DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

January 16, 2025

Jay Ludlam
Deputy Secretary, North Carolina Medicaid
North Carolina Department of Health and Human Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Dear Deputy Secretary Ludlam:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to North Carolina's section 1115(a) demonstration (Project Number 11-W-00313/4), titled "North Carolina Medicaid Reform Demonstration." The technical corrections include updates to various special terms and conditions (STCs) references, grammar and formatting changes, and ensures that the STCs accurately reflect CMS's approval of the demonstration approved December 10, 2024.

We look forward to our continued partnership on the North Carolina Medicaid Reform Demonstration section 1115(a) demonstration. If you have any questions, please contact your project officer, Shelby Higgins at Shelby.Higgins@cms.hhs.gov.

Sincerely,

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosures

cc: Morlan Lannaman, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: 11W00313/4

TITLE: North Carolina Medicaid Reform Section 1115(a) Demonstration

AWARDEE: North Carolina Department of Health and Human Services

Under the authority of Section 1115(a)(1) of the Social Security Act ("the Act"), the following waivers are granted to enable North Carolina (referred to herein as the state or the State) to operate the North Carolina Medicaid Reform Demonstration. These waivers are effective beginning December 10, 2024 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) as set forth in the accompanying document.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the North Carolina Medicaid Reform Demonstration, including the granting of the waivers described below, is likely to assist in promoting the objectives of title XIX of the Act.

Except as provided below with respect to expenditure authority, all requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning December 10, 2024 through December 9, 2029.

1. **Freedom of Choice** **Section 1902(a)(23)(A)**

   To the extent necessary to enable the state to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans, and in some cases, choice of managed care plans. No waiver of freedom of choice is authorized for family planning providers.

2. **Amount, Duration, & Scope** **Section 1902(a)(10)(B)**

   To the extent necessary to enable the state to vary the amount, duration, and scope of services offered to individuals under this demonstration, regardless of eligibility category.

3. **Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release**

   Section 1902(a)(84)(D)

   To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the

approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11W00313/4

TITLE: North Carolina Medicaid Reform Section 1115(a) Demonstration

AWARDEE: North Carolina Department of Health and Human Services

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by North Carolina for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from December 10, 2024 to December 9, 2029, unless otherwise specified, be regarded as expenditures for the state's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable North Carolina to operate the above-identified section 1115(a) demonstration.

Title XIX Expenditure Authority:

1. **Continuous Eligibility for Children.** Expenditures for continued state plan benefits for individuals who have been determined eligible as specified in Table 2 of STC 4.3(b), who are not otherwise excluded under STC 4.3(c) for the applicable continuous eligibility period, and who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 4.3(e)**.**

2. **Former Foster Care Youth from another State.** Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth who are defined as individuals under age 26, that were in foster care under the responsibility of a state (or tribe) other than North Carolina on the date of attaining 18 years of age or such higher age as the former state has elected for termination of federal foster care assistance under title IV-E of the Act, were enrolled in Medicaid on the date of aging out of foster care, and are now applying for Medicaid in North Carolina.

3. **Residential and Inpatient Treatment for Individuals with a Substance Use Disorder (SUD).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD), as described in Section 6 of the STCs.

4. **Expenditures for Community Transition Benefit.** Expenditures to provide a community transition benefit furnished to individuals otherwise eligible for coverage under section 1915(i) of the Act, transitioning out of an institution for mental disease (IMD), pursuant to the limitations and qualifications provided in STC 5.2.

5. **Expenditures for Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid individuals for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the reentry demonstration initiative.

6. **Expenditures for Pre-Release Administrative Costs.** Capped expenditures for payments for allowable administrative costs, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in STC 7.12, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the reentry demonstration initiative.

7. **Behavioral Health Intellectual/Developmental Disability (BH I/DD) Tailored Plans and Children and Families Specialty Plan (CFSP).** Expenditures under contracts with managed care plans that do not meet the requirements of 1903(m)(2)(A) and 1932(a) of the Act as implemented in 42 CFR 438.52(a)(1), to the extent necessary to allow the state to limit the choice to a single managed care organization for eligible individuals outlined in STCs 9.2 and 9.6 and Attachment J for the following two managed care programs: (1) BH I/DD Tailored Plan; and (2) CFSP. For the BH I/DD Tailored Plan, eligible individuals are enrolled into a single MCO in each region, and for CFSP, eligible individuals are enrolled in a single statewide MCO in order to receive all State plan benefits delivered under that managed care program. The BH I/DD Tailored Plan and CFSP programs include specialized State plan benefits only available in these programs and the enrollee loses access to these benefits if the enrollee opts out to the Standard Plan as outlined in STC 9.10.

8. **Health-Related Social Needs (HRSN) Services.** Expenditures for health-related social needs services provided under the Healthy Opportunities Pilots (HOP) that are not otherwise covered and are furnished to individuals who meet the qualifying criteria as described in Section 10 of the STCs. This expenditure authority is contingent on compliance with Section 14 of the STCs, as well as all other applicable STCs.

9. **Expenditures for HRSN Service Infrastructure.** Expenditures for payments for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized in STC 10.7. This expenditure authority is contingent on compliance with Section 14 of the STCs, as well as all other applicable STCs.

10. **Additional Healthy Opportunities Pilots Services.** Expenditures for additional, non-HRSN Healthy Opportunities Pilots services that are not otherwise covered and are furnished to individuals who meet the qualifying criteria as described in STC 10.5.

11. **Expenditures for Healthy Opportunities Pilots non-HRSN Service Infrastructure.** Expenditures for payments for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized in STC 10.8.

12. **Workforce Initiatives.** Expenditures for the Student Loan Repayment for Qualified Providers and Behavioral Health and Long-Term Services and Supports (LTSS) Workforce programs as specified in Section 11 of the STCs.

    Time limited expenditure authority is granted until four years following the end of the demonstration (December 9, 2029), in order for the state to pay close-out administrative costs of operating the programs and monitoring service commitments.

13. **Health Information Technology Programs.** Expenditures for BH and I/DD Technology and School Health Technology incentive programs that meet the criteria as specified in Section 12 of the STCs.

    Time limited expenditure authority is granted until one year following the end of the demonstration (December 9, 2029), in order for the state to pay close-out administrative costs of operating the programs, and incentive payments associated with periods of performance within the approval period for the HIT Programs.

14. **Designated State Health Programs (DSHP).** Expenditures for designated state health programs, described in these STCs (Section 13) which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs. This authority is contingent upon adherence to the requirements within STC Section 14, Provider Rate Increase, and STC Section 9.19(h) under Parity in Mental Health and Substance Use Disorder Benefits, as well as all other applicable STCs.

Title XIX Requirements Not Applicable to the Expenditure Authority for Pre-Release Services.

1. **Statewideness** **Section 1902(a)(1)**

    To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

2. **Amount, Duration, and Scope of Services and Comparability** **Section 1902(a)(10)(B)**

    To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

3. **Freedom of Choice** **Section 1902(a)(23)(A)**

To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

Title XIX Requirements Not Applicable to the Healthy Opportunities Pilots Program, Expenditure Authorities #8-11.

1. **Amount, Duration and Scope** **Section 1902(a)(10)(b)**

To the extent necessary to enable the state to provide a varying amount, duration and scope of Healthy Opportunities Pilots services to a subset of beneficiaries, depending on beneficiary needs.

2. **Comparability; Provision of Medical Assistance** **Section 1902(a)(10)(b), and 1902(a)(17)**

To the extent necessary to allow the state to offer Healthy Opportunities Pilots services to an individual who meets the qualifying criteria for Healthy Opportunities Pilots services, including delivery system enrollment, as described in Section 10 of the STCs.

3. **Statewideness** **Section 1902(a)(1)**

To enable the state to implement the Healthy Opportunities Pilots program in geographically limited areas of the state as described in these STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11W00313/4

TITLE: North Carolina Medicaid Reform Section 1115(a) Demonstration

AWARDEE: North Carolina Department of Health and Human Services

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the "North Carolina Medicaid Reform Demonstration" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the North Carolina Department of Health and Human Services (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective from December 10, 2024 through December 9, 2029.

The STCs have been arranged into the following subject areas:

19	Schedule of Deliverables for the Demonstration Period

Attachment A	Developing the Evaluation Design
Attachment B	Preparing the Interim and Summative Evaluation Reports
Attachment C	Evaluation Design (reserved)
Attachment D	SUD Implementation Plan
Attachment E	SUD Health Information Technology (Health IT) Plan
Attachment F	Monitoring Protocol (reserved)
Attachment G	Reentry Demonstration Initiative Services
Attachment H	Reentry Demonstration Initiative Implementation Plan (reserved)
Attachment I	Reentry Demonstration Initiative Reinvestment Plan (reserved)
Attachment J	Specialized Managed Care Program Eligibility
Attachment K	Milestones to Comply with Mental Health and Substance Use Disorder Benefits
Attachment L	2022-2024 Healthy Opportunities Pilot (HOP) Program Eligibility and Services
Attachment M	Protocol for Assessment of Beneficiary Eligibility Needs and Provider Qualifications for HOP Health Related Social Needs (HRSN) Services
Attachment N	Additional HOP Services Protocol
Attachment O	HOP Services Matrix
Attachment P	HOP Infrastructure Protocol
Attachment Q	HOP Implementation Plan
Attachment R	BH I/DD HIT Incentive Payment Protocol
Attachment S	School Health Technology Program Protocol
Attachment T	Approved List of DSHPs
Attachment U	Provider Rate Increase Attestation Table (reserved)

2. PROGRAM DESCRIPTION AND OBJECTIVES

In September 2015, the state passed legislation to transition its Medicaid (Title XIX) program and Medicaid-expansion Children's Health Insurance Program (M-CHIP) delivery system to a Medicaid managed care program and delegate direct management of medical services and financial risks to Managed Care Organizations (MCO) called Prepaid Health Plans (PHPs) for Medicaid enrollees, except for those excluded.

On October 19, 2018, North Carolina received federal approval for the North Carolina Medicaid Reform Demonstration. The goals of the demonstration were to:

- Measurably improve health outcomes via a new delivery system;
- Maximize high-value care to ensure sustainability of the Medicaid program and M-CHIP; and
- Reduce Substance Use Disorder (SUD).

The demonstration also provided authority for the Healthy Opportunities Pilots (HOP), which tests the impact of providing select evidence-based, upstream interventions related to housing, food, transportation, and interpersonal safety to high-need Medicaid enrollees in three pilot regions of the state.

The demonstration was amended on September 16, 2022 and July 7, 2023 and expanded access to the HOP, modified certain implementation details related to the HOP, and adjusted which populations will and will not be covered under the Behavioral Health Intellectual/Development Disability (BH I/DD) Tailored Plans.

On October 23, 2024, CMS approved a 43-day temporary extension of the demonstration to continue negotiations on the extension application.

As of December 10, 2024, CMS approved an extension of the demonstration to improve health and well-being for all North Carolinians through a whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and aims to advance health access by reducing disparities for historically marginalized populations.

The 1115 demonstration extension seeks to achieve this overarching goal through the following specific objectives and related initiatives:

Objective 1: Support a continued, smooth transition to managed care with a focus on improving care for enrollees with the most complex needs:

- Initiative 1a. Provide integrated whole-person, well-coordinated care for the majority of Medicaid enrollees through continued implementation of Standard Plans.

- Initiative 1b. Provide integrated care for individuals with serious mental illness, serious emotional disturbance, severe SUD, I/DD, and/or traumatic brain injury (TBI), through the launch of the BH I/DD Tailored Plans.

- Initiative 1c. Provide integrated care to address the complex needs of children and families currently and formerly served by the child welfare system the implementation of the Children and Families Specialty Plan (CFSP).

Objective 2: Strengthen access to a person-centered and well-coordinated system of care which addresses both medical and non-medical drivers of health:

- Initiative 2a. Build on HOP infrastructure investment and experience to expand non-medical drivers of health services to North Carolinians across the state.

- Initiative 2b. Promote continuity of care by offering continuous enrollment in Medicaid to children.

- Initiative 2c. Improve health outcomes and support reentry into the community for justice-involved individuals by providing targeted pre-release Medicaid services.

Objective 3: Strengthen the behavioral health and I/DD delivery system:

- Initiative 3a. Provide Medicaid coverage for the full continuum of opioid use disorder (OUD)/SUD services.

- Initiative 3b. Improve the coordinated system of care for people with behavioral health and I/DD needs through targeted new investments in technology.

- Initiative 3c. Bolster the behavioral health and long-term services and supports (LTSS) workforce.

- Initiative 3d. Expand access to critical supports offered under 1915(i) authority.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state

plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plan governs.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS at least 12 months in advance from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(d)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable advance notice requirements and fair hearing rights described at 42 CFR 431 Subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling participants.

3.10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waiver and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

3.11. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR section 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR section 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid or CHIP state plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs or procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. **Eligibility Groups Affected by the Demonstration.** All Medicaid individuals eligible under the Medicaid State Plan (including M-CHIP) are affected by the demonstration, except for those excluded in Table 1. Individuals derive their eligibility through the Medicaid State Plan and are subject to all applicable Medicaid or CHIP laws and regulations in accordance with the Medicaid State Plan, except as expressly waived in this demonstration and described in these STCs. In addition, this demonstration extends eligibility to demonstration expansion populations, specifically:

a. Former Foster Care Youth (FFCY) from another State (see STC 4.2); and

b. Continuous Eligibility for Children (see STC 4.3).

TABLE 1: POPULATIONS EXCLUDED FROM THE DEMONSTRATION ENTIRELY

GROUP NAME	CITATIONS
Medicare Savings Programs • Qualified Medicare Beneficiaries • Qualified Disabled and Working Individuals • Specified Low Income Medicare Beneficiaries • Qualifying Individuals	• 1902(a)(10)(E • 1905(p) • 1905(s)

GROUP NAME	CITATIONS
Individuals with Limited or no Medicaid Coverage (for emergency services only)	• 1903(v)(2) and (3)
Individuals Eligible for Family Planning Services	• 1902(a)(10)(A)(ii)(XXI) • 42 CFR 435.214
Incarcerated Individuals *(except for reentry demonstration initiative populations only)*	• Clause (A) following 1905(a)(29)(A) • 42 CFR 435.1009, 1010
Presumptively Eligible • Presumptively Eligible Pregnant Individuals • Presumptively Eligible MAGI Individuals	• 1902(a)(47) • 1920 • 1920A • 1920B • 1920C
Individuals Participating in the Program of All-Inclusive Care for the Elderly (PACE)	• 1905(a)(26) • 1934

4.2. **Former Foster Care Youth (FFCY) from another State.** Individuals eligible under this demonstration authority are defined as individuals under age 26 that meet the following criteria:

a. Were in foster care under the responsibility of a state other than North Carolina or a tribe in such other state when they turned 18 (or such higher age as the other state has elected for termination of federal foster care assistance until title IV-E of the Act);

b. Were enrolled in Medicaid at the time of aging out of foster care;

c. Turned 18 on or before December 31, 2022;

d. Are now applying for Medicaid in North Carolina; and

e. Are not otherwise eligible for Medicaid.

4.3. **Continuous Eligibility for Children**

a. **Continuous Eligibility:** Eligible populations, identified in STC 4.3(b), will receive continuous eligibility through the demonstration. The state is authorized to provide continuous eligibility for the populations for the durations specified in Table 2 below, regardless of the delivery system through which these populations receive Medicaid benefits.

i. For individuals who qualify for continuous eligibility, the continuous eligibility period begins on the effective date of the individual's eligibility

under 42 CFR 435.915 or the effective date of the most recent redetermination.

ii. Because individuals are continuously eligible regardless of changes in circumstances, the state does not need to conduct renewals or redeterminations of eligibility consistent with 42 CFR 435.916 and 435.919 for individuals who qualify for continuous eligibility until the end of the individual's continuous eligibility period, except in the limited circumstances of a beneficiary meeting one of the exceptions outlined in STC 4.3(e).

iii. At the end of the continuous eligibility period, North Carolina must conduct a renewal of Medicaid eligibility and consider eligibility on all bases consistent with 42 CFR 435.916(d)(1) prior to terminating coverage. Individuals determined eligible on another basis at the end of the continuous period will be moved to the appropriate group at that time. Individuals determined eligible on another basis resulting in a reduction of Medicaid eligibility or services or increase in cost sharing or premiums will be provided advance notice of termination in accordance with 42 CR 435.917 and 42 CFR 431, Subpart E. Individuals determined ineligible for Medicaid on all bases will be provided advance notice of termination in accordance with 42 CR 435.917 and 42 CFR 431, Subpart E and assessed for potential eligibility for other insurance affordability programs in accordance with 42 CFR 435.916(d)(2).

b. **Populations and Duration:** The state is authorized to provide continuous eligibility for the following populations for the associated durations.

i. Children up to age six. Except as provided in STC 4.3(e)**,** individuals age zero through the end of the month of their sixth birthday, who enroll in Medicaid shall qualify for continuous eligibility until the end of the month in which their sixth birthday falls.

ii. Children aged six through 18. Except as provided in STC 4.3(e), the state is authorized to provide 24 months of continuous eligibility for children who enroll in Medicaid aged six until the end of the month in which their 19th birthday falls.

Table 2: Eligible Populations and Associated Duration for Continuous Eligibility (CE)	
Population	**Duration of CE**
Children up to age 6	Until the end of the month of their 6th birthday
Children aged 6 – up to age 19	Greater than 12 months and up to 24 months

c. **Eligibility Exclusions:** The following children are excluded from receiving continuous eligibility:

i. Have only established Medicaid eligibility as medically needy (as set forth in section 1902(a)(10)(C) of the Act),

ii. Have been determined presumptively eligible for Medicaid but have not yet received an eligibility determination based on a regular application, or

iii. Upon the child's renewal is determined to only be eligible for Medicaid based on transitional medical assistance (as set forth in section 1925 of the Act).

d. **Implementation of Continuous Eligibility for Non-MAGI Populations:** When the state initially implements continuous eligibility, the state may exclude individuals who have established Medicaid eligibility subject to non-MAGI methodologies as described in Table 3. However, no later than 12 months after implementation of continuous eligibility for MAGI populations, the state must provide continuous eligibility to the non-MAGI populations described in Table 3.

Table 3: Non-MAGI Populations to Receive Continuous Eligibility	
SSI Beneficiaries and Deemed SSI Beneficiaries	42 CFR 435.120, 42 CFR 435.135, 42 CFR 435.138
Individuals Eligible for but Not Receiving Cash	42 CFR 435.210
Age and Disability Related Poverty Level Group	1902(a)(10)(A)(ii)(X)
Family Opportunity Act Children with a Disability	1902(a)(10)(A)(ii)(XIX)
Individuals Receiving State Plan HCBS	42 CFR 435.219

e. **Exceptions to Continuous Eligibility:** Notwithstanding STC 4.3(b), if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be redetermined or terminated:

i. The beneficiary attains the age limit of the continuous eligibility period or eligibility group (if applicable);

ii. The beneficiary is no longer a North Carolina resident;

iii. The beneficiary or their representative requests termination of eligibility;

iv. The beneficiary dies;

v. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

f. **Beneficiary-Reported Information and Periodic Data Checks:**

i. The state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their continuous eligibility as outlined STC 4.3(e) (such as a change in state residency) and are able to report other information relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

ii. For individuals who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. The state should follow its typical processes that it would otherwise use to verify continued residency at renewal if continuous eligibility was not available for these individuals.

iii. Additionally, at least once every 12 months, the state must follow its typical processes to attempt to confirm the individual is not deceased, consistent with the data sources outlined in the state's verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d). The state must redetermine eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.919 and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j).

iv. Because individuals are receiving continuous eligibility beyond their eligibility period, the state does not need to complete the individual's annual renewal or act on changes in circumstances that would otherwise affect eligibility, except as detailed in STC 4.3(e), until the end of the individual's continuous eligibility period. Additionally, if the state obtains information about changes that may affect eligibility (e.g., change in income), they are not permitted to use the information related to the change to end the continuous eligibility period early and terminate coverage, unless the change relates to one or more of the exceptions detailed in STC 4.3(e).

g. **Annual Updates to Beneficiary Contact Information:** For all continuous eligibility periods longer than 12 months, the state must have procedures and processes in place to accept and update beneficiary contact information and must attempt to update beneficiary contact information on an annual basis, which may include examining data sources annually and partnering with managed care organizations to encourage beneficiaries to update their contact information. The state is reminded that updated contact information obtained from third-party sources with an in-state address is not an indication of a change affecting continuous eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to state residency, but without additional follow up by the state per 42 CFR 435.952(d), the receipt of this

third-party data is not sufficient to make a definitive determination that beneficiaries no longer meet state residency requirements.

h. **Annual Reminders of Continued Eligibility:** The state must have procedures and processes in place to provide individuals who qualify for a continuous eligibility period that exceeds 12 months an annual reminder of continued eligibility. The annual reminder of continued eligibility must:

i. Be written in plain language;

ii. Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with 42 CFR 435.905(b); and

iii. If provided in electronic format, comply with requirements for electronic notices in 42 CFR 435.918.

The annual reminder of continued eligibility, must, at a minimum, include:

iv. An explanation of the individual's continuous eligibility, including the end date of the continuous eligibility period;

v. The circumstances under which the individual must report, and procedures for reporting, any changes that may affect the individual's eligibility;

vi. Basic information on the level of benefits and services available as described at 42 CFR 435.917(b)(1)(iv); and

vii. If the beneficiary's eligibility is based on having household income at or below the applicable MAGI standard, the content regarding non-MAGI eligibility described at 42 CFR 435.917(c).

5. DEMONSTRATION PROGRAM BENEFITS

5.1. **Former Foster Care Youth from Another State.** Beneficiaries enrolled in this eligibility category receive full Medicaid state plan benefits.

5.2. **Community Transition Benefit.** Beneficiaries may receive the following community transition benefit, when the beneficiary is transitioning out of an IMD, if otherwise eligible for North Carolina's 1915(i) SPA benefit except for their placement in an IMD.

a. Services. The community transition benefit is to provide initial setup to facilitate the individual's transition from an IMD to a living arrangement where the individual is directly responsible for their own living expenses. These are one-time, non-reoccurring expenses only available as part of the transition from an IMD to the community. The service may only be provided to facilitate transition to a private home/apartment with a lease in the individual's or their legal guardian's/representative's name or a home owned by the individual. Covered transition services are:

i. Security deposits that are required to obtain a lease on an apartment or home;

ii. Essential furnishings, such as furniture, window coverings, food preparation items, bed/bath linens;

iii. Moving expenses required to occupy and use a community-based domicile;

iv. Setup fees or deposits for utility or service access, such as telephone, electricity, heating and water; and

v. Services necessary for the beneficiary's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

b. Service limitations.

i. Community transition does not cover monthly rental or mortgage expense; food expenses; regular utility charges; or household appliances or diversional/recreational items such as televisions, VCR players and components, and DVD players and components. Service and maintenance contracts and extended warranties are not covered.

ii. Community transition has a limit of $5,000 per individual during the five-year demonstration period.

iii. Expenses to facilitate successful community transition can be incurred up to three months prior to a discharge from an IMD to facilitate the individual's move.

iv. In situations where an individual lives with a roommate, community transition cannot duplicate items that are currently available.

v. Community transition includes the actual cost of services and does not cover provider overhead charges.

vi. Community transition expenses are furnished only to the extent that the beneficiary is unable to meet such expenses or when the support cannot be obtained from other sources.

vii. If North Carolina suspends its 1915(i) SPA benefit under NC-22-0026, this benefit will also cease pending compliance with STC 3.9.

c. Eligibility. Beneficiaries must be eligible for North Carolina's 1915(i) SPA benefit except for their placement in an IMD, to be eligible for this benefit.

i. This STC and expenditure authority #4 covers the costs associated with assessing beneficiaries for 1915(i) eligibility for this benefit.

d. Reporting. The state will follow existing 1915(i) quality reporting requirements for this benefit, and bundle any reporting related to this benefit with that completed for the 1915(i) SPA benefit.

e. All other Medicaid rules and regulations applicable to section 1915(i) benefits apply to this benefit unless otherwise specified in these STCs.

6. SUBSTANCE USE DISORDER (SUD) PROGRAM AND BENEFITS

6.1. **Opioid Use Disorder/Substance Use Disorder Program.** Under this demonstration component, North Carolina Medicaid recipients will continue to have access to high-quality, evidence-based SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state will continue to be eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD. The state will continue to aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the Monitoring Protocol as outlined in STC 15.5 below, to ensure short-term residential treatment stays.

Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD/SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to on-going chronic care for these conditions in cost-effective community-based settings.

6.2. **SUD Implementation Plan.**

a. The state's SUD Implementation Plan, initially approved for the period from April 25, 2019, through October 31, 2023, and later extended through December 13, 2024, remains in effect for the approval period from December 10, 2024, through December 9, 2029, and is affixed to the STCs as Attachment D. Given that the state has experienced delays in implementation, the state must submit a revised implementation plan to CMS no later than 90 days post approval of this demonstration extension. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral. The approved SUD Implementation Plan describes the strategic approach and a detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD demonstration project:

i. **Access to Critical Levels of Care for OUD and other SUDs:** Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings, and medically supervised withdrawal management, within 12-24 months of demonstration approval;

ii. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of demonstration approval;

iii. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;

iv. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in North Carolina Administrative Code (10A NCAC 27G.0401). The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

v. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

vi. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;

vii. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD:** An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of demonstration approval;

viii. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. Im**proved Care Coordination and Transitions between levels of care:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval;

b. **SUD Health IT Plan:** Implementation of a Substance Use Disorder Health Information Technology Plan which describes technology that will support the aims of the demonstration. Further information which describes milestones and metrics are detailed in in STC 6.2(a) and Attachment E; and

SUD Health Information Technology Plan ("Health IT Plan"). The state has provided CMS with an assurance that it has a sufficient health IT infrastructure/ "ecosystem" at every appropriate level (i.e. state, delivery system, and individual provider) to achieve the goals of the demonstration – or it will submit to CMS a plan to develop the infrastructure/capabilities. The "SUD Health IT Plan," or assurance, is included as a section of the state's "Implementation Plan" (see STC 6.2a), which will remain in effect for the approval period from December 10, 2024, through December 9, 2029, and is affixed to the STCs as Attachment D. The SUD Health IT Plan details the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan also is used to identify areas of SUD health IT ecosystem improvement.

i. The state must include in its Monitoring Protocol (see STC 15.5) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

ii. The state must monitor progress, each Demonstration Year (DY), on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines – and report on its progress to CMS within its Annual Report (see STC 15.6).

iii. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory – Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

iv. Whether there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally recognized standards.

v. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use federally recognized ISA standards.

vi. Components of the Health IT Plan include:

i. The Health IT Plan must describe the state's alignment with Section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP)[1].

ii. The Health IT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders. States should favor procurement strategies that incorporate qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in RX Check for Interstate data sharing.

a. The Health IT Plan will describe how technology will support substance use disorder prevention and treatment outcomes described by the demonstration.

b. In developing the Health IT Plan, state should use the following resources:

- States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).

- States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

- States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

- States should review the Office of the National Coordinator's Interoperability Standards Advisory

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

(https://www.healthit.gov/isa/) for information on appropriate standards which may not be required per 45 CFR part 170, subpart B for enhanced funding, but still should be considered industry standards per 42 CFR 433.112(b)(12).

6.3. **Unallowable Expenditures Under the SUD Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

7. REENTRY DEMONSTRATION INITIATIVE

7.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to certain individuals who are inmates residing in state/local jails, state prisons, youth correctional facilities, and tribal jails (hereinafter "correctional facilities"). To qualify for services covered under this demonstration, individuals residing in correctional facilities must be eligible for Medicaid as determined pursuant to an application filed before or during incarceration and must have an expected release date no later than 90 days as further specified in the STCs below.

7.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The reentry demonstration initiative provides short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other Substance Use Disorder (SUD) and behavioral health treatments, as appropriate for the individual.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

c. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), county eligibility workers, and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs, and health-related social needs;

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits, behavioral health crisis services, and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care;

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release.

7.3. **Qualifying Criteria for Pre-Release Services.** To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 7.1;

b. Have been determined eligible for Medicaid; and

c. Have an expected release date within 90 days.

7.4. **Scope of Pre-Release Services.** The pre-release services authorized under the reentry demonstration initiative include the following services, which are described in Attachment G, Reentry Demonstration Initiative Services.

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs, and health-related social needs;

ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;

iii. Practitioner office visit (e.g., physical exam; wellness exam; evaluation and management visit; mental health or substance use disorder treatment, therapy, or counseling; or other);

iv. Diagnostic services, including laboratory and radiology services;

v. Prescribed drugs (in addition to MAT and the 30-day supply of prescription medications) and medication administration; and

vi. Tobacco cessation treatment services.

b. A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid or CHIP state plan coverage authority and policy.

c. Medical equipment and supplies provided upon release.

d. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule, remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the North Carolina Medicaid State Plan, as relevant, that are not included in the above-described pre-release services (e.g., EPSDT treatment services) are not available to qualifying individuals through the reentry demonstration initiative.

7.5. **Participating Correctional Facilities.** The pre-release services will be provided at state/local jails, state prisons, youth correctional facilities, and tribal jails, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to North Carolina Department of Health and Human Services approval of a facility's readiness, according to the implementation timeline described in STC 7.9. States must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the reentry demonstration initiative.

7.6. **Participating Providers.**

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under North Carolina scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as a Medicaid provider.

b. Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional facility-based providers.

c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.

d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

7.7. **Suspension of Coverage.** Upon entry of a Medicaid-enrolled individual into a correctional facility, North Carolina Department of Health and Human Services must not terminate and generally shall suspend their Medicaid coverage.

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid and with submitting an application, unless the individual declines such assistance or wants to decline enrollment.

7.8. **Interaction with Mandatory State Plan Benefits for Eligible Juveniles**. To the extent North Carolina's reentry demonstration includes coverage otherwise required to be provided under section 1902(a)(84)(D) of the Act, and because this coverage is included in the base expenditures used to determine the budget neutrality expenditure limit, the state will claim for these expenditures and related transitional non-service expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

7.9. **Reentry Demonstration Initiative Implementation Timeline.** Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). The North Carolina Department of Health and Human Services will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medicaid application and enrollment processes for individuals who are not enrolled in Medicaid prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 7.3;

c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable;

d. North Carolina will require participating facilities to select a Service Level for implementation. Service Level One consists of the expected minimum set of pre-release services as indicated in the State Medicaid Director Letter (SMDL) (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated) and identified in STC 7.4(a) and (b), and must be the first Service Level category that is implemented. The state may define additional Service Level categories in its Implementation Plan. As applicable, additional service levels may be phased-in by facilities in any order, e.g., Service Level Two would not be a prerequisite for phasing-in Service Level Three, except that no facility may be a participating correctional facility that does not at least achieve and maintain provision of Service Level One. A facility must demonstrate to the state that it is prepared to implement all the services in Service Level One and within any chosen Service Level, if applicable;

e. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, social service departments, and managed care plans;

f. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the 90-day pre-release period, and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;

g. Operational approaches related to implementing certain Medicaid requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

h. A data exchange process to support the care coordination and transition activities described in (e), (f), and (g) of this subsection subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

i. Reporting of data requested by the North Carolina Department of Health and Human Services to support program monitoring, evaluation, and oversight; and

j. A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

7.10. **Reentry Demonstration Initiative Implementation Plan.** The state is required to submit a Reentry Demonstration Initiative Implementation Plan. As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the reentry demonstration initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. The finalized Implementation Plan will be incorporated into the STCs as Attachment H titled "Reentry Demonstration Initiative Implementation Plan."

CMS will provide the state with a template to support developing the Implementation Plan.

7.11. **Reentry Demonstration Initiative Reinvestment Plan.** To the extent that the reentry demonstration initiative covers services that are the responsibility of and were previously provided or paid by the correctional facility with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan (Attachment I), and subject to CMS approval. The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the reentry demonstration initiative, defined as services not previously provided or paid by the correctional facility with custody of qualifying individuals prior to the facility's implementation of the reentry demonstration initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative, with respect to the relevant increase in expenditures, as described in Attachment I, the Reentry Demonstration Initiative Reinvestment Plan) is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:

i. The state share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;

ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing

the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

iii. Improved access to or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;

iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. The reinvestment plan will describe whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c. Within six months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan (Attachment I) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment I titled "Reentry Demonstration Initiative Reinvestment Plan."

7.12. **Reentry Demonstration Initiative Planning and Implementation.**

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid pre-release application and suspension/unsuspension planning and purchase of certified electronic health record (EHR) technology to support Medicaid pre-release applications. In addition, reentry demonstration initiative planning and implementation funds will provide funding over the course of the demonstration to

support planning and IT investments that will enable implementation of the reentry demonstration initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among the North Carolina Department of Health and Human Services and Qualified Applicants listed in STC 7.12(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid. These allowable expenditures may include the following:

i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the reentry demonstration initiative population with Medicaid application and enrollment for demonstration coverage. This includes the development of electronic interfaces for Qualified Applicants listed in STC 7.12(d). to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 7.12(d), in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants listed in STC 7.12(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

iii. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

iv. **Purchase of Billing Systems.** Expenditures for the purchase of billing systems for Qualified Applicants.

v. **Development of Protocols and Procedures.** Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid enrollment process, suspension/unsuspension process for eligible individuals, and provision of care coordination and reentry planning for a period for up to 90 days immediately prior to the expected date of release for individuals qualifying for reentry demonstration initiative services.

vi. **Additional Activities to Promote Collaboration.** Expenditures for additional activities that will advance collaboration among North Carolina's Qualified Applicants in STC 7.12(d). This may include conferences and meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

vii. **Planning.** Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid; (2) assisting with the completion of a Medicaid application; (3) submitting the Medicaid application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

viii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction, or refurbishment of correctional facilities.

b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 4. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 4. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

	DY 7	DY 8	DY 9	DY 10	DY 11	Total
Total Computable Expenditures	$80,000,000	$100,000,000	$40,000,000	$20,000,000	$10,000,000	$250,000,000

c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.

d. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include the state Medicaid Agency, correctional facilities, other state agencies supporting carceral health, Probation Offices, and other entities as relevant to the needs of justice-involved individuals, including health care providers, as approved by the state Medicaid agency.

8. COST SHARING

8.1. **Cost Sharing.** Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

a. Out-of-state former foster care youth will be subject to the same cost-sharing requirements effectuated by the state for the mandatory title IV-E foster care children eligibility category enacted by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272).

b. Individuals receiving continuous eligibility enrolled in this demonstration may be subject to cost sharing responsibilities, such as monthly premiums and co-payments, to the extent allowable under title XIX requirements or as approved under current section 1115 demonstration authority**.** However, beneficiaries may not be disenrolled from this demonstration for failure to pay a premium during the individual's continuous eligibility period approved in the demonstration.

9. DELIVERY SYSTEM

9.1. **Managed Care Organizations (MCOs).** Beneficiaries, except those excluded or exempted, shall be enrolled to receive services through an MCO called a Prepaid Health Plan (PHP) in the state. The MCO may contract with the state to deliver services in one or more of the three managed care programs: (1) Standard Plan; (2) BH I/DD Tailored Plans; or (3) Children and Families Specialty Plan (CFSP). The MCOs are subject to and must comply with the federal laws and regulations as specified in 42 CFR Part 438. The state must comply with 42 CFR Part 438 in connection with managed care programs offered under this demonstration unless specified otherwise in the waiver authority or expenditure authority.

9.2. **Populations Enrolled in Managed Care.** All Medicaid demonstration and state plan groups (including M-CHIP) will be mandatorily enrolled in MCOs for the programs outlined in STC 9.1 except for those excluded or exempt from mandatory enrollment, as specified in STC 9.3 and 9.4.

a. As further outlined in STC 9.6, the state has developed and will maintain clear eligibility criteria for populations that will be enrolled in the BH I/DD Tailored Plans and CFSP.

b. Beneficiaries in foster care, beneficiaries receiving adoption assistance, and beneficiaries who are enrolled in the Former Foster Care eligibility group will be eligible for CFSP at launch and will remain in Medicaid fee-for-service/their behavioral health prepaid inpatient health plan (PIHP) until the CFSP launches. Once launched, these beneficiaries will be enrolled in the CFSP consistent with STCs 9.8 and 9.9.

9.3. **Excluded Population.** Excluded populations are those that will continue to receive benefits through Medicaid fee-for-service or their existing delivery system as outlined in Table 5.

Table 5: **Full Benefit Medicaid Beneficiaries Excluded from MCO Enrollment**

GROUP NAME	CITATIONS
Duals Eligible for Full Medicaid, except those who are enrolled in the state's Innovations and TBI section 1915(c) waiver programs, which qualifies the beneficiary for enrollment in the BH I/DD Tailored Plans	State Plan Eligibility
Medically Needy Individuals, except those covered by Innovations and TBI section 1915(c) waivers	1902(a)(10)(C) 42 CFR 435.123 through 126
Individuals Participating in the NC Health Insurance Premium Payment (HIPP) program except those covered by Innovations or TBI section 1915(c) waivers	1906
Medicaid-only Beneficiaries Receiving Long-Stay Nursing Home Services	State Plan Eligibility
Community Alternatives Program for Children (CAP/C)	1915(c) waiver
Community Alternatives Program for Disabled Adults (CAP/DA)	1915(c) waiver
Previously Incarcerated Individuals *(as defined in an approved 1915(b) waiver)*, subsequent to CMS' approval of a section 1915(b) waiver amendment authorizing this group's mandatory enrollment in the Medicaid Direct delivery system (FFS physical health and section 1915(b) behavioral health PIHP) for the post-release period	
Individuals in any eligibility category not otherwise excluded during their period of retroactive eligibility or prior to the effective date of MCO coverage[2]	1902(a)(34) 42 CFR 435.915

9.4. **Exempt Populations.**

a. "Indians", as the term is defined in 42 CFR § 438.14(a), will be able, but not required, to enroll in MCOs. Such individuals may voluntarily enroll in MCOs on

[2]Individuals in any eligibility category not otherwise excluded during their period of retroactive eligibility or prior to the effective date of MCO coverage are eligible for the SUD component of the demonstration but are not eligible for HOP.

an opt-in basis and may disenroll without cause at any time. In addition, the state must require MCOs to comply with the regulation at 42 CFR § 438.14 when covering such individuals.

9.5. **Managed Care Contracts**. Consistent with section 1903(m) of the Act and the State Medicaid Manual § 2087, no FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR Part 438 requirements prior to CMS approval of such contracts and/or contract amendments. The state will provide CMS with a minimum of 60 calendar days to review and approve changes.

9.6. **Types of Managed Care Programs.** The state is authorized to contract with MCOs, which are defined under 42 CFR 438.2, through the three managed care programs outlined in STC 9.1.

a. Standard Plans that serve Medicaid enrollees (including M-CHIP), except those in excluded populations, individuals in exempt populations who choose not to enroll, or enrollees in BH I/DD Tailored Plans or the CFSP. At a minimum, the state will require that the Standard Plans include coverage of comprehensive services, including integrated physical health, behavioral health, and pharmacy.

b. BH I/DD Tailored Plans that provide integrated physical health, behavioral health, I/DD, TBI, and pharmacy services to their enrollees.

c. Children and Families Specialty Plan (CFSP) that provides integrated physical health, behavioral health and pharmacy services that account for the service needs of children, youth, and families served by the child welfare system.

d. Eligibility for Specialized Managed Care Programs. The full list of populations eligible for the BH I/DD Tailored Plans and/or CFSP is included in Attachment J: Specialized Managed Care Program Eligibility. With the exceptions outlined in (vii) and (viii), the state can update Attachment J to add eligibility groups that are eligible for the BH I/DD Tailored Plans and/or CFSP, if those eligibility groups are already eligible to be enrolled in comprehensive managed care under the 1115 demonstration. Prior to updating Attachment J, the state must:

i. Submit updates to Attachment J, at least 6 months prior the state's desired implementation date. The updates to Attachment J must be approved by CMS prior to the state's implementation.

ii. Provide documentation of Tribal consultation in the same way it would for a 1915(b) waiver. As part of Attachment J describe the efforts the State has made to ensure Federally recognized tribes, Indian Health Services facilities, and Urban Indian Organizations in the State are aware of and have had the opportunity to comment on this waiver proposal.

iii. Submit final contracts and rates 90 days prior to the state's desired implementation date. The state will use the submission system designated by CMS.

iv. Ensure readiness of plans pursuant to STC 9.13, including providing any documentation specified by CMS.

v. Notify newly-eligible potential enrollees of their eligibility to enroll in the BH I/DD Tailored Plans and/or CFSP, and their right to disenroll, per 42 CFR § 438.10(e) and (f)(2), at least 30 days before the intended effective date per 42 CFR § 438.10(g)(4).

vi. Ensure continuity of care pursuant to STC 9.14.

vii. If the state is removing eligibility groups eligible for the BH I/DD Tailored Plans and/or CFSP, then the state must submit an amendment to effectuate this change, consistent with STC 3.7.

viii. If the state is enrolling an eligibility group in the BH I/DD Tailored Plans and/or CFSP that was previously excluded from all comprehensive managed care programs as outlined in STC 9.3, and/or the state is mandating enrollment in the BH I/DD Tailored Plans and/or CFSP that was previously voluntary for exempted groups as outlined in STC 9.4, then the state must submit an amendment to effectuate this/these change(s), consistent with STC 3.7.

9.7. **Comprehensive Services.** The state must require that all Managed Care health plans providing comprehensive coverage have a comprehensive risk contract between the state and the MCO covering comprehensive services, that is, inpatient hospital services and any three or more of the following services:

a. Outpatient hospital services

b. Rural health clinic services

c. Federally Qualitied Health Center (FQHC) services

d. Other laboratory and X-ray services

e. Nursing facility services

f. Early and periodic screening, diagnostic and treatment (EPSDT) services

g. Family planning services

h. Physician services

i. Home health services

9.8. **Standard Plan Enrollment.** Beneficiaries will be mandatorily enrolled into managed care and will be given an opportunity to select an MCO at the time of application. Beneficiaries must have the choice of at least two MCO. A beneficiary who does not make an MCO selection at the time of application may be passively enrolled to an MCO

by the state consistent with 42 CFR § 438.54(d)(5). Upon enrollment, whether by passive enrollment or enrollee selection, the state or its designee must send a notice to enrollees confirming their enrollment in the plan. Enrollees may also request disenrollment pursuant to 42 CFR § 438.56(c).

9.9. **BH I/DD Tailored Plan Enrollment and CFSP Enrollment.** Beneficiary eligibility for BH I/DD Tailored Plans and CFSP will be determined through the use of available information and data (e.g., historical claims and encounters). Enrollees eligible for a BH I/DD Tailored Plan or CFSP may be passively enrolled into that plan. Passive enrollment must be consistent with 42 CFR § 438.54(d)(2)(ii). Enrollees eligible for both the BH I/DD Tailored Plan and the CFSP must have the opportunity to select the plan they would like to be enrolled in, and such enrollees will have the choice of one BH I/DD Tailored Plan or the CFSP. Most enrollees enrolled in the single BH/IDD Tailored Plan in their region or CFSP also have the ability to disenroll from that respective program and opt to enroll in the Standard Plan as outlined in STC 9.10. Enrollees may request disenrollment pursuant to 42 CFR § 438.56(c).

9.10. **Disenrollment from BH I/DD Tailored Plan and CFSP**.

a. Beneficiaries eligible for the BH I/DD Tailored Plan (with the exception of beneficiaries who meet the criteria in STC 9.10(b)) or CFSP may disenroll from either a BH I/DD Tailored Plan or CFSP and opt to enroll into a Standard Plan, but will lose access to the specialized services offered under those specialized plans. Beneficiaries eligible for the CFSP may also disenroll from the CFSP and opt to enroll into a BH I/DD Tailored Plan, if eligible. Beneficiaries must receive adequate notice regarding this option and loss of access to any specialized services. An eligible beneficiary must have the option to re-enroll in a BH I/DD Tailored Plan or the CFSP at any time following the beneficiary's voluntary disenrollment.

b. Beneficiaries who meet one of the below criteria may not disenroll from a BH I/DD Tailored Plan if they receive residential services offered by the BH I/DD Tailored Plan that are not covered in a Standard Plan or the CFSP:

    i. Reside in an intermediate care facility for individuals with intellectual disabilities (ICF/IID)

    ii. Participate in North Carolina's Transitions to Community Living

    iii. Enrolled in the Innovations 1915(c) waiver or Traumatic Brain Injury 1915(c) waiver

    iv. Receive services/supports in state-funded residential treatment (i.e., individuals receiving services to support them in their residence/house setting, including services provided in group homes or non-independent settings such as group living, family living, supported living, and residential supports).

c. Beneficiaries unable to disenroll from the BH I/DD Tailored Plan in STC 9.10(b) must receive notices. The notice must include an explanation as to why the enrollees are currently unable to opt out of the BH I/DD Tailored Plan given the enrollee's

participation in a setting or services outlined in STC 9.10(b) and explain how the beneficiary can opt out of the BH I/DD Tailored Plan by electing to stop receiving the respective service(s) or setting which are not covered in the Standard Plan or CFSP as outlined in STC 9.11.

9.11. **Specialized Behavioral Health Benefits**. Specialized behavioral health services, including services covered under section 1915(i), will be available through BH I/DD Tailored Plans and the CFSP, but will not be provided through Standard Plans. Innovations and TBI section 1915(c) waiver services, intermediate care facilities for individuals with intellectual disabilities (ICF/IID) services, North Carolina's Transitions to Community Living services, and state-funded residential treatment will only be available through BH I/DD Tailored Plans.

9.12. **Managed Care Implementation.** The state has implemented the Standard Plans and the BH I/DD Tailored Plans. The state has authority to implement the CFSP and is working to establish an effective date pending state legislative action. As stated in STC 9.2(b), children in county-operated foster care, children in adoptive placements, and former foster care youth up to age 26 will remain in the Medicaid fee-for-service/PIHP delivery system until the CFSP launches.

9.13. **Managed Care Readiness.** The state must assess readiness pursuant to 42 CFR § 438.66(d). Assignment into an MCO may only begin when each MCO has been determined by the state to meet certain readiness and network requirements.

9.14. **Continuity of Care during the Transition Period for Managed Care Plans.** The state's contracts with all managed care plans must require a transition of care protocol to ensure continuity of care for members. Managed care plans must continue medically necessary services for members in an ongoing course of treatment without any form of prior approval and without regard to whether such services are provided by in-network or out-of-network providers for at least six months, unless the member/family has opted to discontinue such services or selects a provider that is in network. To ensure continuity of care and allow the member to keep their current primary care provider (PCP), if the managed care plan does not have a member's PCP in its network on the date when the member is assigned a PCP prior to the launch of the managed care program, the managed care plan is required to offer to execute a contract or a single case agreement to that PCP.

a. **BH I/DD Tailored Plan Reporting Requirements on Continuity of Care.** Upon BH I/DD Tailored Plan launch and monthly for six months following the launch of the BH I/DD Tailored Plan program (until January 1, 2025), the state must submit a report detailing the total percentage of members who experienced a disruption in primary care across all primary care providers, meaning that their historical primary care provider is not in-network for their BH I/DD Tailored Plan. If the total percentage of members with PCP disruption is greater than 10%, CMS will request the state submit a corrective action plan. In addition, CMS reserves the right to extend the transition of care protocol by an additional six months if the initial report, and subsequent reports, show there is not adequate access for beneficiaries. Any

notice of extension of transition of care protocols shall be communicated no less than 60 days prior to anticipated expiration of the protocols.

9.15. **Assurances of Adequate Capacity and Services for Managed Care Plans.** For all managed care plans that furnish services to Medicaid beneficiaries enrolled in the managed care programs authorized by this 1115(a) demonstration, the state must submit the Assurance of Compliance detailed in 42 CFR § 438.207(d) using the Network Adequacy and Access Assurances Report template provided by CMS. Before implementation, the CFSP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, specialty, and acute services for the anticipated number of enrollees in the service area. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:

a. The number and types of preventive, primary, specialty, and acute providers available to provide covered services to the demonstration population;

b. The number of providers accepting the new demonstration population; and

c. The geographic location of providers, as shown through GeoAccess or similar software.

9.16. **Timing of Submission of Assurances of Adequate Capacity and Services.** The state must submit the Network Adequacy and Access Assurances Report for all managed care plans that furnish services to Medicaid beneficiaries enrolled in the managed care programs authorized by this 1115(a) demonstration. For the initial submissions for CFSP, the state must tailor Network Adequacy and Access Assurances Report submissions based on operational readiness and data availability. For following submissions, the state must provide the complete set of data outlined in the Network Adequacy and Access Assurances Report for all managed care plans that furnish services to Medicaid beneficiaries enrolled in the managed care programs authorized by this 1115(a) demonstration. The state must publish these reports on its public website.

9.17. **Quarterly Appeals and Grievance Report for Managed Care Plans.** CMS reserves the right to request quarterly appeals and grievance data for all programs authorized under this 1115(a) demonstration. The state must submit 60 days after the end of each quarter, appeals and grievance data for BH I/DD Tailored Plans and CFSP. The state must submit the data for four quarters. If additional data is needed after that period, CMS shall provide the state with at least 60 days' notice of the extension of the reporting. In effectuating this requirement, the state must utilize the Appeals and Grievance Reporting Template provided by CMS.

9.18. **State Oversight of Medical Loss Ratio (MLR):** For risk-based plans under the demonstration (i.e., MCOs, and the PIHP), the State must submit the plan generated MLR reports detailed in 42 CFR 438.8(k) as well as any other documentation used to determine compliance with 42 CFR 438.8(k) to CMS at DMCPMLR@cms.hhs.gov. In accordance

with 42 CFR 438.66(e)(2)(i) and 438.66(e)(3)(i), the state must post MLR results on the state's public website.

a. For managed care plans that delegate risk to subcontractors, the State's review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to third-party vendors; see https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf. The State must submit its plan to operationalize STC 9.18 to CMS for review and approval, at DMCPMLR@cms.hhs.gov, no later than six months after the demonstration approval. The workplan must outline key deliverables and timelines to meet the requirements of STC 9.18.

b. Effective January 1, 2026, the State must require risk-based plans contracted with the State to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.

c. No later than January 1, 2027, the State must require risk-based plans contracted with the State to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities.

d. STC 9.18(b) and (c) must apply for all of the following entities:

    i. Risk-based plans for which the State receives federal financial participation for associated expenditures;

    ii. Full and partially delegated plans;

    iii. Other subcontractors, as applicable, that assume delegated risk from either the prime managed care plan contracted with the State, or plans referenced in STC 9.6; and

    iv. Other subcontractors, as applicable, that assume delegated risk from entities, referenced in STC 9.6.

e. The State must work with CMS to effectuate an audit of the MLR data covering all complete rating periods of this 1115 demonstration renewal package. Final audit results and reporting must be provided to CMS no later than two years after the expiration of the current demonstration period. In accordance with 42 CFR 438.602(e) and 438.602(g)(4), the state must post these audit results to the state's public website.

9.19. **Parity in Mental Health and Substance Use Disorder Benefits.** The state and its managed care plans (MCPs) must provide for services to be delivered in compliance with the requirements of 42 CFR § 438.3(n); 42 CFR part 438, Subpart K; and 42 CFR § 440.345(c) and 440.395. The state must:

a. Submit documentation demonstrating how the requirements of 42 CFR 438 subpart K are met no later than 90 days prior to implementation of a new managed care program; a new MCO; or a new prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) that provides services to MCO enrollees.

b. Submit documentation of how the requirements of 42 CFR §§ 440.345(c) and 440.395 are met for Alternative Benefit Plan (ABP) beneficiaries when submitting an ABP State Plan Amendment (SPA) for approval.

c. Post parity compliance documentation for the Standard Plans, BH I/DD Tailored Plans, and CFSP on the state's Medicaid web site as required at 42 CFR § 438.10(c)(3). When implementing a new managed care program or MCP, the state must post parity documentation prior to implementation and explain the intended timing and location (i.e., web site link) for public posting when submitting parity documentation to CMS. After implementation, parity documentation should be maintained and up to date on the state's Medicaid web site concurrently with submission of revised parity documentation to CMS.

d. Revise parity compliance documentation when changes in benefit design or operations could affect compliance (e.g., new benefits, financial requirements, treatment limitations, or correction of deficiencies). This revised parity documentation must be submitted to CMS with the contract submission that effectuates the change in benefit design or operations, subject to CMS review and approval per 42 CFR § 438.3(a).

e. Ensure that all services are delivered to MCO enrollees in compliance with 42 CFR part 438, Subpart K as specified in 42 CFR § 438.920(b), and all essential health benefit (EHB) services to ABP enrollees are delivered in compliance with 42 CFR §§§ 440.345(c) and 440.395. If at any time, the state, MCP(s), or CMS determines that a service is not being delivered in compliance with these parity requirements, the state and each applicable MCP(s) must, without delay and as expeditiously as the enrollee's condition requires, but no later than 30 calendar days after the determination, cease utilizing all treatment limitations that prevent compliance. The state must submit revised SPA(s), contract(s) and rate certification(s) if needed other Federal authority(ies) if needed, and parity compliance documentation to CMS within 90 days of determination of noncompliance.

f. According to the milestones outlined in Attachment K, submit to CMS final documentation of compliance with parity requirements at 42 CFR § 438.3(n) and 42 CFR part 438, Subpart K for the Standard Plan, BH I/DD Tailored Plan, and CFSP MCO programs; and final documentation of compliance with parity requirements at 42 CFR § 440.345(c) and 440.395 for EHBs provided to ABP beneficiaries enrolled in the Medicaid Direct delivery system.

g. Within 90 days of CMS determination of satisfactory completion as described in STC 9.19(h), submit ABP SPA(s) so that the ABP benefit package and all applicable treatment limits therein are described consistent with the State's operational practices as outlined in the completed parity documentation. The ABP must ensure that treatment limitations applicable to all services comply with section 1937 of the Social Security Act. To maintain alignment between the ABP benefits and the traditional state plan, concurrent amendments to the traditional state plan benefit package may also be necessary for the State to ensure that the two benefit packages

remain in alignment in terms of covered benefits and any limitations on amount, duration and scope.

h. The state may not claim FFP for DSHP expenditures described in Section 13 of these STCs until CMS has determined satisfactory completion of removal of all noncompliant parity limits as described further in Attachment K, for all MCO and/or SPA programs operational as of December 10, 2024.

9.20. **Innovations and Traumatic Brain Injury 1915(c) Waiver Programs.** The state will operate this demonstration concurrently with the state's two approved section 1915(c) Home and Community-Based Services (HCBS) waiver programs (Innovations and Traumatic Brain Injury). Together, this 1115 demonstration and the approved section 1915(c) waivers provide the authority necessary for the state to require Medicaid beneficiaries statewide, except those exempted from mandatory enrollment in an MCO in STC 9.4, to enroll in the BH I/DD Tailored Plan to receive these HCBS waiver services.

a. **Eligibility.** Under the demonstration, there is no change in Medicaid eligibility. Standards for eligibility remain as set forth under the state's two concurrent, approved section 1915(c) HCBS waiver programs: Innovations and Traumatic Brain Injury. For the Innovations and Traumatic Brain Injury 1915(c) waiver programs, these waiver program services are delivered through a statewide comprehensive managed care delivery system. Beneficiaries enrolled in either 1915(c) HCBS waiver program are required to enroll in the BH I/DD Tailored Plan in their region to obtain covered 1915(c) waiver benefits.

b. **HCBS Authority.** The 1915(c) waivers of NC-0423 (Innovations) waiver and NC-1326 (Traumatic Brain Injury (TBI) waiver) will continue to be the authority under which the State covers and administers Innovations and Traumatic Brain Injury 1915(c) HCBS. The state must follow the section 1915(c) HCBS waiver amendment process to make all necessary modifications to the HCBS programs and the state must follow the section 1915(c) waiver renewal process to receive approval to continue the 1915(c) HCBS waivers.

10. HEALTHY OPPORTUNITIES PILOTS

During DY 2-6 the state had authority for and began implementation of the Healthy Opportunities Pilots (HOP) program which provided services to address health-related social needs (HRSN).

Beginning in DY 7, the HOP program will comply with the requirements set forth in this new amended and restated Section 10. This section of the STCs establishes a framework for ongoing HOP services, which includes HRSN services (described in STC 10.3 and authorized by expenditure authority #8) as well as additional services authorized through separate non-HRSN expenditure authority (described in STC 10.5 and authorized by expenditure authority #10). The HOP program also includes HRSN infrastructure (described in STC 10.7 and authorized by expenditure authority #9) and non-HRSN infrastructure funding (described in STC 10.8 and authorized by expenditure authority #11) to support providers' investments in

the development and implementation of new HOP program services. All HOP requirements are discussed in this Section 10.

10.1. **HOP Program Glide Path.** Given that the state has already implemented the HOP Program, which is being modified by this demonstration, CMS will permit the state to come into compliance with the terms of STC 10.1 according to the timeframes outlined below. No other flexibility is provided.

a. **HOP Services Phase Out.** By no later than the beginning of DY 8, the state must phase out HOP Services that do not meet the requirements of STCs 10.3-10.6. Prior to DY 8, the state may continue to provide and claim FFP for all HOP Services in currently operated HOP regions that were authorized under the previous North Carolina Medicaid Reform Demonstration. The previously approved services are listed in Attachment L: 2022-2024 Healthy Opportunities Pilot Program Eligibility and Services. The state must provide updates in the monitoring reports on how the state is phasing out the HOP Services that do not meet the requirements of STCs 10.3-6 including utilization of those services during the glide path described in STC 10.1.

i. **Launch of New HOP Services.** The state must not offer new HOP services in the currently operated HOP regions or new regions until the following protocols are approved: Attachment M: Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HOP HRSN Services and Attachment N: Additional HOP Services Protocol.

ii. **Restrictions.** The state cannot launch any existing HOP services approved under Attachment L in new regions which will be phased out during the 1-year glide path period.

b. **HOP Eligibility Transition.** By no later than the beginning of DY 9, the state will limit HOP Covered Populations to those that meet the requirements of STC 10.9. Prior to DY 9, the state may continue to provide HOP Services to (and claim FFP for) any beneficiaries who qualified for HOP Services in currently operated HOP regions under the previous North Carolina Medicaid Reform Demonstration. The previously approved eligibility is listed in Attachment L: 2022-2024 Healthy Opportunities Pilot Program Eligibility and Services in the currently operated HOP Pilot Regions. The state must provide updates in the monitoring reports on steps made towards phasing out the expiring HOP eligibility criteria.

i. **Launch of New HOP Eligibility**. The state must not offer HOP Services to newly eligible beneficiaries in the currently operated HOP regions and new regions until the following protocols are approved: Attachment M: Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HOP HRSN Services and Attachment N: Additional HOP Services Protocol.

ii. **Restrictions.** The state cannot use any existing HOP eligibility criteria approved under Attachment L in the new regions of the state that will be phased out during this 2-year glide path period.

c. **HOP Operational Transitions.** By no later than the beginning of DY 9, the state will come into compliance with all operational requirements of this section, including STCs 10.14, 10.17, 10.21, and 10.22. Prior to the beginning of DY 9, the state may continue to utilize the beneficiary and plan protections, data and systems processes, and rate methodologies that were utilized under the previous North Carolina Medicaid Reform Demonstration, unless otherwise updated in accordance with STC 10.22.

d. **Adjustments to the HOP Program Glide Path for Eligibility and Operational Transitions.** If the state faces unforeseen circumstances in meeting a required timeline for STC 10.1(b) and 10.1(c) transitions, it may request an extension for that timeline, subject to CMS review and approval. The state's extension request must be submitted to CMS no later than 6 months prior to the end of the required timeline associated with the transition and must include the required components outlined below:

i. A description of the unforeseen circumstance impacting the state's ability to implement the transition within the required timeline; and

ii. A proposal for a new timeline to implement the required transition, including a description of why this new timeline is reasonable and appropriate that explains how the state will overcome the challenges that have prevented it from meeting the original timeline and any additional challenges the state anticipates to meeting the proposed new timeline.

In order to request an adjustment to the HOP Program Glide Path, North Carolina must submit a letter signed by the state's State Medicaid Director to CMS accompanied by the materials requested above. CMS reserves the right to ask for additional supporting documentation or to request a revised timeline related to the state's extension request. An approved glidepath extension will be published by CMS, with all of the components outlined above, as an attachment to this demonstration. If an extension of the glide path is granted, CMS reserves the right to impose restrictions on the program. For example, CMS may require the state to pause roll out of the HOP program to new regions of the state or cease new eligibility determinations for the program until the state is compliant.

10.2. **Terms for HOP Services.**

a. The state may claim FFP for expenditures for qualifying HRSN services identified in Attachment M and STC 10.3, subject to the restrictions described below. The state may claim FFP for expenditures for additional non-HRSN HOP services identified in Attachment N and STC 10.5, subject to the restrictions described below. Expenditures are limited to expenditures for items and services not otherwise

covered under title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care.

b. All HOP interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors. The state is required to align clinical and social risk criteria across services and with other non-Medicaid social support agencies, to the extent possible.

c. HOP services may not supplant any other available funding sources, such as housing or nutrition supports available to the beneficiary through other local, state, or federal programs.

d. HOP services will be the choice of the beneficiary; a beneficiary can opt out of HOP services at any time; and HOP services do not absolve the state or HOP Administrators of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on receipt of HOP services.

e. HOP services may be offered statewide.

10.3. **Allowable HOP HRSN Services.** The state may cover the following HOP HRSN services:

a. Housing Interventions, including:

i. Housing supports without room and board, including:

i. Housing transition and navigation services (e.g., finding and securing housing).

ii. Pre-tenancy navigation services.

iii. One-time transition and moving costs to assist with identifying, coordinating, securing, or funding one-time necessary services and modifications to help a person establish a basic household (e.g., security deposit, application and inspection fees, utilities activation fees, movers, relocation expenses, payment in arrears (capped at a total of six months of total arrear and prospective payments), pest eradication, and the purchase of household goods and furniture). Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services.

iv. Tenancy and sustaining services and individualized case management (e.g., linkages to state and federal and state benefit programs, benefit program application assistance and fees, eviction prevention, tenant rights education).

ii. Utility assistance, capped at six months in total per demonstration period prospective/retrospective payments, including activation expenses and back

payments to secure utilities, limited to individuals receiving housing supports as described above. Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services.

iii. Home remediations that are medically necessary, including, for example, air filtration devices, air conditioning, ventilation improvements, humidifiers, refrigeration for medication, carpet replacement, mold and pest removal, and/or housing safety inspections.

iv. Home/environmental accessibility modifications, including, for example, wheelchair accessibility ramps, handrails, and grab bars.

v. Episodic housing interventions with clinical services with room and board limited to:

i. Short-term recuperative care (also referred to as medical respite) where integrated, clinically oriented recuperative or rehabilitative services and supports (e.g., physical, psychosocial, behavioral) are provided for individuals who require ongoing monitoring and continuous access to medical care.

ii. Short-term post-transition housing (also referred to as post-hospitalization housing), where integrated, clinically oriented rehabilitative services and supports (e.g., physical, psychosocial, behavioral) are provided, but ongoing monitoring of the individual's condition by clinicians is not required.

vi. Room and board-only supports limited to:

i. First month's rent as a transitional service.

ii. Short-term rental assistance with room alone or with room and board together, without clinical services included in the rental assistance payment.

b. Nutrition Interventions, considered standalone outside of joint room and board interventions:

i. Case management services for access to food/nutrition, including, for example outreach and education and/or linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees.

ii. Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including guidance on selecting healthy food and meal preparation.

iii. Home delivered meals, medically tailored meals, or pantry stocking, for qualifying beneficiaries not receiving nutrition interventions identified in STC 10.3(b)(iv).

iv. Nutrition prescriptions tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including, for example, fruit and vegetable prescriptions, protein box prescriptions, food pharmacies, and/or healthy food vouchers, for qualifying beneficiaries not receiving nutrition interventions identified in interventions identified in STC 10.3(b)(iii).

10.4. **HRSN Intervention Duration and Frequency**

a. Housing interventions that are classified as episodic interventions, as described in STC 10.3.a.v. may be covered for a qualifying beneficiary, as medically appropriate, up to a combined 6 months per rolling year. For purposes of this demonstration, rolling year is defined as a continuous 12-month period with the start date beginning when the beneficiary begins receiving the service.

b. Housing interventions that are classified as room and board-only support, as described in STC 10.3.a.vi., may be covered for a qualifying beneficiary up to a combined 6 months per household per demonstration period.

c. For each of these 6-month caps, coverage will be permitted in one or more spans or episodes, as long as the total duration remains under the cap for the rolling year or demonstration period. CMS will also apply a total combined cap of 6 months for all types of HRSN housing interventions with room and board, per beneficiary, in any 12-month period.

d. The state will define other HRSN service duration limitations in Attachment M, subject to CMS approval, as indicated in STC 10.10.

10.5. **Additional Allowable HOP non-HRSN Services.** The state may cover the following services as part of the HOP program.

a. Interpersonal Violence/Toxic Stress Services:

i. Interpersonal Violence (IPV) case management services to support individuals with addressing sequelae of community and/or relationship violence.

ii. Violence intervention services, such as individualized psychological education related conflict resolution and linkages to community engagement activities.

iii. Evidence-based parenting classes.

iv. Home-visiting services.

b. Provision of the CDC-recognized Diabetes Prevention Program.

c. Holistic high-intensity enhanced case management, to support individuals who have co-occurring needs related to housing issues and interpersonal violence/toxic stress.

d. Linkages to Health-Related Legal Supports. This service will provide qualifying individuals with assistance in accessing supports to assess legal issues in the housing, nutrition and interpersonal violence/toxic stress service domains. Assistance includes support to help beneficiaries understand their rights and connect them to legal resources and tools that support resolution of the issue provided by individuals with legal expertise.

    i. This service is limited to covering the following activities:

        i. Assessing a beneficiary 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, and/or address other legal needs related to the nutrition domain and services, including by reviewing information such as specific facts, documents (e.g., leases, notices, and letters), laws, and programmatic rules relevant to a beneficiary's current or potential legal problem;

        ii. Helping beneficiaries understand their legal rights related to maintaining healthy and safe housing and/or mitigating or eliminating exposure to interpersonal violence or toxic stress or address other legal needs related to the nutrition domain and services (e.g., explaining rights related to landlord/tenant disputes, explaining the purpose of an order of protection and the process for obtaining one).

        iii. Identifying potential legal resources, tools and strategies that may help a beneficiary to secure or maintain healthy and safe housing, mitigate or eliminate exposure to interpersonal violence or toxic stress, and/or address other legal needs related to the nutrition domain and services, (e.g., providing self-advocacy instructions, connecting with resources to remove a former partner's debts from credit rating).

    ii. This service does not include legal representation, such as making contact with, drafting communication to, or negotiating with a beneficiary's potential adverse party (e.g., landlord, abuser, creditor, or employer) or representing a beneficiary in litigation, administrative proceedings, or alternative dispute resolution proceedings. In addition, this service does not include drafting or preparing any *pro se* documentation.

    iii. To the extent this service constitutes the practice of law, this service may not be provided by someone not licensed or otherwise authorized to practice law in North Carolina.

e. Non-Medical Transportation[3] for HOP HRSN Services:

[3] Non-Medical Transportation is defined as transportation services offered in order to enable participants to gain access to 1915(c) waiver-coverable activities, community services, and resources, as specified by the beneficiary's care plan. NMT may be provided to receive HRSN services.

i. Non-medical transportation (NMT) services may be provided to Medicaid beneficiaries eligible for HOP HRSN services to and from HRSN services authorized under this demonstration. The HRSN services must also be described in the beneficiary's care plan.

ii. All NMT must be provided in alignment with the technical specifications, and safeguards required for non-medical transportation authorized under 1915(c) waiver or under 1915(i) state plan authorities.

f. Non-Emergency Medical Transportation[4] and NMT for HOP non-HRSN Services:

i. Non-emergency medical transportation services may be provided to Medicaid beneficiaries to and from HOP Program services specified n STC 10.5(a-b).

ii. Non-medical transportation services may be provided to Medicaid beneficiaries to and from HOP Program services specified in STC 10.5(c).

iii. The HOP service must also be described in the beneficiary's care plan.

10.6. **Excluded HOP Services and Infrastructure.** Excluded items, services, and activities that are not covered as HOP services or infrastructure include, but are not limited to:

a. Construction (bricks and mortar) except as needed for approved medically necessary home modifications as described in STC 10.3(a)(iv);

b. Capital investments;

c. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months, except as specified in STCs 10.3 and 10.4;

i. Room and board may not be

a. Congregate sleeping space,

b. Facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers),

c. Facilities where sleeping spaces are not available to residents 24 hours a day,

d. Facilities without private sleeping space.

d. Research grants or expenditures not related to monitoring and evaluation of this demonstration;

e. Services furnished to beneficiaries for which payment is not available under the inmate payment exclusion in the matter following the last numbered paragraph of

[4]For purposes of this demonstration, Non-Emergency Medical Transportation is necessary transportation for eligible Medicaid beneficiaries to and from covered medical services.

section 1905(a) of the Act except those HRSN-related case management services provided as part of an approved reentry demonstration initiative;

f. Services provided to individuals who are not lawfully present in the United States;

g. Expenditures that supplant services and activities funded by other state and federal governmental entities;

h. School-based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education or a state or local education agency;

i. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

j. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HOP item or service under this demonstration.

10.7. **HOP HRSN Infrastructure.**

a. The state may claim FFP for expenditures for Human Service Organizations' and Network Leads' infrastructure investments in order to support the development and implementation of HOP HRSN services, subject to STC 10.3. This FFP will be available for the following activities:

i. Technology – e.g., electronic referral systems, shared data platforms, electronic heath record (EHR) modifications or integrations, screening tool and/or case management systems, licensing, databases/data warehouses, data analytics and reporting, data protections and privacy, and accounting and billing systems.

ii. Development of business or operational practices – e.g., developing policies, procedures and workflows, training and technical assistance, and administrative activities to support or expand HOP operations.

iii. Workforce development – e.g., recruiting and hiring, salary and fringe benefits for staff, necessary certifications, cultural competency training, trauma-informed training, developing and training staff on new policies and procedures, and training materials.

iv. Outreach, education, and interested parties convening – e.g., design and production of outreach and education materials, translation, obtaining community input, investments in interested parties convenings and community engagement activities.

b. The state may claim FFP in HOP HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 6. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts

will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 6. Annual Limits of Allowable Total Computable Expenditures for HOP HRSN Infrastructure

	DY7	DY8	DY9	DY10	DY11	Total
Total Computable Expenditures	$39.9M	$119.7M	$99.75M	$19.95M	$19.95M	$299.25M

c. Infrastructure investments will receive the applicable administrative match for the expenditure.

d. This infrastructure funding is separate and distinct from the payment to the applicable HOP Administrators for delivery of HOP HRSN services. The state must ensure that HOP infrastructure expenditures described in this STC 10.7 are not factored into HOP Administrator capitation payments, and that there is no duplication of payments to HOP Administrators.

e. The state may not claim any FFP in HOP infrastructure expenditures until Attachment P: HOP Infrastructure Protocol is approved, as described in STC 10.13, except as otherwise provided in STC 10.1. Once approved, the state can claim FFP in HOP infrastructure expenditures retrospectively to the beginning of when the demonstration expenditure authority for HOP HRSN infrastructure was approved.

f. The state may allocate up to 80% of infrastructure expenditures to the HOP HRSN infrastructure expenditure authority and 20% of infrastructure expenditures to the additional non-HRSN HOP infrastructure expenditure authority as further specified in STC 10.8. However, the expenditure authorities are separate and distinct amounts, and the state cannot shift funds between each expenditure authority amount.

g. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

10.8. **Additional HOP Infrastructure for Non-HRSN Services.**

a. The state may claim FFP for expenditures for Human Service Organizations' and Network Leads' infrastructure investments in order to support the development and implementation of additional HOP non-HRSN services, subject to STC 10.5. This FFP will be available for the following activities:

i. Technology – e.g., electronic referral systems, shared data platforms, electronic heath record (EHR) modifications or integrations, screening tool

and/or case management systems, licensing, databases/data warehouses, data analytics and reporting, data protections and privacy, and accounting and billing systems.

ii. Development of business or operational practices – e.g., developing policies, procedures and workflows, training and technical assistance, and administrative costs to support or expand HOP operations.

iii. Workforce development – e.g., recruiting and hiring, salary and fringe for staff, necessary certifications, cultural competency training, trauma-informed training, developing and training staff on new policies and procedures, and training materials.

iv. Outreach, education, and interested parties convening – e.g., design and production of outreach and education materials, translation, obtaining community input, investments in interested parties convenings, and community engagement activities.

b. The state may claim FFP in additional HOP non-HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 7. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year. As noted in STC 18.4, expenditure authority for HOP infrastructure for non-HRSN services counts against budget neutrality savings.

Table 7. Annual Limits of Allowable Total Computable Expenditures for Additional HOP non-HRSN Infrastructure

	DY7	DY8	DY9	DY10	DY11	Total
Total Computable Expenditures	$10.1M	$30.3M	$25.25M	$5.05M	$5.05M	$75.75M

c. Infrastructure investments will receive the applicable administrative match for the expenditure.

d. This infrastructure funding is separate and distinct from the payment to the applicable HOP Administrators for delivery of HOP non-HRSN services. The state must ensure that HOP infrastructure expenditures described in STC 10.8 are not factored into HOP Administrator capitation payments, and that there is no duplication of payments to HOP Administrators.

e. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

10.9. **Covered Populations.** Expenditures for HOP services may be made for the targeted populations specified in Attachment M and Attachment N, consistent with this STC. Individuals eligible to receive HOP services are Medicaid eligible and have documented medical need for the services and the services must be determined medically appropriate, as described in STC 10.2, for the documented need. Medical appropriateness must be based on clinical and social risk factors. This determination must be documented in the beneficiary's care plan or medical record. Additional detail, including the clinical criteria and social risk factors, is outlined in Attachment M for HOP HRSN services and Attachment N for additional HOP non-HRSN services. Attachment O, the HOP Service Matrix, which is approved with these STCs at the time of the demonstration approval, describes the full list of clinical and social risk factors[5] that the state is authorized to incorporate into Attachment M and Attachment N. Additionally, the state may later include additional clinical and social risk factors in Attachment O in compliance with STC 10.12, subject to CMS review and approval.

10.10. **Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HOP HRSN Services.** The state must submit, for CMS approval, a Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications to CMS no later than 90 days after approval of the expenditure authority for HOP HRSN services. The protocol must include, as appropriate, a list of the HOP HRSN services and service descriptions, the criteria for defining a medically appropriate population (e.g. clinical and social risk factors) for each service, the process by which that criteria will be applied including care plan requirements or other documented processes, and provider qualification criteria for each service. Any changes to the list of clinical and social risk factors reflected in Attachment O must be effectuated through the process indicated in STC 10.12. The state must resubmit a revised protocol as may be required by CMS feedback on the initial submission. The state may not claim FFP for HOP HRSN services until CMS approves the initial protocol, except as otherwise provided in STC 10.1. Once the initial protocol is approved, the state can claim FFP in HOP HRSN services retrospectively to the beginning of the demonstration approval of the expenditure authority for HOP HRSN services. The approved protocol will be appended to the STCs as Attachment M: Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HOP HRSN Services. No later than 90 days after the approval of an amendment to the demonstration that adds new HRSN services, the state must submit revisions to the Protocol to CMS. The revisions must include a list of the new services and service descriptions provided through all delivery systems applicable, the criteria for defining a medically appropriate population for each new service, the process by which that criteria will be applied including service plan requirements or other documented processes, and provider qualification criteria for each new service.

Specifically, the protocol must include the following information:

a. A list of only the covered HOP HRSN services, (i.e., not including HOP non-HRSN services), not to exceed those allowed under STC 10.3, with associated service

[5] At the time of the approval, Attachment O only includes the HRSN social risk factors. The social risk factors for additional HOP non-HRSN services will be incorporated post-approval in Attachment O.

descriptions and service-specific provider qualification requirements.

b. A description of the process for identifying beneficiaries for HOP HRSN services with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

c. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider or HOP Administrator, using their professional judgement, may determine the service to be medically appropriate.

    i. Plan to identify medical appropriateness based on clinical and social risk factors.

    ii. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries, providers, and other interested parties.

d. A description of the process for developing care plans based on assessment of need.

    i. Plan to initiate closed-loop referrals to social services and community providers based on the outcomes of screening.

    ii. Description of how the state will ensure that HOP HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma-informed.

e. Plan to avoid duplication/displacement of existing food assistance/nutrition services, including how the state will prioritize and wrap around Supplemental Nutrition Assistance Program (SNAP) and/or Women Infants and Children (WIC) enrollment, appropriately adjust HRSN Medicaid benefits for individuals also receiving SNAP and/or WIC services, and ensure eligible beneficiaries are enrolled to receive SNAP and/or WIC services.

f. An affirmation that the state agrees to meet the enhanced monitoring and evaluation requirements stipulated in STC 15.6 and STC 16.6 which require the state to monitor and evaluate how the renewals of recurring nutrition services in STC 10.3(b)(iii and iv) affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services. As required in STC 15.5 and STC 16.4, the Monitoring Protocol and Evaluation Design are subject to CMS approval.

10.11. **Additional HOP Services Protocol.** The state must submit, for CMS approval, an Additional HOP Services Protocol to CMS no later than 90 days after approval of the expenditure authority for HOP non-HRSN services. The protocol must include, as appropriate, a list of the HOP non-HRSN services and service descriptions, the criteria for defining a medically appropriate population for each service, the process by which that criteria will be applied including care plan requirements or other documented processes, and provider qualification criteria for each service. The state must resubmit a revised protocol as may be required by CMS feedback on the initial submission. The protocol may

be updated as the services and/or clinical and social risk factors authorized by CMS are changed by the state, consistent with STC 10.12. The state may not claim FFP for HOP non-HRSN services until CMS approves the protocol, except as otherwise provided in STC 10.1. Once the protocol is approved, the state can claim FFP in HOP non-HRSN services retrospectively to the beginning of the demonstration approval of the expenditure authority for HOP non-HRSN services. The approved protocol will be appended to the STCs as Attachment N: Additional HOP Services Protocol. No later than 90 days after the approval of an amendment to the demonstration that adds new additional HOP non-HRSN services, the state must submit revisions to the Protocol to CMS. The revisions must include a list of the new services and service descriptions provided through all delivery systems applicable, the criteria for defining a medically appropriate population for each new service, the process by which that criteria will be applied including service plan requirements or other documented processes, and provider qualification criteria for each new service.

Specifically, the protocol must include the following information:

a. A list of the covered HOP non-HRSN services only, (i.e., not including HOP HRSN services), not to exceed those allowed under STC 10.5, with associated service descriptions and service-specific provider qualification requirements.

b. A description of the process for identifying beneficiaries for HOP non-HRSN services with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

c. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider or HOP Administrator, using their professional judgement, may determine a service to be medically appropriate.

    i. Plan to identify medical appropriateness based on clinical and social risk factors.

    ii. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries, providers, and other interested parties.

d. A description of the process for developing care plans based on assessment of need.

    i. Plan to initiate closed-loop referrals to social services and community providers based on the outcomes of screening.

    ii. Description of how the state will ensure that HOP non-HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma-informed.

10.12. **Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HOP HRSN Services and the Additional HOP Services Protocol.**

a. The state may choose to cover a subset of the HRSN and/or non-HRSN services and/or beneficiary eligibility within what is approved in Attachments M, N, and O. Changes to the state's service offerings and eligibility criteria, within what CMS has approved in Attachment O, do not require additional CMS approval. The state must notify CMS of changes to the HOP services and/or beneficiary eligibility in Attachment M and Attachment N, by the following process:

    i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.

    ii. The state must provide public notice.

    iii. The state must submit a letter to CMS 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.

b. In addition to the requirements in (a) above, if the state seeks to implement additional clinical and social risk factors than what were included in Attachment O at the time of the demonstration's extension, the state must follow the process below to update the protocol:

    i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not increase the state's HOP HRSN expenditure authority and HOP non-HRSN expenditure authority in Table 14, Table 19, and Table 20.

    ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this STC 10.12(b).

    iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in STC 10.12(b). This restriction is not applicable to the process and scope of changes outlined in (a).

10.13. **HOP Infrastructure Protocol.** The state must submit, for CMS approval, a HOP Infrastructure Protocol to CMS no later than 90 days after approval of the expenditure authority for HOP HRSN and non-HRSN infrastructure. The protocol must include uses of HRSN and non-HRSN infrastructure funds. The state must resubmit the revised protocol as may be required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP for HOP HRSN and

non-HRSN infrastructure expenditures until CMS approves the protocol, except as otherwise provided in STC 10.1. Once the protocol is approved, the state can claim FFP in HOP HRSN and non-HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval of the expenditure authority for HOP HRSN and non-HRSN infrastructure. The approved protocol will be appended to the STCs as Attachment P: HOP Infrastructure Protocol. No later than 90 days after the approval of an amendment to the demonstration that adds new HRSN or non-HRSN services, the state must submit revisions to the Protocol to CMS if needed. The revisions must include a list of proposed uses of HRSN and non-HRSN infrastructure funds, if different than previously submitted.

a. Specifically, the protocol(s) must include proposed uses of HRSN and non-HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

10.14. **Service Delivery.** As outlined in STC 10.16, HOP services will be delivered by networks of Human Services Organizations (HSOs) that are contracted and overseen by state-procured Network Leads (NLs). HOP Administrators will be required by the state to contract with NLs and support HOP-related operations, including service authorization and key member-facing functions (e.g., eligibility and service assessments), in collaboration with contracted HSOs.

a. HOP Administrators must contract with NLs operating in their service area.

b. HOP Administrators must offer HOP services in all service areas in which the HOP Administrator operates.

c. The state will phase in HOP services to be offered statewide based on readiness.

d. The state may continue to offer HOP services authorized under the prior demonstration in HOP counties that participated in that demonstration, to the extent those services are also authorized under this demonstration.

e. HOP services will be provided in the managed care delivery system. When HOP services are provided to beneficiaries enrolled in Medicaid managed care, the following terms apply:

i. Under a non-risk payment, the MCO/PIHP/PAHP is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362 and may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, fee-for-service as defined in 42 CFR 447.362 is the fee-for-service authorized in this demonstration for HOP Services paid on a fee-for service basis by the state. The managed care plan contracts must clearly document the process and methodology for non-risk payments.

ii. All non-risk payment contracts must be separate and apart from risk-based contracts. This can be accomplished as either a separate non-risk contract with a prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP) (see the definition of "non-risk contract" at 42 C.F.R. § 438.2) or as an amendment to a state's existing risk-based managed care plan contracts to include a non-risk payment. The state must clearly delineate what services/populations are covered under non-risk contracts either through a separate section of the contract or a separate contract from those services and costs that are part of the risk-based contract. All of the costs of delivering services under a non-risk contract must be excluded from the development of the risk-based capitation rates for the risk-based contracts. Specifically, the costs of delivering the services as well as any costs of administering the non-risk contract must be excluded from the development of the risk-based capitation rates; the state must take measures to ensure there is no duplication of payments for either the delivery of such service or the administrative costs of delivering such services.

iii. Prior written CMS approval pursuant to STC 10.15 is required before the state moves to incorporate the HOP services into the risk-based capitation rates in Medicaid managed care, and the state must comply with all applicable federal requirements, including but not limited to 42 CFR 438.4, 438.5, 438.6, and 438.7. The state may no longer utilize non-risk contracts for those HOP services that have moved into risk-based managed care.

iv. Any applicable HOP services that are delivered by managed care plans in a risk arrangement, must be included in the managed care contracts and rate certifications submitted to CMS for review and approval in accordance with 42 CFR 438.3(a) and 438.7(a). The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the inclusion of HOP services in managed care programs.

v. All expenditures for HOP services delivered under non-risk contracts must be excluded from MLR reporting. When HOP services (i.e., HOP services defined in STC 10.3 and 10.5 for the covered populations outlined in STC 10.9) are included in capitation rates paid to managed care plans under risk-based contracts, and only then, should HOP services be reported in the MLR reporting as incurred claims.

vi. The state must develop an MLR monitoring and oversight process specific to HOP services. This process must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HOP services in risk-based managed care contracts and capitation rates. The state should submit this process to CMS at DMCPMLR@cms.hhs.gov. This process must specify how HOP services will be identified for inclusion in capitation rate setting and in the MLR numerator. The state's plan must indicate how expenditures for HOP administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs.

f. In accordance with STC 10.15 and as part of/after CMS issues written approval for the state to move HOP services into risk-based managed care contracts, CMS expects the state to have appropriate encounter data associated with each HOP service. This is necessary to ensure appropriate fiscal oversight for HOP services as well as monitoring and evaluation. This is also critical to ensure appropriate base data for Medicaid managed care rate development purposes as well as appropriate documentation for claims payment in managed care and FFS. Therefore, CMS requires that for HOP services provided by a HOP Administrator, the state must include the name and definition of each HOP service as well as the coding to be used on claims and encounter data in the HOP Administrator contracts. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology codes that that identify each HOP service. Additionally, for HOP services provided in a FFS delivery system, this information must be clearly documented. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 10.22.

10.15. **Requirements for HOP Services prior to being delivered in risk-based managed care.** The state's plan to incorporate HOP services into risk-based managed care contracts must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HOP services in risk-based managed care contracts and capitation rates. At least 6 months prior to moving HOP services approved under these STCs into risk-based Medicaid managed care contracts, the state must submit to CMS, for review and written prior approval, documentation that details the following information:

a. Each HOP service defined in STC 10.3 and STC 10.5, and each covered population that will receive each HOP service defined in STC 10.9 where the state is seeking CMS written approval to be delivered through one or more risk-based managed care program(s). The applicable managed care program(s) for each service and population should also be specified.

b. If the HOP service will be offered in all regions under each risk-based managed care program or if the offerings will be limited geographically.

c. The first rating period the state is seeking to start offering the HOP service(s) through risk-based managed care. If the HOP services will be delivered through risk-based managed care on a rolling basis, provide the timeline for each service.

d. The state's timeline to complete a readiness review pursuant to 42 CFR 438.66(d). Implementation may only begin when each MCO has been determined by the state to meet certain readiness and network requirements, including providing any documentation specified by CMS.

e. A transition of care plan that provides continuity of care for beneficiaries transitioning from another delivery system (e.g. FFS) or non-risk contracts into risk-based contracts.

f. A description of base data that the state and its actuary plan to use for capitation rate setting process to develop both the benefit and non-benefit costs, including the types of data used (FFS claims data, managed care encounter data, managed care plan financial data, etc.) and the data source(s) that will be used for capitation rate development. Consistent with Medicaid managed care rate development requirements under 42 CFR 438.5(c), CMS requires at least 3 years of encounter data or similar data (e.g. cost reports, claims data) for the HOP services defined in STC 10.3 and 10.5 for the covered populations outlined in STC 10.9 that will be incorporated into risk-based managed care. CMS will consider exceptions to the requirement for 3 years of base data for periods impacted by COVID-19.

g. The methodology the state's actuary will use in the capitation rate setting process, including but not limited to, any trend factors and adjustments to the data the state and its actuary will apply to the base data in the capitation rate setting process. The methodology should also include information on the approach the actuary will take to incorporating the HOP service(s) into capitation rate development (for example, if the actuary will create an add-on that will be applied to some or all existing rates cells, creating a separate rate cell, or some other method) and any changes to or new risk adjustment or acuity adjustments applied due to the inclusion of the HOP services defined in STC 10.3 and 10.5 for the covered populations outlined in STC 10.9.

h. If the state is planning to delegate risk for the delivery of HOP services to clinical providers, community organizations, and/or subcontractors for specific HOP services, the capitation rate setting plan should include a description of these proposed delegated arrangements and/or sub-capitated payment arrangements that the state intends to use in the delivery of any HOP services defined in STC 10.3 and 10.5 for covered populations outlined in STC 10.9.

i. Identification of any in-lieu of services (ILOS) the state currently offers through its managed care programs and if there will be changes to those ILOS as a result of the state moving these HOP service(s) into risk-based managed care contracts.

j. Because of the uncertainty associated with HOP services and in alignment with past guidance about situations with high levels of uncertainty, CMS is requiring the state to implement a 2-sided risk mitigation strategy (such as a 2-sided risk corridor) to provide protection for state and federal governments, as well as managed care plans. The HOP capitation rate setting plan should provide a description of the risk mitigation mechanism(s) that will be used in the transition of HOP services to risk-based managed care. As part of plan to incorporate HOP into risk-based managed care, the State will also need to develop an MLR monitoring and oversight process specific to HOP services. This process must specify how HOP services will be identified for inclusion in the MLR numerator. The state's plan must indicate how expenditures for HOP administrative costs will be identified and reported by managed care plans as non-claims costs.

k. All state directed payments the state plans to implement for any HOP services defined in STC 10.3 and 10.5 for the covered populations outlined in STC 10.9 provided under risk-based contracts must comply with all applicable federal requirements, including but not limited to 42 CFR 438.6(c). The state should submit this information to CMS at statedirectedpayment@cms.hhs.gov.

10.16. **Contracted Providers and Participating Entities.** The following entities will participate in the HOP program.

a. **HOP Administrator.** A HOP Administrator includes any managed care plan participating as one, subject to the requirements outlined below. The HOP Administrator will serve as a point of contact with the state. The HOP Administrator may execute many of its member-facing HOP-related responsibilities in partnership with employed care managers and human service organizations.

i. Under non-risk contracts, HOP Administrators will pay HSOs service delivery rates set by the state for the provision of applicable HOP services, consistent with state guidance for these services, and in compliance with all related federal requirements. Under risk-based contracts, any state direction of managed care plan expenditures would be considered a state directed payment subject to the requirements in 42 CFR 438.6(c).

ii. **MCOs that serve as the HOP Administrator.** Under the oversight of the state's Medicaid managed care program, the state shall require that all MCOs that have any share of their business within any of the HOP regions be contractually obligated to participate in the HOP program and be responsible for authorizing the provision of all HOP services to eligible managed care beneficiaries who are enrolled in the MCO, within state guidelines and these STCs. The BH I/DD Tailored Plans and Children and Family Specialty Plan will be required to participate in the HOP program only after the state determines their readiness to cover HOP services.

iii. **Other Non-MCO Managed Care Plans (MCPs) that serve as the HOP Administrator.** Under the oversight of the state's Medicaid managed care program, the state may allow any other non-MCO MCP with any share of its business within HOP regions, including Primary Care Case Management Entities (PCCM-Es), Primary Care Case Managers (PCCMs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs), to become a HOP Administrator through either a non-risk or risk-based contract, provided the non-MCO MCP demonstrates a readiness to participate in the HOP program and receives approval from the North Carolina Department of Health and Human Services (DHHS) to participate in the program. Approval may only be based on both the non-MCO MCP's readiness and the state's capacity to monitor and oversee another participating non-MCO MCP's performance. Approved non-MCO HOP Administrators, like MCO HOP Administrators, are responsible for authorizing the provision of all HOP services to beneficiaries who are eligible for those services and who are enrolled in (or able to enroll in) the MCP, within state guidelines and

these STCs. The state must notify CMS when it approves a new non-MCO HOP Administrator and must update its Evaluation Design to account for the new populations served by the new HOP Administrator, if applicable. The state may serve as the HOP Administrator in select cases where it is best positioned to administer HOP to those beneficiaries/populations. The state cannot serve as a HOP Administrator in a risk-based arrangement.

b. **Network Leads (NLs).** The state must select a NL for each HOP region. The NL will support the HOP Administrator in its region in identification of eligible HOP beneficiaries. The NL will develop the network of participating HSOs delivering HOP services which helps to ensure the beneficiary receives services based on identified needs.

c. **Human Services Organizations (HSOs).** HSOs are the frontline providers of authorized HOP services. HSOs may contract with one or more NL(s) operating in their region to participate in the HOP network.

    i. HSOs do not need to be licensed, however, staff offering services through HSOs must be licensed, certified, or otherwise credentialed when they are practicing in a field to which licensing, certification, or other credentialing requirements apply in the state.

10.17. **Provider Network Capacity.** HOP Administrators and NLs must collaborate to ensure the HOP services authorized under the demonstration are provided to eligible beneficiaries in a timely manner and shall develop policies and procedures outlining an approach to managing provider shortages or other barriers to timely provision of the HOP services, in accordance with the HOP Administrator and NL contracts and other state Medicaid/operating agency guidance.

10.18. **Compliance with Federal Requirements.** The state shall ensure HOP services are delivered in accordance with all applicable federal statutes and regulations.

10.19. **Person-Centered Service Plan.** The state shall ensure there is a person-centered service plan for each individual receiving HOP services that is person-centered, identifies the member's needs and individualized strategies and interventions for meeting those needs, and be developed in consultation with the member and the member's chosen support network as appropriate. The service plan must be reviewed and revised at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

10.20. **Conflict of Interest.** The state shall ensure appropriate protections against conflicts of interest in the service planning. The state also agrees that appropriate separation of service planning and service provision functions are incorporated into the state conflict of interest policies.

10.21. **CMS Approval of HOP Administrator Contracts.** As part of the state's submission of associated Medicaid HOP Administrator contracts to implement HOP services through managed care, the state must include contract requirements including, but not limited to:

a. Beneficiary and plan protections, including but not limited to:

    i. HOP services must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid covered services.

    ii. Medicaid beneficiaries always retain their right to receive Medicaid covered services on the same terms as would apply if HOP services were not an option.

    iii. Medicaid beneficiaries who are offered or utilize a HOP service retain all rights and protections afforded under 42 CFR 438. The state and its HOP Administrators must ensure these rights and protections are implemented no later than the end of DY 8.

    iv. HOP Administrators are not permitted to deny a beneficiary a Medicaid covered service on the basis that they are currently receiving HOP services, have requested these services, or have previously received these services.

    v. HOP Administrators are prohibited from requiring a beneficiary to utilize HOP services.

b. HOP Administrators must timely submit data requested by the state or CMS, including, but not limited to:

    i. Data to evaluate the utilization and effectiveness of the HOP services.

    ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities.

    iii. Any data necessary to monitor appeals and grievances for beneficiaries.

    iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HOP services.

    v. Any data determined necessary by the state or CMS to monitor and oversee the HOP program.

c. All data and related documentation necessary to monitor and evaluate the HOP program, including cost assessment, to include but not be limited to:

    i. The HOP Administrators must submit timely and accurate encounter data to the state for beneficiaries eligible for HOP services. When possible, this encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the state.

ii. Any additional information requested by CMS, the state or legally authorized oversight body to aid in on-going evaluation of the HOP services or any independent assessment or analysis conducted by the state, CMS, or a legally authorized independent entity.

iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports its progress in building and sustaining its partnership with existing housing agencies and nutrition agencies to utilize their expertise and existing housing resources and avoid duplication of efforts.

iv. Any additional information determined reasonable, appropriate and necessary by CMS.

10.22. **HOP Rate Methodologies.** The state may continue to use rate and/or payment methodologies approved by CMS during the prior demonstration period in alignment with STC 10.1 until an updated methodology is approved. For all subsequent payment methodologies and/or rates, the state must comply with the payment rate-setting requirements in 42 CFR subpart Part 447, subpart B, as though a state plan amendment were required, to establish any payment rate and/or methodology for HRSN services as approved under demonstration expenditure authority 8. The state must conduct state-level public notice under 42 CFR 447.205 prior to the implementation of the applicable payment rates or methodologies for HRSN services and maintain documentation of the payment rates or methodologies on its website as described in 42 CFR 447.203(b)(1).) In addition to submitting the payment rates and/or methodology, the state must also submit all supporting documentation requested by CMS, including but not limited to how the rates and/or methodology were developed, state responses to any public comments on the rates and/or methodology, and information about Medicaid non-federal share financing. The state must also notify CMS at least 60 days prior to the intended implementation if it intends to direct its managed care plans on how to pay for HRSN services. The state may draw FFP for HRSN service expenditures authorized under this demonstration upon implementation of the payment rates and/or methodologies for which it has conducted prior public notice or for which it received CMS approval during the prior demonstration period. However, any payments to providers or claims for FFP prior to CMS approval of the payment rate or methodology must be reconciled to the ultimately approved payment rate and/or methodology within one year of CMS's approval, and all requirements for timely filing of claims for FFP continue to apply.

10.23. **Maintenance of Effort (MOE).** As HOP HRSN services must not supplant existing social services and housing assistance, the state must maintain a baseline level of state funding for ongoing social services related to the categories of housing transition supports and nutrition supports for the duration of this demonstration, not including one time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HOP Implementation Plan that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 15.6, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.

10.24. **Partnerships with State and Local Entities.** The state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority, Supplemental Nutrition Assistance Program (SNAP) state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, in alignment with beneficiary needs identified in the care plans as appropriate. The state will submit a plan to CMS as part of the HOP Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and nutrition supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 15.6, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.

10.25. **Provider Payment Rate Increase.** As a condition of the HOP services and infrastructure expenditure authorities, the state must comply with the provider rate increase requirements in Section 14 of the STCs.

10.26. **HOP Implementation Plan.**

a. The state is required to submit a HOP Implementation Plan that will elaborate upon and further specify requirements for the provision of HOP services (inclusive of HRSN and non-HRSN services) and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The state must submit the MOE information required by STC 10.23 no later than 90 calendar days after approval of demonstration authority to cover HOP HRSN and non-HRSN services. All other Implementation Plan requirements outlined in this STC must be submitted no later than 9 months after the approval of demonstration authority to cover HOP HRSN and non-HRSN services. The Implementation Plan shall be submitted to CMS but does not require CMS approval. CMS will ensure it is complete and contains sufficient detail for purposes of ongoing monitoring. The state may update the Implementation Plan as initiatives are changed or added, with notification to CMS. The Implementation Plan will be appended as Attachment Q.

b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HOP Services, the HOP Infrastructure Protocol, or the Additional HOP Services Protocol; however, as applicable, the information provided in the deliverables must be aligned and consistent with one another.

c. The Implementation Plan must include information on, but not limited to, the following:

i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services interested parties to the extent those entities are vital to provide needed administrative and HOP-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation;

ii. Information about key partnerships related to HOP service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);

iii. Plans for changes to IT infrastructure that will support HOP-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision;

iv. A plan for tracking and improving the share of Medicaid beneficiaries in the state who are eligible and enrolled in the SNAP, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries in the state;

v. An implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout, that can facilitate robust evaluation designs;

vi. Information as required per STC 10.22 (HOP Rate Methodologies);

vii. Information as required per STC 10.23 (MOE); and

viii. Information as required per STC 10.24 (Partnerships with State and Local Entities).

11. WORKFORCE INITIATIVES

To support workforce recruitment and retention to promote the increased availability of certain health care providers who serve Medicaid and demonstration beneficiaries, North Carolina shall implement two statewide workforce initiatives –the Student Loan Repayment for Qualified Providers Program and the Behavioral Health (BH) and Long-Term Services and Supports (LTSS) Workforce Program. Funding for these workforce initiatives must not supplant state and federal funding or duplicate existing workforce programs. North Carolina will consult with the Health Resources and Services Administration (HRSA) as it works on these programs. The aim of these workforce initiatives is to address shortages in qualified providers serving Medicaid members in the state.

11.1. **Student Loan Repayment for Qualified Providers.** The state will make available the following student loan repayments:

a. **Psychiatrists, nurse practitioners with prescribing privileges, and physician assistants** – Up to $300,000, per provider, who make a 4-year full-time commitment to maintaining a personal practice panel, or working at an organization with a panel, that includes at least 40 percent Medicaid and/or uninsured members.

b. **Master's level licensed behavioral health clinicians** – Up to $50,000, per provider, who make a 3-year full-time commitment to maintaining a personal practice panel, or working at an organization with a panel, that includes at least 40 percent Medicaid and/or uninsured members.

c. **Registered nurses and bachelor's-level behavioral health professionals** – Up to $25,000, per provider, who make a 3-year full-time commitment to maintaining a personal practice panel, or working at an organization with a panel, that includes at least 40 percent Medicaid and/or uninsured members.

11.2. **Additional Terms and Operations of the Student Loan Repayment for Qualified Providers Program.** For the demonstration student loan repayment program, the following shall apply:

a. To fulfill the full-time commitment, qualified providers may work at a single organization, or hold part-time positions across multiple organizations or agencies, so long as all organizations and agencies meet eligibility criteria of serving at least 40 percent Medicaid and/or uninsured members.

b. Loan repayments must be made directly only to the student loan servicer by either the state or a procured vendor. Funds will not be provided to individual practitioners. Payments will be made no less than annually.

    i. If the state procures a vendor, the state will first pay the managing vendor the funds, so that it can then in turn make payments to the loan servicers.

c. The state may have multiple rounds/cohorts of disbursements (i.e., awards to new individuals each year), so long as it does not extend beyond the applicable authorized level of funding for each program over the course of the demonstration or demonstration year, as applicable.

d. The state shall have a process for ensuring that providers are continuing to meet the qualifying service commitment no less than every 6 months before making loan repayment disbursements. If the service commitment is not met, except in extraordinary circumstances as determined by the state (for example, circumstances such as disability or death), the state shall not make the loan disbursement and the state shall recoup any student loan payments made on behalf of the program participant. In the case of recoupment, the state shall return the federal share of those payments to CMS. Suspension or revocation of a professional license does not

constitute an extraordinary circumstance for purposes of not meeting the service commitment.

e. The state may only repay an amount up to the student loan amount owed by the provider. It may not pay an amount that exceeds an individual provider's student loan. Only the student loan for educational costs associated with the course of study that led to the highest degree earned as a prerequisite to obtaining the relevant clinical credential may qualify for reimbursement under one of the student loan repayment programs.

f. For the student loan repayment program, the state will define application criteria and eligibility, and select awardees through a competitive process that will allow the state to evaluate the applicants relative to the criteria established. The state may prioritize providers with cultural and linguistic competence that is likely to reflect and respond to the needs of the Medicaid population. The criteria must comply with federal civil rights law and not impermissibly discriminate based on race, ethnicity, national origin, or any other federally protected classes or characteristics.

11.3. **Behavioral Health and Long-Term Services and Supports Workforce Program.** The state will create and operate a program to recruit and retain behavioral health and long-term services and supports (LTSS) qualified providers. This program will provide training and certification supports, as well as recruitment and retention bonus payments to eligible individuals who make a 3-year full-time commitment to working at an organization with a panel that includes at least 30 percent Medicaid and/or uninsured members. Eligible individuals must meet qualifications for or be in the process of obtaining the qualifications for the following professional titles:

a. LTSS and BH Intellectual/Developmental Disability (I/DD) direct care workers and direct support professionals, including Certified Nursing Assistants, Home Health Aides, Hospice Aides, Personal Care Assistants/Aides, Home Care Workers, and Medication Aides.

b. Paraprofessionals as defined in state laws and/or regulations.

c. Other certified professionals, specifically peer support specialists, family partners, community health workers, substance abuse prevention specialists, alcohol and drug counselors, and clinical supervisors.

11.4. **Behavioral Health and LTSS Workforce Program Payments.** Each eligible individual participating in the program may receive up to $15,000 in combined workforce payments, for the payment types listed below, over the course of the demonstration period.

a. **Recruitment and retention bonus payments**. Up to $15,000 per eligible individual for sign-on recruitment payments or retention bonus payments.

b. **Training, certification, and recertification supports.** Up to $2,000 per eligible individual in reimbursement for certification and recertification exams, training programs, and supports. Supports are limited to textbooks and supplies as required

by the educational and training curriculums. The state must identify, screen, and select institutional entities that will provide the education and training to qualified providers.

11.5. **Additional Terms and Operations of the Behavioral Health and LTSS Workforce Program.**

a. To fulfill the full-time commitment, qualified providers may work at a single organization, or hold part-time positions across multiple organizations or agencies, so long as all organizations and agencies meet eligibility criteria of serving at least 30 percent Medicaid and/or uninsured members.

b. The state may have multiple rounds/cohorts of disbursements (i.e., awards to new individuals each year), so long as it does not extend beyond the applicable authorized level of funding for each program over the course of the demonstration or demonstration year, as applicable.

c. The state shall develop a process to routinely monitor and verify that program participants remain in compliance with the training curriculum and qualifying service commitment. If the training or service commitment is not met, except in extraordinary circumstances as determined by the state (for example, circumstances such as disability or death), the state shall recoup from the program participant the payments for recruitment, retention, training, and associated fees made on behalf of the program participant and return the federal share of those payments to CMS within 1 year of the breach in the service commitment.

d. Training payments must be made directly only to the educational entities by either the state or a procured vendor. Funds will not be provided to eligible individuals. Payments will be made no less than annually.

    i. If the state procures a vendor, the state will first pay the managing vendor the funds, so that it can then in turn make payments to the eligible individuals and entities.

e. For the program, the state will define application criteria and eligibility, and select awardees through a competitive process that will allow the state to evaluate the applicants relative to the criteria established. The state may prioritize providers with cultural and linguistic competence that is likely to reflect and respond to the needs of the Medicaid population. The criteria must comply with federal civil rights law and not impermissibly discriminate based on race, ethnicity, national origin, or any other federally protected classes or characteristics.

11.6. **Workforce Initiatives Funding.** The funding table below shows the maximum amount of funding for the workforce initiatives (including 15 percent administrative costs) by demonstration year.

Table 8: Workforce Initiatives Funding

	DY 7	DY 8	DY 9	DY 10	DY 11	Total
Student Loan Repayment for Qualified Providers Program	$25M	$25M	-	-	-	$50M
Behavioral Health and LTSS Workforce Program	$25M	$25M	-	-	-	$50M

a. The state may carry forward prior year workforce initiatives unused expenditure authority from one year to the next. The state must notify CMS of any changes to annual amounts in the quarterly and annual monitoring reports.

b. All expenditures for workforce initiatives are only matchable as administrative expenditures. The state must ensure that the workforce initiatives expenditures described in Section 11 are not factored into managed care capitation payments and there is no duplication of funds.

c. Time limited expenditure authority is granted from December 10, 2029, until December 9, 2033, to allow the state to pay close-out administrative costs of operating the workforce initiatives and monitor remaining service commitments. The state must adhere with federal timely filing requirements during this time-limited expenditure authority period. The expenditures will continue to be claimed on the CMS 64 on the specified waiver lines if the date where claims are made go beyond the demonstration period as part of this demonstration period. No payments for student loans, recruitment and retention bonus payments, and payments for training, certification, recertification, and supports may be made following the demonstration period's expiration (December 9, 2029).

11.7. **Workforce Initiatives Monitoring.** The state must report on the workforce activities in monitoring reports described in STC 15.6. As part of the demonstration's implementation and operational updates, the state must provide details regarding statewide and regional program recruitment, participation, status of service commitments, and statewide provider vacancy rates for the professional titles included in the student loan repayment program.

12. HEALTH INFORMATION TECHNOLOGY (HIT) PROGRAMS

12.1. **Behavioral Health and I/DD HIT Program.** The state may claim as allowable expenditures, up to $30 million (total computable) for five years, payments to incentivize HIT use. Incentive payments for Medicaid providers support the state's goals of increasing use of electronic health records (EHR) and connectivity with the North Carolina Health Information Exchange (HIE) and North Carolina's Behavioral Statewide Central Availability Navigator (BH SCAN).

a. **Eligibility.** Behavioral health facilities are those that serve individuals with mental health conditions, SUD, and/or I/DD located in North Carolina. Behavioral health facilities eligible to receive incentive payments are limited to those whose Medicaid patient volume is at least 20% (CHIP does not count toward the Medicaid patient volume criteria).

b. **Reporting.** The state is expected to provide updates via monitoring reports (STC 15.6) on the activities of the BH I/DD HIT Program, including the number and types of providers participating, the amount of funding given to providers, and how the incentive is helping North Carolina move its data systems forward (e.g., the number of providers statewide connected to the North Carolina HIE).

c. **BH I/DD HIT Incentive Payment Protocol.** The BH I/DD HIT Program Protocol establishes rules and guidelines for participation as well as how the state will claim FFP for incentive payments. The approved BH I/DD HIT Program Protocol will be appended to these STCs as Attachment R. The state must submit the BH I/DD HIT Incentive Payment Protocol to CMS for approval. CMS and North Carolina will work collaboratively with the expectation of CMS approval of the protocol within 120 calendar days after it receives the protocol. The state cannot claim FFP for any incentive payments until the BH I/DD Incentive Payment Protocol has been submitted to and approved by CMS.

d. **Payments.** The state will pay providers directly, and payments to behavioral health facilities will not be included in managed care capitation rates. Payments cannot duplicate reimbursement for provider activities already reimbursed by managed care plans.

e. **Unallowable Expenditures.** Under no circumstances, may the state receive FFP under this expenditure authority for provider incentive payments made to any facility that was previously included under the Health Information Technology for Economic and Clinical Health (HITECH) Act.

    i. The BH I/DD HIT Program will be limited to providing incentives for behavioral health facilities and not individual providers.

12.2. **School Health Technology Program.** The state may claim as allowable expenditures, up to $15 million (total computable) for five years, payments to incentivize HIT use in schools. Incentive payments for schools supports the state's goals of increasing school connectivity with the North Carolina statewide school-based EHR system and adoption and appropriate use of Medicaid billing systems for school-based behavioral health services, including telehealth services. Incentive payments can only be used on allowable funding uses related to connecting to the statewide school EHR system and appropriate billing for Medicaid school-based behavioral health services.

a. **Eligibility.** Eligibility for the School Health Technology Program are limited to the following:

    i. North Carolina Title I elementary, middle and high schools

ii. Tribal-operated schools

iii. Tribal Local Educational Agencies (LEAs)

iv. Privately-run Behavioral health and I/DD specialty schools that primarily serve children and youth with behavioral health conditions, I/DD, and/or TBI and cannot otherwise bill Medicaid as behavioral health and I/DD providers, and are not eligible for the BH I/DD HIT Program.

b. **Reporting.** Likewise, the state's monitoring reports must provide updates on the activities of the School Health Technology Program to describe participation, incentive payments disbursed, and the use of such payments.

c. **School Health Technology Program Protocol.** The School Health Technology Program Protocol establishes rules and guidelines for participation as well as how the state will claim FFP for incentive payments and the allowable funding uses for the incentive payments. The approved School Health Technology Program Protocol will be appending into these STCs as Attachment S. The state must submit the School Health Technology Program Protocol to CMS for approval. CMS and North Carolina will work collaboratively with the expectation of CMS approval of the protocol within 120 calendar days after it receives the protocol. The state cannot claim FFP for any incentive payments until the School Health Technology Protocol has been submitted to and approved by CMS.

d. **Payments.** The state will make payments to eligible schools. Payments cannot be made to individual teachers or other school officials. Payments cannot be made to a school until the allowable funding use has been identified and approved by the state.

e. **Non-duplication.** Payments cannot duplicate reimbursement for activities already reimbursed by federal, state, or other sources. The School Health Technology Program is a distinct program and cannot duplicate the North Carolina Integrated Care for Kids model or the state's School-Based Services Expansion Grant.

12.3. **HIT Program Funding.** The funding table below shows the maximum amount of funding for the HIT programs by demonstration year.

Table 9: Workforce Initiatives Funding

	DY 7	DY 8	DY 9	DY 10	DY 11	Total
BH and I/DD HIT Program	$15M	$15M	-	-	-	$30M
School Health Technology Program	$7.5M	$7.5M	-	-	-	$15M

a. The state may carry forward prior year HIT program unused expenditure authority from one year to the next. The state must notify CMS of any changes to annual amounts in the quarterly and annual monitoring reports.

b. All expenditures for HIT programs are only matchable as administrative expenditures.

c. Time limited expenditure authority is granted from December 10, 2029, until December 9, 2030, to allow the state to pay close-out administrative costs of operating the HIT programs and incentive payments associated with periods of performance within the approval period for the HIT Programs. The state must adhere with federal timely filing requirements during this time-limited expenditure authority period. The expenditures will continue to be claimed on the CMS 64 on the specified waiver lines if the date where claims are made go beyond the demonstration period as part of this demonstration period.

13. DESIGNATED STATE HEALTH PROGRAMS

13.1. **Designated State Health Programs (DSHP).** The state may claim FFP for designated state health programs (DSHP), subject to the limits described in this Section 13 of the STCs. DSHP are specific state programs that: (1) are population- or public health-focused; (2) aligned with the objectives of the Medicaid program with no likelihood that the DSHP will impede the primary objective of Medicaid, which is to provide coverage of services for low-income and vulnerable populations; and (3) serve a community largely made up of low-income individuals. This DSHP authority will enable the state to use state dollars that it otherwise would have spent on the DSHP specified in the Approved DSHP List (Attachment T) for which it may use as non-federal share as specified in Section 13. DSHP Funded Initiatives, on demonstration expenditures to support DSHP-funded initiatives, as described in STC 13.3(c). FFP for DSHP will be available only after receiving CMS determination that the state is compliant with STC 9.19(h).

a. The DSHP will have an established limit in the amount of $381,999,723 total computable expenditures, in aggregate, for DY 7 – DY 11.

b. The state may claim FFP for up to the annual amounts outlined in the table below, plus any unspent amounts from prior years. In the event the state does not claim the full amount of FFP for a given demonstration year, the unspent amount, available for claiming, will roll over to one or more demonstration years not to exceed the total for this demonstration period. The total amount of DSHP FFP that the state may claim in DY 7 - DY 11 combined may not exceed the non-federal share of amounts actually expended by the state for the DSHP-funded initiatives.

Table 10: Annual Limits of Total Computable Expenditures for DSHP					
	DY 7	**DY 8**	**DY 9**	**DY 10**	**DY 11**

Total Computable Expenditures	$115,949,945	$95,949,945	$77,299,945	$56,399,944	$36,399,944

c. The state must contribute $33,705,858 to add in original, non-freed up DSHP funds, for the remaining demonstration period towards its initiatives described in STC 13.3. These funds may only derive from other allowable sources of non-federal share and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.

d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of nonfederal share, which may be subject to CMS financial review.

e. The Approved DSHP List is limited to programs that are: (1) population- or public heath- focused; (2) aligned with the objectives of the Medicaid program with no likelihood that the program will impede the primary objective of Medicaid to provide coverage for services for low-income; and (3) vulnerable populations, and serve a community largely made up of low-income individuals. The state may only claim FFP for DSHP after receiving CMS determination that the state is compliant with STC 9.19(h). The Approved DSHP List is Attachment T. Any changes the state wants to make to its DSHP program will require an amendment as specified in STC 3.7.

13.2. **Prohibited DSHP Expenditures.**

a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, or the Centers for Disease Control and Prevention) or that are included as part of any maintenance of effort or non-federal share expenditure requirements of any federal grant.

b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, 3 percent of total provider expenditures or claims through DSHP will be treated as expended for non-emergency care to individuals who do not meet citizenship or immigration status requirements, and thus not matchable. This adjustment is reflected in the Approved DSHP List (Attachment T) and in the totals in STC 13.1. Therefore, the state can claim up to the program limits in the Approved DSHP List and STC 13.1.

c. In addition to 13.2(a), the following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds, that are not likely to promote the objectives of Medicaid, or are otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:

i. Bricks and mortar;

ii. No shelters, vaccines, or medications for animals;

iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;

iv. Revolving capital funds; and

v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

13.3. **DSHP-Funded Initiatives.**

a. **Definition.** DSHP-funded initiatives are Medicaid section 1115 demonstration activities supported by DSHPs, for which the state may claim FFP in accordance with STC 13.1 and 13.2 to fund the DSHP-funded initiatives as specified in STC 13.3(c).

b. **Requirements.** CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including home- and community-based services and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care.

c. **Approved DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

i. Expansion of the Healthy Opportunities Pilots services into new regions of the state

ii. New Healthy Opportunities Pilots services

iii. New Healthy Opportunities Pilots capacity building

iv. Reentry Initiative services and capacity building

13.4. **DSHP Claiming Protocol.** The state will develop a DSHP Claiming Protocol, which the state will make available to CMS upon request. State expenditures for the DSHP must be

documented in accordance with the protocol. The state may only claim FFP for DSHP after receiving CMS determination that the state is compliant with STC 9.19(h).

a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:

    i. Certification or attestation of expenditures.

    ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 13.2.

b. The state will claim FFP for DSHP quarterly based on actual expenditures.

13.5. **DSHP Claiming Process.** Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS, upon request. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of nonfederal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.

b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.

c. DSHP will be claimed at the administrative matching rate of 50 percent.

d. Expenditures will be claimed in accordance with the state's DSHP Claiming Protocol.

e. DSHP program expenditures are eligible for federal match, for dates of payment made on or after the approval date of the DSHP expenditure authority within an amendment, extension, or new demonstration, as long as the services or costs were incurred in the State Fiscal Year (SFY) that corresponds to the date of the DSHP expenditure authority.

13.6. **DSHP Sustainability Report.** The DSHP Sustainability Report will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. As part of the monitoring reports the state shall submit the DSHP Sustainability Report section in its annual report.

14. PROVIDER RATE INCREASE REQUIREMENTS

14.1. The provider payment rate increase requirements described hereafter are a condition for the DSHP and HRSN expenditure authorities, as referenced in expenditure authorities #8,9, and 14.

14.2. As a condition of approval and ongoing provision of FFP for the DSHP and HRSN expenditures over this demonstration period of performance, DY 7 through DY 11, the state will in accordance with these STCs increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent.

14.3. The state may not decrease provider payment rates for other Medicaid or demonstration covered services to make state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).

14.4. The state will, for the purpose of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increases as may be required under this section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

14.5. No later than 90 days of the demonstration effective date, and if the state makes fee for service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:

i. For primary care and obstetric care services in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); AND

ii. For behavioral health services (the category called, ‘Psychotherapy’ in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3)); OR

b. Provide to CMS for approval for any of the three services categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

i. Service codes must be representative of each service category as defined in STC 14.4;

ii. Medicaid and Medicare data must be from the same year and not older than 2019.

iii. The state’s methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

14.6. To establish the state’s ratio for each service category identified in STC 14.4 as it pertains to managed care plans’ provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 14.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the State pay providers based on state plan fee-for-service payment rate schedules); or

b. The data and methodology for any or all of the service categories as provided in STC 14.5(b) using Medicaid managed care provider payment rate and utilization data.

14.7. In determining the ratios required under STC 14.5 and 14.6, the state may not incorporate fee-for-service supplemental payments that the state made or plans through December 9, 2029, to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d).

14.8. If the state is required to increase provider payment rates for managed care plans per STC 14.2 and 14.6, the state must:

a. Comply with the requirements for state directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of a two-percentage point increase applied to the provider payments rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

14.9. For the entirety of DY 9 through DY 11, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 7, and such rate will be in effect on the first day of DY 9. A required payment rate increase shall apply to all services in a service category as defined under STC 14.4.

14.10. If the state uses a managed care delivery system for any of the service categories defined in STC 14.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 9 through DY 11, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 7 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment increase shall apply to all services in a service category as defined under STC 14.4.

14.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY 9 (or, as applicable, the first day of the first rating period that starts in DY 9), the state will provide an alternative effective date and rationale for CMS review and approval.

14.12. North Carolina will provide the information to document the payment rate ratio required under STC 14.5 and 14.6, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.

14.13. For demonstration years following the first year of provider payment rate increases, if any, North Carolina will provide an annual attestation within the State's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, in the previous year.

14.14. No later than 90 days following the demonstration effective date, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 14.5 and 14.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment U.

Attachment U – North Carolina HRSN and DSHP Related Provider Payment Increase Assessment – Attestation Table.

The reported data and attestations pertain to HRSN and DSHP related provider payment increase requirements for the demonstration period of performance DY 7 through DY 11.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-Service ratio**	**Medicaid Managed Care to Medicare Fee-for-Service Ratio**
Primary Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 14.5(a) or STC 14.5(b)]	[insert approach, either ratio derived under STC 14.6(a) or STC 14.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
Obstetric Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 14.5(a) or STC 14.5(b)]	[insert approach, either ratio derived under STC 14.6(a) or STC 14.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
Behavioral Health Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 14.5(a) or STC 14.5(b)]	[insert approach, either ratio derived under STC 14.6(a) or STC 14.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
In accordance with STCs 14.1 through 14.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or		

Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment increases for each service will be effective beginning on December 10, 2026, and will not be lower than the highest rate for that service code in DY 9 plus a two-percentage point increase relative to the rate for the same or similar Medicare billing code through at least December 9, 2029.

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 14.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

[Select the applicable effective date, must check either a. or b. below]

☐a. The effective date of the rate increases is the first day of DY 9 (December 10, 2026) and will be at least sustained, if not higher, through DY 11 (December 9, 2029).

☐b. North Carolina has a biennial legislative session that requires provider payment approval, and the timing of that session precludes the state from implementing the payment increase on the first day of DY 9 (December 10, 2026). North Carolina will effectuate the rate increases no later than the CMS approved date of December 10, 2026, and will sustain these rates, if not made higher, through DY 11 (December 9, 2029).

North Carolina *[insert does or does not]* make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the DSHP and HRSN STCs, I agree to submit by no later than December 10, 2026 for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all

required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than December 10, 2026. North Carolina *[insert does or does not]* include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care. For any such payments, as necessary to comply with the DSHP and HRSN STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 14.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than December 10, 2026.
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 14.8, I attest that necessary arrangements will be made to assure that 100 percent of the two-percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
North Carolina further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 14.
I, *[insert name of SMD or CFO (or equivalent position)] [insert title]*, attest that the above information is complete and accurate. [*Provide signature_____] [Provide date_____]* *[Provide printed name of signatory]*

15. MONITORING AND REPORTING REQUIREMENTS

15.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C in the amount of $5,000,000 (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due, if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted due to being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps that the state has taken to address such issue, and state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

15.2. **Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 for services rendered in IMDs will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

15.3. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs. The state shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.

15.4. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

15.5. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol addressing components of the demonstration within 150 calendar days after approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 days after receipt of CMS's comments, if any. Once approved, the Monitoring Protocol will be incorporated into the STCs as Attachment F. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment, as applicable. Such amendment Monitoring Protocols are subject to same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as for specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., the performance metrics described in STC 15.6), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and demonstration component.

For the SUD component, the Monitoring Protocol must include an assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 6.2, and information relevant to the state's HIT Plan described in STC 6.2; a description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 15.6; and a description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and target will be benchmarked against performance in best practice settings.

For the HRSN services authorized through this demonstration, the Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities-Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. This set of measures

represents a critical set of equity-focused metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g., the National Quality Forum (NQF) "disparities sensitive" measures) and prioritizes key outcome measures and their clinical and nonclinical (i.e., social) drivers. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Disparities Sensitive Measure Set from CMS. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones, as provided in the Implementation Plan, for the HRSN infrastructure investments.

The state will also be expected to set up its HRSN service delivery system to allow screening of beneficiaries for identified needs, and to develop an appropriate closed-loop referral system or other feedback loop to ensure beneficiaries receive service referrals and provisions, and provide any applicable update on this process via the Monitoring Reports, in alignment with information provided in the Monitoring Protocol.

In addition, the state must describe in the Monitoring Protocol methods and the timeline to collect and analyze relevant non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include but are not limited to data related to carceral status, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts to consult with relevant non-Medicaid agencies to collect and use data in ways that support analyses of data on demonstration beneficiaries and subgroups of beneficiaries, in accordance with all applicable requirements concerning privacy and the protection of personal information.

For the qualitative elements (e.g., operational updates as described in 15.6.a), CMS will provide the state with guidance on narrative and descriptive information, which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Monitoring Reports.

15.6. **Quarterly and Annual Monitoring Reports.** The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each DY. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The monitoring reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key challenges,

underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. For example, for the HOP program, the state must describe conditions that resulted in the phase out of services, including cost, utilization, and HSO network availability, as well as provide updates on the phase out of HOP Services that do not meet the requirements of STC 10.3, 10.5, and STC 10.7, including utilization of those services during the glide path described in STC 10.1. For the workforce activities, the state must provide details regarding statewide and regional program recruitment, participation, status of service commitments, and statewide provider vacancy rates for the professional titles included in the student loan repayment program. The state is also expected to provide updates on the activities of the BH I/DD HIT Program, including the number and types of providers participating, the amount of funding given to providers, and how the incentive is helping North Carolina move its data systems forward (e.g., the number of providers statewide connected to the North Carolina HIE). Similarly, the state must provide updates on the activities of the School Health Technology Program to describe participation, incentive payments disbursed, and the use of such payments.

b. **Performance Metrics**. Per applicable CMS guidance and technical assistance, the performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration's program and policy implementation and infrastructure investments, and transitional non-service expenditures, as applicable and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on beneficiaries' outcomes as well as outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, and grievances and appeals.

   Specifically, the state must undertake reporting on categories of metrics including, but not limited to: enrollment, utilization of services, and quality of care and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

      i. For HRSN components, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, rescreening,

receipt of referrals, recurring nutrition services, and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations, and the contracted providers of applicable services (e.g., managed care plans and their contracted HRSN providers). In alignment with STC 10.24, the state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing and nutrition agencies, leverage their expertise and existing housing and nutrition resources instead of duplicating services. Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

ii. For the SUD component, the state's monitoring must cover metrics in alignment with the respective milestones as outlined in the State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMD #17–003).

iii. The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to: utilization of applicable pre-release and post-release services as defined in STC 7.4, provision of health or social service referrals pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

iv. For the continuous eligibility policy, monitoring metrics must support tracking enrollment and ex parte renewals. The state must describe successes and challenges related to activities to annually update beneficiary contact information, provide beneficiaries reminder of continued eligibility, verify beneficiary residency, and confirm that the beneficiary is not deceased, for all

beneficiaries who qualify for a continuous eligibility period that exceeds 12 months.

v. In order to ensure a link between DSHP-funded initiatives and improvements in health equity and beneficiary health outcomes, CMS and the state will coordinate to use the critical set of disparities-sensitive metrics described above, with applicable demographic stratification. As applicable, if the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the state must use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs and corresponding payment-related metrics; these metrics are specifically relevant for the state's HRSN initiatives and the DSHP-funded initiatives.

vi. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. **Budget Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements, Section 17 of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly, and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. **Evaluation Activities and Interim Findings**. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

15.7. **SUD Mid-Point Assessment.** The state must contract with an independent entity to conduct an independent Mid-Point Assessment by December 9, 2027. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning, and conduct of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to representatives of MCOs, health care providers (including SUD treatment providers), beneficiaries, community groups, and other key partners. The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations.

The state must provide a copy of the report to CMS no later than 60 calendar days after December 9, 2027, and the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any. For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS proposed modifications to the Implementation Plan and Monitoring Protocol, for ameliorating these risks. Modifications to any of these plans or protocols are subject to CMS approval.

Elements of the Mid-Point Assessment must include at least:

a. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plan, and toward meeting the targets for performance measures as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets identified by the independent assessor as at medium to high risk of not being met, recommendations for adjustments in the state's SUD Plan or to other pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the budget neutrality requirements in these STCs.

15.8. **Reentry Demonstration Initiative Mid-Point Assessment.** The state must contract with an independent entity to conduct a mid-point assessment of the Reentry Demonstration Initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment by December 9, 2027, and the state must provide a copy of the report to CMS no later than 60 calendar days after December 9, 2027.

The Mid-Point Assessment must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the Reentry Demonstration Initiative. The report must be submitted to CMS by the end of the third year of the demonstration. In the event that the Reentry Demonstration Initiative is implemented at a timeline within the demonstration approval period, the state and CMS will agree to an alternative timeline for submission of the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any. If requested, the state must brief CMS on the report.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges

and vulnerabilities. In the design, planning, and execution of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including limited to: provider participation in the state's Reentry Demonstration Initiative, eligible individuals, and other key partners in correctional facility and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state and CMS will collaborate to determine whether modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol are necessary for ameliorating these risks, with any modifications subject to CMS approval.

Elements of the Mid-Point Assessment must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment.

15.9. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The draft Close-Out Report must comply with the most current guidance from CMS.

b. The state will present to and participate in a discussion with CMS on the Close-Out report.

c. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

d. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 15.2.

15.10. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

15.11. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within 6 months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

15.12. **Corrective Action Plan Related to Demonstration Monitoring**. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

16. EVALUATION OF THE DEMONSTRATION

16.1. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

16.2. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities that collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation—including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable—in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring, and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 15.1.

16.3. **Evaluation Budget.** A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

16.4. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than one hundred eighty (180) calendar days after the approval date of the demonstration. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The draft Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-indifferences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic)—as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of an independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 16.7 and 16.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment components. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

16.5. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.

16.6. **Evaluation Questions and Hypotheses.** Consistent with attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing must include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures must be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), Consumer Assessment of Health Care Providers and Systems (CAHPS), the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by NQF.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to the HRSN and reentry. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Hypotheses must cover all policies and goals of the demonstration and should be crafted to not only evaluate whether overall demonstration goals were achieved but also the extent to which each component contributed to outcomes. Where demonstration components offer tailored service to specific populations, evaluation hypotheses must include an assessment of whether these programs improved quality of care outcomes and access to health care for the targeted population while also promoting the desired administrative and fiscal efficiencies.

Evaluation hypotheses for the HRSN demonstration components must focus on areas such as assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on prevalence and severity of beneficiaries' HRSNs and the provision of beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care; utilization of and costs associated with potentially avoidable, high-acuity health care; utilization of hospital and institutional care; and beneficiary physical and mental health outcomes. The state must also evaluate the impact of non-HRSN HOP services, as appropriate.

In addition, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys).

Hypotheses must be designed to help understand, in particular, the impact of housing supports, nutritional services, and transportation support on beneficiary health outcomes and experience. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the

HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level. The state must also include research questions and hypotheses focused on how renewals of recurring nutrition services affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing supports and nutrition services change over time in concert with new Medicaid funding toward those services. In addition, considering how the demonstration's HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. Evaluation of the HRSN initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

The state's evaluation efforts must develop robust hypotheses and research questions to assess the effectiveness of the state's DSHP-funded initiatives in meeting the desired goals of such programs in advancing and complementing its broader HRSN and other applicable initiatives for its Medicaid beneficiaries and other low-income populations. The analysis must be designed to help demonstrate how these programs support, for example, expanding coverage, improving access, reducing health disparities, and/or enhancing home-and-community-based services or services to address HRSN or behavioral health.

For the Workforce Initiatives, the state must develop hypotheses and research questions to evaluate the effects of the initiatives on beneficiary access to care, as compared to what may be achieved through direct interventions such as rate increases. The state should also evaluate how close estimated costs and positions awarded were to actual costs and awards, improvements in overall staffing levels, and long-term effects of the workforce programs on retention. The Evaluation Design must outline hypotheses and research questions to assess whether these initiatives sustainably reduce workforce shortages and increase provider retention. Because these initiatives may affect a small number of providers, the state is strongly encouraged to use a mixed-methods approach that would incorporate qualitative data sources, including interviews and/or focus groups with participating providers, and a beneficiary experience survey.

Hypotheses for the SUD program must include an assessment of the objectives of the SUD component of this section 1115 demonstration. Examples include, but are not limited to, initiative and engagement; compliance with treatment, utilization of health services (e.g., emergency department and inpatient hospital settings), and a reduction in key outcomes, such as deaths due to overdose.

Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible

individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

For the continuous eligibility policy, the state must evaluate the impact of the policy on all relevant populations, appropriately tailored for the specific time span of eligibility. Evaluation hypotheses must focus on, but may not be limited to, enrollment continuity, utilization of age-appropriate preventive care, inpatient admissions and avoidable emergency care, and health disparities

As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. As noted above, the state must analyze budgetary effects of the HRSN services and uncompensated care and associated costs for populations eligible for continuous eligibility, including as applicable, in comparison to populations not eligible for such policies. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency,

primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

As noted above, for any amendment to the demonstration, the state will be required to update the approved Evaluation Design or submit a new Evaluation Design to accommodate the amendment component, as appropriate.

16.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension, the Interim Evaluation Report must be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report must discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted. If the state is not requesting an extension for the demonstration, the draft Interim Evaluation Report is due one (1) year prior to the end of the demonstration.

d. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.

e. Once approved, the state must post the final Interim Evaluation Report to the state's website within 30 calendar days.

f. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

16.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.

a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

16.9. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report. Presentations may be conducted remotely.

16.10. **Public Access**. The state must post the final documents (e.g., Implemental Plans, Monitoring Protocols, Monitoring Reports, Mid-Point Assessments, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

16.11. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of deliverables, CMS must be notified prior to presentation of these reports or their findings, including in related publications (for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS must be provided a copy including any associated press materials. CMS must be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

16.12. **Corrective Action Plan Related to Evaluation**. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A correction action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

17. GENERAL FINANCIAL REQUIREMENTS

17.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

17.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

17.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

17.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for

expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

17.5. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

17.6. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

c. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

17.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 15.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

17.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the Section 18:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

17.9. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

17.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 11: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
ABD	Main	X		X	Expenditures for Medical assistance services provided to ABD eligibles not identified as excluded in Table 5 delivered through managed care.

Table 11: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
TANF and Related Adults	Main	X		X	Expenditures for Medical assistance services provided to TANF Adult eligibles and other non-ABD adults not identified as excluded in Table 5 through managed care.
TANF and Related Children	Main	X		X	Expenditures for Medical assistance services provided to TANF Child eligible and other non-ABD children not identified as excluded in Table 5 delivered through managed care.
INN/TBI	Main	X		X	Expenditures for Medical assistance services provided to INN/TBI eligibles not identified as excluded in Table 5 delivered through managed care.
New Adult Group	Main	X		X	Medical expenditures for the Affordable Care Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, not identified as excluded in Table 5 delivered through managed care.
Continuous Eligibility – TANF & Related Children	Hypo 1	X		X	All expenditures for continued benefits for children in the TANF & Related Children MEG who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination.

Table 11: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Continuous Eligibility – ABD Children	Hypo 1	X		X	All expenditures for continued benefits for children in the ABD MEG who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination.
SUD IMD MC TANF	Hypo 2	X		X	Expenditures for all otherwise allowable Medicaid services provided, were it not for the IMD prohibition, to otherwise-eligible TANF and Related Adults enrolled in managed care during a month in which the beneficiary was a resident in an IMD for a primary diagnosis of SUD.
SUD IMD MC ABD	Hypo 2	X		X	Expenditures for all otherwise-allowable Medicaid services provided, were it not for the IMD prohibition, to otherwise-eligible ABD individuals enrolled in managed care during a month in which the beneficiary was a resident in an IMD for a primary diagnosis of SUD.
SUD IMD MC Innovations/ TBI	Hypo 2	X		X	Expenditures for all otherwise-allowable Medicaid services provided, were it not for the IMD prohibition, to otherwise eligible Innovations/TBI

Table 11: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					individuals enrolled in managed care during a month in which the beneficiary was a resident in an IMD for a primary diagnosis of SUD.
SUD IMD FFS	Hypo 2	X		X	Expenditures for all otherwise-allowable Medicaid services provided, were it not for the IMD prohibition, to otherwise-eligible individuals enrolled in fee-for-service during a month in which the beneficiary was a resident in an IMD for a primary diagnosis of SUD.
SUD – FFS Expansion Adults	Hypo 2	X		X	Expenditures for all otherwise-allowable Medicaid services provided, were it not for the IMD prohibition, to otherwise-eligible Affordable Care Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119 enrolled in fee-for-service during a month in which the beneficiary was a resident in an IMD for a primary diagnosis of SUD.
SUD – MC Expansion Adults	Hypo 2	X		X	Expenditures for all otherwise-allowable Medicaid services provided, were it not for the IMD prohibition, to otherwise-eligible Affordable Care Act adult group described in

Table 11: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119 enrolled in managed care during a month in which the beneficiary was a resident in an IMD for a primary diagnosis of SUD.
Community Transition Services	Hypo 3		X	X	Expenditures for the 1915(i) community transition benefit provided to otherwise 1915(i) eligible beneficiaries transitioning from an IMD.
Reentry Services	Hypo 4	X		X	Expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to release from participating facilities.
Reentry Non-Services	Hypo 4		X	X	Expenditures for allowable planning and non-services for the reentry demonstration initiative.
Additional non-HRSN HOP Services	Hypo 5		X	X	Expenditures for non-HRSN HOP services in STC 10.5(a-c), 10.5(e).
HOP HRSN Services	SHAC		X	X	All expenditures for HOP HRSN services.
HOP HRSN Infrastructure	SHAC		X	X	All infrastructure expenditures for HOP HRSN services.
HOP: Health Related Legal Supports	Main			X	All expenditures for Health Related Legal Supports described in STC 10.5(d).

Table 11: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Non-HRSN HOP Infrastructure	Main			X	All infrastructure expenditures for non-HRSN HOP services.
Student Loan Repayment	Main			X	All expenditures for the Student Loan Repayment for Qualified Providers Program described in Section 11.
BH and LTSS Workforce	Main			X	All expenditures for the Behavioral Health and LTSS Workforce Program described in Section 11.
BH and I/DD HIT Program	Main			X	All expenditures for the BH and I/DD HIT Program described in Section 12.
School Health Technology Program	Main			X	All expenditures for the School Health Technology Program described in Section 12.
DSHP	Main			X	All expenditures for DSHP described in Section 13.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

17.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00313/4). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as

WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in Section 18, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in Section 15, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member

months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

For CE MEGs, states will report a calculated number, or percentage, of the actual member months and expenditures of the corresponding non-CE MEG. As applicable, the corresponding non-CE MEG member months and expenditures will then be reduced by the same percentage. For the Children CE MEGs, this percentage will be 0.11 percent. For example, the actual member months and expenditures for the TANF and Related Children MEG will be reduced by .11 percent and the equivalent member months and expenditures will be reported on the Continuous Eligibility – TANF & Related Children MEG so that the total calculated member months and expenditures between the two MEGs are equal to the actual member months and expenditures for the TANF & Related Children group.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
ABD	ABD member months are months of Medicaid eligibility for an individual that is Aged, Blind or Disabled, minus 0.11% of medical assistance expenditures for Continuous Eligibility – ABD Children.	None	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	11/1/19	12/9/29
TANF and Related Adult	TANF Adult member months are months of Medicaid eligibility for an individual receiving coverage within the temporary assistance for needy families program and other non-ABD adults.	None	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	11/1/19	12/9/29

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
TANF and Related Child	TANF Child member months are months of Medicaid eligibility for a child only receiving coverage within the temporary assistance for needy families program and other non-ABD children, minus 0.11% of medical assistance expenditures for Continuous Eligibility – TANF & Related Children.	None	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y, minus 0.11% of medical assistance expenditures for Continuous Eligibility – TANF & Related Children.	11/1/19	12/9/29
INN/TBI	INN/TBI member months are months of Medicaid eligibility for an individual receiving coverage under the 1915(c) waivers.	None	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	11/1/19	12/9/29
New Adult Group	Report all medical assistance expenditures for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.	None	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	12/1/23	12/9/29

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Continuous Eligibility – TANF & Related Children	TANF & Related Children who are eligible via CE, equaling 0.11% of total Medicaid expenditures for the applicable portion of the TANF & Related Children MEG	STC 4.3(c)	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y, 0.11% of total member months for the applicable portion of the TANF & Related Children MEG	12/10/24	12/9/29
Continuous Eligibility – ABD Children	ABD Children who are eligible via CE, equaling 0.11% of total Medicaid expenditures for the applicable portion of the ABD Children MEG	STC 4.3(c)	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y, 0.11% of total member months for the applicable portion of the ABD Children MEG	12/10/24	12/9/29

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SUD IMD MC TANF	SUD IMD MC TANF and Related Member Months are months of TANF and Related Adults Medicaid eligibility enrolled in managed care during which the individual is an inpatient in an IMD under terms of the demonstration for any day during the month and must be reported separately for each SUD IMD MEG, as applicable.	STC 6.3	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/19	12/9/29

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SUD IMD MC ABD	SUD IMD MC ABD Member Months are months of ABD Medicaid eligibility enrolled in managed care during which the individual is an inpatient in an IMD under terms of the demonstration for any day during the month and must be reported separately for each SUD IMD MEG, as applicable.	STC 6.3	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/19	12/9/29

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SUD IMD Innovations/ TBI	SUD IMD MC Innovations/TBI Member Months are months of Innovations/TBI Medicaid eligibility enrolled in managed care during which the individual is an inpatient in an IMD under terms of the demonstration for any day during the month and must be reported separately for each SUD IMD MEG, as applicable.	STC 6.3	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/19	12/9/29

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SUD IMD FFS	SUD IMD Member Months are months of Medicaid eligibility enrolled in fee for service during which the individual is an inpatient in an IMD under terms of the demonstration for any day during the month and must be reported separately for each SUD IMD MEG, as applicable.	STC 6.3	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/19	12/9/29

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SUD – FFS Expansion Adults	SUD IMD Member Months are months of Medicaid eligibility for the Affordable Care Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119 enrolled in fee-for-service during which the individual is an inpatient in an IMD under terms of the demonstration for any day during the month and must be reported separately for each SUD IMD MEG, as applicable.	STC 6.3	Follow standard CMS 64.9 Category of Service Definitions	Date of Service	MAP	Y	12/1/23	12/9/29

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SUD – MC Expansion Adults	SUD IMD Member Months are months of Medicaid eligibility for the Affordable Care Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119 enrolled in managed care during which the individual is an inpatient in an IMD under terms of the demonstration for any day during the month and must be reported separately for each SUD IMD MEG, as applicable.	STC 6.3	Follow standard CMS 64.9 Category of Service Definitions	Date of Service	MAP	Y	12/1/23	12/9/29
Community Transition Services	Report all expenditures for 1915(i) community transition benefit provided to otherwise 1915(i) eligible beneficiaries transitioning from an IMD.	STC 5.2(b)	Follow CMS-64.9 Based Category of Service Definition	Date of service	MAP	N	12/10/24	12/9/29

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Reentry Services	Report all expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to release from participating facilities.	None	Follow CMS-64.9 Based Category of Service Definition	Date of service	MAP	Y	12/10/24	12/9/29
Reentry Non-Services	Report all expenditures for allowable planning and non-services for the reentry demonstration initiative.	None	Follow CMS-64.10 Base Category of Service Definition	Date of payment	ADM	N	12/10/24	12/9/29
HOP HRSN Services	Report all expenditures for HRSN HOP services.	STC 10.6	Follow CMS-64.9 Based Category of Service Definition	Date of service	MAP	N	12/10/24	12/9/29

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
HOP HRSN Infrastructure	Report 80% of HOP infrastructure expenditures as stipulated in STC 10.7(f)	STC 10.6	Follow CMS-64.10 Base Category of Service Definition	Date of payment	ADM	N	12/10/24	12/9/29
Additional non-HRSN HOP Services	Report all expenditures for non-HRSN HOP services that are treated as hypothetical (STC 10.5(a-c) and 10.5(e))	STC 10.6	Follow CMS-64.9 Based Category of Service Definition	Date of Service	MAP	N	12/10/24	12/9/29
HOP: Health Related Legal Supports	Report all expenditures for Health Related Legal Supports.	STC 10.6	Follow CMS-64.9 Based Category of Service Definition	Date of Service	MAP	N	12/10/24	12/9/29

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Non-HRSN HOP Infrastructure	Report 20% of HOP infrastructure expenditures as stipulated in STC 10.7(f)	STC 10.6	Follow CMS-64.10 Base Category of Service Definition	Date of payment	ADM	N	12/10/24	12/9/29
Student Loan Repayment	Report all expenditures for the Student Loan Repayment for Qualified Providers Program.	None	Follow CMS-64.10 Base Category of Service Definitions	Date of payment	ADM	N	12/10/24	12/9/29
BH and LTSS Workforce	Report all expenditures for the Behavioral Health and LTSS Workforce Program.	None	Follow CMS-64.10 Base Category of Service Definitions	Date of payment	ADM	N	12/10/24	12/9/29
BH and I/DD HIT Program	Report all expenditures for the BH and I/DD HIT Program.	None	Follow CMS-64.10 Base Category of Service Definitions	Date of payment	ADM	N	12/10/24	12/9/29
School Health Technology Program	Report all expenditures for the School Health Technology Program.	None	Follow CMS-64.10 Base Category of Service Definitions	Date of payment	ADM	N	12/10/24	12/9/29

Table 12: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
DSHP	Report all expenditures for DSHP.	None	Follow CMS-64.10 Base Category of Service Definitions	Date of payment	ADM	N	12/10/24	12/9/29
ADM	All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.	None	Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	11/1/19	12/9/29

17.12. **Demonstration Years.** The demonstration years for managed care component and the Healthy Opportunities Pilot Program are as follows:

Table 13: Demonstration Years		
Demonstration Year 7	12/10/2024-12/9/2025	12 Months
Demonstration Year 8	12/10/2025-12/9/2026	12 Months
Demonstration Year 9	12/10/2026-12/9/2027	12 Months
Demonstration Year 10	12/10/2027-12/9/2028	12 Months
Demonstration Year 11	12/10/2028-12/9/2029	12 Months

17.13. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in Section 18. The annual budget neutrality status update must be submitted to CMS within 90 days following the end of each DY.CMS will provide technical assistance, upon request.[6]

17.14. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

17.15. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In

this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

17.16. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 17.16(c). If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

18. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

18.1. **Limit of Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, five Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

18.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 11 Master MEG Chart and Table 12 MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the

number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

18.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

18.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 14: Main Budget Neutrality Test								
MEG	**PC or Agg**	**WOW Only, WW Only, or BOTH**	**Trend Rate**	**DY 7**	**DY 8**	**DY 9**	**DY 10**	**DY 11**
ABD	PC	Both	5.5%	$2,601.14	$2,744.20	$2,895.13	$3,054.37	$3,222.36
TANF and Related Adult	PC	Both	4.9%	$835.70	$876.65	$919.61	$964.67	$1,011.94
TANF and Related Child	PC	Both	4.8%	$338.56	$354.81	$371.84	$389.69	$408.39
INN/TBI	PC	Both	5.5%	$9,835.90	$10,376.88	$10,947.60	$11,549.72	$12,184.96
New Adult Group	PC	Both	5.2%	$1,321.50	$1,390.22	$1,462.51	$1,538.56	$1,618.57
HOP: Health Related Legal Supports	Agg	WW only	n/a	$11,930,620	$12,288,538	$12,657,195	$13,036,910	$13,428,018

Table 14: Main Budget Neutrality Test								
MEG	**PC or Agg**	**WOW Only, WW Only, or BOTH**	**Trend Rate**	**DY 7**	**DY 8**	**DY 9**	**DY 10**	**DY 11**
Non-HRSN HOP Infrastructure	Agg	WW only	n/a	$10,100,000	$30,300,000	$25,250,000	$5,050,000	$5,050,000
Student Loan Repayment	Agg	WW only	n/a	$25,000,000	$25,000,000	Carryforward only	Carryforward only	Carryforward only
BH and LTSS Workforce	Agg	WW only	n/a	$25,000,000	$25,000,000	Carryforward only	Carryforward only	Carryforward only
BH I/DD HIT Program	Agg	WW only	n/a	$15,000,000	$15,000,000	Carryforward only	Carryforward only	Carryforward only

Table 14: Main Budget Neutrality Test								
MEG	**PC or Agg**	**WOW Only, WW Only, or BOTH**	**Trend Rate**	**DY 7**	**DY 8**	**DY 9**	**DY 10**	**DY 11**
School Health Technology	Agg	WW only	n/a	$7,500,000	$7,500,000	Carryforward only	Carryforward only	Carryforward only
DSHP	Agg	WW only	n/a	The state must have savings to offset these expenditures				

18.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

18.6. **Hypothetical Budget Neutrality Test 1: Continuous Eligibility Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 15: Hypothetical Budget Neutrality Test 1 – Continuous Eligibility Expenditures

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 7	DY 8	DY 9	DY 10	DY 11

Continuous Eligibility - TANF & Related Children	PC	Both	-	$338.56	$354.81	$371.84	$389.69	$408.39
Continuous Eligibility - ABD Children	PC	Both	-	$2,601.14	$2,744.20	$2,895.13	$3,054.37	$3,222.36

18.7. **Hypothetical Budget Neutrality Test 2: Substance Use Disorder Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 16: Hypothetical Budget Neutrality Test 2 – SUD Expenditures

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 7	DY 8	DY 9	DY 10	DY 11
SUD IMD MC TANF and Related Adults	PC PC	Both	4.9%	$2,994.11	$3,140.82	$3,294.72	$3,456.16	$3,625.51
SUD IMD MC ABD	PC	Both	5.5%	$4,119.28	$4,345.84	$4,584.86	$4,837.03	$5,103.06
SUD IMD MC Innovations/ TBI	PC	Both	5.5%	$8,515.57	$8,983.93	$9,478.04	$9,999.33	$10,549.30
SUD IMD FFS	PC	Both	4.9%	$17,381.53	$18,233.23	$19,126.65	$20,063.86	$21,046.99

SUD FFS Expansion Adults	PC	Both	5.2%	$17,431.24	$18,337.66	$19,291.22	$20,294.37	$21,349.67
SUD MC Expansion Adults	PC	Both	5.2%	$3,002.67	$3,158.81	$3,323.07	$3,495.87	$3,677.65

18.8. **Hypothetical Budget Neutrality Test 3: Community Transition Initiative Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 17: Hypothetical Budget Neutrality Test 3 – Community Transition Initiative

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 7	DY 8	DY 9	DY 10	DY 11
Community Transition Services	Agg	Both	-	$300,000	$300,000	$300,000	$300,000	$300,000

18.9. **Hypothetical Budget Neutrality Test 4: Reentry Demonstration Initiative Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 18: Hypothetical Budget Neutrality Test 4 – Reentry Demonstration Initiative								
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 7**	**DY 8**	**DY 9**	**DY 10**	**DY 11**
Reentry Services	PC	Both	6.4%	$1,419.15	$1,509.98	$1,606.61	$1,709.44	$1,818.84
Reentry Non-Services	Agg	Both	-	$80,000,000	$100,000,000	$40,000,000	$20,000,000	$10,000,000

18.10. **Budget Neutrality Test 5: Additional non-HRSN HOP Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 5 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 19: Hypothetical Budget Neutrality Test 5 – Additional non-HRSN HOP Expenditures								
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 7**	**DY 8**	**DY 9**	**DY 10**	**DY 11**
Additional Non-HRSN HOP Expenditures	Agg	Both	-	$83,662,054	$86,171,915	$88,757,073	$91,419,785	$94,162,378

18.11. **Supplemental HRSN Aggregate Ceiling (SHAC) Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in Section 10), CMS considers these expenditures to be "supplemental HRSN aggregate ceiling (SHAC)" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, SHAC expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped SHAC expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent SHAC Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the SHAC Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's SHAC spending exceeds the Capped SHAC Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped SHAC.

18.12. **SHAC Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the SHAC Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the SHAC Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the SHAC Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 20: SHAC Budget Neutrality Test								
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 7**	**DY 8**	**DY 9**	**DY 10**	**DY 11**
HRSN Services	Agg	Both	-	$400,000,000	$400,000,000	$400,000,000	$400,000,000	$400,000,000
HRSN Infrastructure	Agg	Both	-	$39,900,000	$119,700,000	$99,750,000	$19,950,000	$19,950,000

18.13. **Monitoring Budget Neutrality for FFCY**. CMS has determined that FFCY demonstration coverage is budget neutral based on CMS's assessment that the expenditure authority granted for the demonstration has minimal federal Medicaid expenditures and these populations could have been covered through waiver only authority. The state will not be allowed to obtain budget neutrality "savings" from FFCY demonstration coverage. The demonstration will not include a budget neutrality expenditure limit for FFCY; however, the state is required to report total expenditures and member months in their demonstration monitoring reports, per STC 15.6. The state must still report quarterly claims and report expenditures on the CMS 64.9 WAIVER form. Failure to report FFCY expenditures and member months will result in reinstatement of the budget neutrality requirement. CMS reserves the right to request budget neutrality worksheets, requirements, limits, and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 3.7.

18.14. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to

method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

18.15. **Exceeding Budget Neutrality**. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from December 10, 2024 through December 9, 2029. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period (11/1/2019 to 10/31/2024). If at the end of the demonstration approval period the Main Budget Neutrality Test a Supplemental HRSN Aggregate Ceiling Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

18.16. **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 18.15 or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is $16,727,147,626.

18.17. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 21: SUD Component of the Demonstration

Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 7	Cumulative budget neutrality limit plus:	2.0 percent
DY 7 through DY 8	Cumulative budget neutrality limit plus:	1.5 percent
DY 7 through DY 9	Cumulative budget neutrality limit plus:	1.0 percent
DY 7 through DY 10	Cumulative budget neutrality limit plus:	0.5 percent

DY 7 through DY 11	Cumulative budget neutrality limit plus:	0.0 percent

19. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 22: Schedule of Deliverables for the Demonstration Period

Timeline	Deliverable	STC
30 calendar days after demonstration approval	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 calendar days after demonstration approval	Revised SUD Implementation Plan (including Health IT Plan)	6.2
120 calendar days after approval of the extension	Reentry Demonstration Initiative Implementation Plan	7.10
6 months after approval of the extension	Reentry Demonstration Initiative Reinvestment Plan	7.11
90 calendar days after the approval of the extension	Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services	10.10
90 calendar days after the approval of the extension	HOP Infrastructure Protocol	10.13
90 calendar days after the approval of the extension	Additional HOP Service Protocol	10.11
9 months days after the approval of the extension	HRSN Implementation Plan	10.26
90 calendar days after the approval of the extension	HOP Maintenance of Effort	10.23
At least 60 days prior to intended implementation	Provider Payment Methodologies for HRSN	10.22
-	School Health Technology Program Protocol	12.2
-	BH I/DD HIT Incentive Payment Protocol	12.1
Within 90 calendar days of the extension approval	Provider Rate Increase Attestation Table and Supporting Information	14.14
Annually, as part of the demonstration annual report	Annual Attestation of Provider Rate Increase	14.13
150 calendar days after demonstration approval	Monitoring Protocol	15.5
60 calendar days after receipt of CMS comments	Revised Monitoring Protocol	15.5
180 calendar days after demonstration approval	Draft Evaluation Design	16.4
60 days after receipt of CMS comments	Revised Evaluation Design	16.5
No later than 60 calendar days after December 9, 2027	SUD Mid-Point Assessment	15.7

60 calendar days after receipt of CMS comments	Revised SUD Mid-Point Assessment	15.7
No later than 60 calendar days after December 9, 2027	Reentry Demonstration Initiative Mid-Point Assessment	15.8
60 calendar days after receipt of CMS comments	Revised Reentry Demonstration Initiative Mid-Point Assessment	15.8
December 9, 2028, or with renewal application	Draft Interim Evaluation Report	16.7
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	16.7
Within 18 months after December 9, 2029	Draft Summative Evaluation Report	16.8
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	16.8
Monthly Deliverables	Monitoring Calls	15.10
60 calendar days after end of each quarter, except 4th quarter	Quarterly Monitoring Reports, including implementation updates	15.6
30 calendar days after end of each quarter	Quarterly Expenditure Reports	17.2
Annual Deliverables - Due 90 calendar days after end of each 4th quarter	Annual Monitoring Reports	15.6
Within 120 days of expiration	Draft Close-Out Report	15.9
Within 30 days of receipt of CMS comments	Final Close-Out Report	15.9

ATTACHMENT A

Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

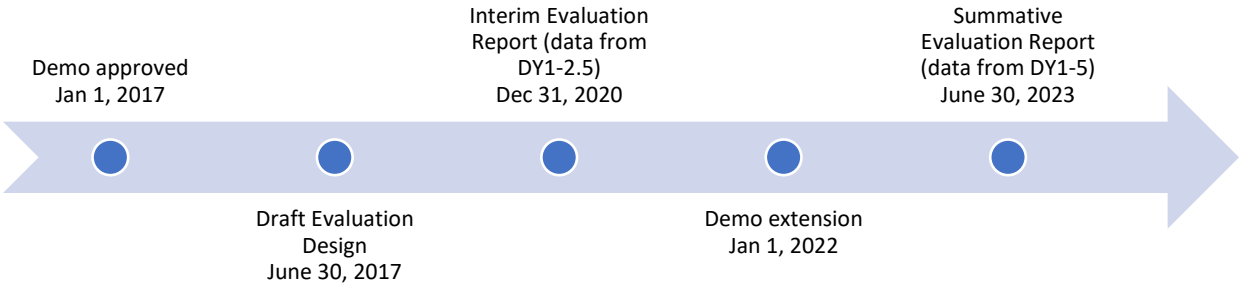
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals.

The format for the Evaluation Design is as follows:

- General Background Information
- Evaluation Questions and Hypotheses
- Methodology
- Methodological Limitations
- Attachments

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. **General Background Information**. In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3. A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5. Describe the population groups impacted by the demonstration.

B. **Evaluation Questions and Hypotheses.** In this section, the state should:

1. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3. Identify the state's hypotheses about the outcomes of the demonstration:

4. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;

5. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. **Methodology**. In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1. Evaluation Design. Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2. Target and Comparison Populations. Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. Evaluation Period. Describe the time periods for which data will be included.

4. Evaluation Measures. List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing;

and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.

b. Qualitative analysis methods may be used and must be described in detail.

c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).

f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5. Data Sources. Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

    a. *If primary data (data collected specifically for the evaluation):* The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6. Analytic Methods. This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

    b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).

d. The application of sensitivity analyses, as appropriate, should be considered.

7. Other Additions. The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table 1: Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome Measures Used to Address the Research Question	Sample or Population Subgroups to be Compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. **Methodological Limitations.** This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

1. When the state demonstration is:

    a. Long-standing, non-complex, unchanged, or

    b. Has previously been rigorously evaluated and found to be successful, or

    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

    a. Operating smoothly without administrative changes; and

    b. No or minimal appeals and grievances; and

    c. No state issues with CMS-64 reporting or budget neutrality; and

    d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments.

1. Independent Evaluator. This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2. Evaluation Budget. A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3. Timeline and Major Milestones. Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B

Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

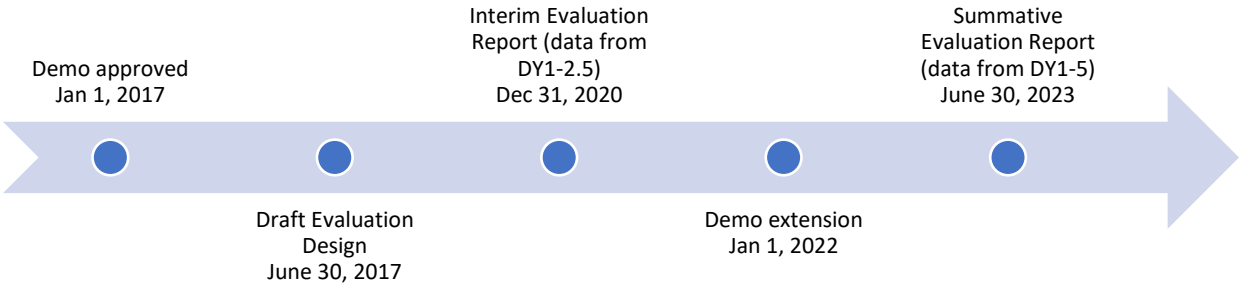
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary
B. General Background Information
C. Evaluation Questions and Hypotheses
D. Methodology
E. Methodological Limitations
F. Results
G. Conclusions
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS, pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. **Executive Summary.** A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. **General Background Information about the Demonstration.** In this section, the state should include basic information about the demonstration, such as:

1. The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;

4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.

5. Describe the population groups impacted by the demonstration.

C. **Evaluation Questions and Hypotheses.** In this section, the state should:

1. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

2. Identify the state's hypotheses about the outcomes of the demonstration;

    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;

    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and

    c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. **Methodology**. In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. Evaluation Design. Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?

2. Target and Comparison Populations. Describe the target and comparison populations; include inclusion and exclusion criteria.

3. Evaluation Period. Describe the time periods for which data will be collected

4. Evaluation Measures. What measures are used to evaluate the demonstration, and who are the measure stewards?

5. Data Sources. Explain where the data will be obtained, and efforts to validate and clean the data.

6. Analytic Methods. Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

7. Other Additions. The state may provide any other information pertinent to the evaluation of the demonstration.

E. **Methodological Limitations.** This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. **Results.** In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration

results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. **Conclusions.** In this section, the state will present the conclusions about the evaluation results.

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

    a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. **Interpretations, Policy Implications and Interactions with Other State Initiatives.** In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. **Lessons Learned and Recommendations.** This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?

2. What would you recommend to other states which may be interested in implementing a similar approach?

F. **Attachment: Evaluation Design.** Provide the CMS-approved Evaluation Design.

ATTACHMENT C

Reserved for Evaluation Design

ATTACHMENT D

SUD Implementation Plan

ATTACHMENT D: SUD Implementation Plan Protocol

North Carolina

Substance Use Disorder Implementation Plan Protocol

March 8, 2019

TABLE OF CONTENTS

TABLE OF CONTENTS

(continued)

Page

Introduction

Like many states, North Carolina is facing an opioid crisis that has rapidly intensified in recent years. Opioid overdose deaths in North Carolina have increased from just over 100 deaths in 1999 to 1,384 in 2016, including a 39% increase in overdose deaths from 2015-2016.[18,19] Since 1999, over 13,000 North Carolinians have died from an opioid overdose. Despite significant efforts to turn the tide on the opioid crisis—including launching North Carolina's Opioid Action Plan, passing the bipartisan Strengthen Opioid Misuse Prevention (STOP) Act, and making changes to North Carolina's Medicaid program—the number of people dying from opioid overdoses each month continues to increase.

As part of its commitment to expand access to treatment for substance use disorders (SUDs), North Carolina's Department of Health and Human Services (the Department) is pursuing a Section 1115 demonstration to strengthen its SUD delivery system by:

- Expanding its SUD benefits to offer the complete American Society of Addiction Medicine (ASAM) continuum of SUD services;
- Obtaining a waiver of the Medicaid institution for mental diseases (IMD) exclusion for SUD services;
- Ensuring that providers and services meet evidence-based program and licensure standards;
- Building SUD provider capacity;
- Strengthening care coordination and care management for individuals with SUDs; and
- Improving North Carolina's prescription drug monitoring program (PDMP).

The following implementation plan provides an overview of North Carolina's current Medicaid SUD delivery system and then details North Carolina's strategic vision for comprehensive SUD delivery reform across six milestones identified by the Centers for Medicare & Medicaid Services (CMS).

Department Overview

The Department includes the following divisions that have significant roles in the delivery and regulation of SUD services for Medicaid enrollees:

- **Division of Health Benefits (North Carolina Medicaid).** The division within the Department responsible for implementing Medicaid transformation and managing the North Carolina (NC) Medicaid and Health Choice (CHIP) programs.
- **Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS).** The division that serves as the single state authority for the Substance Abuse and Mental Health Services Administration (SAMHSA) and administers state-funded mental health, developmental disability and substance abuse services.
- **Division of Health Services Regulation (DHSR).** The division that certifies and monitors healthcare providers.

[18] North Carolina's Opioid Action Plan, 2017-2021. Available at https://files.nc.gov/ncdhhs/NC%20Opioid%20Action%20Plan%208-22-2017.pdf.
[19] North Carolina Opioid Overdose Factsheet, June 2017. Available at https://files.nc.gov/ncdhhs/Opioid_Overdose_Factsheet_FINAL_06_27_17.pdf.

- **Division of State Operated Health Care Facilities (DSOHF).** The division that oversees and manages state-operated health care facilities that treat adults and children with mental illness, SUDs, intellectual and developmental disabilities (I/DDs) and neuro-medical needs.

Current SUD Delivery System

Today, North Carolina Medicaid contracts with seven local management entities–managed care organizations (LME-MCOs), which are prepaid inpatient health plans, to provide mental health, substance use, and I/DD services for Medicaid enrollees located within their catchment areas. Medicaid enrollees obtain physical health services, pharmacy, and most long-term services and support (LTSS) through Medicaid fee-for-service. Additionally, DMH/DD/SAS contracts with the LME-MCOs to manage state and federal block grant-funded mental health, I/DD and SUD services to serve the uninsured and underinsured populations living within their catchment areas. Certain populations that are excluded from LME-MCO enrollment, such as NC Health Choice or legal aliens, receive SUD services through Medicaid fee-for-service. NC Medicaid contracts with a vendor to perform utilization management functions for fee-for-service behavioral health services.

Medicaid Delivery System Transformation

In September 2015, the North Carolina General Assembly (General Assembly) enacted North Carolina Session Law 2015-245, which was amended by Session Laws 2016-121, 2017-57 and 2018-48, directing the transition of North Carolina's Medicaid program from a predominantly fee-for-service model to managed care beginning in 2019. Consistent with best practices, the Department will create integrated managed care products that cover the full spectrum of physical health, behavioral health, LTSS and pharmacy services for all enrollees. North Carolina will permit two types of prepaid health plan (PHPs) products: standard plans and behavioral health and intellectual and developmental disability (BH I/DD) tailored plans. The majority of Medicaid and NC Health Choice enrollees, including adults and children with lower-intensity behavioral health needs, will receive integrated physical health, behavioral health and pharmacy services through standard plans when managed care launches in November 2019. Individuals with significant behavioral health disorders, I/DDs, or traumatic brain injury (TBI) will be enrolled by July 2021 in BH I/DD tailored plans, which will be specialized managed care products that target the needs of these populations.

Both standard plans and BH I/DD tailored plans will cover SUD treatment and withdrawal management services, but the BH I/DD tailored plans will cover a more expansive set of SUD services targeting individuals with significant SUD needs. LME-MCOs will continue to provide all covered SUD treatment services for Medicaid enrollees in the period following approval of the state's 1115 demonstration until standard plan implementation in November 2019. Upon standard plan implementation and until the anticipated launch of BH I/DD tailored plans in July 2021, LME-MCOs will provide SUD services for Medicaid enrollees who are eligible to enroll in the BH I/DD tailored plans or who are delayed or excluded from managed care. Throughout the managed care transition and afterward, the Department will continue to provide the complete array of Medicaid-covered SUD treatment and withdrawal

services in fee-for-service for populations that will phase into managed care in later years of implementation or that will be exempt or excluded from managed care.[20]

[20] Federally recognized tribal members may choose to remain in the fee-for-service system and are not mandated to participate in managed care at any point, unless the mandate is for an Indian Managed Care Entity (IMCE).

Milestone 1: Access to Critical Levels of Care for SUD

North Carolina's Medicaid State Plan covers a wide range of SUD services for enrollees across outpatient, residential and inpatient care settings. While North Carolina's Medicaid program currently covers most services in the ASAM continuum of care, the state seeks to complete its coverage of the ASAM continuum by adding ASAM levels 3.1 (clinically managed low-intensity residential treatment services), 3.3 (clinically managed population-specific high-intensity residential programs), 2-WM (ambulatory withdrawal management with extended on-site monitoring) and 3.2-WM (clinically managed residential withdrawal management) to its State Plan, and expanding coverage of existing services such as ASAM levels 3.5 (clinically managed high-intensity residential services) and 3.7 (medically monitored intensive inpatient services) to include adolescents. The table below provides an overview of North Carolina Medicaid coverage for each ASAM level of care, as well as proposed changes.

ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
0.5	Early intervention	Screening, brief intervention and referral for treatment (SBIRT)	Physicians and physician extenders only	Currently covered for all	Expansion of providers that are eligible for reimbursement	Fee-for service, standard plans and BH I/DD tailored plans
1	Outpatient services	Psychiatric and biopsychosocial assessment; medication management; individual, group and family therapies; psychotherapy for crisis; and psychological testing for eligible enrollees based on clinical severity and function Service includes assisting the individual to achieve changes in	Direct-enrolled licensed behavioral health providers	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans

ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
		his or her substance use or addictive behaviors, serving as a step down from a more intensive level of care, care for an individual in the early stages of change, and care for ongoing monitoring and disease management				
2.1	Intensive outpatient services (substance abuse intensive outpatient program)	Structured program delivering 9–19 hours of services per week to meet complex needs of people with addiction and co-occurring conditions	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service and BH I/DD tailored plans
2.5	Partial hospitalization services (substance abuse comprehensive outpatient treatment)	Structured program delivering 20 or more hours of clinically intensive programming per week, with a planned format of individualized services	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans
3.1	Clinically managed low-intensity residential treatment services	SUD halfway-house services; supportive living environment with 24-hour staff and integration with clinical services; at least five hours of low-intensity treatment per week or more intensive outpatient care as indicated	DHSR-licensed facilities	No coverage	Will be covered for all enrollees meeting medical necessity criteria	Fee-for service and BH I/DD tailored plans

ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
3.3	Clinically managed population-specific high-intensity residential programs	Clinically managed high-intensity SUD residential service for adults with cognitive impairment, including developmental delays, provided in a structured recovery environment	DHSR-licensed facilities	No coverage	Will be covered for all enrollees meeting medical necessity criteria	Fee-for service and BH I/DD tailored plans
3.5	Clinically managed high-intensity residential services (substance abuse non-medical community residential treatment)	Clinically managed high-intensity SUD residential services provided in a structured recovery environment	DHSR-licensed facilities	Currently covered for pregnant and parenting women	Will be covered for all enrollees, including adults and adolescents meeting medical necessity criteria	Fee-for service and BH I/DD tailored plans
3.7	Medically monitored intensive inpatient services (substance abuse medically monitored community residential treatment)	Medically monitored SUD inpatient treatment service with a structured regimen of 24-hour physician-directed evaluation, observation, medical monitoring and addiction treatment	DHSR-licensed specialty units in a community or psychiatric hospital	Currently covered for adult enrollees meeting medical necessity criteria	Will be covered for all enrollees, including adults and adolescents meeting medical necessity criteria	Fee-for service and BH I/DD tailored plans
4	Medically managed intensive inpatient services (inpatient behavioral health services)	Medically managed intensive inpatient services with 24-hour nursing care and daily physician care for severe, unstable problems in ASAM dimension: (1) acute intoxication and/or withdrawal potential; (2)	DHSR-licensed psychiatric hospitals and licensed community hospitals	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans

ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
		biomedical conditions and complications; or (3) emotional, behavioral or cognitive conditions and complications Counseling services also available				
OTP	Opioid treatment program (outpatient opioid treatment)	Service includes methadone or buprenorphine administration for treatment or maintenance; NC Medicaid is exploring creating an integrated service package that includes counseling and case management and other supportive services such as lab work in addition to methadone or buprenorphine	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans
1-WM	Ambulatory withdrawal management without extended on-site monitoring (ambulatory detoxification)	An organized outpatient withdrawal management service under the direction of a physician providing medically supervised evaluation, detoxification and referral services to treat mild withdrawal symptoms	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans
2-WM	Ambulatory withdrawal management with extended on-site monitoring	An organized outpatient withdrawal management service under the direction of a physician providing medically supervised evaluation, detoxification and referral services to treat	DHSR-licensed facilities	No coverage	Will be covered for all enrollees meeting medical necessity criteria	Fee-for service, standard plans and BH I/DD tailored plans

ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
		moderate withdrawal symptoms with extended on-site monitoring				
3.2-WM	Clinically managed residential withdrawal	An organized, clinically managed residential withdrawal management service for individuals who are experiencing moderate withdrawal symptoms and who require 24-hour supervision, observation and support; uses physician-approved protocols to identify individuals who require medical services beyond the capacity of the facility and to transfer these individuals to the appropriate levels of care	DHSR-licensed facilities	No coverage	Will be covered for all enrollees meeting medical necessity criteria	Fee-for service, standard plans and BH I/DD tailored plans
3.7-WM	Medically monitored inpatient withdrawal management (non-hospital medical detoxification)	An organized, medically monitored inpatient withdrawal management service under the supervision of a physician that provides 24-hour observation, monitoring and treatment for individuals who are experiencing severe withdrawal symptoms and require 24-hour nursing care	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans

ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
n/a	Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization	An organized, medically monitored withdrawal management service under the supervision of a physician that provides 24 hour supervision in a permanent facility with inpatient beds; individuals served are often in crisis due to co-occurring severe mental disorders and in need of short term, intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation	DHSR-licensed facilities	Currently covered for adult beneficiaries meeting medical necessity criteria	Will be incorporated into ASAM 4.0-WM	Fee-for service, standard plans and BH I/DD tailored plans
4-WM	Medically managed intensive inpatient withdrawal (inpatient behavioral health services)	An organized, medically managed inpatient service under the supervision of a physician that provides 24-hour, medically directed evaluation and withdrawal management for individuals who are experiencing severe, unstable withdrawal and require an acute care setting	Licensed psychiatric hospitals and licensed community hospitals	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans

The current North Carolina Medicaid coverage of ASAM-level SUD services, proposed changes and an implementation timeline are described in detail below. LME-MCOs currently are required to follow the Department's service definitions as described in the state's clinical coverage policies. Following managed care implementation, standard plans and BH I/DD tailored plans will be subject to these provisions in the clinical coverage policies when they launch on November 1, 2019, and July 1, 2021, respectively. The Department's service definitions will continue to apply to fee-for-service populations following the managed care transition.

Federal law prohibits federal financial participation (FFP) for services delivered to individuals ages 21 to 64 residing in IMDs. An IMD is defined as a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care or related services. One of the primary goals of the SUD-related portion of the 1115 demonstration is to waive this restriction and expand access to SUD treatment for individuals residing in IMDs. As detailed below, providers delivering the following types of services may be considered IMDs:

- ASAM level 3.1: Clinically managed low-intensity residential treatment services
- ASAM level 3.3: Clinically managed population-specific high-intensity residential programs
- ASAM level 3.5: Clinically managed high-intensity residential services
- ASAM level 3.7: Medically monitored intensive inpatient services
- ASAM level 4: Medically managed intensive inpatient services
- ASAM level 3.2-WM: Clinically managed residential withdrawal
- ASAM level 3.7-WM: Medically monitored inpatient withdrawal management
- Medically supervised or ADATC detoxification crisis stabilization
- ASAM level 4-WM: Medically managed intensive inpatient withdrawal

In addition, North Carolina has obtained approval to obtain FFP upon approval of this SUD Implementation Plan Protocol for the following non-residential services delivered to individuals residing in IMDs.

- ASAM level 2.1: Substance abuse intensive outpatient program
- ASAM level 2.5: Substance abuse comprehensive outpatient treatment program
- Opioid treatment program
- Office-based opioid treatment program

Level of Care: 0.5 (Early Intervention)

Current State

The Department provides coverage for several individual services around early intervention, including smoking cessation counseling and SBIRT. Physicians and physician extenders are the only providers who can currently bill LME-MCOs or Medicaid fee-for-service for these services. These services are available to all Medicaid-eligible enrollees without prior authorization.

Future State

North Carolina's Medicaid program plans to expand the types of providers that can bill this service to include direct-enrolled licensed behavioral health providers by updating the state's Medicaid management information system (MMIS) to add the taxonomies of the providers who would be eligible to bill these CPT codes. Additionally, NC Medicaid will post a Medicaid Bulletin informing the behavioral health providers of this change and any relevant clinical and billing criteria.

Summary of Actions Needed

- Implement MMIS modifications: September 2018 – April 2020

Level of Care: 1 (Outpatient Services)

Current State

The Department covers Medicaid-funded outpatient behavioral health services provided by direct-enrolled providers. These services are intended to determine an enrollee's SUD treatment needs and to provide the necessary treatment. Services focus on reducing symptoms of SUD and other BH disorders in order to improve the enrollee's functioning in familial, social, educational or occupational domains. Outpatient behavioral health services are available to eligible enrollees and often involve the participation of family members, significant others and legally responsible person(s) as applicable, unless contraindicated. Based on collaboration between the practitioner and the enrollee, and others as needed, the enrollee's needs and preferences determine the treatment goals and frequency, as well as measurable and desirable outcomes. Outpatient behavioral health services include:

- Comprehensive clinical assessment (CCA)
- Medication management
- Individual, group and family therapies
- Psychotherapy for crisis
- Psychological testing

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers, located here: https://files.nc.gov/ncdma/documents/files/8C_0.pdf.

Future State

The Department will amend the current Medicaid clinical coverage policies 8-A Diagnostic Assessment and 8-C to ensure a determination of ASAM level of care is included in the assessment information of enrollees diagnosed with SUDs. Enrollees with a SUD need will need to meet ASAM level 1 criteria to obtain this service.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policies 8-A Diagnostic Assessment and 8-C to reflect ASAM criteria: September 2018 – April 2020
- Submit SPA for 8A Diagnostic Assessment: September 2018 – April 2020

Level of Care: 2.1 (Intensive Outpatient Services)

Current State

The Department provides Medicaid coverage for substance abuse intensive outpatient program (SAIOP) services, which include structured individual and group SUD services that are provided in an outpatient program designed to assist adult and adolescent enrollees in beginning recovery and learning skills for recovery maintenance. The program is offered at least three hours a day, at least three days a week (no more than 19 hours of structured services per week), with no more than two consecutive days between offered services. SAIOP services include a structured program consisting of, but not limited to, the following services: individual, group and family counseling and support; biochemical assays to identify recent drug use; strategies for relapse prevention to include community and social support systems in treatment; life skills training; crisis contingency planning; disease management; and case management activities. Enrollees must meet the ASAM level 2.1 criteria to demonstrate medical necessity for these services.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here: https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

The Department will amend the current Medicaid clinical coverage policy 8-A to include the structured programming time frame of six to 19 hours for adolescents, reflect the 2013 ASAM criteria, require the presence of a full-time licensed professional, and permit this service to be reimbursed for individuals residing in an IMD. DHSR will update licensure rule 10A NCAC 27G .4400.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect 2013 ASAM criteria, add parameters for adolescents, require the presence of a full-time licensed professional, and permit the service to be reimbursed in an IMD: September 2018 – October 2020
- Update MMIS to permit this service to be reimbursed for individuals residing in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – October 2020
- Revise licensure rule: September 2018 – October 2022
- Revise LME-MCO contracts: September 2018 – October 2020

Level of Care: 2.5 (Partial Hospitalization Services)

Current State

The Department provides Medicaid coverage for substance abuse comprehensive outpatient treatment (SACOT), a time-limited periodic service with a multifaceted treatment approach for adults who require structure and support to achieve and sustain recovery. SACOT is a service that emphasizes the following: reduction in use of substances or continued abstinence; the negative consequences of substance use; the development of a social support network and necessary lifestyle changes; educational skills;

vocational skills that focus on substance use as a barrier to employment; social and interpersonal skills; improved family functioning; understanding of addictive disease; and the continued commitment to a recovery and maintenance program. Enrollees must meet the ASAM level 2.5 criteria to demonstrate medical necessity for this service.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here: https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

The Department will update the current Medicaid clinical coverage policy 8-A to align with the 2013 ASAM criteria, require the presence of a full-time licensed professional and permit this service to be reimbursed for individuals residing in an IMD. The Department will also work with DHSR to update licensure rule 10A NCAC 27G .4500.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to align with ASAM criteria, require the presence of full-time licensed professional, and permit this service to reimbursed in an IMD: September 2018 – October 2020
- Update MMIS to permit this service to be reimbursed for individuals residing in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – October 2020
- Revise licensure rule: September 2018 – October 2022
- Revise LME-MCO contracts: September 2018 – October 2020

Level of Care: 3.1 (Clinically Managed Low-Intensity Residential Treatment Services)

Current State

North Carolina's Medicaid program does not currently cover ASAM level 3.1 clinically managed low-intensity residential treatment services, also called substance abuse halfway-house services. However, DMH/DD/SAS covers substance abuse halfway-house services under ASAM level 3.1 in its state-funded service array. Additionally, North Carolina has a current licensure rule under 10A NCAC 27G .5600 for the services provided in this type of facility.

Future State

The Department will submit a state plan amendment (SPA) to add substance abuse halfway-house services to its State Plan for all enrollees. North Carolina is has obtained expenditure authority to deliver the service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for substance abuse halfway-house services provided to individuals residing in IMDs.

The Department will promulgate a new Medicaid clinical coverage policy for substance abuse halfway-house services. This service will provide a supportive living environment with 24-hour staff and at least five hours of low-intensity treatment per week (i.e., individual, group and/or family therapies; psycho-education) or a more intensive level of outpatient care such as ASAM 2.1 as medically necessary. Additionally, DHSR will work to create a new stand-alone licensure rule to align with ASAM criteria. Enrollees will need to meet the ASAM level 3.1 criteria to access these services.

Summary of Actions Needed

- Develop a Medicaid clinical coverage policy: September 2018 – October 2020
- Create a licensure rule waiver process: September 2018 – October 2020
- Create licensure rule: September 2018 – October 2022
- Implement MMIS modifications: September 2018 – October 2020
- Submit SPA: September 2018 – October 2020

Level of Care: 3.3 (Clinically Managed Population-Specific High-Intensity Residential Programs)

Current State

The Department does not currently cover ASAM level 3.3 clinically managed population-specific high-intensity residential programs in Medicaid.

Future State

The Department will submit a SPA to add clinically managed population-specific high-intensity residential programs to its State Plan for all enrollees meeting the medical necessity criteria. North Carolina has obtained expenditure authority to deliver the service to individuals receiving the service in facilities that meet the definition of an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, and the finalization of new licensure rules, North Carolina will be able to provide Medicaid reimbursement for clinically managed population-specific high-intensity residential services provided to individuals residing in IMDs.

The Department will promulgate a new Medicaid clinical coverage policy that will reflect the 2013 ASAM criteria for this level of care. These programs will provide clinically managed high-intensity SUD residential services in a structured recovery environment to adults with cognitive impairment, including developmental delays. Additionally, working across divisions, the Department will create a licensure rule for this service. Enrollees will need to meet the ASAM level 3.3 criteria to access these services.

Summary of Actions Needed

- Develop a Medicaid clinical coverage policy: September 2018 – October 2020
- Create a licensure rule waiver process: September 2018 – October 2020
- Create licensure rule: September 2018 – October 2022
- Implement MMIS modifications: September 2018 – October 2020
- Submit SPA: September 2018 – October 2020

Level of Care: 3.5 (Clinically Managed High-Intensity Residential Services)

Current State

The Department currently covers ASAM level 3.5 clinically managed high-intensity residential services for pregnant and parenting women at facilities that do not meet the definition of an IMD. Clinically managed high-intensity residential services, also called non-medical community residential treatment (NMCRT), is a 24-hour, professionally supervised residential recovery program that provides trained staff to work intensively with adults with SUDs who provide or have the potential to provide primary care for their minor children.

NMCRT rehabilitation facilities provide planned programs of professionally directed evaluation, care and treatment for the restoration of functioning of enrollees with an addiction disorder. These programs include assessment, referral, individual and group therapy, family therapy, recovery skills training, disease management, symptom monitoring, medication monitoring and self-management of symptoms, after-care, follow-up, access to preventive and primary healthcare including psychiatric care, and case management activities. NMCRT facilities do not provide 24-hour medical nursing or monitoring. Enrollees must meet the ASAM level 3.5 criteria to demonstrate medical necessity for these services.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here: https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

North Carolina has obtained expenditure authority to deliver these services to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to reimburse NMCRT provided to Medicaid enrollees in IMDs.

The Department will revise the current Medicaid clinical coverage policy 8-A to reflect the 2013 ASAM criteria, add adolescents who meet medical necessity as a population eligible to receive this service, include IMDs as eligible service providers, and extend coverage for treatment services provided in a therapeutic community. Working across divisions, the Department will revise the licensure rules 10A NCAC 27G .4100 and 10A NCAC 27G .4300 and create a new licensure rule for both adults and adolescents. The Department will also need to submit a SPA in light of the changes to this clinical coverage policy.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect 2013 ASAM criteria, add adolescents as a population eligible to receive service, include IMDs as eligible service providers, and extend coverage for treatment services provided in a therapeutic community: September 2018 – October 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – October 2020

- Revise existing licensure rules and create new licensure rules: September 2018 – October 2022
- Revise LME-MCO contracts: September 2018 – October 2020
- Submit SPA: September 2018 – October 2020

Level of Care: 3.7 (Medically Monitored Intensive Inpatient Services)

Current State

The Department currently covers ASAM level 3.7 medically monitored intensive inpatient services for adults only at facilities that do not meet the definition of an IMD. Medically monitored intensive inpatient service providers, also called medically monitored community residential treatment (MMCRT) providers, are non-hospital rehabilitation facilities for adults, with 24-hour medical or nursing monitoring, that provide a planned program of professionally directed evaluation, care and treatment for the restoration of functioning of enrollees with alcohol and other drug problems or addiction. Enrollees must meet the ASAM level 3.7 criteria to demonstrate medical necessity for these services.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here: https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

North Carolina has obtained expenditure authority to deliver these services to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for MMCRT delivered to individuals residing in IMDs. North Carolina is planning to make these services available to both adolescents and adults who demonstrate medical necessity.

The Department will revise the current Medicaid clinical coverage policy 8-A to reflect the 2013 ASAM criteria, add adolescents who meet medical necessity as a population eligible to receive this service and add IMDs as eligible service providers. Working across divisions, the Department will create a new licensure rule for this level of care that aligns with the ASAM criteria. The Department will also need to submit a SPA in light of the changes to this clinical coverage policy.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect ASAM criteria, add adolescents as a population eligible to receive service, and include IMDs as eligible service providers: September 2018 – October 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – October 2020
- Revise and create licensure rules: September 2018 – October 2022
- Revise LME-MCO contracts: September 2018 – October 2020
- Submit SPA: September 2018 – October 2020

Level of Care: 4 (Medically Managed Intensive Inpatient Services)

Current State

Since July 2016, LME-MCOs have had the authority to reimburse for inpatient services delivered in an IMD in lieu of settings covered by the NC State Plan.

North Carolina Medicaid currently provides coverage for ASAM level 4 medically managed intensive inpatient services at facilities that do not meet the definition of an IMD. Medically managed intensive inpatient services are behavioral health services provided in a hospital setting 24 hours a day along with supportive nursing and medical care provided under the supervision of a psychiatrist or a physician. These services are designed to provide continuous treatment for enrollees with acute psychiatric or substance use problems. They are appropriate for enrollees whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care. Enrollees who are admitted with an SUD must meet the ASAM level 4 criteria to demonstrate medical necessity for these services.

Additional coverage, code and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-B, Inpatient Behavioral Health Services, located here: https://files.nc.gov/ncdma/documents/files/8B.pdf.

Future State

North Carolina has obtained expenditure authority to deliver these services to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for medically managed intensive inpatient services delivered to individuals residing in IMDs.

The Department will revise the current Medicaid clinical coverage policy 8-B to reflect the 2013 ASAM criteria and include IMDs as eligible service providers for SUD treatment. Working across divisions, the Department will revise the 10A NCAC 27G .6000 licensure rule to align with ASAM criteria.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-B to reflect ASAM criteria and include IMDs as eligible service providers for SUD treatment: September 2018 – July 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: OTP (Opioid Treatment Programs)

Current State

The Department currently covers office-based opioid treatment and opioid treatment programs at the ASAM OTP level of care.

Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone

The clinical coverage policy 1A-41 for office-based opioid treatment outlines the requirements for providers who prescribe buprenorphine and the buprenorphine-naloxone combination product for the treatment of opioid use disorders (OUDs) in office-based settings. The Drug Addiction Treatment Act of 2000 (DATA 2000) permits providers who meet certain qualifications to dispense or prescribe narcotic medications that have a lower risk of abuse, such as buprenorphine and the buprenorphine-naloxone combination product, and that are approved by the Food and Drug Administration (FDA) for OUDs in settings other than an OTP, such as a provider's office. This program allows enrollees who need the opioid agonist treatment to receive this treatment in a qualified provider's office, provided certain conditions are met.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy 1A-41, Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone, located here: https://files.nc.gov/ncdma/documents/files/1A-41_4.pdf?ANpMLgJ7MIhEyt4r38bYvXinBFTk1h23.

Outpatient Opioid Treatment

Outpatient opioid treatment is a service designed to offer the enrollee an opportunity to effect constructive changes in his or her lifestyle by receiving, via a licensed OTP, methadone or other drugs approved by the FDA for the treatment of an OUD, in conjunction with rehabilitation and medical services. North Carolina Medicaid covers methadone- and buprenorphine-assisted treatment at this service level. Enrollees must meet the ASAM OTP criteria to demonstrate medical necessity for this service.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhance Mental Health and Substance Use Services, located here: https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

The Department will revise the current Medicaid clinical coverage policy 8-A to reflect that the 2013 ASAM criteria, permit this service to be reimbursed in an IMD, and to develop an integrated service model for outpatient opioid treatment that includes medication, medication administration, counseling, laboratory tests and case management activities. Working across divisions, the Department will revise the 10A NCAC 27G .3600 licensure rule.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect ASAM criteria, permit service to be reimbursed in an IMD, and create integrated service model: September 2018 – April 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – April 2020
- Revise licensure rule: September 2018 – October 2022
- Submit SPA: September 2018 – April 2020

- Revise LME-MCO contracts: September 2018 – April 2020

Level of Care: 1-WM (Ambulatory Withdrawal Management Without Extended On-Site Monitoring)

Current State

The Department currently provides coverage for ASAM level 1-WM ambulatory withdrawal management without extended on-site monitoring. Ambulatory detoxification is an organized outpatient service delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services in regularly scheduled sessions. The services are designed to treat the enrollee's level of clinical severity, to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol), and to effectively facilitate the enrollee's transition into ongoing treatment and recovery. Enrollees must meet the ASAM level 1-WM criteria to demonstrate medical necessity for this service.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here**:** https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

The Department will need to submit a SPA for 1-WM ambulatory withdrawal management services to reflect the proposed changes to the service based on the ASAM criteria. The Department will promulgate a new Medicaid clinical coverage policy that will reflect the ASAM criteria for this level of care and will work with DHSR to revise the 10A NCAC 27G .3300 licensure rule

Summary of Actions Needed

- Develop new Medicaid clinical coverage policy to align with ASAM criteria: September 2018 – July 2020
- Develop a licensure rule waiver process: September 2018 – July 2020
- Revise licensure rules: September 2018 – October 2022
- Submit SPA: September 2018 – July 2020
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: 2-WM (Ambulatory Withdrawal Management With Extended On-Site Monitoring)

Current State

The Department does not currently provide coverage for ASAM level 2-WM ambulatory withdrawal management with extended on-site monitoring.

Future State

The Department will need to submit a SPA for ambulatory withdrawal management services to reflect that, going forward, the state will cover ambulatory withdrawal management with extended on-site monitoring for all enrollees who meet the medical necessity criteria. The Department will promulgate a new Medicaid clinical coverage policy that will reflect the 2013 ASAM criteria for this level of care. This

service will provide enrollees with an organized outpatient withdrawal management service under the direction of a physician providing medically supervised evaluation, detoxification and referral services to treat moderate withdrawal symptoms with extended on-site monitoring. Enrollees must meet the ASAM level 2-WM criteria to demonstrate medical necessity for this service. Additionally, NC Medicaid will work with DHSR to revise the 10A NCAC 27G .3300 licensure rule to include ambulatory withdrawal management with extended on-site monitoring.

Summary of Actions Needed

- Develop a Medicaid clinical coverage policy: September 2018 – July 2020
- Develop a licensure rule waiver process: September 2018 – July 2020
- Create licensure rule: September 2018 – October 2022
- Implement MMIS modifications: September 2018 – July 2020
- Submit SPA: September 2018 – July 2020
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: 3.2-WM (Clinically Managed Residential Withdrawal)

Current State

Federal restrictions preclude the Department from obtaining FFP for withdrawal services delivered in an IMD to Medicaid enrollees between the ages of 21 and 64.

North Carolina Medicaid does not currently provide coverage for ASAM level 3.2-WM clinically managed residential withdrawal.

Future State

The Department will submit a SPA to add clinically managed residential withdrawal services to its State Plan. North Carolina is also seeking expenditure authority to deliver the service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, and the finalization of new licensure rules, North Carolina will be able to provide Medicaid reimbursement for clinically managed residential withdrawal services, also called social setting detoxification services, that are delivered to individuals residing in IMDs.

The Department will promulgate a new Medicaid clinical coverage policy that will reflect the 2013 ASAM criteria for this level of care and include IMDs as eligible providers. This policy will provide adults with an organized clinically managed residential withdrawal service that offers 24-hour supervision, observation and support for enrollees who are experiencing moderate withdrawal symptoms and who require 24-hour support utilizing physician-approved protocols. Enrollees must meet the ASAM level 3.2-WM criteria to demonstrate medical necessity for this service.
Working across divisions, the Department will revise the 10A NCAC 27G .3200 licensure rule.

Summary of Actions Needed

- Develop a Medicaid clinical coverage policy: September 2018 – July 2020
- Develop a licensure rule waiver process: September 2018 – July 2020

- Revise licensure rule: September 2018 – October 2022
- Implement MMIS modifications: September 2018 – July 2020
- Submit SPA: September 2018 – July 2020
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: 3.7-WM (Medically Monitored Inpatient Withdrawal Management)

Current State

The Department currently covers ASAM level 3.7-WM medically monitored inpatient withdrawal management services at facilities that do not meet the definition of an IMD. Non-hospital medical detoxification, the Department's name for this service, is an organized service delivered by medical and nursing professionals, which provides 24-hour, medically supervised evaluation and withdrawal management in a permanent facility affiliated with a hospital or in a free-standing facility. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols. Enrollees must meet the ASAM level 3.7-WM criteria to demonstrate medical necessity for this service.

Additional coverage, code and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here**:** https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

North Carolina has obtained expenditure authority to deliver the service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for medically monitored inpatient withdrawal management services delivered to individuals residing in IMDs.

The Department will revise the current clinical coverage policy 8-A to reflect the 2013 ASAM criteria and include IMDs as eligible service providers. Working across divisions, the Department will revise the 10A NCAC 27G .3100 licensure rule.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect ASAM criteria and include IMDs as eligible service providers: September 2018 – July 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 –July 2020
- Revise licensure rule: September 2018 – October 2022
- Submit SPA: September 2018 – July 2020
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: Medically Supervised or ADATC Detoxification Crisis Stabilization

Current State

The Department currently covers medically supervised or ADATC detoxification crisis stabilization services. Medically supervised or ADATC detoxification crisis stabilization is an organized service, delivered by medical and nursing professionals, that provides for 24-hour medically supervised evaluation and withdrawal management in a licensed permanent facility with 16 beds or less. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols. Beneficiaries are often in crisis due to co-occurring severe substance related mental disorders (e.g. acutely suicidal or severe mental health problems and co-occurring SUD) and are in need of short term intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation.

Additional coverage, code and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here**:** https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

North Carolina has obtained expenditure authority to deliver the service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for medically supervised or ADATC detoxification crisis stabilization services delivered to individuals residing in IMDs.

Coverage for detoxification services delivered in ADATCs will be incorporated into the Medicaid and Health Choice Clinical Coverage Policy 8-B for Inpatient Behavioral Health Services, which will be updated to align with 2013 ASAM level 4.0-WM criteria and include IMDs as eligible service providers. .

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-B to reflect ASAM criteria: September 2018 – July 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019

Level of Care: 4-WM (Medically Managed Intensive Inpatient Withdrawal)

Current State

Federal restrictions preclude the Department from obtaining FFP for medically managed intensive inpatient withdrawal services delivered in an IMD to Medicaid enrollees between the ages of 21 and 64. Since July 2016, LME-MCOs have had the authority to reimburse for inpatient services delivered to individuals residing in an IMD in lieu of services or settings covered by the Medicaid State Plan.

The Department currently provides Medicaid coverage for ASAM level 4-WM medically managed intensive inpatient withdrawal services at facilities that do not meet the definition of an IMD. Inpatient

behavioral health services provide treatment in a hospital setting 24 hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for enrollees with acute psychiatric or substance use problems. It is appropriate for enrollees whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care. Enrollees must meet the ASAM level 4-WM criteria to demonstrate medical necessity for this service.

Additional coverage, code and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-B, Inpatient Behavioral Health Services, located here: https://files.nc.gov/ncdma/documents/files/8B.pdf.

Future State

North Carolina has obtained expenditure authority to deliver this service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for medically managed intensive inpatient withdrawal services to individuals residing in IMDs.

The Department will revise the current clinical coverage policy 8-B to reflect the 2013 ASAM criteria and include IMDs as eligible service providers. Working across divisions, the Department will revise the 10A NCAC 27G .6000 licensure rule.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-B to reflect ASAM criteria and include IMDs as eligible service providers: September 2018 – July 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Revise LME-MCO contracts: September 2018 – July 2020

Summary of Actions Needed Across All Service Levels

Action	Implementation Timeline
Current Services[21]	
Revise Medicaid clinical coverage policies to reflect 2013 ASAM criteria and expand coverage to adolescents, as indicated	September 2018 – October 2020
Develop a licensure rule waiver process to incorporate ASAM criteria	September 2018 – October 2020
Revise licensure rules to align with ASAM criteria	September 2018 – October 2022
Implement MMIS modifications	September 2018 – October 2020
Submit SPAs, as necessary	September 2018 – October 2020
Revise LME-MCO contracts	September 2018 – October 2020
New Services	
Standard and BH I/DD Tailored Plan Services	
Develop Medicaid clinical coverage policies	September 2018 – July 2020
Develop a licensure rule waiver process	September 2018 – July 2020
Create licensure rules	September 2018 – October 2022
Implement MMIS modifications	September 2018 – July 2020
Submit SPAs	September 2018 – July 2020
Revise LME-MCO contracts	September 2018 – July 2020
BH I/DD Tailored Plan Services Only	
Develop Medicaid clinical coverage policies	September 2019 – October 2020
Create licensure rules	September 2020 – October 2020
Implement MMIS modifications	September 2019 – October 2020
Submit SPAs	September 2019 – October 2020

Milestone 2: Use of Evidence-Based SUD-Specific Patient Placement Criteria

North Carolina has robust, evidence-based policies in place to ensure that enrollees have access to appropriate SUD services according to their diagnosis and ASAM level of care determination. Over the course of the 1115 demonstration, North Carolina will strengthen its assessment and person-centered planning policies, which are prerequisites for obtaining most SUD services, by requiring that all SUD providers conducting assessments document their training with respect to the ASAM criteria.

Enrollee Assessments

Current State

As part of its Medicaid 8-A and 8-C clinical coverage policies, NC Medicaid requires behavioral health providers to complete an assessment before an enrollee can receive behavioral health services, except for selected crisis services. Providers use their clinical expertise to choose between two types of assessments:

[21] For some services, actions will be complete prior to October 2020 as detailed earlier in this section.

1. **Diagnostic assessments:** NC Medicaid requires that a team of at least two licensed professionals interview and assess an enrollee and, based on the assessment, write a joint report recommending the services appropriate for the enrollee. For enrollees with SUDs, at a minimum this team must include (1) a certified clinical supervisor or licensed clinical addiction specialist; and (2) a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP), physician assistant (PA) or licensed psychologist. The clinical coverage policy for diagnostic assessments recommends a level of placement using the ASAM criteria for enrollees with SUD diagnoses, but does not require its use.
2. **Comprehensive clinical assessments (CCA):** Licensed professionals perform the CCA, a clinical evaluation that provides the necessary data and recommendations that form the basis of the enrollee's treatment or person-centered plan, as described in the next section. NC Medicaid does not have a prescribed format for the CCA; providers can tailor the CCA based on the enrollee's clinical presentation.

Diagnostic assessments and CCAs must include the following elements:

- Description of the presenting problems, including source of distress, precipitating events, and the associated problems or symptoms.
- Chronological general health and behavioral health history (including both mental health and substance abuse) of the enrollee's symptoms, treatment and treatment response.
- Current medications (for both physical and psychiatric treatment).
- A review of the biological, psychological, familial, social, developmental and environmental dimensions to identify strengths, needs and risks in each area.
- Evidence of the enrollee's and the legally responsible person's (if applicable) participation in the assessment.
- Analysis and interpretation of the assessment information with an appropriate case formulation.
- DSM-5 diagnosis, including mental health, SUDs or intellectual/developmental disabilities, as well as physical health conditions and functional impairment.
- Recommendations for additional assessments, services, support or treatment based on the results of the CCA.
- Signature of the licensed professional completing the assessment and the date.

Future State

The Department will update clinical coverage policies 8-A and 8-C to require an ASAM determination as part of the diagnostic assessment and CCA. The Department will require all professionals administering diagnostic assessments and CCAs to obtain training in the ASAM criteria.

Upon their launch in 2019 and 2021, respectively, standard plans and BH I/DD tailored plans will be required to follow the provisions related to behavioral health assessments included in Medicaid clinical coverage policies 8-A and 8-C.

Summary of Actions Needed

- Revise clinical coverage policies to require that (1) an ASAM determination is part of the diagnostic assessment and CCA and (2) licensed providers providing SUD services or

assessments document their training with respect to the ASAM criteria: September 2018 – April 2020
- Contractually require standard plans to comply with the provisions related to behavioral health assessments included in Medicaid clinical coverage policies 8-A and 8-C: Completed
- Contractually require BH I/DD tailored plans to comply with the provisions related to behavioral health assessments included in Medicaid clinical coverage policies 8-A and 8-C: September 2018-July 2021

Person-Centered Plan

Current State

Person-centered planning is a guiding principle that must be embraced by all who are involved in the SUD service delivery system. Person-centered thinking and individualized service planning are the hallmarks of the provision of high-quality services in meeting the unique needs of each person served. Each plan is driven by the individual, utilizing the results and recommendations of a comprehensive clinical assessment, and is individually tailored to the preferences, strengths and needs of the person seeking services.

As detailed in the clinical coverage policies for behavioral health services, a person-centered plan is required in order for an enrollee to receive the covered SUD treatment services listed in Milestone 1, with the exception of all detoxification services, outpatient treatment and early intervention services. When a person-centered plan is not required, a plan of care, service plan or treatment plan, consistent with and supportive of the service provided and within professional standards of practice, is required on or before the day the service is delivered. The person-centered plan must be developed and written by a qualified professional or a licensed professional according to the requirements of the specific policy and in collaboration with the individual receiving services, family members (when applicable) and other service providers, in order to maximize unified planning. The person responsible for developing the person-centered plan should present the results and recommendations of the plan as an integral part of the person-centered planning discussions and should incorporate them into the plan as appropriate and as agreed upon by the individual and/or his or her legally responsible person.

The person-centered plan is effective for the 12-month period following the date the qualified or licensed professional signs it, unless there is a change that requires an updated plan. The person-centered plan includes service orders for behavioral health services other than ASAM level 1.0 (outpatient services) that demonstrate medical necessity and are based on an assessment of each enrollee's needs. Service orders are valid for one year from the date of the person-centered plan. At least annually, the LME-MCOs must review medical necessity for the services, and providers must issue a new service order for services to continue. An event such as a hospitalization may trigger a new assessment and a person-centered plan revision.

Future State

Upon their launch in 2019 and 2021, respectively, standard plans and BH I/DD tailored plans will be required to follow the person-centered planning provisions included in current Medicaid clinical coverage policies prior to authorizing SUD services. As noted above, the Medicaid clinical coverage

policies will continue to apply to SUD services delivered through fee-for-service. This means that the process described above related to the development and use of the person-centered plan will continue to occur as it does today.

Summary of Actions Needed

- Contractually require standard plans to comply with the provisions related to person-centered planning included in Medicaid clinical coverage policies 8-A and 8-C: Completed
- Contractually require BH I/DD tailored plans to comply with the provisions related to person-centered planning included in Medicaid clinical coverage policies 8-A and 8-C: September 2018-July 2021

Utilization Management

Current State

NC Medicaid requires LME-MCOs to establish a utilization management program that includes a written plan that addresses procedures used by LME-MCOs to review and approve requests for medical services, and that identifies the clinical criteria used by LME-MCOs to evaluate the medical necessity of the service being requested. Additionally, LME-MCOs are required to ensure consistent application of the review criteria and consult with requesting providers when appropriate. LME-MCOs must conduct an annual appraisal that assesses adherence to the utilization management plan and identifies the need for changes. LME-MCOs are permitted to establish utilization management requirements for behavioral health services that are different from, but not more restrictive than, Medicaid State Plan requirements. NC Medicaid requires LME-MCOs to use the ASAM criteria to determine medical necessity of SUD services.

NC Medicaid requires providers, except those in outpatient, SAIOP and SACOT programs, to obtain prior approval from an enrollee's LME-MCO before providing certain SUD services. For all services, the LME-MCOs performs utilization management. The LME-MCOs follow the requirements listed below, although they have the flexibility to establish their own utilization management criteria, provided they are not more restrictive than the requirements listed below.

For populations receiving SUD services through fee-for-service, the NC Medicaid's behavioral health vendor performs utilization management, which includes prior authorization for selected services, in accordance with NC Medicaid's clinical coverage policy requirements detailed below. The vendor does not have the flexibility to establish its own utilization management criteria.

Medicaid clinical coverage policies:

- **ASAM Level 1: Outpatient services.** For children and adolescents under the age of 21, initial coverage is limited to 16 unmanaged outpatient visits per year, with additional visits requiring prior authorization. For adult enrollees, coverage is limited to eight unmanaged outpatient visits per year, with additional visits requiring prior authorization.
- **ASAM Level 2.1: SAIOP.** The initial 30 calendar days of treatment do not require a prior authorization. Services provided after this initial 30-day "pass-through" period require authorization from the LME-MCO or the Department's approved behavioral health vendor. This

pass-through is available only once per treatment episode and only once per state fiscal year. The amount, duration and frequency of SAIOP services must be included in an enrollee's authorized person-centered plan. Services may not be delivered less frequently than noted in the structured program set forth in the service description described in Milestone 1. Reauthorization shall not exceed 60 calendar days. Under exceptional circumstances, one additional reauthorization up to two weeks can be approved. All utilization review activity shall be documented in the enrollee's person-centered plan.

- **ASAM Level 2.5: SACOT.** The initial 60 calendar days of treatment do not require a prior authorization. Services provided after this initial 60-day pass-through period require authorization from the LME-MCO or the Department's approved behavioral health vendor. This pass-through is available only once per treatment episode and only once per state fiscal year. The amount, duration and frequency of SACOT services, as well as all utilization review activities, must be included in an enrollee's authorized person-centered plan. Reauthorization shall not exceed 60 calendar days.
- **ASAM Levels 3.5 and 3.7: NMCRT and MMCRT.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization shall not exceed 10 days, and reauthorization shall not exceed 10 days. This service and all utilization review activity shall be included in the enrollee's person-centered plan. Utilization management must be performed by the LME-MCO or the Department's approved behavioral health vendor.
- **ASAM Level 4: Medically managed intensive inpatient services.** Authorization from the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization is limited to seven calendar days.
- **Outpatient opioid treatment.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization shall not exceed 60 days. Reauthorization shall not exceed 180 days. All utilization review activity shall be documented in the enrollee's person-centered plan.
- **ASAM Level 1-WM: Ambulatory detoxification.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization is limited to seven days. Reauthorization is limited to three days, as there is a 10-day maximum for this service. This service must be included in an enrollee's person-centered plan.
- **ASAM Level 3.7-WM: Medically monitored inpatient withdrawal management.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization shall not exceed 10 days. Reauthorization shall not exceed 10 days. This service must be included in an enrollee's person-centered plan. All utilization review activity shall be documented in the enrollee's person-centered plan.
- **Medically supervised or ADATC detoxification crisis stabilization.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization shall not exceed 5 days. This is a short-term service that cannot be billed for more than 30 days in a 12-month period. All utilization review activity shall be included in an enrollee's person-centered plan.
- **ASAM Level 4-WM: Medically managed withdrawal management services.** Authorization from the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization is limited to seven calendar days.

Future State

For all newly added SUD services—halfway house for individuals with an SUD, clinically managed population-specific high-intensity residential services, ambulatory detoxification services with extended

on-site monitoring, and social setting detoxification services—the Department will establish prior authorization and utilization management requirements consistent with ASAM standards of care to ensure the appropriateness of patient placement. The clinical coverage policies for these new services will include these prior authorization and utilization management requirements. As described in Milestone 1, the Department will submit SPAs to add these four services to its Medicaid State Plan.

Following the managed care transition in November 2019, and consistent with its utilization management approach for LME-MCOs, the Department will permit standard plans and BH I/DD tailored plans (beginning at their launch in July 2021) to establish utilization management requirements for behavioral health services that are different from, but not more restrictive than, Medicaid State Plan requirements. Standard plans and BH I/DD tailored plans will be required to use the ASAM criteria to review the medical necessity of SUD services versus a "fail first" approach and will ensure that patient placements are appropriate as detailed in the LME-MCO and PHP contracts.

Approximately one to two years following BH I/DD tailored plan launch, the Department will solicit feedback from enrollees and providers, as well as standard plans and BH I/DD tailored plans, on utilization management approaches for SUD services, to determine whether to allow plans greater flexibility to establish their own utilization management approach. The clinical coverage policies will continue to apply to the fee-for-service population.
The Department understands the importance of ensuring that the length of SUD treatment authorized is aligned with an individual's specific needs. The National Institute on Drug Abuse (NIDA) notes that a program of fewer than 90 days of residential or outpatient treatment has shown limited or no effectiveness and recommends a 12-month minimum length of treatment for methadone maintenance.[22] Individuals with SUDs may require treatment that continues over a period of years and for multiple episodes. Client retention and engagement in treatment are critical components of recovery.

Summary of Actions Needed

Action	Implementation Timeline
Revise clinical coverage policies to require that (1) an ASAM determination is part of the diagnostic assessment and CCA and (2) licensed providers providing SUD services or assessments document their training with respect to the ASAM criteria	September 2018 – April 2020
Submit SPAs as needed to reflect updated utilization management requirements	September 2018 – October 2020
Update LME-MCO contracts, as necessary	September 2018 – October 2020
Require standard plans to follow clinical coverage policies 8-A and 8-C	Completed

[22] National Institute on Drug Abuse. (n.d.). 7: Duration of treatment. Retrieved April 12, 2018, from https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iii/6-duration-treatment.

Require BH I/DD tailored plans to follow clinical coverage policies 8-A and 8-C	September 2018 – July 2021

Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

DHSR licenses and regulates outpatient, residential and inpatient SUD providers. The current licensure rules for SUD treatment providers include standards around the services that must be offered, program hours and staff credentials. Today, the degree of alignment between licensure rules for SUD providers and the ASAM criteria varies across provider type. The Department, through cross-division collaboration, intends to update nearly all of the licensure rules for SUD providers to align with the 2013 ASAM criteria and ensure that residential treatment providers either provide medication-assisted treatment (MAT) on-site or facilitate access to off-site MAT providers within a specified distance. The Department will also conduct more robust monitoring of SUD treatment providers to ensure compliance with the ASAM criteria.

Provider Licensure

Current State

Today, DHSR's Mental Health Licensure & Certification Section (MHLC) licenses and regulates non-acute residential facilities and outpatient programs pursuant to NC General Statute 122C. DHSR's Acute and Home Care Section licenses and regulates hospitals and psychiatric hospitals that provide acute inpatient and withdrawal management services. Four outpatient services and five residential services that provide an ASAM level of care are considered to be non-acute residential facilities and outpatient programs. With the exception of ASAM level 2.1 (substance abuse intensive outpatient program) and 2.5 (substance abuse comprehensive outpatient program) providers, none of the licensure rules for covered SUD treatment providers, including residential treatment providers, were written to reflect the ASAM criteria. The table below displays the SUD outpatient programs and the residential and inpatient services that North Carolina Medicaid covers today or intends to add to the State Plan; North Carolina's administrative rule that applies to each service; and the alignment between the current provider qualifications and the ASAM criteria.

The licensing standards for each covered service are memorialized in the 10 NCAC 27G Administrative Code, located here: http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2027%20-%20mental%20health,%20community%20facilities%20and%20services/subchapter%20g/subchapter%20g%20rules.pdf.

ASAM Level of Care	ASAM Title for Level of Care	North Carolina Licensure Rule	Section of NC Administrative Code (10A NCAC 27G)	Current Provider Qualifications
Outpatient Services				
2.1	Intensive outpatient services	Substance abuse intensive outpatient program	.4400	Reflect ASAM criteria with regard to types of services offered, hours of clinical care for adults and credentials of staff
2.5	Partial hospitalization services	Substance abuse comprehensive outpatient treatment	.4500	Reflect ASAM criteria with regard to types of services offered, hours of clinical care for adults and credentials of staff
OTP	Opioid treatment program	Outpatient opioid treatment	.3600	Do not reflect ASAM criteria
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Outpatient detoxification for substance abuse	.3300	Do not reflect ASAM criteria
2-WM	Ambulatory withdrawal management with extended on-site monitoring	N/A	N/A	New service; will require revision of the .3300 licensure rule
Residential Services				
3.1	Clinically managed low-intensity residential treatment services	Supervised-living halfway house	.5600	Will require new stand-alone licensure rule
3.2-WM	Clinically managed residential withdrawal	Social setting detoxification for substance abuse	.3200	Do not reflect ASAM criteria
3.3	Clinically managed population-specific high-intensity residential programs	N/A	N/A	New service; will require new licensure rule

ASAM Level of Care	ASAM Title for Level of Care	North Carolina Licensure Rule	Section of NC Administrative Code (10A NCAC 27G)	Current Provider Qualifications
3.5	Clinically managed high-intensity residential services	Residential recovery programs for individuals with substance abuse disorders and their children Therapeutic community Non-medical community residential treatment services (adults and adolescents)	.4100 .4300 N/A	Do not reflect ASAM criteria Do not reflect ASAM criteria New service; will require new licensure rule
3.7	Medically monitored intensive inpatient services	Residential treatment for individuals with substance abuse disorders	.3400	Do not reflect ASAM criteria
3.7-WM	Medically managed inpatient withdrawal	Non-hospital medical detoxification	.3100	Do not reflect ASAM criteria
N/A	Medically supervised or ADATC detoxification crisis stabilization	N/A	N/A	Do not reflect ASAM criteria
Inpatient Services				
4	Medically managed intensive inpatient services	Psychiatric hospital Psychiatric unit, hospital	.6000 10A NCAC 13B .5200	Do not reflect ASAM criteria
4-WM	Medically managed intensive inpatient withdrawal	Psychiatric hospital	.6000 10A NCAC 13B	Do not reflect ASAM criteria

ASAM Level of Care	ASAM Title for Level of Care	North Carolina Licensure Rule	Section of NC Administrative Code (10A NCAC 27G)	Current Provider Qualifications
		Psychiatric unit, hospital		

Future State

DHSR, in collaboration with other divisions of the Department, will develop a licensure rule waiver process to expedite the process of aligning its provider qualifications for SUD outpatient programs and residential treatment services with ASAM criteria within the next 24 months. DHSR will also leverage the state's administrative rulemaking process to update its licensure rules for SUD outpatient programs and residential treatment services to align with the ASAM criteria. DHSR will continue to evaluate whether it needs to revise its licensure rules for inpatient services to align with ASAM criteria. When developing licensure rules for new services or new populations that will be able to access a service (e.g., adolescents), DHSR will ensure that they reflect ASAM's specifications regarding service definitions, hours of clinical care provided and program staff credentialing.

Summary of Actions Needed

- Develop a licensure rule waiver process to incorporate ASAM criteria: September 2018 – October 2020
- Revise existing licensure rules to align provider qualifications with 2013 ASAM criteria: September 2018 – October 2022

Monitoring of SUD Treatment Providers

Current State

To ensure that high-quality SUD treatment services are delivered in accordance with state licensure rules, DHSR regularly monitors outpatient OTPs and residential treatment providers. DHSR's monitoring of residential and OTP providers includes annual surveys, complaint investigations and follow-up surveys to determine compliance with the North Carolina administrative rules regarding services offered, hours of clinical care and program staffing. DHSR does not conduct annual surveys of outpatient treatment providers other than OTPs, but investigates complaints and conducts follow-up surveys to ensure that the provider has addressed the cited deficiencies.

Future State

DHSR will incorporate questions assessing compliance with the ASAM criteria, as memorialized in the state's updated licensure rules, into its annual surveys of licensed SUD treatment providers. In addition, DHSR will begin surveying ASAM level 2.1, 2.5 and 1-WM providers annually for compliance with the licensure rules. DHSR, in collaboration with other divisions of the Department, will train its inspectors to ensure they are equipped on how to monitor providers for compliance with ASAM standards. As part of these education efforts, DHSR will also revise its Survey Process Guide, which includes written

instructions for surveyors regarding how to consistently assess compliance with administrative rules. These actions are expected to be completed by October 2020.

Summary of Actions Needed

- Revise DHSR MHLC's annual survey process to provide the ability to assess compliance with 2013 ASAM standards: September 2018 – October 2020

Requirement That Residential Treatment Providers Offer MAT On-Site or Facilitate Access to Off-Site Providers

Current State

DMH/DD/SAS currently requires state-funded ASAM level 3.5 (clinically managed high-intensity residential services) providers, many of which may be Medicaid providers as well, to provide MAT on-site or coordinate care with a licensed OTP or office-based opioid treatment (OBOT) provider. ASAM level 3.7 (medically monitored intensive inpatient services) providers are not subject to a similar requirement, although some ASAM 3.7 providers may offer MAT on-site if the individual was receiving MAT prior to seeking care at the residential facility and/or if the physicians at the facility have completed buprenorphine training required under DATA 2000.

To ensure that all residential treatment providers either offer MAT on-site or facilitate access to MAT off-site, North Carolina is conducting two different assessments of MAT capacity. First, the state is working to identify which residential treatment providers offer MAT on-site today. Second, the state is plotting the locations of licensed OBOT providers and OTPs that currently provide MAT services and comparing them to the locations of residential treatment providers to understand access to OBOT and OTP.

Future State

The Department will require residential treatment providers that do not provide MAT on-site to have the ability to link individuals to a licensed OBOT or OTP located within a minimum number of miles or minutes. The Department will develop this requirement based on the results of its analysis of the geographic locations of residential treatment providers compared with OBOT providers and OTPs. This standard may vary for residential treatment facilities located in urban and rural areas of the state. To ensure provider compliance with this requirement, the Department will conduct outreach and additional training, as well as provide technical assistance to residential treatment providers.

Summary of Actions Needed

- Develop requirement for residential treatment providers to be able to refer patients to MAT within a minimum number of miles or minutes: September 2018 – October 2020

Summary of Actions Needed

Action	Implementation Timeline
Develop a licensure rule waiver process to incorporate ASAM criteria	September 2018 – October 2020
Revise existing licensure rules to align provider qualifications with 2013 ASAM criteria	September 2018 – October 2022
Revise DHSR MHLC's annual survey process to provide the ability to assess compliance with 2013 ASAM standards	September 2018 – October 2020
Develop requirement for residential treatment providers to be able to refer patients to MAT within a minimum number of miles or minutes	September 2018 – October 2020

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care, Including for Medication-Assisted Treatment for OUD

Today, LME-MCOs manage SUD provider networks and are required to comply with NC Medicaid choice and time and distance standards for all covered Medicaid services. Rural areas, in particular, face ongoing staffing shortages at critical levels of SUD care, including with respect to OTPs and residential treatment services. To ensure that Medicaid enrollees, whether they receive services through the LME-MCOs or fee-for-service, have access to SUD treatment providers at critical levels of care, the Department will conduct an assessment of all Medicaid-enrolled providers. As part of this assessment, the Department will identify providers that are accepting new patients. The Department will use the results of the assessment to target network development efforts for LME-MCOs, standard plans and BH I/DD tailored plans.

Current State

The Department tasks the LME-MCOs with overseeing the development and management of a qualified SUD provider network in accordance with community needs. LME-MCOs are responsible for the enrollment, disenrollment, credentialing, and assessment of qualifications and competencies of providers, in accordance with applicable state and federal regulations. The LME-MCOs are subject to the following network adequacy standards for Medicaid covered behavioral health services:

Provider Type	Urban Standard	Rural Standard[23]
Outpatient Services[24]	≥ 2 providers of each outpatient service within 30 minutes or 30 miles of residence	≥ 2 providers of each outpatient service within 45 minutes or 45 miles of residence
Location-Based Services[25]	≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence	≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence
Crisis Services[26]	≥ 1 provider of each crisis service within each LME-MCO region	
Specialized Services[27]	≥ 1 provider of each service within each LME-MCO region	
Inpatient Services	≥ 1 provider of each service within each LME-MCO region	

LME-MCOs endeavor to ensure that enrollees have a choice of providers within time and distance requirements set forth by the Department. LME-MCOs must ensure a provider directory is made available to the enrollees to support their selection of a provider. In the event of limited services, LME-MCOs may request an exception for a specific access-to-care gap. The Department determines whether to grant an exception by examining service utilization, provider availability and the LME-MCO's plan for ensuring enrollees have access to the required service. In addition, the LME-MCO must have a plan for meeting the network adequacy requirement in the future.

Each LME-MCO is required to conduct an annual gap analysis and needs assessment of its provider network that incorporates data analysis of access to and choice of providers, as well as input from enrollees, family members, providers and other stakeholders. LME-MCOs review all services, identify service gaps, and prioritize strategies to address any gaps or weaknesses identified. The assessment takes into consideration the characteristics of the population in the entire catchment area and includes input from individuals receiving services and their family members, the provider community, local public agencies, and other local system stakeholders. Each LME-MCO assesses the adequacy, accessibility, and availability of its current provider network and creates a network development plan to meet identified community needs, following the Department's published gap analysis requirements.
Notwithstanding the LME-MCOs' robust time and distance standards, there are gaps in provider access in rural areas of North Carolina across all ASAM levels. Recent gap analyses have

[23] For the purposes of the state's network adequacy standards, "urban" is defined as "non-rural counties," or counties with an average population density of 250 or more people per square mile. This includes 20 counties categorized by the North Carolina Rural Economic Development Center (the Rural Center) as "regional cities or suburban counties" or "urban counties." These 20 counties include 59% of the state's population. "Rural" is defined as counties with a population density below 250 people per square mile. Per the Rural Center, 80 counties in North Carolina meet this definition; these counties are home to 41% of the state's population. See more at http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf.

[24] Outpatient services include behavioral health services provided by direct enrolled providers such as psychiatrists.

[25] Location-based services include ASAM levels 2.1 (SAIOP), 2.5 (SACOT) and OTPs.

[26] Detoxification services include ASAM levels 1-WM (ambulatory detoxification services without extended on-site monitoring), and 3.7-WM (non-hospital medical detoxification). For medically supervised or ADATC detoxification crisis stabilization, each LME-MCO is required to contract with all three ADATCs in the state.

[27] Specialized services include ASAM levels 3.5 (NMCRT) and 3.7 (MMCRT).

highlighted gaps in access to OTPs, ASAM level 2.5 (SACOT) providers, residential treatment programs and withdrawal management services.

To ensure that enrollees in fee-for-service have sufficient access to services, NC Medicaid enrolls any willing provider, reviews the adequacy of its network on a service-level basis, and collaborates with stakeholders to expand its network for services where shortages exist.

Future State

Within 12 months of the demonstration approval, the Department will complete its statewide assessment of the availability of enrolled Medicaid and state-funded providers, which will include identifying those who are accepting new patients at the critical levels of care. This assessment will also identify providers delivering state-funded services at ASAM level 3.1 (substance abuse halfway house) and ASAM level 3.2-WM (social setting detoxification services), which will be added to the Medicaid service array.

Summary of Actions Needed

Conduct an assessment of all Medicaid-enrolled providers, to include the identification of providers that are accepting new patients at the critical levels of care: September 2018 – October 2019

Network Adequacy Standards for LME-MCOs, Standard Plans and BH I/DD Tailored Plans

As described above, LME-MCOs are subject to a strong set of SUD network adequacy standards today. Standard plans and BH I/DD tailored plans will also be expected to maintain and monitor a robust network of SUD providers beginning at their launches in November 2019 and July 2021, respectively. The Department will develop a monitoring system to ensure compliance with all applicable network adequacy standards for LME-MCOs, standard plans and BH I/DD tailored plans. In alignment with the final federal Medicaid managed care rule, the Department will monitor the following indicators from the report "Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability." North Carolina will also use consumer experience to verify and monitor access to care and adjust time and distance standards, if necessary. The state will monitor appropriate service use through performance measure indicators that align with HEDIS measures.

Indicators of Provider Network Adequacy and Service Availability

Availability	Accessibility	Accommodation	Acceptability	Realized Access
Provider Capacity	**Timely Access to Care**	**Cultural Competency & Operating Hours**	**Customer Service**	**Appropriate Service Use**
Number of providers accepting new Medicaid enrollees	Percentage of consumers living within 30 minutes/30 miles for urban and 45 minutes/45 miles for rural areas	Availability and delivery of services in a culturally competent manner regardless of cultural and ethnic backgrounds; disabilities; and	Consumer perception of care surveys Number of appeals, grievances and complaints	Critical performance indicators: Follow-up after care Readmissions

Availability	Accessibility	Accommodation	Acceptability	Realized Access
Provider Capacity	**Timely Access to Care**	**Cultural Competency & Operating Hours**	**Customer Service**	**Appropriate Service Use**
	Percentage of consumers able to be seen within maximum wait time for emergent, urgent and routine care	gender, sexual orientation or gender identity		Initiation and engagement Physical healthcare visits

As part of its managed care design process, the Department has developed the following time and distance standards for proposed SUD services that will be covered by standard plans. These services include one of the new services at ASAM level 2-WM (ambulatory detoxification with extended on-site monitoring). The Department will develop network adequacy standards for BH I/DD tailored plans in the coming year.

Standard Plan Network Adequacy Standards for Behavioral Health Services

Provider Type	Urban Standard	Rural Standard
Outpatient Services[28]	≥ 2 providers of each outpatient service within 30 minutes or 30 miles of residence	≥ 2 providers of each outpatient service within 45 minutes or 45 miles of residence
Location-Based Services[29]	≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence	≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence
Crisis Services[30]	≥ 1 provider of each crisis service within each standard plan region	
Inpatient Services	≥ 1 provider of each crisis service within each standard plan region	

Building Capacity for New Services

The state intends to support LME-MCOs, standard plans and BH I/DD tailored plans in building network capacity for new or expanded services that will be covered through fee-for-service as well.

- **Expand service offerings to include ASAM level 2-WM.** The Department plans to work with the LME-MCOs to encourage their ASAM level 1-WM providers to expand their service offerings to include ASAM level 2-WM.

[28] Outpatient services include behavioral health services provided by direct-enrolled providers such as psychiatrists.
[29] Location-based services include ASAM levels 2.1 (SAIOP), 2.5 (SACOT) and OTPs.
[30] Crisis services include ASAM levels 1-WM (ambulatory detoxification services without extended on-site monitoring), 2-WM (ambulatory detoxification with extended on-site monitoring), and 3.7-WM (non-hospital medical detoxification). For medically supervised or ADATC detoxification crisis stabilization, the standard plan will be required to contract with all three ADATCs in the state.

- **Leverage state-funded networks for ASAM levels 3.1, 3.7 and 3.2-WM.** The Department plans to work with LME-MCOs to enroll in Medicaid their current state-funded providers for ASAM levels 3.1 and 3.2-WM, in order to build Medicaid provider networks for these services. In addition, the state will work with LME-MCOs to enroll in Medicaid their state-funded providers serving adolescents for ASAM level 3.7 (medically monitored community residential treatment).
- **Engage with stakeholders for ASAM level 3.3.** To build sufficient networks for ASAM level 3.3 (clinically managed population-specific high-intensity residential programs), the state will engage with disability advocates representing individuals with TBI or I/DD as well as LME-MCOs, in order to identify providers that may be interested in offering this service.
- **Provide training for new Medicaid SUD providers.** The Department will educate and require the LME-MCOs, standard plans and BH I/DD tailored plans to provide training for new Medicaid SUD providers, to orient them to Medicaid and managed care, including topics such as utilization management, credentialing and billing.

Strategies to Ensure Adequate Capacity Post-Managed Care Transition

While standard plans and BH I/DD tailored plans will be required to meet minimum standards set by the Department, they will be given sufficient flexibility to innovate to improve quality and efficiency of care. In the event a service gap is identified, the standard plan or BH I/DD tailored plan may request an exception for a specific access-to-care gap in a specific region, consistent with current LME-MCO practice. The Department will determine if an exception is granted by looking at service utilization, the availability of providers, history of complaints, and the plan's short- and long-term plans for meeting ASAM level of care needs.

Standard plans and BH I/DD tailored plans will be allowed to develop their own telemedicine policies to ensure access to needed services, consistent with departmental guidance and approval. However, plans will not be permitted to use telemedicine to meet the state's network adequacy standards (unless the state has approved a request for an exception that involves telemedicine). When a Medicaid enrollee requires a medically necessary service that is not available within a standard plan's or BH I/DD tailored plan's network, the plan may offer the service, if applicable and clinically appropriate, through telemedicine, in addition to providing access to an out-of-network provider of the needed service. In these instances, the enrollee will have a choice between out-of-network provider and telemedicine and will not be forced to receive services through telemedicine. Medicaid enrollees receiving services through fee-for-service will be able to access telemedicine services consistent with the Department's clinical coverage policies. The Department is also exploring additional ways to leverage telemedicine for SUD treatment. As discussed in greater detail in Milestone 5 below, the state is supporting an expansion of Project Extension for Community Healthcare Outcomes (ECHO) to expand access to MAT in underserved and rural communities.

Standard plans and BH I/DD tailored plans will be required to submit an Access Plan annually to the Department, which will be reviewed and monitored by department staff. The Access Plan will demonstrate that the plans have the capacity to serve the expected enrollment in their service area in accordance with the Department's network requirements and network adequacy standards. NC Medicaid will review each Access Plan to ensure the standard plan or BH I/DD tailored plan meets all the

expectations and requirements and provides a reasonable approach to a plan's oversight and management of its providers and networks.

NC Medicaid will continue to ensure that it is has an adequate network of SUD providers in its fee-for-service program.

Expanding Access to MAT

The state has identified approximately 800 certified OBOT providers across North Carolina, and is working to determine the composition of active and non-active MAT prescribers. A robust network of active OBOT providers can complement the growing network of 65 OTPs licensed across the state. To build the network of active OBOT providers, the state intends to provide ongoing training programs and technical support to prescribers on the following:

Implementing safe prescribing practices.
Collaborating with pharmacists as part of a care team.
Incorporating component services including counseling into the practice.
Billing the PHP for component services (e.g., prescription, laboratory and counseling services).

Summary of Actions Needed

Action	Implementation Timeline
Conduct an assessment of all Medicaid-enrolled providers, to include the identification of providers that are accepting new patients at the critical levels of care	September 2018 – October 2019
Work to build Medicaid provider networks for new Medicaid levels of care	September 2018 – October 2020
Develop BH I/DD tailored plan network adequacy standards for SUD treatment services, taking into account results of provider assessment	September 2018 – October 2019

Milestone 5: Implementation of Comprehensive Strategies to Address Prescription Drug Abuse and Opioid Use Disorders

North Carolina has intensified its efforts over the past year to address the opioid crisis. As described below, the state developed and is making progress on an Opioid Action Plan outlining statewide goals and priorities for tackling the epidemic. Recent state legislation implementing opioid prescribing guidelines and expanding access to naloxone, Medicaid pharmacy program initiatives, the state's requirements for PHPs and a federal 21st Century Cures Act grant of $31 million have also bolstered North Carolina's efforts.

The North Carolina Opioid Action Plan

In June 2017, North Carolina announced North Carolina's Opioid Action Plan, which outlines the key actions the state and its partners are taking to combat the epidemic and calls for measuring and

assessing the effectiveness of the strategies. The Opioid Action Plan was developed through collaboration among state agencies and various health, law enforcement, education, business, nonprofit and government partners. It aims to reduce opioid addiction and overdose deaths in the period from 2017 to 2021 by implementing the following key strategies:

- Create a coordinated infrastructure between the state, stakeholders and local coalitions.
- Reduce oversupply of prescription opioids.
- Reduce diversion of prescription drugs and flow of illicit drugs.
- Increase community awareness and prevention.
- Make naloxone widely available, and link overdose survivors to care.
- Expand treatment and recovery-oriented systems of care.
- Measure impact and revise strategies based on results.

The Department has thus far conducted numerous activities in support of the Opioid Action Plan. In October 2017, the Department purchased nearly 40,000 units of nasal naloxone to make the overdose reversal drug more widely available and thus help reduce the number of unintentional opioid-related deaths. The naloxone has been distributed to partners across the state that work with individuals at high risk of opioid overdose, including OTPs and other treatment providers, EMS agencies, Oxford House, and other community partners. The Department established a North Carolina Payers Council to bring together healthcare payers across the state to partner on benefit design, member services, and pharmacy policies to reduce opioid overuse and overdose. The Department also made important changes to the Medicaid program in order to increase access to treatment by removing prior-approval requirements for suboxone.

Strengthen Opioid Misuse Prevention Act

In June 2017, North Carolina's General Assembly passed and Governor Roy Cooper signed the STOP Act, North Carolina Session Law 2017-57, Senate Bill 257. The STOP Act seeks to reduce drug addiction and overdoses through smarter prescribing practices by doctors and dentists, restrictions on pharmacies dispensing opioids, expanding the availability of naloxone, and strengthening the state's Controlled Substance Reporting System (CSRS). STOP Act provisions apply broadly across the state; they are not specific to the Medicaid program.[31] North Carolina will require standard plans and BH I/DD tailored plans to incorporate STOP Act requirements into their opioid misuse programs. Key provisions, most of which became effective immediately, include:

Prescriber Provisions

- **Reduce unused, misused and diverted pills with five-day limit on initial prescriptions for acute pain.** A prescriber may not prescribe more than a five-day supply of a controlled substance (or a seven-day supply after surgery) when first treating a patient for acute pain, effective January 1, 2018.[32]
- **Reduce doctor shopping and improve care with required scan of state prescription database.** Before prescribing controlled substances, a doctor, dentist or other prescriber must check the CSRS

[31] STOP Act, https://www.ncleg.net/gascripts/billlookup/billlookup.pl?Session=2017&BillID=H243.

[32] This requirement does not apply to cancer care, palliative care, hospice care or MAT for substance use disorders.

to learn of a patient's other prescriptions, effective upon completion of certain upgrades to the CSRS.[33]

- **Reduce fraud through e-prescribing.** A prescriber must electronically prescribe controlled substances to reduce fraud stemming from stolen prescription pads or forged prescriptions—except for drugs administered by the prescriber or drugs administered in a healthcare or residential facility, effective January 1, 2020.
- **Reduce diversion of veterinary drugs.** Veterinarians who dispense controlled substances must register and report to CSRS to enable detection of drug diversion by pet owners, effective January 1, 2019.
- **Tighter supervision.** PAs and NPs must consult their supervising physicians the first time they prescribe controlled substances and every 90 days thereafter, effective July 1, 2017.

Pharmacy Provisions

- **Implement universal registration and reporting.** All pharmacies dispensing controlled substances must register for and report to CSRS—consistent with the current practice of most pharmacies.
- **Enable near-time reporting to detect and stop doctor-shopping.** Pharmacies dispensing controlled substances must report to CSRS within 24 hours of each transaction—down from the current requirement of 72 hours but consistent with the current practice of many pharmacies, effective September 1, 2017.
- **Detect fraud, misuse and diversion.** Pharmacies must consult the CSRS before dispensing a controlled substance when there is reason to suspect fraud, misuse or diversion, and must consult the prescriber when there is reason to believe the prescription is fraudulent or duplicative. Pharmacies are required to remedy missing or incomplete data upon request, effective upon completion of certain upgrades to the CSRS.

Provisions Expanding Access to Community-Based Treatment and Naloxone

- **Improve health and save money by investing in local treatment and recovery services.** The STOP Act appropriates $10 million for FY 2017-18 and $10 million for FY 2018-19 for community-based treatment and recovery services for substance use disorders, including MAT.
- **Reverse overdoses and save lives.** The STOP Act facilitates wider distribution of the overdose-reversal drug naloxone by clarifying that standing orders cover not only individuals at risk, family members, law enforcement and local health departments, but also community health groups. In addition, the act underscores that no state funds may be used to support needle exchange programs, but that does not preclude a local government from supporting such a program in its community.

Other Provisions

- **Stronger oversight.** The Department will audit doctor, dentist and other prescriber use of the CSRS and will report violations to the appropriate licensing boards, effective upon completion of certain upgrades to the CSRS.
- **Better data use.** The STOP Act expands use of data to detect and prevent fraud and misuse.
- **More secure funding.** The STOP Act creates a non-reverting special revenue fund to support the CSRS.

[33] This scan is allowed but not required for cancer treatment, palliative care, hospice care, drugs administered in a healthcare or residential facility, or prescriptions for five or fewer days (or seven or fewer days after surgery).

Medicaid Pharmacy Program

The NC Medicaid pharmacy program has worked to (1) update clinical coverage criteria for the use of opioids for pain management based on the Centers for Disease Control and Prevention (CDC) guideline "Prescribing Opioids for Chronic Pain"; (2) align clinical coverage criteria for prescription of opioids with strategies targeted toward reducing the oversupply of prescription opioids available for diversion and misuse; (3) strengthen its enrollee lock-in program; and (4) expand access to suboxone.[34] The Medicaid pharmacy program has also adopted the STOP Act provisions, as applicable.

In 2010, North Carolina established the NC Medicaid Enrollee Lock-In Program to establish a "prescription gatekeeper" for enrollees deemed to have potential for misuse of their prescription benefits.[35] In March 2017, the state strengthened its Medicaid lock-in program by increasing the number of enrollees subject to the lock-in from 200 to 600 per month and by lengthening the duration of enrollment in the program to two years. Next, in May 2017, Medicaid increased the early refill threshold for all opioids and benzodiazepine prescriptions from 75% to 85%, meaning that an enrollee cannot refill a prescription for one of these drugs until less than 15% of his or her current supply remains.

Effective June 1, 2018, NC Medicaid limited the prior authorization threshold for opioids to 90 mg of morphine equivalents per day. In addition, NC Medicaid began to require prior approval for opioid prescriptions exceeding the maximum daily dosage; for opioid prescriptions that are for longer than five or seven days, consistent with the STOP Act; or for any non-preferred opioid product.[36] The state requires opioid prescribers to consult the CSRS, review the CDC chronic pain guidelines for prescribing opioids and, if applicable, explain the need to exceed daily dosage limits prior to prescribing opioids. Finally, the Medicaid program eliminated the prior authorization requirements for suboxone as of November 1, 2017, to provide timely access to opioid withdrawal treatment.

New Medicaid Managed Care Provisions

North Carolina recognizes that a strong partnership with standard plans and BH I/DD tailored plans is necessary to build on its ongoing efforts to combat the opioid epidemic. To that end, the Department will require its PHPs to implement a comprehensive opioid misuse prevention program. To monitor potential abuse or inappropriate utilization of prescription medications, the Department will give plans the choice of either participating in the NC Medicaid Enrollee Lock-In Program or develop their own lock-in program consistent with state law and subject to Department approval. PHPs will provide care coordination for enrollees in the lock-in program in conjunction with the enrollee's primary care provider. Plans will be required to report to the Department lock-in program outcomes including, but not limited to, changes in emergency department visits and changes in opioid misuse, to inform monitoring efforts and identify the need for further interventions.

---

[34] NC Division of Medical Assistance. Outpatient Pharmacy Prior Approval Criteria Opioid Analgesics, available at https://www.nctracks.nc.gov/content/dam/jcr:45fd795f-2681-4fab-b59c-07b350801d6b/Criteria-Opioid%20Analgesics%2090mme%20and%20III%20and%20IV.pdf.

[35] Today, the program restricts enrollees who meet at least one of the following criteria to a single prescriber and pharmacy: enrollees with six claims of opiates, benzodiazepines and certain anxiolytics; beneficiaries receiving prescriptions for these drugs from more than three prescribers in two consecutive months; or referral from a provider, NC Medicaid or Community Care of North Carolina (CCNC). NCHC enrollees are not subject to lock-in provisions. Source: NC Outpatient Pharmacy Clinical Coverage Policy.

[36] North Carolina Medicaid Pharmacy Newsletter, June 2017.

Additionally, plans will be required to implement a maximum morphine milligram equivalent dose for opioid prescriptions as point-of-service edits, as well as drug utilization review programs to address opioid misuse.

Opioid Initiatives Supported by the 21st Century Cures Act Grant

North Carolina is using a $31 million grant received through the 21st Century Cures Act in May 2017 to expand access to prevention, treatment and recovery supports to reduce opioid-related deaths over the next two years.[37] It will also be used to purchase 6,600 naloxone kits statewide to be distributed to law enforcement, paramedics and OTPs. The state expects to serve approximately 1,500 individuals annually over the two-year period through the grant as a whole. In addition to expanding treatment services, funding will be available for prevention, education and outreach; screening/triage/referral; recovery supports; and provider education and development. Two specific examples of current projects funded by this grant follow:

Project Extension for Community Healthcare Outcomes (ECHO) The Department is using its 21st Century Cures Act grant to expand training on MAT and associated barriers for providers and interdisciplinary clinical teams through the University of North Carolina's (UNC) research initiative, Project ECHO, in collaboration with the University of New Mexico Project ECHO. The core goals of the UNC ECHO for MAT demonstration project are to (1) increase understanding about how known barriers to the implementation of MAT in primary care can be overcome; (2) evaluate strategies to overcome those barriers; and (3) simultaneously expand access to MAT in rural and underserved counties, reducing the risk of accidental overdose deaths through a multilayered provider and practice engagement strategy. Additional ECHOs may focus on highlighting best practices and evidence-based care, as well as building treatment capacity for pregnant women or mothers, individuals with OUD who are also HIV positive or hepatitis C positive, and/or for individuals with OUD in North Carolina prisons.

Training on ASAM Levels of Care. During March and April 2018, the state used funds from its 21st Century Cures Act grant to offer and subsidize the cost of eight two-day and four one-day trainings on the ASAM criteria, primarily targeting medical professionals and clinical staff employed at OTPs and OBOT programs across the state. The training provided participants with a comprehensive overview of the ASAM criteria, including:

- Services that are part of the ASAM continuum of care.
- ASAM's six dimensions used to complete a holistic, biopsychosocial assessment that evaluates an individual's substance use and withdrawal history; health history and current physical condition; readiness to change; and emotional, behavioral or cognitive conditions, among others.
- ASAM's continued stay and discharge criteria for residential SUD services.

North Carolina has been a leader in the fight against the opioid crisis. By deploying these initiatives, the state has made and will continue to make progress in curbing this nationwide epidemic.

[37] Governor Cooper Announces $31 Million Grant to Fight Opioid Epidemic in NC.

Summary of Actions Needed

Action	Implementation Timeline
Continue implementation of the STOP Act provisions on an ongoing basis.	September 2018 – October 2020

Milestone 6: Improved Care Coordination and Transitions Between Levels of Care

Care Coordination

Current State

Today, LME-MCOs are responsible for providing care coordination for Medicaid enrollees, including those with special healthcare needs and those who meet the state's definition of being "at risk," but cannot duplicate case management functions that enrollees receive as part of select behavioral health services. The population with special healthcare needs includes the following individuals with SUDs:

- Individuals with an SUD diagnosis and current ASAM patient placement criteria (PPC) of at least level 3.7 or 3.2-WM.
- Adults who reported use of drugs by injection.
- Children with a mental health or SUD diagnosis, who are currently residing or have resided in the past 30 days in a facility operated by the Department of Juvenile Justice or the Department of Corrections, an inpatient hospital setting, a therapeutic group home, or a psychiatric residential treatment facility.
- Individuals with co-occurring SUD and mental illness or I/DD as follows:
    - Individuals with both a mental illness diagnosis and a substance use diagnosis and a current LOCUS/CALOCUS of V or higher, or current ASAM PPC level of 3.5 or higher.
    - Individuals with both an I/DD and an SUD diagnosis and current ASAM PPC level of 3.3 or higher.

Medicaid defines at-risk individuals as those enrollees who:

- Do not appear for scheduled appointments and are at risk for inpatient or emergency treatment.
- Receive a crisis service as their first service, in order to facilitate engagement with ongoing care.
- Are discharged from an inpatient psychiatric unit or hospital, a psychiatric residential treatment facility, or a facility-based crisis or general hospital unit following admission for a mental health, SUD or I/DD condition.

LME-MCOs' care coordination responsibilities for the populations listed above include the following:

- Identifying enrollees' clinical needs.
- Determining level of care through case review.
- Arranging assessments.
- Linking enrollees to necessary psychological, behavioral, educational and physical evaluations.
- Engaging in clinical discussions with enrollees' treatment providers.
- Conducting deliberate organization of care activities.

Facilitating appropriate delivery of healthcare services and connecting enrollees to the appropriate level of care.
Addressing support services and resources.
Assisting enrollees with obtaining referrals and arranging appointments.
Educating enrollees about other available supports as recommended by clinical care coordinators.
Monitoring enrollees' attendance in treatment.
Identifying and addressing enrollees' needs and barriers to treatment engagement.
Developing engagement strategies for individuals with special healthcare needs.
Coordinating and linking all Medicaid-funded services for the enrollee, as appropriate.
Assisting with developing a person-centered treatment plan in consultation with the enrollee and his or her primary care provider.

In addition to the care coordination functions performed by the LME-MCOs, case management is provided as part of select SUD services. In particular, SAIOP and SACOT services include case management components to arrange, link, or integrate across multiple types of SUD services and supports.

The state's fee-for-service behavioral health contractor provides care coordination services to populations excluded from the LME-MCOs. Care coordinators provide the following care coordination functions telephonically:

Information intake;
Evaluation;
Referral to inpatient providers or to appropriate level of care;
Utilization review;
Quality assurance;
Discharge and aftercare planning; and
Monitoring.

Transitions of Care

Current State

Among their care coordination functions, LME-MCOs are required to coordinate and monitor services provided to enrollees during transitions of care. Responsibilities include assisting hospitals, facilities and other institutional providers with discharge planning for short-term and long-term hospital and institutional stays when the admission is primarily based on the enrollee's behavioral health diagnosis. Transitional care coordination performed by LME-MCOs cannot duplicate inpatient facilities' requirements for discharge planning. The inpatient facility must involve the patient, family, staff members and referral sources in discharge planning. If a patient is being referred to another facility for further care, appropriate documentation of the patient's current status must be forwarded with the patient within 48 hours of discharge. The discharge summary must include the reasons for referral, the diagnosis, functional limitations, services provided, the results of services, referral action recommendations, and activities and procedures used by the patient to maintain and improve functioning.

Future State

Upon their launches in 2019 and 2021, respectively, the standard plans and BH I/DD tailored plans will be responsible for care coordination and care management for enrollees with SUDs, including managing transitions between levels of care. LME-MCOs will continue to manage care coordination and care transitions for certain Medicaid enrollees with SUDs until BH I/DD tailored plans launch. For populations that will remain in fee-for-service, the state will develop care coordination protocols that include transitions of care across service levels. In developing the care coordination and care management approaches for these new managed care products, North Carolina has prioritized the establishment of specific requirements related to serving enrollees with SUDs as described below.

Standard Plans: Care Coordination and Care Management

When standard plans launch in November 2019, they will be responsible for overseeing, funding and organizing all aspects of care management in a way that improves health outcomes and manages the total cost of care for their enrollees. They will be required to complete care needs screenings and to perform claims analysis and risk scoring to identify enrollees at risk; stratify their populations by level of need; perform comprehensive assessments for those identified as part of "priority populations"; and perform localized care management at the site of care, in the home or in the community, where face-to-face interaction is possible.

Standard plans will be required to establish policies and procedures to deliver care to and coordinate services for all enrollees regardless of risk or needs. As part of their care coordination for all enrollees, standard plans will be required to do the following:

- Establish policies and procedures for coordination between physical and behavioral health providers, and between mental health and substance use providers.
- Establish policies and procedures to coordinate enrollee transitions from LME-MCOs or Medicaid fee-for-service into standard plans and from one standard plan to another, or between delivery systems.
- Design an evidence-based tool to conduct a care needs screening that can identify enrollees' behavioral health needs, incorporating the ASAM criteria to screen for opioid usage and other SUDs.
- Make best efforts to conduct a care screening of every enrollee within 90 days of enrollment as required by the managed care rule, to identify enrollees with unmet healthcare needs (including SUDs) who may require a comprehensive assessment for care management.

Additionally, standard plans will designate enrollees with SUDs as meeting the state's definition of special healthcare needs, and thereby as a high-priority population for receiving care management. All care management must include coordination of physical health, behavioral health, pharmacy and social services. In addition, the Department will require that all care managers receive training on integrated and coordinated physical and behavioral healthcare, and care managers serving individuals with behavioral health needs will also receive training on behavioral health crisis response.

Standard Plans: Transitions of Care

Among their care coordination responsibilities for all enrollees, including those with SUDs, standard plans will manage transitions of care for all enrollees moving from one clinical setting to another, to

prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes. Following standard plan contracting, standard plans will be required to share with the Department their transitional care management policies and procedures, the experience and qualifications of care managers performing transitional care management, and how their transitional care management approach relates to the staffing and contracting approach for high-need enrollees' care management. In order to identify enrollees in transition who are at risk of readmissions and other poor outcomes, standard plans shall develop a methodology that considers the frequency, duration and acuity of inpatient, skilled nursing facility (SNF), and LTSS admissions or emergency department visits; discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised treatment centers or alcohol drug abuse treatment centers; and neonatal intensive care unit (NICU) discharges. In addition, the standard plan may target enrollees for transitional care management by severity of condition, medications and other factors the standard plan may prioritize.

Standard plans will ensure that the entity conducting transitional care management performs the following functions:

- Conducts outreach to the member's advanced medical home/primary care provider and all other medical providers.[38]
- Facilitates clinical handoffs, including those to behavioral health providers.
- Obtains a copy of the discharge plan/summary, and verifies that the enrollee's care manager receives and reviews the discharge plan with the enrollee and the facility.
- Ensures that a follow-up outpatient and/or home visit is scheduled, within a clinically appropriate time window.
- Conducts medication reconciliation and support medication adherence.
- Ensures that a care manager is assigned to manage the transition.
- Rapidly follows up with the enrollee via the assigned care manager following discharge.
- Develop a protocol for determining the appropriate timing and format of such outreach.

BH I/DD Tailored Plans: Care Coordination and Care Management

By design, BH I/DD tailored plans will serve a high-cost population with complex needs. BH I/DD tailored plan enrollees will have a significant need for robust, whole-person care management services that will address their physical health, mental health, substance use, I/DD, TBI, pharmacy, community support and social needs. Specifically, care management for BH I/DD tailored plan enrollees will take into account the following:

- Future BH I/DD tailored plan enrollees are closely engaged with mental health, SUD, I/DD and TBI providers with whom they have frequent interaction and trusting relationships, and conflict-free care management services should be provided at these sites or in primary care settings that have expertise in serving populations with significant BH or I/DD needs to the maximum extent possible.
- Care management services for populations that will enroll in BH I/DD tailored plans, including individuals with SUDs, should generally be more intensive than those provided to the standard plan population and should occur face-to-face for all BH I/DD tailored plan enrollees.

[38] The AMH program will be the framework under which providers can choose to take primary responsibility for care management, either at the individual practice level or in a contractual relationship with a care management/population management entity (e.g., a Clinically Integrated Network)—and receive higher reimbursement for such responsibility—or choose to coordinate with PHPs' care management approaches.

Care managers serving BH I/DD tailored plan enrollees must have specialized expertise, including training in mental health, SUD, I/DD and/or TBI care; experience managing physical and behavioral healthcare and I/DD co-morbidities; and specialized clinical supervision experience to support the coordination of care between physical and behavioral healthcare.

The BH I/DD tailored plan care management model will meet federal standards for health home services, and North Carolina anticipates submitting a health home SPA prior to the BH I/DD tailored plan launch. Health home funds will flow to BH I/DD tailored plans. Given that BH I/DD tailored plans will not launch until July 2021, the Department is still in the process of establishing the full set of BH I/DD care management requirements.

BH I/DD Tailored Plans: Transitions of Care

Among their care management responsibilities, entities delivering health home care management services will be required to provide comprehensive transitional care management services, including all standard plan transitional care services. Additional responsibilities will include:

Instituting evidence-based care transition programs directed toward individuals with mental health disorders SUDs and I/DD.

Developing relationships with local hospitals, nursing homes, SUD residential treatment facilities, SUD rehabilitation providers and inpatient psychiatric facilities to promote smooth care transitions.

Developing working relationships with the justice system and the Division of Social Services to support transitions back to the community.

The Department recognizes the importance of ensuring that standard plan enrollees who meet the BH I/DD tailored plan level of need or require a service that will only be covered by BH I/DD tailored plans are transitioned as quickly and smoothly as possible. To that end, these enrollees will be able to transfer across standard plans and BH I/DD tailored plans throughout the coverage year.

Summary of Actions Needed

Action	Implementation Timeline
Incorporate care management provisions into standard plan contracts	January 2019 – November 2019
Incorporate care management provisions into BH I/DD tailored plan contracts	January 2021 – July 2021
Submit a health home SPA to authorize the creation of behavioral health homes	July 2019 – March 2020

Attachment E, SUD HIT Plan: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
1. Enhanced interstate data sharing in order to better track patient-specific prescription data	▪ North Carolina's PDMP, which is called the CSRS, enables practitioners to see patient prescription history of 24 states, Washington DC, Puerto Rico and the Military Health System using National Associations of Boards of Pharmacy's (NABP) PMP Interconnect (PMPi). The states are: Alabama, Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Maine, Minnesota, Mississippi, New Jersey, New Mexico, New York, North Dakota, Ohio, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, and West Virginia.	▪ The state will update its HIT plan as more states are included in PMPi sharing. ▪ By September 2019, 11,250 prescriber and 580 pharmacies will be approved for integration. ▪ Two-way data sharing will be established between North Carolina and all other states.	▪ Review necessary steps to join RxCheck. ▪ Enhance interstate data sharing (ex. KY) through connection with the RxCheck hub, and continue to reach out to remaining states (provided funds are available). **Timeline:** September 2018 – April 2020
2. Enhanced "ease of use" for prescribers and other state and federal stakeholders.	▪ In order to facilitate ease for prescribers, DMH/DD/SAS successfully updated the CSRS platform in September 2018 ▪ North Carolina launched new efforts to integrate CSRS and other states' PDMP data into clinical workflows in November 2018. ▪ At this time, 3,213 prescribers have been approved for integration.	▪ North Carolina has a CSRS integration plan that includes a variety of EHR platforms, including the state's HIE as an option in the event an EHR vendor is not willing to participate. ▪ The state has developed a prioritization matrix based on healthcare entities' geographic location, specialty,	▪ Continue to approve additional prescribers and pharmacies for integration with the CSRS, as well continue its integration efforts with the HIE. **Timeframe:** September 2018 - September 2019

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	▪ Forty-three pharmacies are currently approved to be integrated. ▪ The state's Health Information Exchange (HIE), NC HealthConnex, is expected to complete integration by September 2019. ▪ The UNC Health Care System integrated independent of the state's effort in the Summer of 2018. ▪ Large pharmacy chains, such as CVS (367 stores), Walmart (229), Kroger (125), Kmart (14), Costco (8), Harris Teeter (8) and Walgreens (474) have integrated independently as well.	past prescribing practices, and overdose rates in their area. ▪ Integration goals are 11,250 prescribers and 580 pharmacies by September 2019. ▪ Ultimately, all NC prescribers and dispensers will have CSRS data integrated into their daily workflows (December 2023, contingent on availability of funds).	
3. Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange.	▪ The Department is working to connect the CSRS with the state's HIE, known as NC HealthConnex. ▪ In May 2018, the Department executed a contract with a vendor to use PMP Gateway to develop an interface between the CSRS and NC HealthConnex.	▪ Transmissions between the CSRS and the HIE will be bi-directional and occur in real time. ▪ The interface with NC HealthConnex is expected to be complete in September 2019, following NC HealthConnex's migration to a new platform.	▪ Complete the interface with HealthConnex in September 2019. **Timeframe**: September 2018 - September 2019
4. Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns (see also "Use of PDMP" #6, below).	▪ On a quarterly basis, DMH/DD/SAS is providing the NC Medical Board, Nursing Board and Board of Pharmacy with advanced analytics collected through the CSRS, based on criteria established by each board aimed at	▪ DMH/DD/SAS plans to partner with additional state licensing boards, such as the NC Board of Podiatry Examiners and the NC State Board of Dental Examiners, to identify prescribers with	▪ Continue to partner with Medical, Nursing and Pharmacy Boards to refine reports. ▪ Establish partnerships with additional state licensing boards.

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	flagging providers with potentially questionable prescribing patterns. ▪ The licensing boards use these reports to identify prescribers for investigation. ▪ In addition to quarterly reports to the licensing boards, the system utilizes threshold reports to notify prescribers directly when a patient has exceeded established thresholds of a number of prescribers and pharmacies visited in a 90-day period.	questionable prescribing patterns. ▪ DMH/DD/SAS will work with new partners to develop a process for reporting. ▪ Additionally, DMH/DD/SAS will improve reporting sensitivity by improving identity resolution for patients, prescribers and dispensers in the CSRS. ▪ In September 2019, "clinical alerts" will be deployed, which will enable any prescriber to see these threshold alerts when a patient is queried. Current threshold reports are only visible to the practitioner who wrote the prescription.	▪ Deploy clinical alerts in September 2019. **Timeframe**: September 2018 - September 2019
Current and Future PDMP Query Capabilities			
5. Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e., the Entity Resolution [ER] strategy with regard to PDMP queries).	▪ The CSRS' current approach to matching patients with prescriptions to patients in the CSRS involves first examining patients' first and last names, dates of birth, and street addresses. ▪ Based upon that review, the CSRS identifies cases where records with similar names used to fill multiple opioid prescriptions are likely a single	▪ DMH/DD/SAS plans to continue its efforts to improve identity resolution among prescribers, patients and dispensers, including leveraging the HIE's MPI capabilities.	▪ Prescriber and dispenser Entity Resolution is moving forward using DEA and NPI data in routine system auditing in addition to the Entity Resolution plan. ▪ Continue partnership with GDAC and expand scope of work to include

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	patient, or separates records when it identifies that two different patients have used the same identifying information to fill their prescriptions. ▪ Since 2017, DMH/DD/SAS has partnered with the state's Government Data Analytics Center (GDAC) to facilitate data sharing to improve patient, prescriber and dispenser identity resolution. ▪ The CSRS is also using data from the U.S. Drug Enforcement Agency (DEA) to improve identity resolution for patients, prescribers and dispensers. ▪ Finally, DMH/DD/SAS is working to identify additional data sources that can further improve the resolution of patient identity.		making the business case to other state agencies to obtain permissions and consult with GDAC on defining the methodology for patient and prescriber entity resolution. ▪ Begin discussions with the HIE Authority on additional strategies to coordinate NC HealthConnex and CSRS information. **Timeframe**: September 2018 - September 2021
Use of PDMP – Supporting Clinicians with Changing Office Workflows			
6. Develop enhanced provider workflow/business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance, to address the issues that follow.	▪ DMH/DD/SAS co-chairs the Department's Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC), which is focused on implementing the state's Opioid Action Plan, as described in Milestone 5. ▪ As part of the Opioid Action Plan, the Department aims to expand clinicians' access and use of the CSRS as a tool to combat the opioid epidemic.	▪ All HCEs using EHRs and PMS will have CSRS data integrated into their workflows	▪ Continue to collaborate with vendor to integrate EHR/PMS and CSRS data and acquire additional licenses for pharmacies and prescribers. **Timeframe**: November 2018 - December 2023 (Contingent upon available funds)

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	▪ The Department recommends that a patient's report is queried within 48 hours of a patient's initial visit. ▪ The CSRS integration plan simplifies providers' abilities to query the report while a patient is in clinic without interrupting the clinician's workflow. ▪ For those entities that are not integrated, state law permits delegate access to the system for querying patients' prescription history on behalf of the practitioner. ▪ Practitioners use the CSRS separate from their EHR and Pharmacy Management Systems (PMS) to acquire patient controlled substance prescription history. ▪ The state is in the process of integrating CSRS and EHR data for individual Healthcare Entities (HCEs)		
7. Develop enhanced supports for clinician review of patient CSRS data prior to prescribing a controlled substance	▪ PDMP users currently use NarxCare analytics, available since September 2018 to review prescription history. ▪ In addition to the information provided in #6, the new CSRS platform includes additional supports for clinical decision-making by providing visualization of the history and overdose risk scores. ▪ The SAMHSA MAT locator is embedded in the system along with links to printable Centers for Disease Control	▪ The state will enhance educational resources available to users on effective NarxCare usage	▪ Extend NarxCare funding to continue availability of NarxCare analytics to CSRS users. **Timeline**: September 2018 - December 2019

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	and Prevention (CDC) pamphlets to help practitioners discuss topics with their patients. ▪ CSRS also provides a morphine milligram equivalent (MME) or lorazepam milligram equivalent (LME) to assist prescribers in identifying risky behavior.		
Master Patient Index/Identity Management			
8. Enhance patient and prescriber profiles by leveraging other state databases in support of SUD care delivery.	▪ DMH/DD/SAS is in the early stages of Entity Resolution. ▪ The CSRS' current approach to matching patients is detailed above, under #5, "Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP."	▪ Collaborate with GDAC to mirror the current database and use other databases (e.g., Division of Motor Vehicles, Department of Public Safety, HIE Authority) that GDAC has access to, with proper permissions, to better link prescriptions and identify patients and prescribers.	▪ Continue partnership with GDAC and expand scope of work to include making the business case to other state agencies to obtain permissions. ▪ Consult with GDAC on defining the methodology for patient and prescriber Entity Resolution. **Timeframe**: September 2018 - September 2021
Overall Objective for Enhancing PDMP Functionality & Interoperability			
9. Leverage the above functionalities/capabilities/supports (in concert with any other state health IT, technical assistance or workflow effort) to implement effective controls to	▪ DMH/DD/SAS has started a pilot project with NC Medicaid to minimize the risk of inappropriate opioid overprescribing and to ensure that Medicaid does not inappropriately pay for opioids. ▪ Through this pilot, DMH/DD/SAS and NC Medicaid match CSRS data with Medicaid claims data to identify	▪ DMH/DD/SAS and NC Medicaid will work to expand the pilots and run reports analyzing all Medicaid claims for opioid prescriptions on a monthly basis. ▪ Following the managed care transition, standard plans (as	▪ Expand pilots to run reports analyzing all Medicaid claims for opioid prescriptions on monthly basis. ▪ DMH/DD/SAS and NC Medicaid will meet to plan for: (1) cleaning and

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
minimize the risk of inappropriate opioid overprescribing and to ensure that Medicaid does not inappropriately pay for opioids.	Medicaid prescribers who may be overprescribing opioids, as well as patients who may be at risk of developing or have OUDs.	of November 2019) and BH I/DD tailored plans (as of July 2021) will be required to submit pharmacy encounter data to the Department on a weekly basis. ▪ Once NC Medicaid receives the encounter data, it will clean and process the data to identify opioid prescriptions and share with DMH/DD/SAS to identify (1) prescribers who are overprescribing opioids, and (2) patients who have or may be at risk of developing OUDs.	processing data received from standard plans and BH I/DD tailored plans, and (2) sharing information on prescribers who may be overprescribing opioids and patients who have or may be at risk of developing OUDs. **Timeframe**: September 2018 - July 2021

10. North Carolina has sufficient health IT infrastructure at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of this demonstration.

11. North Carolina's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan (SMHP).

12. The Department will include appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B in subsequent PHP contract amendments or PHP re-procurements.

Attachment A, Section II—Implementation Administration

Please provide the contact information for the state's point of contact for the SUD Health IT Plan.

Name and Title: Katherine Nichols, Assistant Director, DMH/DD/SAS
Telephone Number: 919-715-2027
Email Address: Katherine.Nichols@dhhs.nc.gov

Attachment A, Section III—Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

ATTACHMENT F

Reserved for Monitoring Protocol

ATTACHMENT G
Reentry Demonstration Initiative Services

Covered Service	Definition
Case Management	Case management will be provided in the period up to 90 days immediately prior to the expected date of release and for up to 30 days post-release, as needed and to be further defined in the Implementation Plan. Case management is intended to facilitate reentry planning into the community in order to: (1) Support the coordination of physical health, behavioral health, intellectual and developmental disability (I/DD), traumatic brain injury (TBI), and pharmacy services as well as long-term services and supports (LTSS) delivered during the pre-release period and upon reentry; (2) Ensure smooth linkages to health-related social need (HRSN) services and supports; and (3) Ensure arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community. Services shall include: • Providing pre-release case management, including: o Conducting a health risk assessment o Using the health risk assessment to develop a reentry person-centered care plan ▪ This plan will be informed by input from clinicians providing consultation services and correctional facility's reentry planning team. The scope of the plan and related case management activities extend beyond release and will address physical and behavioral health needs, needs for LTSS, including for I/DD or TBI, pharmacy needs, and HRSNs identified during both the pre- and post-release periods. o Obtaining informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care o Ensuring that necessary appointments with physical and behavioral health care providers, including, as relevant to care needs, with post-release care managers are arranged o Preparing individuals for reentry through education related to health literacy and health system navigation support and education

Covered Service	Definition

	• Providing a warm hand-off, as appropriate, to post-release care managers, including:
	  ○ Sharing discharge/reentry person-centered care plans with the post-release care manager, if different from pre-release care manager, upon reentry who will facilitate access to services under the Medicaid State Plan or other waiver or demonstration authority
	  ○ Coordinating with community-based providers/care management entities to facilitate access to community-based services and supports, such as educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups
	  ○ Ensuring that, as allowed under federal and state laws and through consent with the beneficiary, data are shared with post-release care managers, and, as relevant, to physical and behavioral health providers to enable timely and seamless hand-offs
	• Providing post-release case management, including:
	  ○ Following up with the individual within seven days post-release to ensure engagement between individual and appropriate community-based providers; if no response, conducting another follow-up no later than 30 days from release
	  ○ Following up with community-based providers, as needed, to ensure engagement between individual and community-based providers

Medication-Assisted Treatment	• MAT for opioid use disorders (OUD) will cover all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29) • MAT for alcohol use disorders (AUD) and non-opioid substance use disorders includes all FDA-approved drugs and services to treat AUD and other SUDs • Psychosocial services delivered in conjunction with MAT for OUD as covered in the State Plan, and MAT for AUD and non-opioid substance use disorders as covered in the State Plan, including assessment; individual/group counseling; patient education; prescribing, administering, dispensing, ordering, monitoring, and/or managing MAT
Practitioner office visit (e.g., physical exam; wellness exam; immunizations;	Practitioner office visits includes targeted preventive, physical, and behavioral health clinical consultation services. These services are intended to support the creation of a comprehensive, robust, and successful reentry person-centered care plan, including:

Covered Service	Definition
evaluation and management visit; or other)	• Conducting screening or diagnostic services (including a behavioral health screening or diagnostic service) which meet reasonable standards of medical and dental practice; • Delivering stabilization and treatment in preparation for release (including behavioral health treatment and recommendations or orders for needed labs, radiology, and/or medications needed post-release); • Providing recommendations or orders for needed medications and medical supplies, equipment, and appliances (i.e., durable medical equipment (DME)) that will be needed upon release; and • Consulting with the pre-release care manager to help inform the reentry person-centered care plan. These services are also intended to support reentry into the community by providing opportunities for incarcerated Medicaid beneficiaries to meet and form relationships with the community-based providers who will be caring for them upon release, including, but not limited to, behavioral health providers, and enable information sharing and collaborative clinical care between pre-release providers and the providers who will be caring for the Medicaid beneficiary after release. Services may include, but are not limited to: • Addressing service gaps that may exist in correctional facilities; • Diagnosing and stabilizing individuals while incarcerated to prepare them for release; and • Providing behavioral health clinical consultation and treatment services authorized by the Medicaid State Plan or the existing 1115 Demonstration including but not limited to clinical assessment, patient education, therapy, counseling, and/or peer support services.
Diagnostic Services	Laboratory and radiology services will be provided consistent with the Medicaid State Plan.
Prescribed drugs and medication administration	Medications and medication administration will be provided consistent with the Medicaid State Plan.
Tobacco Cessation Treatment Services	Tobacco cessation treatment services will be provided as clinically appropriate and may include a range of evidence-based interventions, including but not limited to tobacco cessation counseling services, consistent with the Medicaid State Plan and other state protocols/guidelines for tobacco cessation.
Services Provided Upon Release	Covered outpatient prescribed medications (a minimum 30-day supply as clinically appropriate, consistent with the Medicaid State Plan).

Covered Service	Definition
	Medical supplies, equipment, and appliances (i.e. durable medical equipment (DME)) consistent with Medicaid State Plan requirements.

Attachment H

Reserved for Reentry Demonstration Initiative Implementation Plan

ATTACHMENT I

Reserved for Reentry Demonstration Initiative Reinvestment Plan

ATTACHMENT J

Specialized Managed Care Plans Eligibility

As indicated in STC 9.6(b), Behavioral Health/Intellectual Developmental Disability (BH I/DD) Tailored Plans provide integrated physical health, behavioral health, I/DD, TBI, and pharmacy services to its enrollees. Medicaid beneficiaries with needs associated with the following conditions, as determined by diagnosis and/or service utilization, are eligible for the BH I/DD Tailored Plans:

- Serious Mental Illness;
- Serious Emotional Disturbance;
- Severe SUD; and
- I/DD and /or TBI.

As indicated in STC 9.6(c), the Children and Families Specialty Plan (CFSP) provides integrated physical health, behavioral health and pharmacy services that account for the service needs of children, youth, and families served by the child welfare system. The following Medicaid beneficiaries are eligible for the CFSP:

The following populations will be eligible for CFSP at launch:

- Beneficiaries in foster care;
- Beneficiaries receiving adoption assistance;
- Beneficiaries who are enrolled in the Former Foster Care eligibility group;
- Minor children of aforementioned populations while the parent is CFSP-enrolled (i.e., minor children of beneficiaries in foster care, beneficiaries receiving adoption assistance, and beneficiaries who are enrolled in the Former Foster Care eligibility group); and).
- Members of a federally recognized tribe or those eligible for Indian Health Services (IHS) who also meet eligibility for the CFSP;

The remaining populations will be eligible to enroll during a second phase (no sooner than July 2026):

- Parents, Caretaker Relatives, Guardians, and Custodians of children in Foster Care
- Minor siblings of Beneficiaries in Foster Care;
- Adults identified on an open CPS In-Home Family Services Agreement case and any minor children living in the same home; and
- Adults identified in an open Eastern Band of Cherokee Indians (EBCI) Department of Public Health and Human Services Family Safety program case and any children living in the same home.

The following populations will be excluded from CFSP enrollment:

- Beneficiaries who are enrolled in the Innovations or TBI waivers;
- Beneficiaries residing in an ICF-IID;ICF-IID;
- Beneficiaries receiving State-funded residential services, including group living, family living, supported living, and residential supports; and
- Recipients enrolled in and being served under Transitions to Community Living.

These beneficiaries must enroll in a BH I/DD Tailored Plan to access a benefit package that includes those services.

ATTACHMENT K

Milestones to Comply with Mental Health and Substance Use Disorder Benefits

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Managed Care Group

October 23, 2024

Jay Ludlam, Deputy Secretary
North Carolina Medicaid
Division of Health Benefits
NC Department of Health and Human Services
1985 Umstead Drive, Kirby Building
Raleigh, NC 27603

RE: Formal Notice Regarding North Carolina Medicaid Mental Health Parity Noncompliance

Dear Jay Ludlam:

The Centers for Medicare & Medicaid Services (CMS) is sending this notice regarding North Carolina's Standard Plan, Tailored Plan, and Alternative Benefit Plan (ABP) parity compliance. This notice also follows up on the March 2024 Office of Inspector General (OIG) report, *CMS Did Not Ensure That Selected States Complied with Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements (A-02-22-01016)*[1]. North Carolina was identified in the OIG report as having a previous or newly identified compliance issue related to parity requirements for the provision of mental health and substance use disorder (MH/SUD) services. CMS takes the OIG's findings very seriously and is committed to assuring that Medicaid and Children's Health Insurance Program (CHIP) enrollees have timely access to high quality care.

In accordance with 42 CFR § 438.3(n), all managed care organization (MCO) contracts must provide for services to be delivered in compliance with the mental health parity requirements in 42 CFR § 438 subpart K. In addition, if the state provides any services to MCO enrollees using a delivery system other than the MCO delivery system, CMS requires documentation from the state regarding compliance with the requirements in 42 CFR § 438 subpart K during our review and approval of the MCO contract. Lastly, Section 1937(b)(6) of the Social Security Act applies parity requirements to essential health benefits (EHBs) delivered through fee-for-service (FFS) and managed care delivery systems for ABP enrollees.

North Carolina has implemented the following programs that are subject to mental health parity requirements and remain out of compliance:

- The ***Standard Plan MCO program on July 1, 2021***. The state submitted its initial parity analysis summary report on November 30, 2021. CMS provided feedback on January 14, 2022, that the Standard Plan parity documentation appeared incomplete and included parity violations. The state has submitted two partial parity analysis summary reports to CMS with

[1] OIG Report A-02-22-01016

revised analyses. CMS provided feedback on these partial reports on October 27, 2023, and February 2, 2024 to inform the state's ongoing work.

- The ***Medicaid expansion ABP on December 1, 2023.*** The approval of ABP State Plan Amendment (SPA) 23-0029 included a companion letter requiring the incorporation of the ABP service package and delivery systems in the state's ongoing parity compliance documentation process, specifically that the state must analyze the parity of its clinical coverage policies (CCPs), which apply to ABP beneficiaries in all delivery systems. ABP beneficiaries can be enrolled in the Standard Plan, Tailored Plan, or the Medicaid Direct delivery system that includes medical/surgical services delivered through FFS and MH/SUD services delivered through behavioral health prepaid inpatient health plans (PIHPs).
- The ***Tailored Plan MCO program on July 1, 2024***. The state submitted two partial parity analysis summary reports. CMS provided feedback on these partial reports on April 6, 2023, and June 29, 2023 to inform the state's ongoing work.

On May 31, 2024, in response to a missed state deadline on April 30, 2024, CMS provided North Carolina with the following parity analysis milestones and compliance documentation timeline:

1. Submit CCP treatment limitation inventory to CMS by July 5, 2024;
2. Submit CCP analysis of dollar limits, financial requirements, and quantitative treatment limits (QTLs) to CMS by July 26, 2024;
3. Submit complete CCP parity analysis, including non-quantitative treatment limitations (NQTLs), compliance determinations, and next steps for remediation, by August 30, 2024;
4. Direct state staff, MCOs, PIHPs, and other vendors as applicable to immediately cease utilizing noncompliant parity limits in operations that will be removed from CCPs by September 6, 2024;
5. Submit, and publicly post, comprehensive Tailored Plan report by November 29, 2024;
6. Complete all remediation steps identified in CCP analysis by December 31, 2024; and
7. Submit, and publicly post, the comprehensive Standard Plan report by December 31, 2024.

The state subsequently met Milestones 1 – 3 above and partially met Milestone 4. The Milestone 3 CCP parity analysis conducted by the state indicated noncompliant determinations for QTLs and NQTLs applied across the inpatient, outpatient, and prescription drug benefit classifications. The state sent a notice of findings to MCOs and PIHPs on September 6, 2024, listing noncompliant QTLs and NQTLs proposed for removal. However, our understanding is that due to projected increases in MH/SUD service utilization and associated fiscal impact to Standard Plan MCO, Tailored Plan, and/or PIHP capitation rates, the state has not yet ceased applying the impermissible limits or directed its MCOs/PIHPs to do so. In addition, the state plans to retain some limits deemed noncompliant in the Milestone 3 submission due to insufficient documentation regarding strategies, evidentiary standards, and processes supporting how the design and application of certain NQTLs are comparable and comparably stringent to medical/surgical benefits in the classification. Because the state must develop documentation to demonstrate parity compliance for these limits prior to submitting final parity analysis reports, these benefits are also being delivered out of compliance.

In late September 2024, the state informed CMS it may not be able to meet the December 31, 2024, deadline memorialized in the most recent pre-compliance letter delivered August 2, 2024. However, CMS expects the state to be in compliance for the Standard Plan (see updated Milestone 5), Tailored Plan (see updated Milestone 6), and ABP (see updated Milestone 4) no later than

December 31, 2024. If the state cannot meet this deadline, the state must inform CMS promptly and, no later than November 22, 2024, submit an action plan and timeline for the following updated milestones:

1. Cease utilizing noncompliant parity limits that the state has proposed removing;
2. Collect updated parity questionnaires from MCOs/PIHPs;
3. Submit a section 1915(b) waiver amendment to update self-referral requirements and revise prospective cost effectiveness projections as needed;
4. Submit final FFS/CCP and PIHP parity analysis that demonstrates noncompliant limits have either been removed or, for retained NQTLs, remediated with sufficient documentation supporting parity compliance;
5. Submit, and publicly post, final Standard Plan parity analysis summary report;
6. Submit, and publicly post, final Tailored Plan parity analysis summary report; and
7. Within 90 days after receiving CMS confirmation that the parity documentation in updated Milestones 4 – 6 is complete and compliant:
    a. Submit managed care contract and capitation rate amendments as needed.
    b. Submit ABP SPA(s) so that the ABP benefit package and all applicable treatment limits therein are described consistent with the State's operational practices as outlined in the completed parity documentation. To maintain alignment between the ABP benefits and the traditional state plan in terms of covered benefits and any limitations on amount, duration and scope, concurrent amendments to the traditional state plan benefit package may also be necessary.

The state must comply with all parity requirements per federal regulations. CMS will determine whether state submissions for the updated milestones above comply for all operational MCO and/or state plan programs, including the Standard Plan, Tailored Plan, and ABP, as well as the Children and Families Specialty Plan (CFSP) after implementation. The state must submit the CFSP parity analysis summary report at least 90 days prior to implementation.

The state has notified CMS that Vaya and Partners, both of which are contracted Tailored Plan MCOs as well as Medicaid Direct PIHPs, serve regions of the state that have been heavily affected by Hurricane Helene; a federal public health emergency (PHE) was declared for North Carolina on September 28, 2024. The state also notified CMS that disaster recovery efforts may delay Vaya's and Partners' efforts to come into compliance but that NC Medicaid is currently waiving all prior authorization (PA) limits and some concurrent review (CR) limits for medically necessary services, including, but not limited to, those on MH/SUD services, due to the disaster. CMS acknowledges that it may take more time to update Vaya's and Partners' information in the Tailored Plan and PIHP parity analyses. In the meantime, CMS expects the state to work as quickly as possible toward satisfactory completion of all milestones above for all other entities providing benefits in the Standard Plan, Tailored Plan, and ABP programs, and that both of the following conditions specific to Vaya's and Partners' disaster recovery efforts are met:

1. Vaya and Partners waive impermissible limits—including QTLs, PAs, and CRs where applicable—in operations until such time as these limits can be permanently removed and parity documentation updated; and

2. Final parity analysis summary documentation is submitted to CMS, inclusive of Vaya and Partners information meeting the milestone requirements above, within 90 days after the federal PHE for Hurricane Helene ends in North Carolina.

CMS will withhold approval of pending managed care plan contracts until CMS determines satisfactory completion of the updated milestones above for the applicable MCO and/or PIHP program. CMS will continue to hold biweekly calls with the state to monitor progress and offer technical assistance. If North Carolina does not meet the milestones described in this fourth letter, CMS may take formal compliance action, including, but not limited to, a Corrective Action Plan (CAP) and/or CMS disapproval of North Carolina's managed care contracts.

Thank you for promptly addressing the parity-related compliance issues identified above and for your continued collaboration to comply with mental health parity requirements. Please forward any additional documentation to your Division of Managed Care Operations lead managed care analyst, Sarah Abbott, at sarah.abbott@cms.hhs.gov or (410) 786-8286; and your Division of Benefits and Coverage lead ABP analyst, Brandon Smith, at brandon.smith@cms.hhs.gov or (410) 786-1151.

Sincerely,

John Giles
Director, Managed Care Group

Alissa DeBoy
Director, Medicaid Benefits and Health Programs Group

ATTACHMENT L

2022-2024 Healthy Opportunities Pilot (HOP) Program Eligibility and Services

Below are the clinical criteria, social risk factors, and fee schedule that are currently operating in the Healthy Opportunities Pilots. As stipulated in STC 10.1, CMS will provide a glidepath for the state to come into compliance with STC requirements.

- Prior to DY 8, the state may continue to provide and claim FFP for all HOP services in currently operated HOP regions that were authorized under the previous North Carolina Medicaid Reform Demonstration, which include:
    - Impact Health Region: Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey County
    - Community Care of the Lower Cape Fear Region: Bladen, Brunswick, Columbus, New Hanover, Onslow, and Pender County
    - Access East Region: Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, and Pitt County
- Prior to DY 9, the state may continue to provide HOP services to (and claim FFP for) any beneficiaries who qualified for HOP services in currently operated HOP regions under the previous North Carolina Medicaid Reform Demonstration, which are listed throughout this Attachment.
- The state has authority to use a capped allocation approach until June 30, 2026. This is further discussed in this attachment.

Eligible Enrollees

Table 1: Needs-Based Criteria

Eligibility Category	Age	Needs-Based Criteria (at least one, per eligibility category)
Adults	21+	• 2 or more chronic conditions. Chronic conditions that qualify an individual for pilot enrollment include: BMI over 25, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, substance use disorder, chronic endocrine, cognitive conditions, chronic musculoskeletal conditions, chronic mental illness, chronic neurological disease, chronic infectious disease, cancer, autoimmune disorders, chronic liver disease, chronic renal failure, intellectual or developmental disability (I/DD), and traumatic brain injury (TBI). • Meets the clinical eligibility criteria for Tailored Care Management, North Carolina's Health Home benefit (SPA 22-0024)[7] • Repeated incidents of emergency department use (defined as more than four visits per year) or hospital admissions. • Former placement in North Carolina's foster care or kinship placement system.

[7] Individuals are eligible for Tailored Care Management if they have one serious and persistent mental health condition, I/DD, TBI, or severe substance use disorder, as defined further in North Carolina's approved SPA.

Eligibility Category	Age	Needs-Based Criteria (at least one, per eligibility category)
		• Previously experienced three or more categories of adverse childhood experiences (ACEs).
Pregnant Women	n/a	• Multifetal gestation • Chronic condition likely to complicate pregnancy, including hypertension and mental illness • Current or recent (month prior to learning of pregnancy) use of drugs or heavy alcohol • Adolescent ≤ 15 years of age • Advanced maternal age, ≥ 40 years of age • Less than one year since last delivery • History of poor birth outcome including: preterm birth, low birth weight, fetal death, neonatal death • Former or current placement in NC's foster care or kinship placement system • Previously experienced or currently experiencing three or more categories of ACEs • Intellectual or developmental disability (I/DD) • Traumatic brain injury (TBI) • Meets the clinical eligibility criteria for Tailored Care Management, North Carolina's Health Home benefit (SPA 22-0024)
Children	0-3	• Neonatal intensive care unit graduate • Neonatal Abstinence Syndrome • Prematurity, defined by births that occur at or before 36 completed weeks gestation • Low birth weight, defined as weighing less than 2500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit
	0-20	• One or more significant uncontrolled chronic conditions or one or more controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need, including: asthma, diabetes, underweight or overweight/obesity as defined by having a BMI of $<5^{th}$ or $>85^{th}$ percentile for age and gender, developmental delay, cognitive impairment, substance use disorder, behavioral/mental health diagnosis (including a diagnosis under DC: 0-5), attention- deficit/hyperactivity disorder, cancer, autoimmune diseases, learning disorders, intellectual or developmental disability (I/DD), and traumatic brain injury (TBI). • Meets the clinical eligibility criteria for Tailored Care Management, North Carolina's Health Home benefit (SPA 22-0024) • Experiencing or previously experienced three or more categories of adverse childhood experiences (e.g. Psychological, Physical, or Sexual Abuse, or Household dysfunction related to substance abuse, mental illness, parental violence, criminal behavioral in household) • Enrolled or formerly enrolled in North Carolina's foster care or kinship placement system

Table 2: Risk Factors

Risk Factor	Definition
Homelessness or housing insecurity	Homelessness, as defined in 42 C.F.R. § 254b(h)(5)(A), or housing insecurity, as defined based on the principles in the questions used to establish housing insecurity in the Accountable Health Communities Health Related Screening Tool or the North Carolina Social Determinants of Health (SDOH) screening tool.[2,3]
Food insecurity	As defined by the US Department of Agriculture commissioned report on Food Insecurity in America:[4] • Low Food Security: reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake. • Very low food security: Reports of multiple indications of disrupted eating patterns and reduced food intake Or food insecure as defined based on the principles in the questions used to establish food insecurity in the North Carolina Social Determinants of Health (SDOH) screening tool.[5]
Transportation insecurity	Defined based on the principles in the questions used to establish transportation insecurities in the Accountable Health Communities Health Related Screening Tool or the North Carolina SDOH screening tool.[6]
At risk of, witnessing, or experiencing interpersonal violence	Defined based on the principles in the questions used to establish interpersonal violence in the Accountable Health Communities Health Related Screening Tool or the North Carolina SDOH screening tool.[7]

[2] The Accountable Health Communities Health-Related Social Needs Screening Tool. Available https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf.
[3] North Carolina's SDOH Screening Questions. Available: https://www.ncdhhs.gov/about/department- initiatives/healthy-opportunities/screening-questions
[4] USDA Economic Research Service [Internet]. Washington: USDA Economic Research Service; [updated 2017 Nov 27]. Definitions of Food Insecurity; [updated 2017 Oct 4; cited 2017 Nov 27]. Available from: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security/ [5] North Carolina SDOH Screening Tool. Available: https://www.ncdhhs.gov/about/department-initiatives/healthy- opportunities/screening-questions
[6] *Ibid*
[7] *Ibid*.

Table 3: Healthy Opportunities Pilots Services

Service Sub-Category	Healthy Opportunities Pilots Services
Housing	
Tenancy Support and Sustaining Services	• Assisting the individual with identifying preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration. • Supports to assist the individual in budgeting for housing/living expenses, including financial literacy education on budget basics and locating community based consumer credit counseling bureaus. • Assisting the individual to connect with social services to help with finding housing necessary to support individual in meeting their medical care needs. This pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan. • Assisting the individual with housing application and selection process, including filling out housing applications and obtaining and submitting appropriate documentation. • Assisting the individual to develop a housing support plan based on the functional needs assessment, including establishing measurable goal(s) as part of the overall person centered plan. • Developing a crisis plan for an individual, which must identify prevention and early intervention services if housing is jeopardized. • Participating in the person centered plan meetings to assist the individual in determination or with revisions to housing support plan. • Assisting the individual to review, update and modify his or her housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. • Assisting the individual to complete reasonable accommodation requests as needed to obtain housing. • Supporting individuals in the development of independent living skills, such as skills coaching, financial counseling and anger management. • Connecting the individual to education and training on tenants' and landlords' role, rights, and responsibilities. • Assisting in reducing risk of eviction by providing services such as services that help the individual improve his or her conflict resolution skills, coaching, role-playing and communication strategies targeted towards resolving disputes with landlords and neighbors; communicate with landlords and neighbors to reduce the risk of eviction; address biopsychosocial behaviors that put housing at risk; and provide ongoing support with activities related to household management.

	• Assessing potential health risks to ensure living environment is not adversely affecting an individual's health. • Providing services that will assist the individual with moving into stable housing, including arranging the move, assessing the unit's and individual's readiness for move-in, and providing assistance (excluding financial assistance) in obtaining furniture and essential household items. This pilot service and the assistance and items furnished under this service are coverable only to the extent they are reasonable and necessary as clearly identified through an individual's care plan and the individual is unable to meet such expense or when the services cannot be obtained from other sources. • Providing funding related to utility set-up and moving costs provided that such funding is not available through any other program. This pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an individual's care plan and the individual is unable to meet such expense or when the services cannot be obtained from other sources.
Housing Quality and Safety Improvement Services	• Repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost-effective method of addressing an individual's health condition, as documented by a health care professional, and remediation is not covered under any other program or provision of law, such as tenancy law. This pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an individual's care plan and the individual is unable to meet such expense or when the services cannot be obtained from other sources. • Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs) when necessary to ensure an individual's health and the modification is not covered under any other provision such as the Americans with Disabilities Act.
Legal Assistance	• Assistance with connecting the individual to expert community resources to address legal issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions. This pilot service does not include legal representation or payment for legal representation.
Securing House Payments	• Provide a one-time payment for an individual's security deposit and first month's rent provided that such funding is not available through any other program. This payment may only be made once for each individual during the life of the demonstration, except for state determined extraordinary circumstances such as a natural disaster. This pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an individual's care plan and the individual is unable to meet such expense or when the services cannot be obtained from other sources.

Short-Term Post-Hospitalization	• Post-hospitalization housing for short-term period, not to exceed six [6] months, due to individual's imminent homelessness provided that such a service is not available under any other programs. Temporary housing may not be in a congregate setting. To the extent temporary housing services are available under other programs, this service could cover connecting the individual to such program and helping them secure housing through that program.
Food	
Food Support Services	• Assist the individual with applications for SNAP and WIC. • Assist the individual with identifying and accessing school based food programs. • Assist the individual with locating and referring individuals to food banks or community-based summer and after-school food programs. • Nutrition counseling and education for the individual, including on healthy meal preparation. • Providing funding for meal and food support from food banks or other community based food programs, including funding for the preparation, accessibility to, and food for medical condition specific "healthy food boxes" for the individual, provided that such supports are not available through any other program. Meal and food support services must be provided according to the individual's care plan and must not constitute a "full nutritional regimen" (three meals per day per person).
Meal Delivery Services	• Providing funding for targeted nutritious food or meal delivery services for individuals with medical or medically-related special dietary needs provided such funding cannot be obtained through any other source. Meals provided as part of this service must be provided according to the enrollee's care plan and must not constitute a "full nutritional regimen" (three meals per day, per person).
Transportation	
Non-emergency health-related transportation	• Transportation services to social services that promote community involvement for the individual. • Providing educational assistance to the individual in gaining access to public or mass transit, including access locations, pilot services available via public transportation, and how to purchase transportation passes. • Providing payment for public transportation (i.e., bus passes or mass transit vouchers) to support the individual's ability to access pilot services and other community-based and social services, in accordance with the individual's care plan. • Providing account credits for cost-effective private forms of transportation (taxi, ridesharing) in areas without access to public transit. Pilot transportation services must be offered in accordance with an individual's care plan, and transportation services will not replace non-emergency medical transportation as required under 42 CFR 431.53.

	• Whenever possible, the individual will utilize family, neighbors, friends, or community agencies to provide transportation services.
Interpersonal Violence (IPV)/Toxic Stress	
Interpersonal Violence-Related Transportation	• Transportation services to/from IPV service providers for individuals transitioning out of a traumatic situation.
IPV and Parenting Support Resources	• Assistance with linkages for individuals transitioning out of a traumatic situation to community-based social service and mental health agencies with IPV expertise. • Assistance with linking the individual to high quality child care and after-school programs. • Assistance with linkages to programs that increase adults' capacity to participate in community involvement activities. • Providing navigational services focusing on identifying and improving existing factors posing a risk to the safety and health of victims transitioning out of traumatic situations (i.e., obtaining a new phone number, updating mailing addresses, securing immediate shelter and longer-term housing, school arrangements to minimize disruption of school schedule, connecting enrollees to medical-legal partnerships to • address overlap between healthcare and legal needs).
Legal Assistance	• Assistance with directing the individual to available legal services within the legal system for interpersonal violence related issues, such as securing a Domestic Violence Protection Order. This pilot service does not include legal representation or payment for legal representation.
Child-Parent Support	• Evidence-based parenting support programs (i.e., Triple P – Positive Parenting Program, the Incredible Years, and Circle of Security International). • Evidence-based Maternal, Infant, and Early Home Visiting services to promote enhanced health outcomes, whole person care and community integration.

HOP Capped Allocations

North Carolina distributes a capped allocation of funding to each HOP Administrator based on a state-developed methodology which considers regional Medicaid/CHIP enrollment to support the delivery of authorized HOP services to the HOP Administrator's beneficiaries who are eligible for the HOP services. This payment is inclusive of an administrative fee to support the HOP Administrators' and their contracted care managers' pilot-related operational responsibilities. The majority of the cumulative service payment must be used to pay for the delivery of Pilot services. HOP Administrators must only use the allocation for the Pilot specified purposes and must return all unused Pilot funds to the state. The state has authority to use this capped allocation approach until June 30, 2026. This will provide the state sufficient time to navigate their state legislative process and make any updates to their managed care contracts.

Updated Healthy Opportunities Pilots Fee Schedule
Effective July 1, 2024

The Healthy Opportunities Pilot Fee Schedule (Fee Schedule) was originally approved by CMS and posted in December 2019. Below is a summary of changes to date. The Fee Schedule will continue to be updated in the future based on DHHS experience implementing the Pilots and any feedback from CMS.

- In March 2022, the Pilot Fee Schedule was updated to reflect recent data on wages, inflation, employee-related expenses and updates to rates for similar services offered by other Department programs.
- In March 2023, DHHS implemented updates to Pilot housing services to streamline enrollment in and delivery of these services.
- In April 2024, DHHS implemented additional updates to the Pilot Fee Schedule services rates/ caps to reflect the costs of delivering Pilot services in 2024 (e.g., inflation, wage increases, etc.). DHHS has also made minor, non-rate refinements to the Fee Schedule, including, for example: clarifying that individuals enrolled in Tailored Care Management (TCM) are not eligible for the Food and Nutrition Case Management service to avoid service duplication, that housing application fees can be covered under the Housing Move-in Support Service, and to align the service durations for Short-term Post Hospital Housing and several food and nutrition services with CMS' HRSN Framework (2023).

** *This version of the Healthy Opportunities Pilot Fee Schedule is not part of the Prepaid Health Plan- Network Lead and Network Lead-Human Service Organization model contracts. This version is meant to provide guidance outside of the model contracts by incorporating information about frequency, duration, setting, and minimum eligibility criteria for each service, where applicable.* **

Healthy Opportunities Pilots Fee Schedule		
Service Name	**Unit Of Service/Payment**	**Rate or Cap**
Housing		
Housing Navigation, Support and Sustaining Services	PMPM	$433.62
Inspection for Housing Safety and Quality	Cost-Based Reimbursement Up to A Cap	Up to $294.17 per inspection
Housing Move-In Support	Cost-Based Reimbursement Up to A Cap	• 1 BR: Up to $1,159.00 per month • 2 BR: Up to $1,335.50 per month • 3 BR: Up to $1,453.17 per month • 4 BR: Up to $1,512.00 per month • 5+ BR: Up to $1,570.83 per month

Essential Utility Set-Up[1]	Cost-Based Reimbursement Up to A Cap	• Up to $588.33 for utility deposits, and • Up to $588.33 for reinstatement utility payment, and • Up to $588.33 for utility arrears
Home Remediation Services	Cost-Based Reimbursement Up to A Cap	Up to $5,883.33 per year[2]
Home Accessibility and Safety Modifications	Cost-Based Reimbursement Up to A Cap	Up to $13,000 per lifetime of waiver demonstration[3]
Healthy Home Goods	Cost-Based Reimbursement Up to A Cap	Up to $2,941.66 per year[4]
One-Time Payment for Security Deposit and First Month's Rent	Cost-Based Reimbursement Up to A Cap	• First month's rent: Up to 115% FMR[5] (based on home size) • Security deposit: Up to 115% FMR (based on home size) x2
Short-Term Post Hospitalization Housing	Cost-Based Reimbursement Up to A Cap	• First month's rent: Up to 115% FMR (based on home size) • Security deposit: Up to 115% FMR (based on home size) x2
Interpersonal Violence / Toxic Stress		
IPV Case Management Services	PMPM	$256.66
Violence Intervention Services	PMPM	$194.45
Evidence-Based Parenting Curriculum	One class	$27.96
Home Visiting Services	One home visit	$75.71
Food		
Food and Nutrition Access Case Management Services	15 minute interaction	$13.94

[1] The HSO that coordinates the delivery of the Essential Utility Set-Up service will receive $105.90 as a one-time payment per enrollee. If an enrollee receives this service more than once per year, the HSO may receive the coordination fee each time they coordinate the service on behalf of the enrollee.
[2] The HSO that coordinates the contractors to deliver the Home Remediation Service will receive $147.08 per Home Remediation Service project that costs no more than $1,470.83 and will receive $294.17 per Home Remediation Service project that costs between $1,470.83 and $5,883.33.
[3] The HSO that coordinates the contractors to deliver the Home Accessibility and Safety Modification will receive $325 per Home Accessibility Modification project that costs no more than $3,250 and will receive $650 per Home Accessibility and Safety Modification project that costs between $3,250 and $13,000.
[4] The HSO that coordinates the delivery of the Healthy Home Goods service will receive $105.90 as a one-time payment per enrollee. If an enrollee receives this service more than once per year, the HSO may receive the coordination fee each time they coordinate the service on behalf of the enrollee.
[5] 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

Evidence-Based Group Nutrition Class	One class	$25.11

Diabetes Prevention Program	• Four classes (first phase)
	• Three classes (second phase)[6]
		• **Phase 1: $289.83**
		  • Completion of 4 classes: $28.77
		  • Completion of 4 additional classes (8 total): $57.55
		  • Completion of 4 additional classes (12 total): $71.93
		  • Completion of 4 additional classes (16 total): $131.58
		• **Phase 2: $108.69**
		  • Completion of 3 classes: $32.59
		  • Completion of 3 additional classes
		  • (6 total): $76.10

Fruit and Vegetable Prescription	Cost-Based Reimbursement Up to A Cap	Up to $248.43 per month[7]
Healthy Food Box (For Pick-Up)	One food box	• Small box: $97.47 • Large box: $169.01
Healthy Food Box (Delivered)	One food box	• Small box: $104.97 • Large box: $176.51
Healthy Meal (For Pick-Up)	One meal	$7.10
Healthy Meal (Home Delivered)	One meal	$7.70
Medically Tailored Home Delivered Meal	One meal	$7.92
Transportation		
Reimbursement for Health-Related Public Transportation	Cost-Based Reimbursement Up to A Cap	Up to $130.78 per month
Reimbursement for Health-Related Private Transportation	Cost-Based Reimbursement Up to A Cap	Up to $342.34 per month[8]
Transportation PMPM Add-On for Case Management Services	PMPM	$78.75

[6] The Centers for Disease Control and Prevention recognized Diabetes Prevention Program is offered in two phases, including a minimum of 16 classes in Phase 1 and 6 classes in Phase 2. The DPP program is paid for in allocations so HSOs that participate in the Pilot are able to receive pro-rated payments as enrollees complete four classes.
[7] The HSO that coordinates the Fruit and Vegetable Prescription service will receive $6.21 per person served in a given month.
[8] 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 $2,054.04, reflecting six months of capped private transportation services.

Cross-Domain		
Holistic High Intensity Enhanced Case Management	PMPM	$548.70
Medical Respite	Per diem	$219.57
Linkages to Health-Related Legal Supports	15 minute interaction	$28.36

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:

Category	Information
	○ Coordinating transportation for enrollees to housing-related services necessary to obtain housing (e.g. apartment/home visits). ○ Coordinating the enrollee's move into stable housing including by assisting with the following: ▪ Logistics of the move (e.g., arranging for moving company or truck rental); ▪ Utility set-up and reinstatement; ▪ Obtaining furniture/commodities to support stable housing ○ Referral to legal support to address needs related to finding and maintaining stable housing. ***Tenancy Sustaining Services*** • Assisting the enrollee in revising housing support/crisis plan. • Assisting the enrollee to develop a housing stability plan and support the follow through and achievement of the goals defined in the plan, including assistance applying to related programs to ensure safe and stable housing (e.g., Social Security Income and weatherization programs), or assuring assistance is received from the enrollee's Medicaid care manager. • Assisting the enrollee with completing additional or new reasonable accommodation requests. • Supporting the enrollee in the development of independent living skills. • Connecting the enrollee to education/training on tenants' and landlords' role, rights and responsibilities. • Assisting the enrollee in reducing risk of eviction with conflict resolution skills. • Coordinating other Pilot housing-related services, including: ○ Assisting the enrollee to complete annual or interim housing re- certifications. ○ Coordinating transportation for enrollees to housing-related services necessary to sustain housing. ○ 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

Category	Information
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 HOP Administrator authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollees may not simultaneously receive the Housing Navigation, Support and Sustaining Services and the IPV Case Management Services. Individuals with co- occurring housing and IPV-related needs should receive the Holistic High Intensity Case Management service. • This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Inspection for Housing Safety and Quality

Category	Information
Service Name	Inspection for Housing Safety and Quality
Service Description	A housing safety and quality inspection by a certified professional includes assessment of potential home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Inspections may assess the habitability and/or environmental safety of an enrollee's current or future dwelling. Inspections may include: • Inspection of building interior and living spaces for the following: o Adequate space for individual/family moving in; o Suitable indoor air quality and ventilation; o Adequate and safe water supply; o Sanitary facilities, including kitchen, bathroom and living spaces o Adequate electricity and thermal environment (e.g. window condition) and absence of electrical hazards;

Category	Information
	- 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	- Enrollee 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 - 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)

Category	Information
	waiver service, or Housing and Urban Development grant) may still receive this Pilot service if deemed eligible. The provider delivering the substantially similar service must coordinate with the enrollee's Medicaid care manager (if applicable) to determine the necessity of the Pilot service and ensure appropriate documentation in the enrollee's care plan. o Home Remediation Services o Home Accessibility and Safety Modifications o Holistic High Intensity Enhanced Case Management • Inspections may be conducted for individuals who are moving into new housing units (e.g., HQS Inspection) or for individuals who are currently in housing that may be adversely affecting their health or safety. • Services are authorized in accordance with HOP Administrator 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: • Housing application fees • Moving expenses required to occupy and utilize the housing (e.g., moving service to transport an individual's belongings from current location to new housing/apartment unit, delivery of furniture, etc.) • Discrete goods to support an enrollee's transition to stable housing as part of this service. These may include, for example: o Essential furnishings (e.g., mattresses and beds, dressers, dining table and chairs); o Bedding (e.g., sheets, pillowcases and pillows); o Basic kitchen utensils and dishes; o Bathroom supplies (e.g., shower curtains and towels); o Cribs; o Cleaning supplies. This service shall not cover used mattresses, cloth, upholstered furniture, or other used goods that may pose a health risk to enrollees.

Category	Information
Frequency *(if applicable)*	Enrollees that meet minimum service eligibility criteria may receive housing move-in support services when they move into a housing/apartment unit for the first time or move from their current place of residence to a new place of residence. This service may be utilized more than once per year, so long as overall spending remains below the annual cap.
Duration *(if applicable)*	N/A
Setting	Variable. Many housing move-in support services will occur in the enrollee's current place of residence or potential residence. Some discrete goods may be given to an enrollee in a location outside the home, including an HSO site or clinical setting.
Minimum Eligibility Criteria	• Enrollee must be receiving Housing Navigation, Support and Sustaining Services or Holistic High Intensity Enhanced Case Management. o Enrollees receiving services substantially similar to Housing Navigation, Supports and Sustaining Services through a different funding source (e.g. Medicaid State Plan, a 1915(c) waiver service, or Housing and Urban Development grant) may still receive this Pilot service if deemed eligible. The provider delivering the substantially similar service must coordinate with the enrollee's Medicaid care manager (if applicable) to determine the necessity of the Pilot service and ensure appropriate documentation in the enrollee's care plan. • Housing move-in support services are available for individuals who are moving into housing from homelessness[9] 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: o Transitioning from homelessness or shelter to stable housing; o Addressing the sequelae of an abusive relationship o Evicted or at risk of eviction from current housing; o Current housing is deemed unhealthy, unsafe or uninhabitable by a certified inspector; o Displaced from prior residence due to occurrence of a natural disaster. • This Pilot service is furnished only to the extent that the enrollee is unable to meet such expense or when the services cannot be reasonably obtained from other sources. • Services are authorized in accordance with HOP Administrator 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.

[9] 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), available at: https://www.govinfo.gov/content/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapII-partD- subparti.pdf

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). The cost associated with coordinating service delivery is included in the service rate. See Fee Schedule chart for more information.
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 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. • 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 HOP Administrator 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. The cost associated with coordinating service delivery is included in the service rate. See Fee Schedule chart for more information.
Frequency *(if applicable)*	Enrollees may receive home remediation services at any point at which they meet minimum service eligibility criteria and have not reached the cap.
Duration *(if applicable)*	N/A
Setting	Home remediation services occur in the enrollee's current place of residence or potential residence.
Minimum Eligibility Criteria	• Enrollee must be moving into a new housing unit or must reside in a housing unit that is adversely affecting his/her health or safety. ○ The housing unit may be owned by the enrollee (so long as it is their primary place of residence) or rented. • The enrollee's landlord has provided written confirmation that they consent to have the approved home remediation service provided on behalf of the enrollee prior to service delivery. An enrollee who lives in a home where they do not pay rent (e.g., home owned by the enrollee or enrollee's family member) would not be required to provide such written consent. • Prior to service delivery, landlord or enrollee has provided written confirmation that the enrollee can reasonably be expected to remain in the residence for at least 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. • Services are authorized in accordance with HOP Administrator 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). The cost associated with coordinating service delivery is included in the service rate. See Fee Schedule chart for more information.
Frequency *(if applicable)*	Enrollees may receive home accessibility modifications at any point at which they meet minimum eligibility criteria and have not reached the cap.
Duration *(if applicable)*	N/A
Setting	Home accessibility and safety services will occur in the enrollee's current place of residence or potential residence.
Minimum Eligibility Criteria	• Enrollee must be moving into a new housing unit or must reside in a housing unit that is adversely affecting his/her health or safety. ○ The housing unit may be owned by the enrollee (so long as it is their primary place of residence) or rented. • The enrollee's landlord has provided written confirmation that they consent to have the approved home accessibility or safety modifications provided on behalf of the enrollee prior to service delivery. An enrollee who lives in a home where they do not pay rent (e.g., home owned by the enrollee or enrollee's family member) would not be required to provide such written consent. • Prior to service delivery, landlord or enrollee has provided written confirmation that the enrollee can reasonably be expected to remain in the residence for at least 12 months after the authorized home accessibility or safety modification service. An enrollee who lives in a home where they do not pay rent (e.g., home owned by the enrollee or enrollee's family member) would not be subject to this requirement. • Services are authorized in accordance with HOP Administrator 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. The cost associated with coordinating service delivery is included in the service rate. See Fee Schedule chart for more information.
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 HOP Administrator 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

Category	Information
Setting	N/A
Minimum	• Enrollee must be receiving Housing Navigation, Support and Sustaining Services
Eligibility Criteria	or Holistic High Intensity Enhanced Case Management. o Enrollees receiving services substantially similar to Housing Navigation, Supports and Sustaining Services through a different funding source (e.g. Medicaid State Plan, a 1915(c) waiver service, or Housing and Urban Development grant) may still receive this Pilot service if deemed eligible. The provider delivering the substantially similar service must coordinate with the enrollee's Medicaid care manager (if applicable) to determine the necessity of the Pilot service and ensure appropriate documentation in the enrollee's care plan. • 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 HOP Administrator 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 of service in a 12 month period, 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

Category	Information
	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 of service in a 12 month period, 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. o Enrollees receiving services substantially similar to Housing Navigation, Supports and Sustaining Services through a different funding source (e.g. Medicaid State Plan, a 1915(c) waiver service, or Housing and Urban Development grant) may still receive this Pilot service if deemed eligible. The provider delivering the substantially similar service must coordinate with the enrollee's Medicaid care manager (if applicable) to determine the necessity of the Pilot service and ensure appropriate documentation in the enrollee's care plan. • Enrollee is imminently homeless post-inpatient hospitalization. • Enrollee must receive assistance with developing a reasonable plan to address future ability to pay rent through a housing stability plan. • Housing unit must pass a Housing Quality Standards (HQS) inspection prior to move-in or, in certain circumstances, a habitability inspection performed by the case manager or other staff. If a habitability inspection is performed, an HQS inspection must be scheduled immediately following move-in. • Landlord or appropriate dwelling owner or administrator must be willing to enter into an agreement that maintains a satisfactory dwelling and access to needed medical services for the enrollee throughout the duration of the agreement, unless there are appropriate and fair grounds for termination of the agreement. • This Pilot service is provided only to the extent that the enrollee is unable to meet such expense or when the services cannot be obtained from other sources.

Category	Information
	• Services are authorized in accordance with HOP Administrator 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

Category	Information
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.[10] • Services are authorized in accordance with HOP Administrator authorization policies, such as but not limited to service being indicated in the enrollee's person centered care plan. • Enrollee is not currently receiving duplicative support through other Pilot services. • Enrollees may not simultaneously receive the Housing Navigation, Support and Sustaining Services and the IPV Case Management Services. Individuals with co- occurring housing and IPV-related needs should receive the Holistic High Intensity Case Management service. • Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

Violence Intervention Services

Category	Information
Service Name	Violence Intervention Services
Service Description	This service covers the delivery of services to support individuals who are at risk for being involved in community violence (i.e., violence that does not occur in a family context). Individuals may be identified based on being the victim of a previous act of crime, membership in a group of peers who are at risk, or based on other criteria. Once identified, Peer Support Specialists and case managers provide: • Individualized psychosocial education related to de-escalation skills and alternative approaches to conflict resolution • Linkages to housing, food, education, employment opportunities, and after-school programs and community engagement activities. 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

[10] 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.

Category	Information
	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 HOP Administrator 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.

Category	Information
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 HOP Administrator 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.

Category	Information
Minimum Eligibility Criteria	• Services are authorized in accordance with HOP Administrator 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.

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

Category	Information
Setting	• May be offered: o At a community setting (e.g. community center, health care clinic, Federally Qualified Health Center (FQHC), food pantry, food bank) o At an enrollee's home (for home-bound individuals) o Via telephone or other modes of direct communication
Minimum Eligibility Criteria	• Services are authorized in accordance with HOP Administrator 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. • Enrollee is not engaged in Tailored Care Management, as Tailored Care Management provides food and nutrition access support that duplicates HOP Food and Nutrition Access Case Management Services.

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)[11] • A Taste of African Heritage (for Kids, Adults) [12] 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 HOP Administrator.
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.

Category	Information
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 HOP Administrator 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.

[11] More information on Cooking Matters available at: https://cookingmatters.org/community-resources/
[12] 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.[13]
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: o Be 18 years of age or older, o Have a BMI ≥ 25 (≥23 if Asian), o Not be pregnant at the time of enrollment o Not have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment, o 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"[14] • Services are authorized in accordance with HOP Administrator 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.

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

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

Fruit and Vegetable Prescription

Category	Information
Service Name	Fruit and Vegetable Prescription
Service Description	Food voucher to be used by an enrollee with a diet or nutrition-related chronic illness to purchase fruits and vegetables from a participating food retailer. Participating food retailers must sell an adequate supply of WIC-eligible fruits and vegetables (i.e., fresh, frozen, canned without any added fats, salt, or sugar). Food retailers may include but are not limited to: • Grocery stores • Farmers markets • Mobile markets • Community-supported agriculture (CSA) programs • Corner stores A voucher transaction may be facilitated manually or electronically, depending on the most appropriate method for a given food retail setting. The cost associated with coordinating service delivery is included in the service rate. See Fee Schedule chart footnote for more information.
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)*	• Up to 6 months, contingent on determination of continued Pilot eligibility. • Services provided beyond 6 months are contingent on reassessment of Pilot eligibility to ensure the enrollee meets the qualifying physical/behavioral needs and social risk factors to be eligible for the Pilots.
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 HOP Administrator 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)*	• Up to 6 months, contingent on determination of continued Pilot eligibility. • Services provided beyond 6 months are contingent on reassessment of Pilot eligibility to ensure the enrollee meets the qualifying physical/behavioral needs and social risk factors to be eligible for the Pilots.
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 HOP Administrator 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)*	• Up to 6 months, contingent on determination of continued Pilot eligibility. • Services provided beyond 6 months are contingent on reassessment of Pilot eligibility to ensure the enrollee meets the qualifying physical/behavioral needs and social risk factors to be eligible for the Pilots.
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 HOP Administrator 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,[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)*	Frequency of meal services will differ based on the severity of the individual's needs.
Duration *(if applicable)*	• Up to 6 months, contingent on determination of continued Pilot eligibility. • Services provided beyond 6 months are contingent on reassessment of Pilot eligibility to ensure the enrollee meets the qualifying physical/behavioral needs and social risk factors to be eligible for the Pilots.
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 HOP Administrator 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.

[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://www.dietaryguidelines.gov/resources/2020-2025-dietary-guidelines-online-materials

Healthy Meal (Home Delivered)

Category	Information
Service Name	Healthy Meal (Home Delivered)
Service Description	A healthy, home-delivered meal consists of a hot, cold, or frozen meal that is delivered to an enrollee's home, aimed at promoting improved nutrition for the service recipient. This service includes preparation and delivery of the meal. Meals must provide at least one-third of the recommended Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences,[17] 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.[18] 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)*	• Up to 6 months, contingent on determination of continued Pilot eligibility. • Services provided beyond 6 months are contingent on reassessment of Pilot eligibility to ensure the enrollee meets the qualifying physical/behavioral needs and social risk factors to be eligible for the Pilots.
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 HOP Administrator 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.

[17] Dietary Reference Intakes available at: https://www.nal.usda.gov/fnic/dietary-reference-intakes.
[18] Most recent version of the Dietary Guidelines for Americans is available at: https://www.dietaryguidelines.gov/resources/2020-2025-dietary-guidelines-online-materials

Medically Tailored Home Delivered Meal

Category	Information
Service Name	Medically Tailored Home Delivered Meal
Service Description	Home delivered meal which is medically tailored for a specific disease or condition. This service includes an initial evaluation with a Registered Dietitian Nutritionist (RD/RDN) or Licensed Dietitian Nutritionist (LDN) to assess and develop a medically- appropriate nutrition care plan, the preparation and delivery of the prescribed nutrition care regimen, and regular reassessment at least once every 3 months. Meals must be in accordance with nutritional guidelines established by the National Food Is Medicine Coalition (FIMC) or other appropriate guidelines.[19] 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)*	• Up to 6 months, contingent on determination of continued Pilot eligibility. • Services provided beyond 6 months are contingent on reassessment of Pilot eligibility to ensure the enrollee meets the qualifying physical/behavioral needs and social risk factors to be eligible for the Pilots.
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 HOP Administrator authorization policies, such as but not limited to service being indicated in the enrollee's person-centered care plan.
	• Enrollee is not currently receiving duplicative support through other Pilot services.
	• This service is not covered as a Pilot service if the receiving individual would be eligible for substantially the same service as a Medicaid covered service.
	• Enrollee is not currently receiving duplicative support through other federal, state, or locally-funded programs.

[19] FIMC standards available at: https://static1.squarespace.com/static/580a7cb9e3df2806e84bb687/t/5ca66566e5e5f01ac

91a9ab4/1554408806530/FIMC+Nutriton+Standards-Final.pdf

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
Category	**Information**
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 HOP Administrator 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)[20] • 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):[21] • Repairs to an enrollee's vehicle • Reimbursement for gas mileage, in accordance with North Carolina's Non- Emergency Medical Transportation clinical policy[22] 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.

[20] 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.

[21] 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.

[22] Reimbursement for gas mileage must be in accordance with North Carolina's Non-Emergency Medical Transportation (NEMT) Policy, available at: https://medicaid.ncdhhs.gov/nc-medicaid-managed-care-non-emergency-medical-transportation-policy-v7/download?attachment

Category	Information
Frequency *(if applicable)*	As needed
Duration *(if applicable)*	N/A
Setting	N/A
Minimum Eligibility Criteria	• Services are authorized in accordance with HOP Administrator 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 HOP Administrator 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. • Enrollee engaged in Tailored Care Management may only receive a combination of Housing Navigation, Support and Sustaining Services and IPV Case Management through this service (i.e., may not receive HOP Food and Nutrition Case Management as part this service), as Tailored Care Management provides food and nutrition access support that duplicates HOP Food and Nutrition Access Case Management Services)

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 per a 12 month period, 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.

Category	Information
	Meals must be in accordance with nutritional guidelines established by the National Food Is Medicine Coalition (FIMC) or other appropriate guidelines.[23] Meals may be tailored to meet cultural preferences. For health conditions not outlined in the Food Is Medicine Coalition standards above, an organization must follow a widely recognized nutrition guideline approved by the LPE. This service does not constitute a full nutritional regimen (three meals per day per person). **Transportation Services** Provision of private/semi-private transportation services, reimbursement for public transportation and reimbursement for private transportation (e.g., taxis and ridesharing apps—only in areas where public transportation is unavailable) for the enrollee receiving medical respite care to social services that promote community engagement, health and well-being. *Refer to service definitions for Reimbursement for Health-Related Public Transportation and Reimbursement for Health-Related Private Transportation for further service description detail.* Medical respite program staff are required to check-in regularly with the individual's Medicaid care manager to coordinate physical, behavioral and social needs.
Frequency *(if applicable)*	N/A
Duration *(if applicable)*	Up to six months, contingent on determination of continued Pilot eligibility.
Setting	• The majority of the services will occur in the allowable short-term post- hospitalization housing settings described in the service description. • Some services will occur outside of the residential setting (e.g., transportation to wellness-related activities/events, site visits to potential housing options).
Minimum Eligibility Criteria	• Individuals who are homeless or imminently homeless, have recently been discharged from a hospital setting and require continuous access to medical care. • Enrollee should remain in Medical Respite only as long as it is indicated as necessary by a healthcare professional. • Enrollee requires access to comprehensive medical care post-hospitalization • Enrollee requires intensive, in-person case management to recuperate and heal post- hospitalization. • Services are authorized in accordance with HOP Administrator 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.

[23] FIMC Standards available at: https://static1.squarespace.com/static/580a7cb9e3df2806e84bb687/t/5ca66566e5e5f01ac 91a9ab4/1554408806530/FIMC+Nutriton+Standards-Final.pdf.

Linkages to Health-Related Legal Supports

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

Category	Information
Minimum Eligibility Criteria	• Service does not cover legal representation. • Services are authorized in accordance with HOP Administrator 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.

Attachment M: Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for Healthy Opportunities Pilots (HOP) HRSN Services

HOP HRSN Services Protocol: In accordance with the Special Terms and Conditions (STCs) of the state's Section 1115 Demonstration, this Protocol provides additional detail on the requirements for the delivery of services for Health-Related Social Needs (HRSN) services as part of the Healthy Opportunities Pilots (HOP) program, as specifically required by STC 10.10. The state has discretion to choose which services and eligibility criteria to cover within what is permissible under this Protocol, as further outlined in Section 5.

Appendix 1 indicates the HRSN services and eligibility criteria the state intends to cover within what is permissible under this Protocol. Appendix 1 can be updated at any time, with notification to CMS as detailed in STC 10.12, to include any subset of the HRSN services and eligibility criteria outlined in Attachment L: *2022-2024 Healthy Opportunities Pilot Program Eligibility and Services* (in DY7 only) and Sections 1 through 4 of this Protocol, and to include additional regions of the state or new delivery systems. Changes to Appendix 1 do not require CMS approval, but require notification to CMS consistent with STC 10.12.

1. Member Eligibility

a. HOP HRSN services are intended to be used by Medicaid enrollees who can benefit most from them, to maximize the benefit of limited HRSN funding. Receipt of HOP services is always at the option of the HOP enrollee, including when the HOP enrollee has a choice between multiple cost-effective services to address the same need.
b. The following qualifying criteria for HRSN services take into account a person's health status (including both physical and behavioral health) and unmet, non-medical needs.
c. To ensure that services are medically appropriate, the North Carolina Department of Health and Human Services (the Department) will require that individuals identified as in need of HRSN services meet the following clinical and social risk criteria. To qualify for an HRSN service, a member must:
    i. Have at least one HRSN qualifying health criteria (described below);
    ii. Have at least one HRSN qualifying social risk factor (described below); and
    iii. Meet any additional eligibility criteria and requirements that apply in connection with the specific HRSN service.
d. The Department will maintain the qualifying health criteria and social risk criteria for HRSN services on a public facing Department webpage. The content will be updated if the criteria are changed.
    i. The Department's process for changing service offerings and eligibility for HRSN services is described below under "Availability of HRSN Services Under HOP."
    ii. Within this Protocol, the Department has discretion to adjust which services and eligibility criteria are covered under HOP, based on readiness and following the process and transparency requirements defined under "Availability of HRSN Services Under HOP." The Department must notify CMS via the process identified in STC 10.12 when changing which services and eligibility criteria it covers within what is permissible under this Protocol.

2. HRSN Qualifying Health Criteria

In order to receive HRSN services through HOP, members must meet at least one of the qualifying health criteria listed below.

Table 1: HRSN Qualifying Health Criteria

Eligibility Group	HRSN Qualifying Health Criteria
Adults (21+)	• One or more chronic condition • Meets the clinical eligibility criteria for Tailored Care Management[16] • Repeated incidents of emergency department use (defined as more than two visits per six months) or hospital admissions • Experiencing or previously experienced interpersonal violence (IPV) • Children under the age of 21 with a health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, or neglect • Individuals under the age of 26 who were 1) previously placed in North Carolina's foster care or kinship placement system, and/or 2) formerly justice-involved with a health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect • Pregnancy
Children (0 – 20)	
Children (0 – 3)	• Neonatal intensive care unit graduate • Neonatal Abstinence Syndrome • Prematurity, defined by births that occur at or before 36 completed weeks gestation • Low birth weight, defined as weighing less than 2500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit

3. HRSN Qualifying Social Risk Factors

In order to receive HRSN services, members must meet at least one of the qualifying social risk factors listed below. All qualifying social risk factors must be included in the individual's care plan.

[16] Individuals are eligible for Tailored Care Management if they have one serious and persistent mental health condition, I/DD, TBI, or severe substance use disorder, as defined further in North Carolina's approved SPA.

Table 2: HRSN Qualifying Social Risk Factors

Domain	HRSN Qualifying Social Risk Factors

Housing	• Homelessness, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5
	• At risk of homelessness, as defined in 24 CFR 91.5, with two adjustments:
	  ○ Members do not need to meet HUD's income standards; and
	  ○ Notification in writing that the member's right to occupy their current housing or living situation will be terminated can be within 31 days, rather than 21 days, of the date of application for assistance.
	• Housing insecurity, defined as an individual or family who:
	  ○ Requires a clinically appropriate home modification/remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs a home inspection and/or to transition to another housing option;
	  ○ Lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition and the housing can either be modified cost effectively, or the housing cannot be modified cost-effectively and the member needs a home inspection and/or to transition to another housing option;
	  ○ Is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained, and the member either needs a home inspection or healthy home good, or the member needs to transition to another housing option;
	  ○ Is missing one or more monthly rent payment, and/or has received at least one lease violation that may lead to eviction and needs to transition to another housing option;
	  ○ Has utility payments in arrears or lacks income for utility payments, including to restart utilities payments that have been turned off, such that the lack of utilities may negatively impact their health; or
	  ○ Requires support in identifying, preparing for, and/or sustaining stable housing options to avoid adverse impacts on health.

Nutrition	Low food security or very low food security, as defined by the United States Department of Agriculture (USDA).[17]

[17] Definitions of Food Security. USDA. Available: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/

4. HRSN Services

The state will cover a set of HRSN services through HOP, as defined below:

Table 3: HRSN Service Definitions

Housing Services

Service	Description

Housing Navigation, Support and Sustaining Services
 	
Authorized under STC 10.3(a)(i)(1), 10.3(a)(i)(2), and 10.3(a)(i)(4)
	Provision of one-to-one case management and/or educational services to prepare an enrollee for stable, long-term housing and to support an enrollee in maintaining stable, long-term housing. 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 HOP housing-related services, including coordinating transportation for enrollees to housing-related services.
	• Coordinating the enrollee's move into stable housing including by assisting with the following:
	  ○ Logistics of the move;
	  ○ Utility set-up and reinstatement;
	  ○ Obtaining furniture/commodities to support stable housing;
	  ○ Referral to legal support to address needs related to finding and maintaining stable housing.

Service	Description
	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, 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 HOP 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 HOP enrollee present. The Human Services Organization (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 Network Lead can facilitate partnerships of this kind.
Inspection for Housing Safety and Quality Authorized under STC 10.3(a)(i)(3) and 10.3(a)(iii)	A housing safety and quality inspection by a certified professional includes assessment of potential home-based health and safety risks to ensure living environment is not adversely affecting occupants' health and safety. Inspections may assess the habitability and/or environmental safety of an enrollee's current or future dwelling. Inspections may include: • Inspection of building interior and living spaces for the following: o Adequate space for individual/family moving in; o Suitable indoor air quality and ventilation; o Adequate and safe water supply; o Sanitary facilities, including kitchen, bathroom and living spaces; o Adequate electricity and thermal environment and absence of electrical hazards;

Service	Description
	○ Potential lead exposure; ○ Conditions that may affect health; ○ Conditions that may affect safety. • Inspection of building exterior for the following: ○ Condition of building foundation and exterior, including building accessibility; and, ○ Condition of equipment for heating, cooling/ventilation and plumbing. This service can cover Housing Quality Standards (HQS) or National Standards for the Physical Inspection of Real Estate (NSPIRE) 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. Enrollees are eligible for this service if they have a qualifying clinical criteria and are: • Homeless; • At risk of homelessness; or • Meet one of the below housing insecurity definitions: ○ Requires a clinically appropriate home modification/remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs a home inspection and/or to transition to another housing option; ○ Lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition and the housing can either be modified cost effectively, or the housing cannot be modified cost-effectively and the member needs a home inspection and/or to transition to another housing option; ○ Is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has

Service	Description
	exposure to pathogens/hazards, and/or the property is inadequately maintained, and the member either needs a home inspection or healthy home good, or the member needs to transition to another housing option; or o Is missing one or more monthly rent payment, and/or has received at least one lease violation that may lead to eviction and needs to transition to another housing option.
Housing Move-In Support Authorized under STC 10.3(a)(i)(3)	Housing move-in support services are non-recurring set-up expenses. Allowable expenses include the following: • Housing application fees • Storage fees if necessary to secure and maintain the unit • Moving expenses required to occupy and utilize the housing • Discrete goods to support an enrollee's transition to stable housing as part of this service. These services are limited to: o Essential furnishings; o Bedding and other essential linens; o Basic kitchen utensils, dishes, and cookware; o Basic appliances to warm food and beverages; o Bathroom supplies; o Cribs; o Fire extinguishers; o First aid kits; o Toolkits; o Initial supply of toiletries; o Storage and organizational supplies; and, o Cleaning and laundry supplies. Enrollees are eligible for this service if they have a qualifying clinical criteria and are: • Homeless; • At risk of homelessness; or • Meet one of the below housing insecurity definitions: o Requires a clinically appropriate home modification/remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs a home inspection and/or to transition to another housing option; o Lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition and the housing can either be modified cost effectively, or the housing cannot

Service	Description
	be modified cost-effectively and the member needs a home inspection and/or to transition to another housing option; o Is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained, and the member either needs a home inspection or healthy home good, or the member needs to transition to another housing option; or o Is missing one or more monthly rent payment, and/or has received at least one lease violation that may lead to eviction and needs to transition to another housing option.
Essential Utility Set-Up Authorized under STC 10.3(a)(i)(3) and STC 10.3(a)(ii)	The Essential Utility Set Up service is a non-recurring payment offered to those whom utilities will be imminently discontinued, have been discontinued, or were never turned on at move-in to: • Provide non-refundable, utility set-up costs for utilities essential for habitable housing. • Cover non-refundable utility set-up costs to restart the service if it has been discontinued in a HOP enrollee's home, putting the individual at risk of homelessness or otherwise adversely impacting their health. Allowable expenses for the following utility types are covered: • Garbage • Water • Sewage • Recycling • Gas • Electric • Internet • Phone (inclusive of land line phone service and cell phone service) This service may be used in association with essential home utilities that have been discontinued (i.e., initial payments to activate any of the utility types listed above). Enrollees are eligible for this service if they have a qualifying clinical criteria and are: • Homeless; • At risk of homelessness; or • Meet one of the below housing insecurity definitions: o Requires a clinically appropriate home

Service	Description
	modification/remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs a home inspection and/or to transition to another housing option; ○ Lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition and the housing can either be modified cost effectively, or the housing cannot be modified cost-effectively and the member needs a home inspection and/or to transition to another housing option; ○ Is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained, and the member either needs a home inspection or healthy home good, or the member needs to transition to another housing option; ○ Is missing one or more monthly rent payment, and/or has received at least one lease violation that may lead to eviction and needs to transition to another housing option; or ○ Has utility payments in arrears or lacks income for utility payments, including to restart utilities payments that have been turned off, such that the lack of utilities may negatively impact their health.
Home Remediation Services Authorized under STC 10.3(a)(iii)	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 are limited to: • Pest prevention, eradication, and remediation; • Carpet removal; • Mold/mildew containment, removal, and remediation; • Installation or repair of air purifiers, ventilation systems, humidifiers, washable curtains, and/or synthetic blinds to prevent allergens and maintain clean air quality; • Hoarding cleanup services; • Chore services (inclusive of heavy housecleaning and removal of hazardous debris or dirt); • Repairs to plumbing, boilers, dehumidifiers, sump pumps, airducts, insulation, and drains if the services eliminate known home-based health and safety risks to the member; and • Installation or repair of air conditioning/heating systems and

Service	Description

	generators if the services eliminate known home-based health and safety risks to the member.
	
	Remediation services that are only cosmetic in nature (e.g., new paint or decorations) are not permitted.
	
	Enrollees eligible for this service if they have a qualifying clinical criteria and are:
	• Homeless;
	• At risk of homelessness; or
	• Meet one of the below housing insecurity definitions:
	  ○ Requires a clinically appropriate home modification/remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs a home inspection and/or to transition to another housing option; or
	  ○ Is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained, and the member either needs a home inspection or healthy home good, or the member needs to transition to another housing option.

Healthy Home Goods Authorized under STC 10.3(a)(iii)	Healthy 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. Healthy home goods are limited to: • HEPA-vacuums; • Mops/steamers; • Air purifiers and filters; • Water filters; • Non-toxic cleaning supplies; • Hypoallergenic bedding; • Non-toxic pest control and prevention supplies; • Air conditioners, fans and/or heaters; • Humidifiers and dehumidifiers; • Tools to measure and track temperature and humidity; and • Refrigeration units. Healthy home goods do not alter the physical structure of an enrollee's

Service	Description

	housing unit.
	
	Enrollees eligible for this service if they have a qualifying clinical criteria and are:
	• Homeless;
	• At-risk of homelessness; or
	• Meet one of the below housing insecurity definitions:
	  o Requires a clinically appropriate home modification/remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs a home inspection and/or to transition to another housing option; or
	  o Is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained, and the member either needs a home inspection or healthy home good, or the member needs to transition to another housing option.

Home Accessibility and Safety Modifications
 	
Authorized under STC 10.3(a)(iv)
	Evidence-based home accessibility and safety modifications are coordinated and furnished to eliminate known home-based health and safety risks to ensure the living environment is not adversely affecting occupants' health and safety. Home accessibility modifications are adjustments to homes that improve enrollee mobility, enable independent and safe living, or accommodate clinically-appropriate assistive technology and supplies. These services are limited to:
	• Clinically-appropriate installation of:
	  o Assistive technology;
	  o Ramps;
	  o Adaptive door and window openers;
	  o Hand-held shower controls;
	  o Nonslip surfaces;
	  o Grab bars;
	  o Hand rails;
	  o Stair rails;
	  o Handles and knobs;
	  o Alert devices; and
	  o Lighting.
	• Clinically-appropriate modifications to:
	  o Appliances;

Service	Description
	○ Bathroom facilities; ○ Cabinets and sinks; ○ Counters; ○ Doorways (in order to widen); ○ Electrical outlets/equipment; ○ Safety devices; ○ Floors; ○ Entryways; ○ Hallways; ○ Steps/stairways; and ○ Lighting. Enrollees are eligible to receive this service if the Enrollee is 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. Enrollees are eligible for this service if they have a qualifying clinical criteria and are: • Homeless; • At-risk of homelessness; or • Meets one of the below housing insecurity definitions: ○ Requires a clinically appropriate home modification/remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs a home inspection and/or to transition to another housing option; ○ Lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition and the housing can either be modified cost effectively, or the housing cannot be modified cost-effectively and the member needs a home inspection and/or to transition to another housing option; or ○ Is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained, and the member either needs a home inspection or healthy home good, or the member needs to transition to another housing option.
One-Time	Provision of a one-time payment for an enrollee's security deposit and first

Service	Description
Payment for Security Deposit and First Month's Rent Authorized under STC 10.3(a)(i)(3) and 10.3(a)(vi)(1)	month's rent to secure affordable and safe housing for enrollees transitioning from unhealthy or unsafe housing into a new living situation or transitioning from homelessness or institutional settings to avoid homelessness. This service counts towards the six-month coverage cap on room and board services offered through HOP. The payment for a security deposit does not count against this six-month limit. As part of the assessment for HOP eligibility and service, the enrollee must work with the care manager to determine whether the living environment is unhealthy or unsafe. Individuals may only use this service once per demonstration. Allowable expenses if necessary to secure and maintain the unit include: • First month's rent • Security deposit(s) • Renter's insurance All units that enrollees move into through this HOP service must: • Pass a Housing Quality Standards (HQS) or National Standards for the Physical Inspection of Real Estate (NSPIRE) inspection. Individuals will not be required to leverage a certified inspector. • Meet fair market rent and reasonableness check • Meet a debarment check Enrollees are eligible for this service if they have a qualifying clinical criteria and are: • Homeless; • At risk of homelessness; or • Meet one of the below housing insecurity definitions and it is more cost effective to move the beneficiary and the beneficiary chooses to receive this service: o Requires a clinically appropriate home modification/remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs a home inspection and/or to transition to another housing option; o Lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition and the housing can either be modified cost effectively, or the housing cannot be modified cost-effectively and the member needs a home inspection and/or to transition to another housing option;

Service	Description
	○ Is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained, and the member either needs a home inspection or healthy home good, or the member needs to transition to another housing option; or ○ Is missing one or more monthly rent payment, and/or has received at least one lease violation that may lead to eviction and needs to transition to another housing option. 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.
Recuperative Care (i.e., Medical Respite) Authorized under STC 10.3(a)(v)(1)	Medical respite settings provide a safe and stable place for eligible individuals transitioning out of institutions, and who are at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits. This service may be offered for up to 6 months in duration once every 12 months (assessed on a rolling basis) and is intended to provide short-term residential and post-acute medical care for patients experiencing homelessness who are too ill or frail to recover from an injury or illness to recover in the community but who are not ill enough to be hospitalized. Coverage is permitted in one or more spans or episodes, as long as the total duration remains under the six-month cap for the rolling year. Additionally, this service is subject to the 6 month global cap on housing services per rolling year in combination with other housing services that include room and board (i.e., short-term post-hospitalization housing and short-term rental assistance). This setting may include full room and board, including up to three meals per person, per day. Medical respite provides a clinical environment for recuperative care. Eligible settings for medical respite: • Must have access to clinicians onsite who can provide appropriate medical and/or behavioral health care. • May not be primarily used for room and board without the necessary additional clinical support services. For example, a hotel room in a commercial hotel, where there are no medical or behavioral health supports provided onsite appropriate to the level of need, would not be considered an appropriate setting, but if a hotel had been converted to a recuperative care facility with appropriate clinical

Service	Description
	supports, then it would be an eligible setting. • Other examples of eligible settings that are compliant with STC 10.6 (c)(i) include: o Interim housing facilities with additional on-site support o Converted homes with additional on-site support o Publicly operated or contracted recuperative care facilities Enrollees are eligible to receive this service if: • Enrollee is homeless or at risk of homelessness, has recently been discharged from an institutional setting, and requires ongoing monitoring and continuous access to medical care.
Short-Term Post-Transition Housing (i.e., Short-Term Post Hospitalization Housing) Authorized under STC 10.3(a)(v)(2)	Short-term post-hospitalization housing offers a less intensive clinical environment than medical respite care. It may provide a "step-down" from medical respite care or from other institutional settings prior to a member's transition into the community. This service may be offered for up to 6 months in duration once every 12 months (assessed on a rolling basis). Coverage is permitted in one or more spans or episodes, as long as the total duration remains under the six-month cap for the rolling year or demonstration period, in combination with other housing services that include room and board (i.e., medical respite and short-term rental assistance). Eligible settings for short-term post-hospitalization housing: • Must have access to clinicians on call who can provide appropriate medical and/or behavioral health care onsite as needed. • May not be primarily used for room and board without access to the necessary additional clinical support services. For example, a hotel room in a commercial hotel, where there are no medical or behavioral health supports provided onsite appropriate to the level of need, would not be considered an appropriate setting, but if a hotel had been converted to a recuperative care facility with appropriate clinical supports, then it would be an eligible setting. • Other examples of eligible settings that are compliant with STC 10.6(c)(i) include: o Interim housing facilities with additional on-call support o Converted homes with additional on-call support o Publicly operated or contracted recuperative care facilities Enrollees are eligible to receive this service if: • Enrollee is homeless or at risk of homelessness, has recently been discharged from an institutional setting, and does not require ongoing monitoring and continuous access to medical care.
Short-Term	This service includes payment for rent and/or short-term, temporary stays for

Service	Description
Rental Assistance Authorized under STC 10.3(a)(vi)(2)	up to six months per household, per demonstration period. This service must be provided in a non-congregate setting. Allowable costs include: • Past or prospective rent payments for non-congregate settings, including: apartments, single room occupancy (SRO) units, single-family homes, multifamily homes, mobile home communities, accessory dwelling units (ADUs), co-housing communities, middle housing types, trailers, manufactured homes, and manufactured home lots; a motel or hotel room when it is serving as the member's primary residence; and transitional and recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming. • Renter's insurance if required by the lease Enrollees are eligible to receive this service if they have a qualifying clinical criteria and are: • Homeless; or • At risk of homelessness. This service is subject to a cap of 6 months per household per demonstration period. Coverage may be permitted in one or more episodes, so long as the total duration remains under the cap for the demonstration period. Additionally, this service is subject to the 6 month global cap on housing services per rolling year in combination with other housing services that include room and board (i.e., medical respite and short-term post-hospitalization housing). This service may be combined with the first month's rent as a transitional service, so long as the total number of months is below 6 months per demonstration and all costs are non-duplicative.
Utilities Costs Authorized under STC 10.3(a)(ii)	This service includes resolution of arrears related to unpaid utility bills and prospective payment of utility bills. The combination of arrears payments and prospective payments cannot exceed 6 months per beneficiary, per demonstration period. Allowable costs for this service include payments for the following utilities: • Garbage/waste management • Water • Sewage • Recycling • Gas • Electric • Internet • Phone (inclusive of land line phone service and cell phone service)

Service	Description
	Enrollees that can receive this service include individuals who have a qualifying clinical criteria, are receiving at least one other housing-related HOP service, and: • Are homeless; • Are at risk of homelessness; or • Meet the following housing insecurity definition: have utility payments in arrears or lack income for utility payments, including to restart utilities payments that have been turned off, such that the lack of utilities may negatively impact their health.

Food and Nutrition Services

Service	Description

Food and Nutrition Access Case Management Services
 	
Authorized under STC 10.3(b)(i)
	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. Food and Nutrition Access Case Managers will address more complex and specialized needs. However, if a Food and Nutrition Access Case Manager identifies an individual for whom 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.

Evidence-Based Group	This service covers the provision of an evidence-based or evidence-informed nutrition related course to a group of individuals. The purpose of

Service	Description
Nutrition Class Authorized under STC 10.3(b)(ii)	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 will choose an evidence-based curriculum. For curricula not outlined by the Department, an organization must follow an evidence-based curricula that is approved by the Department, in consultation with the Network Lead and HOP Administrator. Enrollees are eligible to receive this service if they have a nutrition sensitive condition.
Fruit and Vegetable Prescription Authorized under STC 10.3(b)(iv)	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. This service is available for up to 6 months. This intervention may be renewed for additional 6-month periods if it is determined the beneficiary still meets the qualifying health-related and social-risk factors. Enrollees are eligible to receive this service if they have a nutrition sensitive condition. Individuals who receive fruit and vegetable prescriptions cannot concurrently receive healthy meals or medically tailored meals.
Healthy Food Box (For Pick-Up) Authorized	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 is available for up to 3 meals a day, for

Service	Description
under STC 10.3(b)(iv)	up to 6 months. This intervention may be renewed for additional 6-month periods if it is determined the beneficiary still meets the qualifying health-related and social-risk factors. 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. Enrollees are eligible to receive this service if they have a nutrition sensitive condition. Individuals who receive healthy food boxes cannot concurrently receive healthy meals or medically tailored meals.
Healthy Food Box (Home Delivered) Authorized under STC 10.3(b)(iv)	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 is available for up to 3 meals a day, for up to 6 months. This intervention may be renewed for additional 6-month periods if the determines the beneficiary still meets the qualifying health-related and social risk factors. Healthy food boxes should be provided alongside nutrition education materials related to topics including but not limited to healthy eating and cooking instructions. Enrollees are eligible to receive this service if: • 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 nutrition sensitive condition. Individuals who receive healthy food boxes cannot concurrently receive healthy meals or medically tailored meals.
Healthy Meal (For Pick-Up) Authorized under STC 10.3(b)(iii)	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

Service	Description
	Medicine of the National Academy of Sciences[18] 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.[19] Meals may be tailored to meet cultural preferences and specific medical needs. This service is available for up to 3 meals a day, for up to 6 months. This intervention may be renewed for additional 6-month periods if the determines the beneficiary still meets the qualifying health-related and social risk factors. Enrollees are eligible to receive this service if: • Enrollee does not have capacity to shop and cook for self or have adequate social support to meet these needs. • Enrollee has a nutrition sensitive condition. Individuals who receive healthy meals cannot concurrently receive medically tailored meals, fruit and vegetable prescriptions, or healthy food boxes.
Healthy Meal (Home Delivered) Authorized under STC 10.3(b)(iii)	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[20] 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.[21] Meals may be tailored to meet cultural preferences and specific medical needs. This service is available for up to 3 meals a day, for up to 6 months. This intervention may be renewed for additional 6-month periods if the determines the beneficiary still meets the qualifying health-related and social risk factors. Enrollees are eligible to receive this service if: • Enrollee does not have capacity to shop and cook for self or have

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

[19] Most recent version of the Dietary Guidelines for Americans is available at: https://www.dietaryguidelines.gov/resources/2020-2025-dietary-guidelines-online-materials

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

[21] Most recent version of the Dietary Guidelines for Americans is available at: https://www.dietaryguidelines.gov/resources/2020-2025-dietary-guidelines-online-materials

Service	Description
	adequate social support to meet these needs. • Enrollee has a nutrition sensitive condition. Individuals who receive healthy meals cannot concurrently receive medically tailored meals, fruit and vegetable prescriptions, or healthy food boxes.
Medically Tailored Home Delivered Meal Authorized under STC 10.3(b)(iii)	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. Meals must be in accordance with nutritional guidelines established by the National Food Is Medicine Coalition (FIMC) or other appropriate guidelines.[22] 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 widely recognized nutrition guidelines approved by the Network Lead. This service is available for up to 3 meals a day, for up to 6 months. This intervention may be renewed for additional 6-month periods if the determines the beneficiary still meets the qualifying health-related and social risk factors. Enrollees are eligible to receive this service if: • 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. Individuals who receive medically tailored home delivered meals cannot concurrently receive healthy meals, fruit and vegetable prescriptions or healthy food boxes.

5. Availability of HRSN Services Under HOP

a. The Department is permitted to expand or narrow the member eligibility criteria and HRSN services offered under HOP, within those outlined in this protocol.

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

b. Up-to-date member eligibility criteria and allowable HRSN services must be publicly available on both the Department's website and on each HOP Administrator's website. Changes to member eligibility criteria and HRSN service offerings must be posted online at least 10 calendar days prior to their effective date.
c. In accordance with 42 CFR 438.404, HOP Administrators must give members advance notice of at least 10 calendar days prior to any reduction, suspension, or termination of a previously authorized HRSN service.
d. The following parameters will be followed for changes to member eligibility criteria:
    i. Changes to member eligibility criteria may only be made by the Department, not HOP Administrators.
    ii. The Department may choose to change the qualifying health criteria and/or the qualifying social risk factor for one or more specific HRSN services, or across all HRSN services.
e. Changes to member eligibility criteria will apply to all members in a delivery system. The Department may implement different eligibility criteria by delivery system. Such changes must be reflected in Appendix 1 of this Protocol in accordance with STC 10.12. The following parameters will be followed for changes to allowable HRSN services:
    i. Changes to allowable HRSN services may be made by the Department or by HOP Administrators, within parameters set by the Department. Changes made by the Department will be made by updating Appendix 1 and will supersede changes made by HOP Administrators. Changes made by HOP Administrators will proceed as follows.
    ii. The Department will maintain a publicly available "tiered" version of the active HRSN services list, which will align with Appendix 1 of this protocol. This tiered list will provide guidance to HOP Administrators on how to scale back services should they meet the conditions described in (iv) below.
    iii. Each HOP Administrator will be assigned an HRSN service spending projection for a state-specified period of time (the "assessment period"), based on factors such as enrollment and member acuity. HOP Administrators must monitor their HRSN service spending in comparison to their spending projection.
    iv. HOP Administrators will be required to cover all services on the tiered list. If a HOP Administrator has reached a monitoring threshold established by the state (to be no greater than 70% of its spending projection) and anticipates exceeding its spending projection before the end of its assessment period, the HOP Administrator may request approval from the Department to receive more HOP funding, if available under the federal/state budget for HOP. If additional federal/state funding for HOP is not available, the HOP Administrator may request to narrow its HRSN service offerings for the remainder of its assessment period. In such cases, this request must follow the order of HRSN services on the Department's tiered list, with lower tiered services being scaled back before higher tiered services.
    v. If approved by the Department, the HOP Administrator may narrow its HRSN service offerings as outlined in its approved request. These changes must be

reflected in Appendix 1 of this Protocol in accordance with STC 10.12. When narrowing its service offerings, HOP Administrators must follow the online posting and member notice requirements described above.

6. HSO Provider Qualifications for HRSN Services Under HOP

a. All providers of HRSN services under HOP (Human Services Organizations or "HSOs") are expected to meet certain qualifications that ensure they are capable of providing high-quality services to qualifying members as well as have culturally specific expertise to connect with members.
b. Service providers will be required to meet minimum qualifications to provide HRSN services under HOP. Network Leads assess potential HSOs to serve as HRSN providers in their HOP networks and to ensure they are qualified to participate. Provider qualifications include, for example:
    i. Demonstrate the capacity or the experience to provide HRSN services or closely related services;
    ii. Demonstrate a readiness to participate in HOP as an HRSN Provider and serve individuals with qualifying physical, behavioral and social needs;
    iii. Maintain a physical presence in North Carolina, with one or more offices located in or serving the HOP Region for the term of the contract;
    iv. Demonstrate strong community relationships, as determined by the Network Lead;
    v. Demonstrate a history of serving Medicaid beneficiaries in the community;
    vi. The ability to receive referrals through NCCARE360, a Department standardized platform, and to close the loop on referrals by reporting service delivery outcomes;
    vii. The ability to submit invoices for HRSN services using standardized processes;
    viii. Demonstrate the hours of operation and staffing are sufficient to serve needs of HOP participants;
    ix. Demonstrate cultural competency, as defined by the Department;
    x. Demonstrate non-discriminatory practices;
    xi. Attested willingness to serve all HOP participants referred to the organization in accordance with its capacity constraints and contract with the Network Lead;
    xii. Business licensing or accreditation that meets industry standards, if required to provide the service to HOP participants;
    xiii. Demonstrated history of responsible financial stewardship and integrity. In a case where an organization is new or does not have a recent audit or other mechanism for demonstrating financial stewardship, the organization must demonstrate the capacity to develop responsible financial stewardship and integrity;
    xiv. Capability to comply with all reporting and oversight requirements; and,
    xv. Agree to not use HOP funds to refinance or displace activities already in process or performed by the HSO.

7. Member Identification and Assessment of Service Need

a. Identifying Potentially Eligible Members

i. The Department will ensure individuals can be identified for HRSN services through a no-wrong-door approach as described below.

ii. At a minimum, the Department will require HOP Administrators to utilize the following pathways to identify members that may be potentially eligible for HRSN services under HOP:

1. Proactive identification of potentially HOP-eligible members through data mining and other strategies available to the HOP Administrator
2. Referral by a care manager or other member of a care team
3. Referral by a health care provider
4. Referral by an HSO (HOP-participating or non-HOP-participating)
5. Self/family referral by individuals

iii. Upon identification of an individual who is potentially eligible for HOP HRSN services, that individual will be assessed for eligibility and needed services.

b. HOP Eligibility and Service Assessments

i. In order to receive HOP HRSN services, individuals must be assessed for their qualifying clinical and social risk factors and which HOP HRSN services will best meet their needs.

ii. HOP Administrators and other members of the individual's HOP care team will assess individuals for eligibility and needed services.

iii. The assessment should assess and document the following related to eligibility and needed services:

1. Member contact information;
2. Physical and social risk factors supporting eligibility;
3. Recommended service or services;
4. Service-specific eligibility criteria for recommended services; and,
5. Required documentation for specific services (as needed).

iv. The results of the assessment must be documented, reviewed and authorized by the HOP Administrator (see below).

c. HOP Eligibility Determination, Service Authorization and Enrollment

i. The HOP Administrator will review all eligibility and service assessments and determine eligibility, authorize services, and document enrollment.

ii. Once the HOP Administrator has all the required information, they will undertake the following steps to determine a member eligible and authorize them to receive HOP HRSN services:

1. Verify enrollment in Medicaid, based on information provided.
2. Verify that the individual meets at least one qualifying clinical and social risk factor.
3. Review the HOP HRSN service(s) the individual is recommended to receive.
4. Ensure individual is not enrolled in other duplicative programs or services.

5. Seek consent from the beneficiary to receive HOP services.

iii. If the HOP Administrator is missing any information related to eligibility determination/service authorization, they must work with the appropriate organization (e.g., care management entity, HSO, member) to obtain it.

iv. The HOP Administrator must consider someone enrolled once:
    1. The member has been found to be eligible for HOP, and,
    2. The member has been authorized for at least one HOP service.

v. The HOP Administrator must keep a record of HOP enrollment.

vi. The HOP Administrator will be required to notify an individual of approval or denial of a service and provide information about grievance, appeals and state fair hearing rights. Individuals who are denied HRSN Services or are authorized for HRSN Services but such authorization is limited in scope, amount, or duration, have grievance and appeals rights. The Department and its HOP Administrators will ensure these processes are implemented by the end of year two of this demonstration period.

d. Referral to Authorized HOP HRSN Services

i. Upon notification of service authorization and eligibility determination, the individual will be referred to an HSO(s) that will provide authorized HOP HRSN services. The referral may be made by the HOP Administrator or another member of the individual's HOP care team (e.g., a care coordinator).

ii. The referral must consider and support the individual's preference for specific HSOs.

iii. The entity generating the referral must track the status to ensure that an HSO 1) accepts the referral and 2) that HOP HRSN service delivery is initiated.

iv. All HOP service referrals must be "closed-loop" referrals, in which the outcome of the referral is communicated back to the HOP Administrator or HOP care team.

e. Care Planning for HOP HRSN

i. Care planning for HOP HRSN services will include, at a minimum:
    1. Developing a HOP-specific care plan that is reviewed at least annually, or more frequently if required for the particular service, or when the individual's needs change significantly. This review process may include the following activities, based on the member's needs:
        a. Understanding if HOP services are meeting the individual's needs;
        b. Identifying whether additional/new services are needed;
        c. Confirming the individual is still eligible for HOP; and,
        d. Determining whether HOP HRSN services are duplicating other services they are receiving.
    2. Coordinating with the HSO(s) delivering the individual's services, as needed.

f. Disenrollment from HOP HRSN Services

i. An individual will be disenrolled from HOP when any of the following reasons apply:

1. The individual is no longer enrolled in Medicaid.
2. The individual's needs have been met.
3. The individual no longer meets HOP HRSN eligibility criteria.
4. The individual requests to be disenrolled from the program.

8. Conflicts of Interest for HOP HRSN Services

a. To protect against conflict of interest and ensure compliance with conflict of interest standards, the Department will require that the HOP Administrator perform the service authorization function and prohibit the subcontracting of such functions where that would result in a single entity conducting the assessment, service planning, and service provision, except as provided below, or otherwise approved by the Department.

b. Assessment, service planning, and service provision for select services may be provided by the same entity, subject to approval by the Department and in line with CMS conflicts of interest regulations at 42 CFR 441.301(c)(1)(vi), to ensure that assessment, service planning, and service provision are performed in a manner that guards against conflicts of interest in accordance with all applicable requirements.

9. Avoiding Duplication/Displacement of Existing Food Assistance Nutrition Services

a. As required in STC 10.11(f), the Department is committed to avoiding the duplication / displacement of the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). HOP seeks to complement and enhance enrollment in those programs through the following strategies:
    i. If eligible, HOP enrollees should be enrolled in SNAP, WIC, and/or Older Americans Act Nutrition Services, have an application in progress, or have been recently denied in order to receive HOP nutrition supports.
    ii. HSOs will work with HOP enrollees receiving food services to 1) ensure they are meeting their needs and 2) avoid waste and/or misallocation. HSOs will adjust the amount of food assistance provided through HOP as necessary to meet those goals.

10. Enhanced Monitoring Requirements

a. As required in STC 10.10(f), the Department affirms that it will meet the enhanced monitoring and evaluation requirements stipulated in STC 15.5 and 16.6 which require the state to monitor and evaluate how the renewals of recurring nutrition services in STC 10.3(b)(iii and iv) affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services.

Appendix 1: Active HOP HRSN Service Coverage and Eligibility Criteria

The state will provide services to the eligible populations outlined in *Attachment L: 2022-2024 Healthy Opportunities Pilot Program Eligibility and Services* through the end of Demonstration Year (DY) 7. The table below outlines the HRSN services and eligibility criteria that the state will cover in DY8. This Appendix can be updated at any time, with notification to CMS as detailed in STC 10.12, to include any subset of the HRSN services and eligibility criteria outlined in Attachment L (in DY7 only) and Sections 1 through 4 of this Protocol, and to include additional regions of the state or new delivery systems.

Applicable Geography	Applicable HOP Administrators	Program Feature	Program Coverage Details
• **Impact Health Region:** Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey County • **Community Care of the Lower Cape Fear Region:** Bladen, Brunswick, Columbus, New Hanover, Onslow, and Pender County • **Access East Region:** Beaufort,	• Standard Plans • Tailored Plans • Prepaid Inpatient Health Plans (PIHPs) • Eastern Band of Cherokee Indians (EBCI) Tribal Option • Children and Families Specialty Plan	**Covered Services**	• Housing Navigation, Support, and Sustaining Services • Inspection for Housing Safety and Quality • Housing Move-In Supports • Essential Utilities Set-Up • Home Remediation Services • Healthy Home Goods • Home Accessibility and Safety Modifications • One-Time Payment for Security Deposit and First Month's Rent • Recuperative Care (i.e., Medical Respite) • Short-Term Post-Transition Housing • Food and Nutrition Access Case Management Services • Evidence-Based Group Nutrition Classes • Fruit and Vegetable Prescriptions • Healthy Food Boxes (For Pick-Up) • Healthy Food Boxes (Home-Delivered) • Healthy Meals (For Pick-Up) • Healthy Meals (Home-Delivered) • Medically Tailored Home-Delivered Meals
		Qualifying Health Criteria	For individuals ages 21+, at least one of the following: • 2 or more chronic conditions

Applicable Geography	Applicable HOP Administrators	Program Feature	Program Coverage Details
Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, and Pitt County			• Repeated incidents of emergency department use or hospital admissions (defined as more than four visits per year) For pregnant individuals, at least one of the following: • Multifetal gestation • Chronic condition likely to complicate pregnancy • Current or recent (month prior to learning of pregnancy) use of drugs or heavy alcohol • Adolescence ≤ 15 years of age • Advanced maternal age ≥ 40 years of age • Less than one year since last delivery • History of a poor birth outcome including preterm birth, low birth weight, fetal death, or neonatal death For children ages 0 through 3, at least one of the following: • Neonatal intensive care unit graduate • Neonatal Abstinence Syndrome • Prematurity defined by birth occurring at or before 36 completed weeks gestation • Low birth weight defined as weighing less than 2500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit For children ages 0 through 20, at least one of the following: • One or more significant uncontrolled chronic conditions or one or more controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need • A health condition, including a behavioral health or developmental syndrome, stemming from trauma, child abuse, or neglect For individuals under the age of 26 who were previously placed in North Carolina's foster care or kinship placement system and/or formerly justice-involved:

Applicable Geography	Applicable HOP Administrators	Program Feature	Program Coverage Details
			• A health condition, including a behavioral health or developmental syndrome, stemming from trauma, child abuse, and neglect
		Qualifying Social Risk Factors	• Homelessness • At risk of homelessness • Housing insecurity • Food insecurity
Statewide Expansion Counties: Alamance, Alexander, Alleghany, Anson, Ashe, Cabarrus, Caldwell, Camden, Carteret, Caswell, Catawba, Chatham, Cleveland, Craven, Cumberland, Currituck, Dare, Davidson, Davie, Duplin, Durham, Forsyth, Franklin, Gaston, Gate, Granville, Greene, Guilford, Harnett, Hoke, Hyde, Iredell, Johnston, Jones, Lee, Lenoir, Lincoln, Mecklenburg, Montgomery, Moore, Nash, Orange, Pamlico, Pasquotank, Perquimans, Person, Randolph, Richmond,	No participation in DY8	**Covered Services**	Not covered in DY8
		Qualifying Health Criteria	Not covered in DY8
		Qualifying Social Risk Factors	Not covered in DY8

Applicable Geography	Applicable HOP Administrators	Program Feature	Program Coverage Details
Robeson, Rockingham, Rowan, Sampson, Scotland, Stanly, Stokes, Surry, Tyrrell, Union, Vance, Wake, Warren, Washington, Watauga, Wayne, Wilkes, Wilson, and Yadkin			

Attachment N: Additional HOP Non-HRSN Services Protocol

Additional HOP Non-HRSN Services Protocol: In accordance with the Special Terms and Conditions (STCs) of the state's Section 1115 Demonstration, this Protocol provides additional detail on the requirements for the delivery of services for non-Health-Related Social Needs (non-HRSN) services as part of the Healthy Opportunities Pilots (HOP) program, as specifically required by STC 10.12. The state has the discretion to choose which services and eligibility criteria to cover within what is permissible under this Protocol, as further outlined in Section 5.

Appendix 1 indicates the non-HRSN services and eligibility criteria the state intends to cover within what is permissible under this Protocol. Appendix 1 can be updated at any time, with notification to CMS as detailed in STC 10.12, to include any subset of the non-HRSN services and eligibility criteria outlined in Attachment L: 2022-2024 Healthy Opportunities Pilot Program Eligibility and Services (in DY7 only) and Sections 1 through 4 of this Protocol, and to include additional regions of the state or new delivery systems. Changes to Appendix 1 do not require CMS approval, but require notification to CMS consistent with STC 10.12.

1. Member Eligibility

a. HOP non-HRSN services are intended to be used by Medicaid enrollees who can benefit most from them, to maximize the benefit of limited HOP funding. Receipt of HOP services is always at the option of the HOP enrollee, including when the HOP enrollee has a choice between multiple cost-effective services to address the same need.
b. The following qualifying criteria for HOP non-HRSN services take into account a person's health status (including both physical and behavioral health) and unmet, non-medical needs.
c. To ensure that services are medically appropriate, the North Carolina Department of Health and Human Services (the Department) will require that individuals identified as in need of HOP non-HRSN services meet the following clinical and social risk criteria. To qualify for a HOP non-HRSN service, a member must:
    i. Have at least one HOP non-HRSN qualifying health criteria (described below);
    ii. Have at least one HOP non-HRSN qualifying social risk factor (described below); and
    iii. Meet any additional eligibility criteria and requirements that apply in connection with the specific HOP non-HRSN service.
d. The Department will maintain the qualifying health criteria and social risk criteria for HOP non-HRSN services on a public facing Department webpage. The content will be updated if the criteria are changed.
    i. The Department's process for changing service offerings and eligibility for non-HRSN services is described below under "Availability of Non-HRSN Services Under HOP."
    ii. The Department has discretion to adjust which services and eligibility criteria are covered under HOP, based on readiness and following the process and

transparency requirements defined under "Availability of Non-HRSN Services Under HOP." The Department must notify CMS via the process identified in STC 10.12 when changing which services and eligibility criteria it covers within what is permissible under this Protocol.

2. HOP Non-HRSN Qualifying Health Criteria

In order to receive non-HRSN services through HOP, members must meet at least one of the qualifying health criteria listed below.

Table 1: Non-HRSN Qualifying Health Criteria

Eligibility Group	Non-HRSN Qualifying Health Criteria
Adults (21+)	• One or more chronic condition • Meets the clinical eligibility criteria for Tailored Care Management[23] • Repeated incidents of emergency department use (defined as more than two visits per six months) or hospital admissions • Experiencing or previously experienced interpersonal violence (IPV) • Children under the age of 21 with a health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, or neglect • Individuals under the age of 26 who were 1) previously placed in North Carolina's foster care or kinship placement system, and/or 2) formerly justice-involved with a health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect • Pregnancy
Children (0 – 20)	
Children (0 – 3)	• Neonatal intensive care unit graduate • Neonatal Abstinence Syndrome • Prematurity, defined by births that occur at or before 36 completed weeks gestation • Low birth weight, defined as weighing less than 2500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit

3. HOP Non-HRSN Qualifying Social Risk Factors

In order to receive HOP non-HRSN services, members must meet at least one of the qualifying social risk factors listed below. All qualifying social risk factors must be included in the individual's care plan.

[23]Individuals are eligible for Tailored Care Management if they have one serious and persistent mental health condition, I/DD, TBI, or severe substance use disorder, as defined further in North Carolina's approved SPA.

Table 1: Non-HRSN Qualifying Social Risk Factors

Domain/Service	Non-HRSN Qualifying Social Risk Factors
Interpersonal Violence/Toxic Stress	Individual is at risk of, witnessing, or experiencing interpersonal violence and/or toxic stress, as defined based on the principles in the questions used to establish interpersonal violence in the Accountable Health Communities Health Related Screening Tool or the North Carolina SDOH screening tool.
Diabetes Prevention Program	Individual is eligible for (see service-level eligibility criteria below) and would benefit from participation in the CDC-recognized Diabetes Prevention Program to avoid or delay onset of diabetes.
Holistic High Intensity Enhanced Case Management	Individual has co-occurring social risk factors requiring intensive case management, defined as at least two of the following: • Housing social risk factor(s), as defined in Attachment M; and/or, • Nutrition social risk factor, as defined in Attachment M; and/or, • Is at risk of, witnessing, or experiencing interpersonal violence as described above.
Linkages to Health-Related Legal Supports	Individual requires assistance in accessing supports to assess legal issues and has one of the following social risk factors: • Housing social risk factor(s), as defined in Attachment M; and/or, • Nutrition social risk factor, as defined in Attachment M; and/or, • Is at risk of, witnessing, or experiencing interpersonal violence as described above.
Non-Medical Transportation (NMT) & Non-Emergency Medical Transportation (NEMT) Need	Individual has been authorized for any other HOP service (HRSN or non-HRSN) and requires transportation to access that service.

4. Non-HRSN Services

The state will cover a set of non-HRSN services through HOP, as defined below:

Table 2: HOP Non-HRSN Service Definitions

Interpersonal Violence/Toxic Stress Services	
Service	**Description**
Interpersonal Violence (IPV) Case Management Services Authorized	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

Service	Description
under STC 10.5(a)(i)	• Linkages to childcare 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 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 Activities listed above may occur without the HOP 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 Network Lead can facilitate partnerships of this kind. Enrollees are eligible to receive this service if the enrollee requires ongoing engagement.[24]
Violence Intervention Services Authorized under STC 10.5(a)(ii)	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. • Informal or peer counseling and advocacy related to enrollees' needs and concerns. These may include accompanying the recipient

[24] 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.

Service	Description
	to appointments, providing support during periods of anxiety or emotional distress, or encouraging constructive parenting activities and self-care. 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 HOP enrollee present. This service should be informed by an evidence-based program such as (but not limited to) Cure Violence.
Evidence-Based Parenting Classes Authorized under STC 10.5(a)(iii)	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 should be delivered in a trauma-informed, developmentally appropriate, and culturally relevant manner.
Home Visiting Services Authorized under STC 10.5(a)(iv)	Home Visiting services are meant to provide: • One-on-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 should be delivered in a trauma-informed, developmentally appropriate, and culturally relevant manner.

Other HOP Non-HRSN Services

Service	Description
Diabetes	Provision of the Center for Disease and Control (CDC)-recognized

Service	Description

Prevention Program
 	
Authorized under STC 10.5(b)
	"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.[25]
	
	HOP enrollees are eligible to receive this service if:
	• Enrollee is 18 years of age or older,
	• Enrollee has a BMI ≥ 25 (≥23 if Asian),
	• Enrollee is not pregnant at the time of enrollment,
	• Enrollee does not have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment, and
	• Enrollee has 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"[26]

Holistic High Intensity Enhanced Case Management Authorized under STC 10.5(c)	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 food insecurities. Activities may include those outlined in the following three service definitions: • Housing Navigation, Support and Sustaining Services *(available in Attachment M)* • Food and Nutrition Access Case Management Services *(available in Attachment M)* • IPV Case Management Services *(described above)* Some activities listed above may occur without the HOP enrollee present.
Linkages to Health-Related Legal Supports Authorized	This service will provide qualifying individuals with assistance in accessing supports to assess legal issues in the housing, nutrition and interpersonal violence/toxic stress service domains. Assistance includes support to help beneficiaries understand their rights and connect them to legal resources and tools that support resolution of the issue provided by

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

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

Service	Description
under STC 10.5(d)	individuals with legal expertise. This service is limited to covering the following activities: • Assessing a beneficiary 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, and/or address other legal needs related to the nutrition domain and services, including by reviewing information such as specific facts, documents (e.g., leases, notices, and letters, nutrition-related public assistance program application and policies), laws, and programmatic rules (e.g., SNAP, WIC, school meal programs) relevant to a beneficiary's current or potential legal problem. • Helping beneficiaries understand their legal rights related to maintaining healthy and safe housing and/or mitigating or eliminating exposure to interpersonal violence or toxic stress or address other legal needs related to the nutrition domain and services (e.g., explaining rights related to landlord/tenant disputes, explaining the purpose of an order of protection and the process for obtaining one, explaining appeals rights related to accessing nutrition-related public benefit assistance programs). • Identifying potential legal resources, tools and strategies that may help a beneficiary to secure or maintain healthy and safe housing, mitigate or eliminate exposure to interpersonal violence or toxic stress, and/or address other legal needs related to the nutrition domain and services (e.g., providing self-advocacy instructions, connecting with resources to remove a former partner's debts from credit rating, providing information on fair hearing processes or guidance on submitting appeals for wrongful denial from nutrition-related public assistance programs such as SNAP or WIC). This service does not include legal representation, such as making contact with, drafting communication to, or negotiating with a beneficiary's potential adverse party (e.g., landlord, abuser, creditor, or employer) or representing a beneficiary in litigation, administrative proceedings, or alternative dispute resolution proceedings. In addition, this service does not include drafting or preparing any pro se documentation.
Non-Medical and Non-Emergency Medical Transportation to HOP	Provision of non-medical transportation to and from HOP HRSN services and Holistic High Intensity Enhanced Case Management and non-emergency medical transportation to and from other HOP non-HRSN services (i.e. IPV services and the Diabetes Prevention Program) for HOP enrollees that have been authorized for one or more of these HOP services and require transportation to that service. Allowable transportation services

Service	Description
Services Authorized under STC 10.5(e) and STC 10.5(f)	include: • Reimbursement for public transportation options (e.g., bus passes) • 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) This service may only be furnished to transport HOP enrollees to and from all authorized HOP HRSN[27] and non-HRSN services except for Linkages to Health-Related Legal Supports. This service must be documented in the member's care plan. Beneficiaries are not reimbursed/paid directly for the above transportation. Payments flow through a financial mediary or directly from a HOP Administrator to a designated provider of the service.

5. Availability of Non-HRSN Services Under HOP

The Department is permitted to expand or narrow member eligibility criteria for HOP non-HRSN services within the parameters approved in this Attachment. The Department will follow all requirements in Section 5 of Attachment M related to this process. The tiered list of services described in Section 5 of Attachment M will be inclusive of non-HRSN services, and the service spending projections assigned to each HOP Administrator will account for both HRSN and non-HRSN service utilization.

6. HSO Provider Qualifications for Non-HRSN Services Under HOP

All providers of non-HRSN services under HOP (Human Services Organizations or "HSOs") are expected to meet certain qualifications that ensure they are capable of providing high-quality services to qualifying members as well as have culturally specific expertise to connect with members.

The Department will utilize the same provider qualifications for HOP non-HRSN services as those outlined for HRSN services in Section 6 of Attachment M.

[27]Transport to and from authorized HOP HRSN services must be provided in alignment with the technical specifications, and safeguards required for non-medical transportation authorized under 1915(c) waiver or under 1915(i) state plan authorities.

7. Member Identification and Assessment of Service Need for HOP Non-HRSN Services

The Department will follow the same process for identifying members, assessing their needs and connecting them to HOP non-HRSN services as those outlined for HRSN services in Section 7 of Attachment M.

8. Conflicts of Interest for HOP Non-HRSN Services

The Department will follow the same conflict of interest requirements for HOP non-HRSN services as those outlined for HRSN services in Section 8 of Attachment M.

Appendix 1: Active HOP Non-HRSN Service Coverage and Eligibility Criteria

The state will provide services to the eligible populations outlined in *Attachment L: 2022-2024 Healthy Opportunities Pilot Program Eligibility and Services* through the end of Demonstration Year (DY) 7. The table below outlines the non-HRSN services and eligibility criteria that the state will cover in DY8. This Appendix can be updated at any time, with notification to CMS as detailed in STC 10.12, to include any subset of the non-HRSN services and eligibility criteria outlined in Attachment L (in DY7 only) and Sections 1 through 4 of this Protocol, and to include additional regions of the state or new delivery systems.

Applicable Geography	Applicable HOP Administrators	Program Feature	Program Coverage Details
• **Impact Health Region:** Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey County • **Community Care of the Lower Cape Fear Region:** Bladen, Brunswick, Columbus, New Hanover, Onslow, and Pender County • **Access East Region:** Beaufort,	• Standard Plans • Tailored Plans • Prepaid Inpatient Health Plans (PIHPs) • Eastern Band of Cherokee Indians (EBCI) Tribal Option • Children and Families Specialty Plan	**Covered Services**	• Interpersonal Violence (IPV) Case Management Services • Violence Intervention Services • Evidence-Based Parenting Classes • Home Visiting Services • Diabetes Prevention Program • Holistic High Intensity Enhanced Case Management • Linkages to Health-Related Legal Supports • Reimbursement for NMT and NEMT
		Qualifying Health Criteria	For individuals ages 21+, at least one of the following: • 2 or more chronic conditions • Repeated incidents of emergency department use or hospital admissions (defined as more than four visits per year) For pregnant individuals, at least one of the following: • Multifetal gestation • Chronic condition likely to complicate pregnancy • Current or recent (month prior to learning of pregnancy) use of drugs or heavy alcohol • Adolescence ≤ 15 years of age • Advanced maternal age ≥ 40 years of age • Less than one year since last delivery • History of a poor birth outcome including preterm birth, low birth weight, fetal death, or neonatal death

Applicable Geography	Applicable HOP Administrators	Program Feature	Program Coverage Details
Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, and Pitt County			For children ages 0 through 3, at least one of the following: • Neonatal intensive care unit graduate • Neonatal Abstinence Syndrome • Prematurity defined by birth occurring at or before 36 completed weeks gestation • Low birth weight defined as weighing less than 2500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit For children ages 0 through 20, at least one of the following: • One or more significant uncontrolled chronic conditions or one or more controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need • A health condition, including a behavioral health or developmental syndrome, stemming from trauma, child abuse, or neglect For individuals under the age of 26 who were previously placed in North Carolina's foster care or kinship placement system and/or formerly justice-involved: • A health condition, including a behavioral health or developmental syndrome, stemming from trauma, child abuse, and neglect
		Qualifying Social Risk Factors	• Individual is at risk of, witnessing, or experiencing interpersonal violence and/or toxic stress, as defined based on the principles in the questions used to establish interpersonal violence in the Accountable Health Communities Health Related Screening Tool or the North Carolina SDOH screening tool. • Individual is eligible for and would benefit from participation in the CDC-recognized Diabetes Prevention Program to avoid or delay onset of diabetes.

Applicable Geography	Applicable HOP Administrators	Program Feature	Program Coverage Details

			• Individual has co-occurring social risk factors requiring intensive case management, defined as at least two of the following:
			  ○ Housing social risk factor(s), as defined in Attachment M; and/or,
			  ○ Nutrition social risk factor, as defined in Attachment M; and/or,
			  ○ Is at risk of, witnessing, or experiencing interpersonal violence as described above.
			• Individual requires assistance in accessing supports to assess legal issues in the housing, nutrition, and/or interpersonal violence/toxic stress service domains.
			• Individual has been authorized for any other HOP service (HRSN or non-HRSN) and requires transportation to access that service.

Statewide Expansion Counties: Alamance, Alexander, Alleghany, Anson, Ashe, Cabarrus, Caldwell, Camden, Carteret, Caswell, Catawba, Chatham, Cleveland, Craven, Cumberland, Currituck, Dare, Davidson, Davie, Duplin, Durham, Forsyth, Franklin, Gaston, Gate, Granville, Greene, Guilford, Harnett, Hoke, Hyde, Iredell,	No participation in DY8	**Covered Services**	Not covered in DY8
		Qualifying Health Criteria	Not covered in DY8
		Qualifying Social Risk Factors	Not covered in DY8

Applicable Geography	Applicable HOP Administrators	Program Feature	Program Coverage Details
Johnston, Jones, Lee, Lenoir, Lincoln, Mecklenburg, Montgomery, Moore, Nash, Orange, Pamlico, Pasquotank, Perquimans, Person, Randolph, Richmond, Robeson, Rockingham, Rowan, Sampson, Scotland, Stanly, Stokes, Surry, Tyrrell, Union, Vance, Wake, Warren, Washington, Watauga, Wayne, Wilkes, Wilson, and Yadkin			

ATTACHMENT O

HRSN Service Matrix

Attachment O - HOP HRSN Services Matrix

HOP Service Domains	HOP HRSN Services	HOP Eligibility Criteria: Individuals must have a co-occurring, qualifying "Clinical Criteria" and "Social Risk Factor"									
		Clinical Criteria *(see tab titled "All HOP Clinical Criteria" for specific conditions)*		**Social Risk Factors** *See tab titled "HOP HRSN Social Risk Factors" for Specific Definitions*							
		Adults 21+/ Children 0-20	Children 0-3	Homelessness or At-Risk of Homelessness	HI #1	HI #2	HI #3	HI #4	HI #5	HI #6	Food Insecurity
Housing/Home Environment interventions without room and board	Housing navigation and tenancy support*	X	X	X	X	X	X	X	X	X	
	Case management for housing	X	X	X	X	X	X	X	X	X	
	One-time transition and moving costs other than rent	X	X	X	X	X	X	X			
	Utility assistance	X	X	X					X		
	Medically necessary home remediation services	X	X	X	X		X				
	Home/environmental accessibility modifications	X	X	X	X	X	X				
Housing interventions with room and board (rent only interventions)	Short-term rental assistance	X	X	X							
	First month's rent, as a transitional service	X	X	X	X	X	X	X			
Housing interventions with room and board (episodic interventions)	Short-term recuperative care (also referred to as medical respite)	X	X	X							
	Short-term post-transition housing (also referred to as post-hospitalization housing)	X	X	X							
Nutrition interventions without food	Case management services for access to food/nutrition	X	X								X
	Nutrition counseling and instruction	X	X								X
Nutrition interventions with food	Home Delivered Meals	X	X								X
	Medically tailored meals	X	X								X
	Nutrition prescriptions	X	X								X

*Includes Housing transition and navigation services, Pre-tenancy navigation services, and Tenancy sustaining services

Attachment O - HOP HRSN Social Risk Factors

Categories	Specific Eligibility Criteria
Homeless	As defined by the US Department of Housing and Urban Development (HUD) in 24 CFR 91.5
At-Risk of Homelessness	Components of the US Department of Housing and Urban Development (HUD) in 24 CFR 91.5 with a modification to 2c, to expand the eviction notice from 21 days to 31 days. 1. Does not have sufficient resources or support networks, (e.g., family, friends, faith-based or other social networks), immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "homeless" definition in this section; and 2. Meets one of the following conditions: a. Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance; b. Is living in the home of another because of economic hardship; c. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 31 days after the date of application for assistance; d. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by Federal, State, or local government programs for low-income individuals; e. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 persons reside per room, as defined by the U.S. Census Bureau; f. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or g. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness.
Housing Insecure #1	An individual or family who requires a clinically appropriate home modification/ remediation service and the housing can either be modified or remediated cost-effectively, or the housing cannot be modified or remediated cost-effectively and the member needs a home inspection and/or to transition to another housing option.
Housing Insecure #2	An individual or family who lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition and the housing can either be modified cost effectively, or the housing cannot be modified cost-effectively and the member needs a home inspection and/or to transition to another housing option.
Housing Insecure #3	An individual or family who is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained, and the member either needs a home inspection or healthy home good, or the member needs to transition to another housing option.
Housing Insecure #4	An individual or family who is missing one or more monthly rent payment, and/or has received at least one lease violation that may lead to eviction and needs to transition to another housing option.
Housing Insecure #5	An individual or family who has utility payments in arrears or lacks income for utility payments, including to restart utilities payments that have been turned off, such that the lack of utilities may negatively impact their health.
Housing Insecure #6	An individual or family who requires support in identifying, preparing for, and/or sustaining stable housing options to avoid adverse impacts on health.
Food Insecurity	As defined by the US Department of Agriculture commissioned report on Food Insecurity in America: • **Low Food Security**: reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake. • **Very low food security**: Reports of multiple indications of disrupted eating patterns and reduced food intake

Attachment O - HOP Clinical Criteria

Categories	Specific Eligibility Criteria
Adults 21+ and Children (0-20)	• Individuals who are currently experiencing one or more chronic conditions. • Meets the clinical eligibility criteria for Tailored Care Management, North Carolina's Health Home benefit (SPA 22-0024) • Repeated incidents of emergency department use (defined as more than two visits per six months) or hospital admissions. • Experiencing or previously experienced interpersonal violence (IPV) • Pregnancy • Children under the age of 21 with a health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect • Individuals under the age of 26 who were 1. previously placed in North Carolina's foster care or kinship placement system and/or 2. formerly justice-involved: with a health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect.
Children 0-3	• Neonatal intensive care unit graduate • Neonatal Abstinence Syndrome • Prematurity, defined by births that occur at or before 36 completed weeks gestation • Low birth weight, defined as weighing less than 2500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit

Attachment O - HOP Non-HRSN Services Matrix

HOP Service Domains	HOP Non-HRSN Services	HOP Eligibility Criteria: Individuals must have a co-occurring, qualifying "Clinical Criteria" and "Social Risk Factor"						
		Clinical Criteria *(see tab titled "All HOP Clinical Criteria" for specific conditions)*		**Social Risk Factors** *See tab titled "HOP Non-HRSN Social Risk Factor" for Specific Definitions*				
		Adults 21+/ Children 0-20	Children 0-3	IPV/Toxic Stress	Diabetes Prevention Program	Holistic High Intensity Enhanced Case Management	Linkages to Health-Related Legal Supports	NMT & NEMT Need
Interpersonal Violence/Toxic Stress Services	IPV Case Management Services	X	X	X				
	Violence Intervention Services	X	X	X				
	Evidence-Based Parenting Classes	X	X	X				
	Home Visiting Services	X	X	X				
Diabetes Prevention Program	Diabetes Prevention Program	X	X		X			
Holistic High Intensity Enhanced Case Management	Holistic High Intensity Enhanced Case Management	X	X			X		
Linkages to Health-Related Legal Supports	Linkages to Health-Related Legal Supports	X	X				X	
Transportation	Non-emergency Medical Transportation to HOP Services	X	X					X
	Non-medical Transportation to HOP Services	X	X					X

Attachment O - HOP Non-HRSN Social Risk Factors

Categories	Specific Eligibility Criteria
Interpersonal Violence/Toxic Stress	Individual is at risk of, witnessing, or experiencing interpersonal violence and/or toxic stress, as defined based on the principles in the questions used to establish interpersonal violence in the Accountable Health Communities Health Related Screening Tool or the North Carolina SDOH screening tool.
Diabetes Prevention Program	Individual is eligible for and would benefit from participation in the CDC-recognized Diabetes Prevention Program to avoid or delay onset of diabetes.
Holistic High Intensity Enhanced Case Management	Individual has co-occurring social risk factors requiring intensive case management, defined as at least two of the following: • Housing social risk factor(s), as defined in Attachment M; and/or, • Nutrition social risk factor, as defined in Attachment M; and/or, • Is at risk of, witnessing, or experiencing interpersonal violence as described above.
Linkages to Health-Related Legal Supports	Individual requires assistance in accessing supports to assess legal issues and has one of the following social risk factors: • Housing social risk factor(s), as defined in Attachment M; and/or, • Nutrition social risk factor, as defined in Attachment M; and/or, • Is at risk of, witnessing, or experiencing interpersonal violence as described above.
Non-Medical Transportation (NMT) & Non-Emergency Medical Transportation (NEMT) Need	Individual has been authorized for any other HOP service (HRSN or non-HRSN) and requires transportation to access that service.

Attachment P
HOP Infrastructure Protocol

HOP Infrastructure: In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions (STC) this protocol provides additional detail on the requirements on infrastructure investments for the Healthy Opportunities Pilot (HOP) program, as specifically required by STC 10.13. Infrastructure funding may be used to support the delivery of all HOP services, including HRSN and non-HRSN HOP services. Over the course of the demonstration the state is authorized to spend up to $375M on infrastructure investments necessary to support the development and implementation of HOP services. This protocol outlines the proposed uses of HOP infrastructure expenditures, types of entities that will receive funding, intended purposes of funding, and approach to tracking expenditure amounts.

HOP Infrastructure

I. Implementation Timeline and Approach

a. Timeline for Disbursement of Infrastructure Funding

i. The state intends to begin awarding infrastructure funds to Network Leads (NLs) no sooner than the demonstration extension's approval.

ii. NLs may apply to the state for infrastructure funding at regular intervals throughout the duration of the demonstration.

b. Approach for Infrastructure Funding Applications and Disbursements

i. The state will review HOP infrastructure applications from NLs and disburse approved funding amounts.

1. NLs will distribute a portion of the HOP infrastructure funding provided by the state to contracted Human Service Organizations (HSOs) to support their delivery of HOP services.

ii. NLs will conduct the following activities to distribute infrastructure funding to HSOs:

1. Develop the infrastructure funding application and budget template, within parameters set by the state
2. Conduct outreach and education to HSOs regarding opportunity to participate in HOP provider network and access infrastructure funding
3. Review funding request applications and corresponding budgets from HSOs to ensure compliance with requirements
4. Contract with and award infrastructure funding to HSOs
5. Disburse funding to awarded HSOs
6. Monitor infrastructure funding uses amongst HSOs to prevent fraud, waste, and abuse
7. Develop reporting templates for HSOs to report on funding uses
8. Review and analyze reports from HSOs on how infrastructure funding was utilized
9. Provide data and reports on NL and HSO infrastructure funding usage to state

c. Monitoring and Oversight

i. The state will ensure that any HOP infrastructure fund disbursements are consistent with the state's STCs. The state will ensure that any HOP infrastructure funding is subject to program integrity standards, including:

1. **Monitoring eligible entities' use of infrastructure funding.** The state will require NLs to report on their uses of infrastructure funding. NLs will be required to develop expenditure reports detailing total expenditures of each applicable permitted use of infrastructure funding and how the expenditures have been used. NLs are required to monitor HSO use of infrastructure funding through regular HSO reporting on uses of infrastructure funding, which will be provided to the state.
2. **Monitoring for fraud, waste, and abuse:** The state will oversee contracted NLs' use of infrastructure building funding through regular reporting, audits and other strategies to monitor for fraud, waste, and abuse**.** In addition**,** NLs will develop a HSO Program Integrity Monitoring and Oversight Plan that includes policies and procedures for how they will monitor for fraud, waste, and abuse by HSOs, including related to their use of infrastructure funding. NLs are required to investigate and report to the state on any suspected instances of fraud, waste, and abuse related to uses of infrastructure funding. The state will ensure that action is taken to address any identified non-compliance with infrastructure funding parameters. If the NL or any contracted HSO has failed to demonstrate appropriate performance, the state may choose to impose corrective actions (e.g., caps on funding, discontinuation of funding, and/or recoupment of funding). Any federal share of recouped funds must be returned to CMS following the applicable timelines in regulations and statute.
3. **Ensuring non-duplication of funds.** NLs and HSOs will be required to attest to non-duplication of funding with other federal, state and local funds. The state will monitor for funding irregularities and potential duplication of funds.

ii. The state will separately track the following:

1. Infrastructure allocated for the provision of HRSN vs non-HRSN HOP services, as needed by CMS.
    a. The state will apply a cost allocation approach in which the state will split reporting for all HOP infrastructure spending (inclusive of Network Lead and HSO spending) in alignment with the state's total expenditure authority for HOP services. Consistent with the state's total expenditure authority for HOP services, 80 percent of total HOP infrastructure spending will be allocated to HRSN-related infrastructure spending and 20 percent will be allocated to non-HRSN-related infrastructure spending.
    b. The cost allocation methodology will be applied in quarterly reporting.

2. Infrastructure funding going to HSOs in new HOP counties and for new services, for the purposes of Designated State Health Program (DSHP) funding, as needed by CMS

II. Eligible Entities. The following entities may be eligible to apply for, receive and utilize HOP infrastructure funding:

a. ***Contracted NLs*** for the costs associated with standing up and launching a HOP network
b. ***Contracted HSOs*** for the necessary costs to execute HOP responsibilities
    i. HSOs contracted to provide a HOP service in any domain (housing, nutrition, transportation, interpersonal violence/toxic stress) are eligible to apply for infrastructure funding

III. Intended Purpose and Proposed Uses of HOP Infrastructure Funding. The state may claim federal financial participation (FFP) in infrastructure investments to support the development and implementation of HOP services across the following domains.

a. Technology
b. Development of business or operational practices
c. Workforce development
d. Outreach, education and stakeholder convening

The state intends to provide infrastructure funding to eligible entities for the following activities. NLs and HSOs may only request the amount of infrastructure funding that corresponds with the use of the item/activity in the HOP program. If an NL or HSO incurs a cost associated with services provided across both HOP and non-HOP initiatives, they must calculate what percentage of their services/individuals served are related to HOP and may only receive infrastructure funding for that percentage of the total cost.

a. **Technology**
    i. Cost of procuring and implementing IT infrastructure/data platforms/systems to support HOP service delivery
    ii. Cost of licensing and other related/ongoing fees for technology platforms supporting HOP
    iii. Modifying existing systems to support HOP
    iv. Integration of data platforms/systems/tools
    v. Onboarding to new, modified or existing systems
    vi. Training for use of new, modified or existing systems

b. Development of business or operational practices

i. Development of polices/procedures related to:
    1. Program management and administration
    2. HOP referral and service delivery workflows
    3. Billing/invoicing
    4. Data sharing/reporting
    5. Program oversight/monitoring
    6. Evaluation
    7. Privacy and confidentiality

ii. Training/technical assistance on HOP program and roles/responsibilities or other related topics
iii. Administrative or overhead startup costs that support delivery of HOP services and/or expand HOP service delivery capacity (e.g., initial month of lease payments for new or an extension of existing office spaces needed to support HOP operations)
iv. Costs of office furnishings, supplies, and equipment that support the delivery of HOP services (e.g., computers, desks, chairs, etc.)
v. Procurement of administrative supports to assist implementation of HOP
vi. Cost of hiring vendors to support key HOP functions (e.g., oversight and monitoring)

c. Workforce Development

i. Cost of recruiting, hiring and training new staff to provide HOP services
ii. Salary and fringe for staff that will have a direct role in overseeing, designing, implementing, operationalizing and/or executing HOP responsibilities. Requires percentage allocation of time if portions of time are devoted to non-HOP programs and functions.
iii. Necessary certifications, training, technical assistance and/or education for staff participating in the HOP program (e.g., on culturally competent and/or trauma informed care)
iv. Privacy/confidentiality training/technical assistance (TA) related to HOP service delivery
v. Production costs for training materials and/or experts as it pertains to the HOP program outreach, education, and stakeholder convening

d. Outreach, education, and stakeholder convening

i. Production of materials necessary for marketing, outreach, training and/or education related to HOP
ii. Translation of materials
iii. Planning for and facilitation of community-based outreach events to support awareness of HOP services
iv. Planning for and facilitation of learning collaboratives or stakeholder convenings for HOP
v. Community engagement activities necessary to support HOP program implementation, and launch and ongoing refinement
vi. Administrative or overhead costs associated with outreach, education or convening directly tied to HOP
vii. Costs related to convening HOP-participating entities and community stakeholders on topics related to HOP

Upon the HSO leaving the NL's HSO network, the HSO shall be required to surrender any unspent infrastructure funds to the NL. NLs that cease serving as a contracted NL with the Department shall be required to return any unspent infrastructure funds to the Department.

IV. Tracking Expenditure Amounts: For purposes of monitoring the infrastructure spending cap, the state will notify CMS if spending approaches 90 percent of the allowable infrastructure amount.

Attachment Q
HOP Implementation Plan

HOP Implementation Plan: In accordance with the state's Section 1115 Demonstration and Special Term and Condition (STC) 10.26, the Healthy Opportunities Pilots (HOP) Implementation Plan provides additional detail on the strategic approach to implementing the state's HOP initiative.

1. **HOP Approach and Implementation Timeline**
    a. **Demonstration Year (DY) 7:** ***Procurement of Essential Partners, Delivery of Existing Services and Compliance with Glide Path Requirements***
        i. The state will continue its successful HOP initiative under the prior 1115 demonstration. Accordingly, the state intends to cover the services and eligible populations outlined in *Attachment L: 2022-2024 Healthy Opportunities Pilot Program Eligibility and Services* through the end of DY7 in the three regions that participated in HOP in the prior demonstration.
        ii. The state will also begin working towards compliance with STC 10.1, *HOP Glide Path*. Specifically, the state will begin working towards the following requirements:
            1. Phasing out HOP services that do not meet the requirements of STCs 10.3-10.5
            2. Limiting HOP covered populations to those that meet the requirements of STC 10.10
            3. Implementing operational requirements outlined in STCs 10.15, 10.18, 10.22, and 10.23 (e.g., new requirements related to beneficiary protections)
        iii. In addition, the state expects to procure additional Network Leads to cover additional regions of the state, which will enable HOP to operate statewide. Once procured, new Network Leads will develop networks of Human Services Organizations (HSOs) to provide HOP services to qualifying members throughout the remainder of the demonstration. Finally, new and old Network Leads will be expected to use and distribute HOP infrastructure funding to qualifying HSOs in their network, in accordance with *Attachment P: HOP Infrastructure Protocol.*
    b. **DY 8:** ***Preparing to Launch Statewide and Compliance with Glide Path Requirements***
        i. The state expects to provide HOP services in alignment with *Attachment M*: *Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for Healthy Opportunities Pilots (HOP) HRSN Services* and *Attachment N: Additional HOP Non-HRSN Services Protocol*, which will be in effect at the beginning of DY 8.
        ii. The state expects to continue working with HOP entities, including HOP Administrators, Network Leads and HSOs, on readiness to launch

statewide. This may include provision of additional technical assistance and training on roles and responsibilities, convening of key partners, IT infrastructure training and technical assistance, readiness check-ins, etc.

iii. The state will work towards compliance with remaining glide path requirements, including:
    1. Limiting HOP covered populations to those that meet the requirements of STC 10.10.
    2. Implementing operational requirements outlined in STCs 10.15, 10.18, 10.22, and 10.23 (e.g., new requirements related to beneficiary protections).

c. **DY 9-11: *Delivering HOP Services Statewide***
    i. At the start of DY9, the state expects to be in compliance with all HOP Glide Path requirements articulated in STC 10.1.
    ii. The state intends to continue phasing in HOP services throughout DY9-11 based on HOP entity readiness and on-the-ground experience with HOP rollout.
    iii. The state expects to begin phasing in HOP services statewide in DY9. The specific list of HOP services that will launch first will depend on HOP entity readiness, as defined by the state. The state expects to make a subset of HOP services available statewide in the first phase of statewide service delivery, which may include:
        1. Housing Navigation, Support and Sustaining Services
        2. Utilities Assistance
        3. Fruit and Vegetable Prescriptions
        4. Healthy Food Boxes (for pick-up and delivery)
        5. Non-Medical Transportation to HOP Services
    iv. The state will consider phasing in additional HOP services to operate statewide throughout DY9-11 in the following order:
        1. Additional nutrition services, as defined in Attachment M
        2. Additional housing services, as defined in Attachment M
        3. Linkages to Health-Related Legal Supports, as defined in Attachment N
        4. Interpersonal violence (IPV)/toxic stress services, as defined in Attachment N
        5. Other services listed in Attachment N (i.e., Diabetes Prevention Program and Holistic High Intensity Enhanced Case Management)

d. **Improving Data Sharing and Partnerships.** The state will continue to work with HOP entities—including HOP Administrators, Network Leads and HSOs—to enable robust HOP data exchange to provide essential HOP-related data on key administrative activities.
    i. The state expects to continue promoting robust data sharing regarding HOP program features through NCCARE360, the state's core

infrastructure for HOP *(see section 3 "Supporting HOP-Related Data Exchange and IT Infrastructure" for additional details).*

ii. The state will require HOP entities to maintain and report on key data elements related to HOP service delivery. The state, in collaboration with HOP entities, will be required to track and report on key data elements, including, for example:
    1. Number of members who have been assessed for HOP services
    2. Number of members authorized to receive HOP services
    3. Number of members denied for HOP services
    4. Number of members who have received HOP services
    5. Data to support evaluation of HOP, including, for example:
        a. Data on improvements in member health-related resource needs, if applicable
        b. Data on member health outcomes, if applicable

iii. In addition, the state will require HOP entities to document and exchange data related to program integrity. Activities may include, for example:
    1. Tracking payments to HSOs for HOP service deliveries and monitoring for outliers;
    2. Conducting invoice analysis to avoid payment irregularities (e.g., overpayment or underpayment);
    3. Conducting quarterly accounting on HOP services delivered; or
    4. Other activities required by the state.

2. **Key Partnerships for HOP Service Delivery**. Cross-sector and community-based partnerships are essential to the successful delivery of HOP services to eligible members. Based on the success of the prior demonstration, the state has developed the following proposed approach to engaging with and incorporating input from partners, which may include:
    a. **HOP Administrator and Care Manager Engagement.** The state intends to continue utilizing its robust engagement strategy with HOP Administrators and their care managers. Activities may include, for example:
        i. Regularly engaging with HOP Administrators and care managers to provide training and technical assistance regarding HOP roles and responsibilities;
        ii. Facilitating regular "office hours" for HOP entities to ask questions, share best practices, and discuss barriers/issues that arise; or
        iii. Developing resource guides to support HOP Administrators and care managers with member screening, service authorizations, etc.
    b. **Network Lead Engagement.** Once procured, the state will provide training and support for new Network Leads related to their HOP roles and responsibilities, HOP services being offered, use of NCCARE360 and other administrative processes. Activities may include, for example:

i. Facilitating regular training and technical assistance sessions for new Network Leads to enable a successful statewide launch;
ii. Engaging with existing Network Leads on key barriers/issues that arise;
iii. Providing a forum for Network Leads that were active in the prior demonstration to support, train and answer questions for new Network Leads in statewide expansion regions; or
iv. Partnering with Network Leads to engage with their networks of HSOs and members to understand barriers and best practices for providing and accessing HOP services.

c. **Ad Hoc Interviews and Listening Sessions.** In addition to regular engagement with HOP entities, the state expects to utilize ad hoc interviews and listening sessions with HOP participating entities and members on key topics as they arise.

3. **Supporting HOP-Related Data Exchange and IT Infrastructure.**
   a. The state will ensure appropriate updates to existing IT infrastructure to support and promote the successful delivery and monitoring of HOP services.
   b. At a minimum, the state plans to continue leveraging the state's NCCARE360 platform as the core IT infrastructure for the HOP program. NCCARE360 is a statewide network throughout North Carolina that connects health care providers and HSOs to help individuals access community resources.
      i. The state may also consider utilizing additional systems to support data collection and exchange on key HOP activities.
   c. NCCARE360 provides functionalities essential to the delivery of HOP services, including, for example:
      i. A centralized directory of HOP-participating HSOs
      ii. HOP enrollment and service authorization tracking
      iii. Closed-loop referral system
      iv. System for invoicing
      v. Analytics on key HOP features that will support monitoring and evaluation (e.g., member eligibility criteria, HOP enrollment status, services authorized and provided)
   d. The state expects to work with its technical vendors to enhance connectivity to NCCARE360 and to enable HOP to roll out statewide. The state, in collaboration with technical vendors, HOP Administrators and Network Leads, will provide technical assistance to entities connecting to NCCARE360 for the first time.
   e. The state expects to solicit and document feedback from HOP partners regarding the usability of NCCARE360 and to implement system changes based on comments from users.

4. **Tracking and Improving the Share of Medicaid Beneficiaries Enrolled in the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and federal and state housing assistance programs.** The

state will seek to implement policies designed to ensure that all Medicaid members, whether receiving HOP services or not, have the appropriate supports needed to learn about and apply for the key benefits they need. The state expects that health plans, providers and care managers will all play a role in improving the share of individuals that are enrolled in key benefit programs for which they are eligible.

a. **For HOP Enrollees:** HOP seeks to complement and enhance enrollment in key programs. As described below, the HOP service access pathway creates an infrastructure to strengthen supports for members receiving HOP services who are also applying for and maintaining other key benefits for which they may be eligible. The state expects to utilize the following strategies:
    i. HOP enrollees are expected to be enrolled in SNAP and/or WIC, have an application in progress, or have had an application recently denied in order to receive HOP nutrition supports.
    ii. Many of the HOP services may support individuals in accessing federal and state benefit programs for which they are eligible, including:
        1. Housing Navigation, Support, and Sustaining Services
        2. Food and Nutrition Access Case Management Services
        3. Linkages to Health-Related Legal Supports
        4. IPV Case Management
        5. Holistic High Intensity Enhanced Case Management
b. **For Non-HOP Medicaid Members:**
    i. Beyond HOP, care managers are expected to support members in accessing federal and state programs through which they are entitled to receive benefits, including SNAP, WIC and housing assistance.
    ii. Care managers are expected to ask members questions to understand their current eligibility and enrollment status for key benefit programs for which they may be eligible.
        1. For individuals who need help accessing federal and state benefits, care managers are expected to coordinate application assistance—either directly or through partnerships with other entities.
c. The state expects to work across departments and agencies to track enrollment in key benefit programs, with the shared goal of increasing enrollment in such programs to the greatest extent possible.

5. **Partnerships with State and Local Entities.** The state will seek to develop partnerships with other state and local agencies to help assist Medicaid members in obtaining non-Medicaid funded supports related to HOP-covered domains, upon the conclusion of temporary Medicaid payment via HOP. Network Leads, in particular, are expected to be conveners of partners in the community that may include local housing authorities and Continuums of Care (CoCs). The state anticipates exploring partnerships that may include:
    a. **SNAP, WIC and TANF**. HOP provides the opportunity for closer coordination between state agencies to maximize enrollment in federal and state programs. The

state will continue to explore inter-departmental/agency connections to identify opportunities to ensure eligible individuals are seamlessly enrolled in other federal and state programs for which they are eligible—including SNAP, WIC, and TANF. Efforts to promote these connections may include identifying opportunities in the HOP design to establish requirements for HOP Administrators, Network Leads, care managers, HSOs and others that support the goal of connecting members to programs for which they are eligible.

b. **Continuums of Care.** The state has active CoCs that develop locally appropriate strategies to end homelessness. Throughout the demonstration, the state will explore opportunities to formalize partnerships between the Medicaid delivery system and CoCs. For example, the state may encourage HOP entities to be active partners by joining their local CoC board, attending CoC meetings, or joining CoC sub-committees to build relationships with their local housing partners.
c. **Local Public Housing Authorities.** The state will seek to explore partnerships with local housing authorities over the course of the demonstration. Specifically, the state will seek to identify opportunities to provide additional and longer-term housing supports to members beyond what is covered through HOP or other Medicaid initiatives. For example, HOP-participating care management or care coordination staff may work with local public housing authorities to identify funding sources to support rental payments and/or housing units for members beyond the six month's rent service covered through Medicaid.

The state intends to explore the partnerships referenced above no later than the start of DY 9.

6. **HRSN Rate Methodologies.** *The state to submit to CMS at least 60 days prior to implementation.*

7. **Maintenance of Effort (MOE).** *The state submitted the required MOE information to CMS separately on November 27, 2024.*

Maintenance of Effort State of North Carolina for HRSN Services Under 1115 Demonstration (DHHS Programs Only)

Division	Program Area	Program Description	Total Program Budget, 7/1/24 - 6/30/25 (Recurring State Funds Only)	Total State Funds Not Used for Match or Other MOE
Division of Aging	Home and Community Based Services	Home and Community Care Block Grant (HCCBG) services are provided through funding allocated to counties through Area Agencies on Aging to provide a variety of services to older adults and their caregivers. These services may include: - In-home services such as in-home aid, adult day services, home repair and home health care. - Home-delivered meals for those unable to leave their homes. Through the HCCBG, counties set their own priorities and determine which services will be provided. The services are provided to adults age 60 and over, with an emphasis on serving minorities and socially and economically needy seniors.	$36,088,323	$31,264,364
Division of Aging	Key Program Assistance	Key Program services operate in partnership with the NC Housing Finance Agency with the purpose of making available affordable rental units set aside for extremely low income households headed by adults with disabilities. Key Program services provide operating assistance to properties that do not have another form of rental assistance to assure the units are affordable to persons with incomes as low as Supplemental Security Income (SSI) and pays the difference between what a person on SSI income can afford to pay as rent and a state wide operating standard.	$8,328,081	$8,328,081

Division of Social Services	Work First Family Assistance	Work First Family Assistance provides monthly financial assistance to meet the basic needs of families with children, such as food and shelter. The local department of social services/human services agencies processes applications for cash assistance within 45 days. Cash assistance is limited to 24 months for cases including adults. Families also receive intensive employment services to help them become self-supporting. The service benefits low-income families with children.	$648,325	$481,325
Division of Employment and Independence for Persons with Disabilities	Independent Living Guidance and Counseling	Independent living programs support community living and independence for people with disabilities based on the belief that all people can live with dignity, make their own choices, and participate fully in society. The Independent Living program provides person-centered services, tools, resources, and supports that help eligible individuals achieve their goals for more independent living and actively participate in family and community life. Housing and Community Integration services help a person with disabilities make a transition back into the home and community. Consumers use these services after completing an individualized plan for independent living and as the final phase in returning to the community. These services include: - Payment for rent and utilities. - Rent and utility deposits. - Basic furniture and small appliances. - Recreational therapy. - Moving expenses. - Transportation and vehicle expenses.	$5,942,872	$583,272

Central Management and Support	Transition to Community Living (TCL)	The Transitions to Community Living (TCL) provides eligible adults living with serious mental illnesses the opportunity to choose where they live, work and play in North Carolina. This initiative promotes recovery through providing long-term housing, community-based services, supported employment and community integration. Specifically, TCL provides Community-based Supported Housing: permanent, integrated, affordable housing for people who are TCL-eligible and choose to live and receive services in the community. Tenancy supports are provided to every person with a housing slot.	$41,188,813	$41,188,813
	Total		**$92,196,414**	**$81,845,855**

ATTACHMENT R

Attachment R: Protocol for Behavioral Health and I/DD HIT Program

---

Behavioral Health and I/DD HIT Program Protocol: In accordance with the Special Terms and Conditions (STCs) of the state's Section 1115 Demonstration, this protocol provides additional detail on the rules and guidelines for participation as well as how the state will claim Federal Financial Participation (FFP) for incentive payments and the allowable funding uses for the incentive payments for the Behavioral Health and Intellectual and Development Disabilities (I/DD) Health Information Technology (HIT) Program, as specifically required by STC 12.1(c).

1. Eligible Participants

a. Eligible participants for the Behavioral Health and I/DD HIT Program are limited to behavioral health facilities (e.g., individual practices, group practices, or agencies / organizations that provide behavioral health, traumatic brain injury (TBI), and/or I/DD services) that meet the following criteria. Individual providers within a group practice (e.g., an individual clinician who practices as part of a group practice) are not eligible independently:
   i. Serve individuals with mental health conditions, substance use disorder (SUD), TBI, and/or I/DD;
   ii. Are located in North Carolina;
   iii. Have Medicaid patient volume of at least 20% (CHIP does not count toward the Medicaid patient volume criteria); and
   iv. Have not previously participated in or received payments under the Health Information Technology for Economic and Clinical Health (HITECH) Act.

b. In order to receive Behavioral Health and I/DD HIT Program funding, eligible participants must meet the following criteria:
   i. Submit all necessary documentation, including but not limited to registration as a participating entity in the Behavioral Health and I/DD HIT Program and progress reporting;
   ii. Be reviewed and approved by the state;
   iii. Must be in good standing with the North Carolina Department of Health and Human Services (NC DHHS), including the Division of Mental Health, Developmental Disabilities and Substance Use Services (DMHDDSUS), and the Centers for Medicare & Medicaid Services (CMS), and contracted health plans;
   iv. Attest that funding received will only be used on allowable uses and will not duplicate activities already reimbursed by federal, state, or other sources; and
   v. Meet program monitoring requirements.

2. Allowable Uses of Funding

a. Behavioral Health and I/DD HIT Program payments can only be spent on allowable funding uses related to increasing HIT capacity and interoperability.

b. Allowable uses of funding include:

i. Adoption and use of certified health electronic health record (EHR) technology
ii. Adoption and use of telehealth services technology
iii. Onboarding to the North Carolina Health Information Exchange, NC HealthConnex
iv. Connecting with North Carolina's Behavioral Statewide Central Availability Navigator (BH SCAN) and related behavioral health electronic systems (e.g. for mobile crisis deployment)

3. Funding Milestones

a. The state will make Behavioral Health and I/DD HIT Program payments directly to eligible behavioral health facilities, not individual providers. Payments will only be made to eligible behavioral health facilities (e.g., individual practices, group practices, or agencies / organizations that provide behavioral health, TBI, and/or I/DD services). Individual providers within a group practice (e.g., an individual clinician who practices as part of a group practice) are not eligible independently. Behavioral Health and I/DD HIT Program payments to behavioral health facilities will not be included in managed care capitation rates.
b. Behavioral Health and I/DD HIT Program payments cannot duplicate reimbursement for provider activities already reimbursed by managed care plans.
c. Behavioral Health and I/DD HIT Program payments will be distributed to eligible behavioral health facilities by the state in accordance with meeting specified milestones. Payments will only be made to a behavioral health facility once registration as a participating entity in the Behavioral Health and I/DD HIT Program is completed and the allowable funding uses and achievement of specified milestones has been identified and approved by the state.
d. Behavioral Health and I/DD HIT Program payments will be limited to up to $200,000 per behavioral health facility. The earnable dollar amounts per milestone are defined below. Payments can only be earned for new completion and/or implementation of specified milestones and cannot be earned for past completion and/or implementation.
e. Payment milestones include:
    i. **Milestone 1:** Signed agreement to implement, or substantively upgrade or reconfigure, certified EHR technology, where modern, interoperable EHR capabilities did not previously exist, to support the delivery of informed patient care
    ii. **Milestone 2:** Achievement of EHR go-live, with evidence of meaningful and regular use within modified workflows to improve clinical documentation and responsive care delivery
    iii. **Milestone 3:** Signed agreement to onboard with, contribute, and receive data from NC HealthConnex
    iv. **Milestone 4:** Establishment of connection with NC HealthConnex, with evidence of data exchange to support informed patient care delivery
    v. **Milestone 5:** Signed agreement to onboard with, contribute, and receive data from BH SCAN
    vi. **Milestone 6:** Establishment of connection with BH SCAN with evidence of data exchange to support informed patient care delivery

vii. **Milestone 7:** Evidence of meaningful and regular telehealth technology utilization where capabilities did not previously exist

Milestone Payments	
Milestones	**Payment Amount**
Milestone 1: Signed agreement to implement, or substantively upgrade or reconfigure, certified EHR technology, where modern, interoperable EHR capabilities did not previously exist, to support the delivery of informed patient care	$42,000
Milestone 2: Achievement of EHR go-live, with evidence of meaningful and regular use within modified workflows to improve clinical documentation and responsive care delivery	$22,000
Milestone 3: Signed agreement to onboard with, contribute, and receive data from NC HealthConnex	$42,000
Milestone 4: Establishment of connection with NC HealthConnex, with evidence of data exchange to support informed patient care delivery	$22,000
Milestone 5: Signed agreement to onboard with, contribute, and receive data from BH SCAN	$42,000
Milestone 6: Establishment of connection with BH SCAN with evidence of data exchange to support informed patient care delivery	$22,000
Milestone 7: Evidence of meaningful and regular telehealth technology utilization where capabilities did not previously exist	$8,000
Max Earnable Amount	$200,000

4. Monitoring and Non-Duplication

a. The state will monitor payments and achievement of milestones to ensure program integrity and non-duplication with activities already reimbursed by managed care plans and federal, state, or other sources. The state will specifically monitor payments to ensure non-duplication with funding received under the HITECH Act.
b. Eligible participants will be required to register as a participating entity in the Behavioral Health and I/DD HIT Program and submit progress reporting to the state with information detailing their progress towards the specified milestones, description of how funds were used, and attestation of non-duplication with other sources of funding.
c. The state will utilize standardized auditing and corrective action processes for eligible applicants who are not meeting progress reporting or other requirements for receipt of Behavioral Health and I/DD HIT Program funding.

d. Eligible behavioral health providers may request reconsideration if they feel that they have been denied an incentive payment, have received an inaccurate payment, or believe audit findings are incorrect.
e. In the event the state detects fraud, waste, or abuse, the state will initiate an investigation and take action to recover, recoup, and/or suspend payments.
f. The state will provide updates to CMS on the number and types of providers participating, the amount of funding given to providers, and how the incentive is helping North Carolina move its data systems forward (e.g., the number of providers statewide connected to NC HealthConnex and BH SCAN) in its annual monitoring reports.

5. FFP Claiming

a. The state will be responsible for making payments directly to eligible behavioral health facilities and reporting to CMS the expenditures for the Behavioral Health and I/DD HIT Program on the state's quarterly budget reports.
b. These reports will be used as the basis for the state to claim the total computable costs in order to draw down FFP at the applicable administrative Federal Medical Assistance Percentage (FMAP) rate for the Behavioral Health and I/DD HIT Program.
c. Under no circumstances, will the state claim FFP for payments made to any behavioral health facility that was previously included under the HITECH Act.

ATTACHMENT S

Attachment S: Protocol for School Health Technology Program

School Health Technology Program Protocol: In accordance with the Special Terms and Conditions (STCs) of the state's Section 1115 Demonstration, this protocol provides additional detail on the rules and guidelines for participation as well as how the state will claim Federal Financial Participation (FFP) for incentive payments and the allowable funding uses for the incentive payments for the School Health Technology program, as specifically required by STC 12.2(c).

1. Eligible Participants

a. Eligible participants for the School Health Technology Program are limited to the following school and/or Public School Units (PSUs) types:
   i. North Carolina Title I elementary, middle and high schools
   ii. Tribal-operated schools
   iii. Tribal Local Educational Agencies (LEAs)
   iv. Privately-run Behavioral health and I/DD specialty schools that primarily serve children and youth with behavioral health conditions, I/DD, and/or TBI and cannot otherwise bill Medicaid as behavioral health and I/DD providers, and are not eligible for the BH I/DD HIT Program

b. In order to receive School Health Technology Program funding, eligible participants must meet the following criteria:
   i. Submit all necessary documentation, including but not limited to registration as a participating entity in the School Health Technology Program and progress reporting;
   ii. Be reviewed and approved by the state;
   iii. Must be in good standing with the North Carolina Department of Health and Human Services (NC DHHS) and the Centers for Medicare & Medicaid Services (CMS), contracted health plans, and the North Carolina Department of Public Instruction (DPI);
   iv. Attest that funding received will only be used on allowable uses and will not duplicate activities already reimbursed by federal, state, or other sources; and
   v. Meet program monitoring requirements.

2. Allowable Uses of Funding

a. School Health Technology Program payments can only be spent on allowable funding uses related to connecting to the statewide school electronic health record (EHR) system and appropriate billing and reimbursement for Medicaid school-based behavioral health services including telehealth services.

b. Allowable uses of funding include:
   i. Hiring a part-time or full-time employee to support Medicaid billing and reimbursement, or integrity monitoring of the school Medicaid program
   ii. Hiring an HIT technical assistance contractor

iii. Purchasing (if applicable) and paying for costs related to staff participation in a credentialing or training program for Medicaid reimbursement and/or EHR proficiency
iv. Developing, implementing, and/or modifying the necessary referral, billing and reimbursement, data reporting or other infrastructure and IT systems, including to support telehealth services. Direct investments in modifications to or new systems or technology must be approved by the state and must not duplicate technology already available, including the statewide school electronic health record system

3. Funding Milestones

a. The state will make School Health Technology Program payments directly to eligible PSUs. Payments cannot be made to individual teachers or other school officials.
b. School Health Technology Program payments will be distributed to eligible PSUs by the state in accordance with meeting specified milestones. Payments will only be made to a PSU once registration as a participating entity in the School Health Technology Program is completed and the allowable funding uses and achievement of specified milestones has been identified and approved by the state.
c. School Health Technology Program payments will be limited to up to $200,000 per PSU with more than 75 schools, up to $150,000 per PSU with between 5 and 75 schools, and up to $100,000 per PSU with fewer than 5 schools. The earnable dollar amounts per milestone and PSU size are defined below. Payments can only be earned for new completion and/or implementation of specified the milestones and cannot be earned for past completion and/or implementation.
d. Payment milestones include:
    i. **Milestone 1:** Signed agreement to adopt the statewide school EHR
    ii. **Milestone 2:** Completion of statewide school EHR credentialing and/or training
    iii. **Milestone 3:** Completion of Medicaid billing and reimbursement credentialing and/or training
    iv. **Milestone 4:** Signed agreement to adopt add-on statewide school EHR module (if approved by the State) for Medicaid billing and reimbursement capabilities
    v. **Milestone 5:** Implementation of add-on statewide school EHR module for Medicaid billing and reimbursement capabilities (if approved by the State)
    vi. **Milestone 6:** Achievement of statewide school EHR go-live, with evidence of school sending clinical, encounter, billing and reimbursement data to Medicaid systems
    vii. **Milestone 7:** 50 percent of schools or a 20 percent increase within a PSU connecting with statewide school EHR and/or implementing Medicaid billing and reimbursement
    viii. **Milestone 8:** Signed agreement for system upgrades to statewide school EHR system, such as telehealth services (if approved by the State)
    ix. **Milestone 9:** Completion of system upgrades to statewide school EHR system, such as telehealth services (if approved by the State)

Milestone Payments			
Milestones	**PSU with < 5 schools**	**PSU with 5 to 75 schools**	**PSU with > 75 schools**
Milestone 1: Signed agreement to adopt the statewide school EHR	$30,000	$45,000	$60,000
Milestone 2: Completion of statewide school EHR credentialing and/or training	$7,500	$11,250	$15,000
Milestone 3: Completion of Medicaid billing and reimbursement credentialing and/or training	$7,500	$11,250	$15,000
Milestone 4: Signed agreement to adopt add-on statewide school EHR module (if approved by the State) for Medicaid billing and reimbursement capabilities	$7,500	$11,250	$15,000
Milestone 5: Implementation of add-on statewide school EHR module for Medicaid billing and reimbursement capabilities (if approved by the State)	$7,500	$11,250	$15,000
Milestone 6: Achievement of statewide school EHR go-live, with evidence of school sending clinical, encounter, billing and reimbursement data to Medicaid systems	$20,000	$30,000	$40,000
Milestone 7: 50 percent of schools or a 20 percent increase within a PSU connecting with statewide school EHR and/or implementing Medicaid billing and reimbursement	$10,000	$15,000	$20,000
Milestone 8: Signed agreement for system upgrades to statewide school EHR system, such as telehealth services (if approved by the State)	$5,000	$7,500	$10,000
Milestone 9: Completion of system upgrades to statewide school EHR system, such as telehealth services (if approved by the State)	$5,000	$7,500	$10,000
Max Earnable Amount	$100,000	$150,000	$200,000

4. Monitoring and Non-Duplication

a. The state will monitor payments and achievement of milestones to ensure program integrity and non-duplication with activities already reimbursed by federal, state, or other sources. The state will specifically monitor payments to ensure non-duplication with the North Carolina Integrated Care for Kids model and School-Based Services Expansion Grant.

b. Eligible participants will be required to register as a participating entity in the School Health Technology Program and submit progress reporting to the state with information detailing their progress towards the specified milestones, description of how funds were used, and attestation of non-duplication with other sources of funding.
c. The state will utilize standardized auditing and corrective action processes for eligible applicants who are not meeting progress reporting or other requirements for receipt of School Health Technology Program funding.
d. Eligible PSUs may request reconsideration if they feel that they have been denied an incentive payment, have received an inaccurate payment, or believe audit findings are incorrect.
e. In the event the state detects fraud, waste, or abuse, the state will initiate an investigation and take action to recover, recoup, and/or suspend payments.
f. The state will provide updates to CMS on participation, incentive payments disbursed, and payment uses in its annual monitoring reports.

5. FFP Claiming

a. The state will be responsible for making payments directly to eligible PSUs and reporting to CMS the expenditures for the School Health Technology Program on the state's quarterly budget reports.
b. These reports will be used as the basis for the state to claim the total computable costs in order to draw down FFP at the applicable administrative Federal Medical Assistance Percentage (FMAP) rate for the School Health Technology Program.
c. Under no circumstances, will the state claim FFP for payments to eligible PSUs that duplicate funding under the North Carolina Integrated Care for Kids model and School-Based Services Expansion Grant.

ATTACHMENT T

Approved List of DSHPs

The DSHP-eligible expenditures in this list exclude prohibited costs, in accordance with STC 13.2.

NC DHHS Division	Service	Estimated 5-Year State Investment	Population Served	Program Description
Public Health	Building Capacity for Service Delivery	$ 58,078,950	Virtually all individuals, including low-income and underserved populations, in NC are impacted in some way due to the service of local health departments (LHDs) in all 100 counties	This program seeks to ensure local health departments (LHDs) are equipped with the necessary training, education, and resources. Under this program, LDHs receive training and education on nursing practices, the eight public health foundational areas (assessment and surveillance, community partnership development, equity, organizational competencies, policy development and support, accountability and performance management, emergency preparedness and response, and communications), and workforce programs. LHDs are also provided resources for school health staff to access electronic records submission systems, host/participate in community events, and attend trainings to equip staff with essential knowledge to address public health concerns. Through providing education, training and resources to LHDs, they gain the knowledge and tools to better serve and promote the health of all North Carolinians, especially low-income and underserved populations.
Public Health	Maternal Health	$ 30,543,695	Pregnant women needing additional wrap around support services, serves low-income pregnant women	The Maternal Health program seeks to provide women, regardless of income, early and continuous access to prenatal care, pregnancy management, and additional maternal care services. This program utilizes local health department prenatal clinics to deliver services.
Public Health	Family Planning	$ 24,486,130	Women of reproductive age, targets low-income women of reproductive age	Family Planning services reduce unintended pregnancies and improve the well-being of children and families in North Carolina. This service is available to all individuals regardless of income on a sliding fee scale.

Public Health	State Laboratory Services - Testing, Training & Consultation	$ 21,652,410	All populations receiving certain laboratory services from LHDs and providers across NC, including the newborn screening program which tests virtually every child born in NC	This program provides funding for medical and environmental laboratory services to public and private health provider organizations responsible for the promotion, protection and assurance of the health of North Carolina citizens. The laboratory services include the newborn screening program, testing and consultation for environmental sciences, blood lead testing, bioterrorism and emerging pathogens, diseases, molecular epidemiology, newborn screening, virology, and serology. This program also provides consultations for local health departments and providers across the State on these tests and emerging public health concerns and outbreaks. Additionally, because laboratory services and tests must be up to date, this program also provides training to ensure staff are equipped with the knowledge and tools to run tests and analyses to improve the health and safety of North Carolinians.
DMH/DD/SUS	Directed grants - Mental Health and Substance Use Disorders	$ 8,240,184	Children and adults with mental illness and/or substance use disorders	This program provides state appropriations via directed grants to community non-profits that support children and adults with substance use disorders and/or mental health disorders. These include mental health services and programs for youth through the North Carolina Alliance of YMCAs, addiction medicine services through SAIL Initiative, Inc., substance use recovery services through Oxford Houses of North Carolina, and drug and alcohol addiction recovery services through Hope Center Ministries.
DMH/DD/SUS	I/DD Cross Area Service Program Funds (Single Stream)	$ 26,747,080	Adults and children with I/DD	This program provides statewide behavioral health, crisis and other supportive services to adults and children with I/DD who are uninsured or underinsured (services not covered by primary insurance).
DMH/DD/SUS	Community TBI Services	$ 19,865,430	Uninsured and underinsured individuals with TBI	This program provides statewide habilitative and rehabilitative services to adults with traumatic brain injury who are uninsured or underinsured (services not covered by primary insurance).
DMH/DD/SUS	Community Child IDD Services	$ 2,500,000	Uninsured and underinsured children with I/DD	This program provides statewide habilitative services to children with I/DD who are uninsured or underinsured.

DMH/DD/SUS	Community Adult IDD Services	$ 32,473,460	Uninsured and underinsured adults with I/DD	This program provides statewide habilitative services to adults with I/DD who are uninsured or underinsured.
DMH/DD/SUS	Child Behavioral Health	$ 25,000,000	Children with behavioral health needs, including low-income and underserved populations	This program supports families and other caregivers of children with high behavioral health or other special needs by expanding intensive out-of-home treatment and intensive supports in the community and increasing specialty care options for meeting the needs of these children.
Division of Child and Family Well-Being (DCFW)	Child Behavioral Health	$ 28,000,000	Children with behavioral health needs, including low-income and underserved populations	This program provides community based services that help children stay in/return to their homes by providing: access behavioral health services in schools; expanding access to family-focused community-based support and care coordination (e.g., High-Fidelity Wrap, family peer support services); establishing emergency respite pilots for caregivers. This program also provides funding to increase availability and quality of family-type therapeutic placements including crisis stabilization and assessment in a family-type setting (e.g., IAFT, Therapeutic Foster Care) and expand access to Evidence-Based (EBP) Community-Based Treatment Services (e.g., ACTT, Intensive In-Home, MST, TFCBT, PSBCBT, FCT).
DCFW	School Health and Teen Pregnancy Prevention Initiatives (TPPI)	$ 8,000,000	Individuals and families at risk of compromised health and safety, including low-income and underserved populations	This program works to prevent teen pregnancies by funding projects in local health departments and community-based organizations, and supporting school health services to provide direct services, program development, health education, consultation, and technical assistance to strengthen and support community school nurses and school health centers.
Office of Rural Health (ORH)	Telehealth Infrastructure Grant Program	$ 20,000,000	Rural populations, including low-income and underserved populations, with priority to those served by independent primary care practices and independent obstetrics and gynecology practices	This program establishes a telehealth infrastructure grant program to award grants on a competitive basis to rural healthcare providers to be used to purchase equipment, high-speed internet access, and other infrastructure necessary to establish telehealth services, defined as the use of two-way, real-time interactive audio and video where the healthcare provider and the patient can hear and see each other.

ORH	Telepsychiatry	$ 9,165,685	Rural populations, including low-income and underserved populations	This program provides funding for the continuation of a statewide telepsychiatry program to expand access to psychiatric services in rural areas where resources are not currently available, both in community-based telepsychiatric and hospital emergency room settings.
ORH	Community Health Grant Program	$ 68,561,123	Uninsured and/or medically indigent individuals	The Community Health Grant Program was established to increase access to preventative and primary care services for uninsured or medically indigent patients. Grant awards are made to qualified sites based on ability to demonstrate increased access and patient care. Grants can be used to increase access to preventive and primary care services for uninsured or medically indigent patients, to establish new services in community health centers where no such services previously existed, or to increase capacity to serve the uninsured by upgrading or replacing equipment or technologies and increasing use of telehealth services. The funding can be used for (1) medically necessary face-to-face encounter-based reimbursement for low-income, uninsured, and underinsured residents, who do not have health care coverage or access to primary health care services; and (2) reimbursement for eligible expenses which include salary/fringe benefits for clinical staff and medical/office supplies and equipment.
ORH	Medication Assistance / Prescription Drug Program	$ 10,500,000	Uninsured and/or medically indigent individuals	This program provides funds to MedAssist of Mecklenburg (NC MedAssist), a nonprofit organization, for additional prescription assistance services for indigent and uninsured persons.
Total Allowable DSHP-Eligible Expenditures		$ 393,814,147		
Total Allowable DSHP-Eligible Expenditures with Adjustment from STC 3.2(b)		$ 381,999,723		

ATTACHMENT U

Reserved for Provider Rate Increase Attestation Table