on-one case management and/or educational services to assist	<ul style="list-style-type: none"> • Enrollee is not currently receiving duplicative support through other Pilot services. 	<ul style="list-style-type: none"> • Frequency: ad hoc sessions as needed; it is estimated that on average individuals will not receive

	<p>an enrollee in addressing food insecurity</p> <p><i>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.</i></p>		<p>more than 2-3 sessions with a case manager</p> <ul style="list-style-type: none"> • Duration: N/A
Evidence-Based Group Nutrition Class	<p>Provision of an evidence-based or evidence-informed nutrition related course to a group of individuals 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</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Frequency: typically weekly • Duration: typically 6 weeks
Diabetes Prevention Program	<p>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</p>	<ul style="list-style-type: none"> • Enrollee must be: <ul style="list-style-type: none"> ○ 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 	<ul style="list-style-type: none"> • Frequency: minimum of 16 sessions in Phase I; minimum of 6 sessions in Phase II • Duration: typically 1 year

		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”	
Fruit and Vegetable Prescription	Food voucher to be used by an enrollee with a diet or nutrition-related chronic illness to purchase fruits and vegetables from a participating food retailer	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Frequency: 1 voucher per enrollee and each voucher will have a duration as defined by the HSO providing it Duration: 6 months (on average)
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 and designed to supplement the daily food needs for food-insecure individuals with diet or nutrition-related chronic illness	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Frequency: typically weekly Duration: 3 months (on average); service would continue until services are no longer needed
Healthy Food Box (Delivered)	Consists of an assortment of nutritious foods that is delivered to and enrollee’s home, aimed at promoting improved nutrition for the service recipient and designed to supplement the daily food needs for food-insecure individuals with diet	<ul style="list-style-type: none"> 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, 	<ul style="list-style-type: none"> Frequency: typically weekly Duration: 3 months (on average); service would continue until services are no longer needed

	or nutrition-related chronic illness	prediabetes/diabetes, hypertension, cardiovascular disease, gestational diabetes or history of gestational diabetes, history of low birth weight, or high-risk pregnancy.	
Healthy Meal (For Pick-Up)	A healthy meal for pick-up consists of a frozen or shelf stable meal that is provided to an enrollee in a community setting, aimed at promoting improved nutrition for the service recipient	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Frequency: frequency of meal services will differ based on the severity of the individual's needs • Duration: service would continue until services are no longer needed
Healthy Meal (Home Delivered)	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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Frequency: enrollees receive 2 meals per day (or 14 meals per week) but meal delivery services will differ based on the severity of the individual's needs • Duration: service would continue until services are no longer needed

		<ul style="list-style-type: none"> • Enrollee is not currently eligible for substantially similar Medicaid-covered service. 	
Medically Tailored Home Delivered Meal	Home delivered meal which is medically tailored for a specific disease or condition	<ul style="list-style-type: none"> • 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. • Enrollee is not currently receiving duplicative support through other Pilot services. 	<ul style="list-style-type: none"> • Frequency: enrollees receive 2 meals per day (or 14 meals per week) but meal delivery services will differ based on the severity of the individual's needs • Duration: service would continue until services are no longer needed.
Transportation Services			
Reimbursement for Health-Related Public Transportation	Provision of health-related transportation through vouchers for public transportation to transport Pilot enrollees to <i>non-medical</i> services that promote community engagement, health and	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Frequency: as needed • Duration: N/A

	<p>well-being, such as to a grocery store or gym</p> <p>NC Health Choice-enrolled members may also use this service for medical transportation (e.g., to a doctor’s office, pharmacy). However, Medicaid-enrolled members must use the Medicaid-covered service of Non-Emergency Medical Transportation (NEMT) for such purposes.</p>	<ul style="list-style-type: none"> • Enrollee is not currently receiving duplicative support through other Pilot services. 	
<p>Reimbursement for Health-Related Private Transportation</p>	<p>Provision of private health-related transportation through community transportation options (e.g., chartered community bus routes), private vendors, or account credits for taxis or ridesharing to transport Pilot enrollees to non-medical services that promote community engagement, health and well-being, such as to a grocery store or gym. Repairs to enrollee’s vehicle and reimbursement for gas mileage are allowable alternatives</p> <p>NC Health Choice-enrolled members may also use this service for medical</p>	<ul style="list-style-type: none"> • Enrollee is not currently receiving duplicative support through other Pilot services. 	<ul style="list-style-type: none"> • Frequency: as needed • Duration: N/A

	transportation (e.g., to a doctor's office, pharmacy). However, Medicaid-enrolled members must use the Medicaid-covered service of Non-Emergency Medical Transportation (NEMT) for such purposes.		
Transportation PMPM Add-On for Case Management Services	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	Not Applicable	N/A
Interpersonal Violence/ Toxic Stress Services			
Interpersonal Violence (IPV) Case Management Services	This service covers a set of activities that aim to support an individual in addressing sequelae of an abusive relationship (e.g., ongoing safety planning, assistance with transition-related needs referrals to legal supports, linkages to child-care)	<ul style="list-style-type: none"> • Enrollee requires ongoing engagement • 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 Pilot services. 	<ul style="list-style-type: none"> • Frequency: as needed • Duration: until services are no longer needed

<p>Violence Intervention Services</p>	<p>Covers the delivery of services to support individuals who are at risk for being involved in community violence such as individualized psychosocial education related to de-escalation skills and alternative approaches to conflict resolution and linkages to housing, food, education, employment opportunities, and after-school programs and community engagement activities.</p>	<ul style="list-style-type: none"> • 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). 	<ul style="list-style-type: none"> • Frequency: as needed • Duration: until services are no longer needed
<p>Evidence-Based Parenting Classes (“Incredible Years” Curriculum)</p>	<p>This service covers the “Incredible Years (Parent) – Preschool/School” curriculum and is meant to provide: group and one-on-one instruction from a trained facilitator, written and audiovisual materials to support learning, and additional services to promote attendance and focus during classes; this service is offered to families</p>	<p>No additional minimum-eligibility criteria</p>	<ul style="list-style-type: none"> • Frequency: N/A • Duration: 18-20 sessions, typically lasting 2-2.5 hours each.

	that may be at risk of disruption due to parental stress or difficulty coping with parenting challenges, or child behavioral or health issues. It is typically offered in a classroom setting or with limited visits to recipients' homes.		
Home Visiting Services ("Parents as Teachers" Curriculum)	This service covers the "Parents as Teachers" curriculum and is meant to provide: one-one observation, instruction and support from a trained case manager who may be a licensed clinician and written and/or audiovisual materials to support learning; this service is 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. This service is appropriate in multiple settings, including at an individual's home, school, HSO site, or other community setting.	No additional minimum-eligibility criteria	<ul style="list-style-type: none"> • Frequency: N/A • Duration: 18-20 sessions, typically lasting 2-2.5 hours each.
Cross-domain Services			

<p>Holistic High Intensity Enhanced Case Management</p>	<p>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</p>	<ul style="list-style-type: none"> • Enrollee must concurrently require both Housing Navigation, Support and Sustaining Services and IPV Case Management services. • Enrollee is not currently receiving duplicative support through other Pilot services or eligible for substantially similar Medicaid-covered service. 	<ul style="list-style-type: none"> • Frequency: as needed • Duration: service duration would persist until services are no longer needed
<p>Linkages to Health-Related Legal Supports</p>	<p>Assists enrollees with a specific matter with legal implications that influence their ability to secure and/or maintain healthy and safe housing and mitigate or eliminate exposure to interpersonal violence or toxic stress; this service is limited to providing advice and counsel to enrollees and does not include legal representation</p>	<ul style="list-style-type: none"> • Service does not cover legal representation. • 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. 	<ul style="list-style-type: none"> • Frequency: as needed • Duration: services are provided in short sessions that generally total no more than 10 hours.
<p>Medical Respite</p>	<p>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 should include, at a minimum: Short-Term Post-</p>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Frequency: N/A • Duration: up to 6 months

	Hospitalization Housing, Medically Tailored Meal (delivered to residential setting), and Transportation Services	<ul style="list-style-type: none">• Enrollee requires intensive, in-person case management to recuperate and heal post-hospitalization.• Enrollee is not currently receiving duplicative support through other Pilot services.	
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