Care Coordination, Housing and Medicaid Integration: Oregon Context

Homelessness remains a complex public health challenge in Oregon. Oregon faces an unprecedented housing crisis – in 2015, Oregon’s homeless population increased by 9 percent (from 2014), and on a single night there were 13,176 homeless individuals of which 3,991 were chronically homeless.¹ In Oregon’s most populous region, Multnomah County, more than half of those counted as homeless in 2013 suffered from one or more serious physical, mental or substance use-related conditions. Limited services exist to address homelessness, and often available care coordination and supportive housing services contain gaps, lack coordination and education to ensure services are available and used.

Homeless individuals and families are at greater risk of poor health outcomes, including complications of chronic illness, substance use disorders, and behavioral health issues such as post-traumatic-stress disorder.² Compared with other states, Oregon experienced the third highest percentage increase in the number of homeless individuals from 2014-2015, has the highest rate of unsheltered homeless people, and was the only state in which more than half of the homeless people in families with children were unsheltered (53 percent).³ In addition to the unprecedented housing crisis in both rural and urban communities, Oregon’s current health care system faces several challenges in caring for those at-risk of homelessness or experiencing homelessness. This is largely due to the fact that federal, state, and local programs that target homeless individuals and families, or those at risk of becoming homeless are often siloed. The diverse number of programs often have a targeted client base, and lack the critical care coordination infrastructure required to integrate availability of services across federal, state and local programs serving similar populations. For example, in Oregon, there is no vehicle through which Medicaid can pay for transitional services or supportive housing services for people who do not qualify under the state’s Section 1915 waivers and state plan for eligibility and covered services.

Coinciding with Oregon’s housing crisis was Oregon’s Medicaid expansion. In the first two years (2014-15), 436,000 low-income adults became newly enrolled in the Oregon Health Plan (OHP) through the Affordable Care Act (ACA). Expansion dramatically altered the age and gender distribution of Medicaid members – adults now outnumber children on OHP and there are significantly more adult male members. With expansion, a significant number of Oregon’s chronically homeless and individuals at-risk of homelessness are now eligible and enrolled in Medicaid. The opportunities in Oregon with respect to addressing the social determinants related to health and housing are:

- Oregon’s successful health system transformation and 16 CCOs can be leveraged;
- Oregon’s Legislature and local municipalities have invested millions in expanding affordable housing (2015 and 2016).

• An existing US Department of Justice agreement with Oregon and the Oregon State Hospital to improve community behavioral health treatment and programs is in place.

The World Health Organization defines social determinants of health as the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status. To avoid unnecessary utilization of health care services and increases in total Medicaid costs, Oregon seeks to address social service needs of high-risk, high-need individuals by ensuring development of infrastructure, partnerships and resources to deliver care in appropriate settings and provide supportive housing services. To avoid unnecessary utilization of health care services and increases in total Medicaid costs, Oregon proposes creating Coordinated Health Partnerships (CHPs) to pilot the improvement of housing services and health service needs of homeless individuals or individuals at risk of homelessness.

1115 Waiver Demonstration: Oregon’s Strategy

To promote population health and further address social determinants of health, Oregon proposes to create a five-year pilot program, referred to as the Coordinated Health Partnerships (CHP), for adults at risk of homelessness, including adults eligible for both Medicare and Medicaid programs (often referred to as dual eligibles), and families. Through the CHPs, at-risk populations would be offered a combination of housing, health care integration, care transitions and supportive services to improve health outcomes and reduce Medicaid costs. The CHPs interventions are designed to help communities across Oregon adopt a multi-faceted and multi-sectoral approach to simultaneously address issues around access to health and health care and those of the physical environment such as housing that affect behavioral and physical health outcomes among those served by Medicaid. The CHPs serve as an unprecedented opportunity to address policy, system, organizational and individual level changes through the development of new community-based partnerships that focus on transitions of care and stable, affordable housing. The CHPs will also offer an effective set of strategies for improving health and health care for underserved individuals, communities and populations across Oregon. Because the CHPs have been designed as a pilot program, Oregon recognizes that the CHPs will be limited in their ability to address the broad array of social determinants that contribute to health inequities. Nonetheless, the program will provide Oregon an opportunity to develop, implement, and evaluate new and innovative interventions that will begin to address housing issues and care transitions from institutional settings to the community.

Oregon is proposing a multi-faceted, incremental approach to the state’s integration of health care and supportive housing for the 2017-2022, 1115 demonstration renewal:

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• Year 1: Convening and planning initiatives, regionally and statewide. Select proposals and create CHPs.
• Years 1-5: Statewide investment in infrastructure development and creation of CHPs
• Years 2-5: Pilot and test new models of housing supportive programs among CHPs
• Years 2-5: Transition from paying for process to paying for outcomes based on evidence-based practices
• Years 3-5: Dissemination and spread of best practices

Coordinated Health Partnerships

Overview

Coordinated Health Partnerships (CHPs) pilot program will be a voluntary program funded throughout the five-year waiver renewal. The CHPs will test new models to increase collaboration and coordination among CCOs, local hospitals, community-based organizations, housing authorities, county government and public health agencies, affordable housing providers, corrections and behavioral health and substance use disorder (SUD) providers. The program will provide funding to local CHPs to increase integration of services and build infrastructure among the participating entities. CCOs will serve as lead entities for the CHPs. OHA is currently working with tribal governments to develop a CHP(s) for tribal members.

The CHP pilot program will develop and advance locally designed solutions through a menu of strategies implemented by the lead entities and partnering organizations (see page 38). The CHP pilot program will achieve the following:

• Support care coordination among non-medical settings and promote transitions from institutional settings to less costly community-based care settings;
• Reduce inappropriate emergency, inpatient and residential treatment facility utilization;
• Increase access to and use of primary, behavioral and substance use disorder services;
• Increase coordination of housing supportive services for targeted at-risk populations; and
• Invest in health IT infrastructure among non-traditional providers to improve data collection and sharing among local entities to support ongoing case management, monitoring, and sustainability for CHP pilots.

CHP Target Population

Target populations will include but are not limited to high-risk, high needs individuals:

• With repeated incidents of avoidable emergency use or hospital admissions;
• With two or more chronic conditions;
• With mental health and/or substance use disorders;
• Who are eligible for Medicare and Medicaid;
• Who are currently experiencing homelessness; and/or
• Individuals who are at risk of homelessness, including those eligible for Medicare and Medicaid, and Indian Health Services (IHS), Tribal, and Urban Indian program constituents; and,
• Individuals who will experience homelessness upon release from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, Institutions of Mental Diseases (IMD), county jail).

CHPs will have the ability to define the populations they would like to target based on regional needs and the broad criteria for the population included in the proposal. CHPs may choose to limit the population served within their pilot application and OHA will work with CHPs to determine the number and focus of the target population. OHA anticipates that individuals who are not currently enrolled in CCOs but are served through fee-for-service will be eligible for the CHP pilot program. Oregon will ensure that services are not duplicated with other services currently offered through existing waiver and state plan authority.

Program Design and Key Components

The CHP program consists of three foundational elements, referred to as domains. Taken as a whole, the domains create a continuum of services available within a community to the defined target population. Each CHP pilot will be expected to provide services in all three domains (see CHP framework on pg. 38).

• Homelessness Prevention/Transitions of Care: support to ensure care coordination among non-medical settings; fund services to support an individual’s ability to move from institutional settings to less costly community-based care settings.
• Housing Transition Services: invest in pre-tenancy services to decrease health care costs and reduce use of high-cost health care services.
• Tenancy Sustaining Services: invest in services that support the individual in being a successful tenant in his/her housing arrangement.

In an effort to address the social determinations of health, the CHPs will have the flexibility to address interpersonal violence and trauma informed care under the homelessness prevention/transitions of care domain. This is in recognition that there is a likelihood of trauma among individuals experiencing homelessness, as well as a causal relationship between domestic violence and rates of homelessness for women and families.6

To date, Oregon is proposing several other requirements that will apply to the entire program.

- Individuals eligible for Medicaid coverage in Oregon can opt out of services at any time; individuals will be provided with information about their enrollment options to make an informed choice.
- Each CHP will be required to develop its own payment methodology and strategies for financing of services and distribution of funds among its partners, within broad parameters that are consistent with the state’s federal approvals for payment.
- Payments to CHPs will be based on meeting process measure targets in the first 3 years; by the fifth year, payments will be made based on outcomes of members.

Through the CHP pilot program and the proposed domains, Oregon’s goal is to improve care transitions and coordination with a focus on ensuring effective care transitions from institutional to community-based settings, particularly among county correctional facilities, the Oregon State Hospital and acute care facilities. The lead entities of the CHPs will target pre-adjudicated incarcerated individuals in county correctional facilities and individuals in an institution for mental diseases since these populations often experience disruptions in care when entering institutions and often experience poor health and housing outcomes when exiting these settings. Pre-adjudicated individuals comprise 61 percent of the county jail population; two-thirds have mental illness and/or substance use disorders, with an average length of two-week stay for pretrial (<12 days). In 2014, there were 179,332 bookings across Oregon’s county jails.

For the justice-involved population, failure to ensure access to health care services upon release has a major impact on recidivism rates and the rising health care costs that Oregon’s health system transformation aims to reduce. Based on feedback received during the public comment period, Oregon will also explore whether the pilot target population should include pre-adjudicated juveniles.

In Oregon, a person’s hospitalization at the state hospital (IMD) continues to be an overall disruption to an individual’s health care – individuals are disenrolled from Medicaid/CCO upon entry and the CCO is not involved in the individual’s care from entry to discharge from the Oregon State Hospital (OSH). Oregon proposes to engage CCOs in the discharge planning process during the last 30 days of an individual’s time at the Oregon State Hospital. Oregon would like to increase the ability of Oregon State Hospital members to successfully re-enter and remain in the community, which can be achieved by increasing care coordination services during the last 30 days prior to discharge. Timely and effective discharges and transitions into the community will increase available beds in the Oregon State Hospital and will minimize the burden on other parts of the adult mental health system – a recent problem is psychiatric boarding in emergency departments while individuals wait for an acute care bed. Oregon wants to avoid solutions to psychiatric boarding that require an increase in acute care beds and instead focus our efforts on providing effective transitions to community-based services.

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The CHP networks will also require participation by local hospitals. Each CHP will be required to work with local hospitals to identify high-risk patients (i.e. homeless admitted for in-patient services) for needed medical, behavioral, and social services available through the CHPs. The goal is to incentivize the use of community-based care options and use of transitional housing to reduce avoidable hospital use and over-utilization of expensive, inpatient care in hospital settings. Short-term transitional housing of up to 60 days to receive health services coupled with care management services is intended to support longer-term rehabilitation, stabilization, and self-management for the program’s target population.

Implementation Considerations

Oregon will develop and implement a robust accountability framework for the CHP pilots, including financial accountability, safeguards and performance metrics to demonstrate the impact of the pilot program in terms of health outcomes and overall cost-savings.

Leveraging the success of OHA’s Transformation Center, the Transformation Center will convene the new partnerships to share learnings with each other. The Transformation Center will facilitate Learning Collaboratives to spread best practices across Oregon and promote use of flexible services to fund medically appropriate housing supportive services and services not funded through the CHP program.

The final design and implementation details will be based on extensive public input and involve robust collaboration among Indian Tribal leaders, CCOs, housing authorities, affordable housing providers, health care providers (including behavioral and substance use disorder providers), counties and local public health agencies, corrections and organizations serving Oregon’s homeless population. OHA anticipates convening a CHP Advisory Committee. The committee will consist of a broad range of stakeholders and initially will be tasked with informing the final design of the program and the implementation work plan.

The committee will be convened in the summer of 2016, while OHA requests federal approval for the program, and will provide an opportunity for extensive public input prior to the launch of the program. The committee will continue to meet throughout the duration of the demonstration. The committee will advise OHA on a range of potential issues that may include:

- Refining the definition of the target population.
- Advising on the structure of CHPs when there are multiple CCOs in a single region.
- Advising on the specific requirements for creation of CHPs and make recommendations on the criteria for Request for Proposals.
- Addressing differences between rural and urban CHPs, including availability of affordable housing units and local area housing supportive service providers (i.e. workforce).
- Recommending process and outcome requirements for payment to CHPs.

**HIT infrastructure needed to support CHPs:**
As a result of the public input process, OHA will support the health information technology (HIT) component of CHPs by building upon the current physical health-centric health information sharing infrastructure to support data exchange between the partners involved, including between corrections, social services, CCOs and health care providers. Current infrastructure supports Direct secure messaging (through state-operated CareAccord, regional HIE efforts, and organizational electronic health records), as well as more robust exchange affiliated with certain communities or organizations. OHA intends to partner with the CHPs to further understand remaining gaps in HIT and necessary actions for strengthening the infrastructure. In addition, OHA will leverage new federal HITECH Health Information Exchange (HIE) onboarding funds to connect behavioral health, long term care, corrections, and other social services providers where appropriate to regional and statewide health information exchange services. Finally, OHA will support the development of notification to CCOs and their partners of transitions in and out of the corrections system, the State Hospital, and other settings as appropriate; and supplementing Oregon’s current statewide hospital event notifications infrastructure (Emergency Department Information Exchange/PreManage).

**Coverage of Homelessness Prevention/Transitions of Care Services, Housing Transition Services, and Tenancy Sustaining Services in CHP Pilot**

Oregon is proposing to fund a range of care coordination and supportive housing services based on the types of services described in the June 26, 2015 CMCS Information Bulletin. Additional services may include outreach to individuals experiencing homelessness and care management services for care coordination, see page 38. Oregon is not requesting federal authority to use Medicaid funds to cover the cost of room and board or pay rental assistance, except for those transitioning from acute care facilities to transitional and affordable housing units to receive needed health services (up to 60 days coverage).

Oregon is proposing that care coordination services offered by the CHPs be covered by Medicaid during the final 30 days prior to discharge for individual’s undergoing treatment at the Oregon State Hospital. Care coordination would focus on providing relevant community treatment information to the state hospital for treatment and discharge planning (e.g., community services and discharge planning). As directed by the Supreme Court’s Olmstead decision, individuals can be swiftly returned to an integrated setting in the community. Oregon also believes that well-coordinated short lengths of stay could support the decreased use of higher levels of care upon discharge. For example, of the (approximately) 45 patients currently on the ready-to-discharge list, about 90 percent have been referred to secure residential treatment.

Several research studies indicate that individuals involved with the criminal justice system are considered high utilizers of acute care services. Individuals with mental illness are 14 times more likely to be incarcerated than hospitalized. A recent Miami-Dade County study of individuals with serious mental illness found that individuals with several incarcerations were high utilizers of hospital services – over a five year period, 97 individuals with serious mental illness were arrested 2,200 times and utilized 13,000 days at an emergency department or psychiatric facility.

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Oregon is proposing that CHPs be able to provide care coordination services to pre-adjudicated individuals while they are in jail. CHPs would have the opportunity to put resources in place to provide care coordination services for the first 30 days of an individual’s incarceration in jail, which would help coordinate treatment and care planning at the beginning of incarceration (e.g., arranging proper medication) and assist in re-entry into the community, given that the average length of a county jail stay is approximately 12-15 days.\(^\text{10}\)

To authorize federal financial participation to provide care coordination services to individuals in Institutions of Mental Diseases (IMD) and for pre-adjudicated incarcerated individuals in county correctional facilities, Oregon seeks to waive federal authorities in 42 CFR §438.3, 42 CFR § 435.1009 and 42 CFR § 435.1010. Recent guidance from the Centers for Medicare and Medicaid Services (SHO# 16-007) indicates that individuals who are on parole, probation, or have been released to the community pending trial are not considered inmates, and thus are not subject to the prohibition on federal financial participation (FFP) for providing Medicaid-covered services to inmates. If the individual is otherwise eligible for Medicaid, FFP is available for covered services provided to such individuals.

**Partnership Requirements and Integrated Networks for CHP Pilots**

Key community partnerships led by CCOs or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/Us) can build the capacity of high-need, at-risk individuals for self-support through strategies that identify homelessness and assist individuals in accessing appropriate housing that includes health-related supportive services. CHP lead entities will be responsible for coordination with all partner entities participating in the CHP. CHPs will be comprised of the following entities:

- CCOs (lead)
- Tribes (may be lead)
- County and/or city government
- Local housing agencies
- County jails and/or State Hospital
- Local public health departments
- Hospitals
- Affordable housing providers
- Supportive housing service providers
- Community-based organizations (CBOs) focused on health equity

\(^\text{10}\) A 2013 Jail Survey conducted by the Association of Oregon County Mental Health providers found that 61.5% of individuals in jail were pre-adjudicated and two-thirds of those had a mental illness or substance use disorder.
OHA will work with the CHP advisory committee and tribal governments to develop the minimum criteria for entities that must be included in CHP applications. Lead entities for the CHP will be expected to partner with local housing entities to help build an understanding of the housing situation in the region. CHPs may select to involve other entities and organizations that serve the targeted populations selected by individual regions. Other entities could include those focused on diversity, disabilities, aging, youth, etc.

CCOs will be provided with the flexibility to develop their individual integrated networks based on existing delivery systems, affordable housing providers, and additional regional partners that will be involved in the CHP pilot. To help ensure successful CHP pilots, Oregon plans to require CHPs to deploy case managers or care coordinators from varying professions, including but not limited to social workers, counselors, behavioral specialists, nurses, resident advocates, community health workers, and peer support specialists.

To achieve the overall goal of the CHP Pilot Program, the individual pilots require flexibility in types of workforce needed to support the different projects that reflect community resources, availability of the local workforce, and redeployment of existing professions and staff in terms of health care providers and housing supportive specialists. The CHPs will likely consist of multidisciplinary teams made up of physical, behavioral, and substance use treatment providers, social workers, traditional health workers, and other care providers. Oregon will ensure there is a set of minimum standards for CHP pilots to protect the health and welfare of the individuals served by the pilots. If applicable, Oregon seeks to waive federal authority in 42 CFR §441.700 pertaining to federal requirements regarding provider qualifications for Home and Community-based Supports (HCBS) program.

**Initial Financing and Return on Investment**

Oregon is requesting federal support for five-year pilots to CCOs to support capacity-building, developing community-based partnerships and infrastructure investment, as well as care management funding to target essential non-medical services. OHA will encourage CHPs to work with local organizations and foundations to earmark funds for capital investments. With the CHP advisory committee, counties and tribal governments, OHA will explore the possibility of including intergovernmental transfers (IGTs) as part of the CHP infrastructure to provide additional investment in the CHP programs.

During the demonstration, Oregon will assess whether homelessness prevention, care coordination and supportive housing services through the CHPs result in significant reductions in total Medicaid costs among the target population, including which services may contribute to lower monthly costs on a per member per month basis (PMPM). The goal is to demonstrate that upfront investments through the CHP pilot projects will achieve cost-savings for federal and state Medicaid, producing a positive return on investment.

Based on several Oregon-based studies, we anticipate that the CHP pilots will result in up to 10 to 15 percent total reduction in Medicaid costs among the population served during the waiver
period, with the largest gains in savings likely transpiring in years 3-5 of the program.\textsuperscript{11,12} This is based on the assumption that more efficient management of health needs in appropriate settings and addressing social needs, including stable housing, will reduce the incidence of acute health crises, decrease the use of more expensive types of utilization, and improve health outcomes, ultimately producing reductions in overall Medicaid costs.

Oregon Health Authority’s Office of Health Analytics conducted a series of analyses using Medicaid claims, encounter, and enrollment data to estimate the potential number of individuals currently in OHP who could be eligible for the CHP pilot program including estimating the potential number of high-risk populations using the criteria for the target population within a two-year period from October 2013 through September 2015.

Based on OHA’s preliminary analysis, we anticipate that between 10 to 20 percent of OHP clients (219,112 individuals out of 1.1 million individuals enrolled in OHP) could benefit from targeted interventions through the CHP pilot program. Many of those included in the analysis are at higher-risk of homelessness due to increased complexities in health and often have other challenges that contribute to poor health status, are often disconnected from community services, and have unmet, complex needs that span the social service continuum.

The total expenditures for the individuals included in the analysis is roughly $3.5 billion over the two year period (2013-2015). If the CHPs are successful during the five-year renewal period in achieving a decrease of 10 to 15 percent in Medicaid costs for the target population, Oregon could potentially realize as much as $350-$525 million of savings during a two-year biennium during the waiver renewal period.\textsuperscript{13} OHA will work with CMS to further refine the potential savings to federal and state Medicaid costs during the five year renewal period.

\textsuperscript{11} Wright, B., Vartanian, K., Royal, N., Li H., & Matson, J. (2016). Formerly homeless people had lower overall health expenditures after moving into supportive housing. \textit{Health Affairs, 35(1)}, 20-27.


\textsuperscript{13} The cost savings estimate included in this proposal is based on the 10-15 percent savings found in the Providence CORE research. Savings may be less than the noted amount and OHA will work with CMS to refine the cost savings.
Table 1. OHP Members Identified as High-Risk, High-need – Oct. 2013 through September 2015

<table>
<thead>
<tr>
<th>Population definition</th>
<th>Number of Medicaid beneficiaries</th>
<th>Total Actual Costs (2 year period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-duals that met the following definitions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Repeat emergency department use/hospital use and two or more chronic conditions</td>
<td>142,855</td>
<td>$2,488,951,687</td>
</tr>
<tr>
<td>• Repeat ED use/hospital use and mental health or substance use disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Repeat emergency department use/hospital use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chronic conditions (two or more)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mental health or substance use disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals dually eligible for Medicare and Medicaid</td>
<td>76,257</td>
<td>$1,028,014,524</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>219,112</strong></td>
<td><strong>$3,516,966,211</strong></td>
</tr>
</tbody>
</table>

Source: OHA Office of Health Analytics, May 2016

Oregon also analyzed data available from the Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) funded by the Center for Medicare and Medicaid Innovation (CMMI) and fielded in 2014. The survey gathers information from adult Medicaid members about:

- Behaviors that put health at risk
- Behaviors that are protective of health
- Receipt of clinical preventive services
- Health care access and use
- Social and environmental determinants of health

The survey asked enrolled, adult Medicaid members about needing or receiving housing services over the past 12 months. Statewide, 15.9 percent of adult Medicaid individuals responded with having needed or received housing services. Based on the survey results, 48,906 Medicaid enrollees indicated having at least one chronic condition and experiencing housing instability during the past 12 months. The survey also collected information to assess situations in which an individual is: (1) homeless or residing in a shelter, or (2) at-risk of being homeless. The homelessness indicator is based on whether an individual indicated currently as “homeless” or residing in a “shelter” and had at least one chronic condition. The at-risk indicator is based on whether an individual responded that they “needed shelter” or “housing services” in the past 12 months and had at least one chronic condition.
Table 2. Housing Instability among Oregon Adults Medicaid Enrollees with Chronic Conditions 2014

<table>
<thead>
<tr>
<th>Coverage 2014</th>
<th>“Homelessness/Shelter”</th>
<th>At-risk for Homelessness</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA Expansion</td>
<td>2,386</td>
<td>26,278</td>
</tr>
<tr>
<td>Traditional Medicaid</td>
<td>1,268</td>
<td>22,628</td>
</tr>
<tr>
<td>Total</td>
<td>3,654</td>
<td>48,906</td>
</tr>
</tbody>
</table>

**Evaluation of CHP Pilot Activities**

Oregon will assess whether transitions of care and supportive housing services for the target populations result in improved outcomes. Potential measures that will be assessed for including in the CHP pilots will include:

- Reductions in ED use and psychiatric acute care hospitalizations or boarding
- Decreases in inpatient admissions and hospital days
- Rate of emergency department visits
- Increases in primary care and behavioral health care use, including medication adherence
- Decreased discharges to secure residential treatment facilities
- Increase in transitions from recovery to permanent housing settings
- Increase in access to care and quality of care after moving into housing
- Retention in housing unit for 12 months or longer
- Increase in percentage of adults accessing employment and benefits services
- Increase in the percentage of individuals that transition to affordable housing (market rate housing/community housing placement)
- Increase in self-sufficiency among those served

**CMS Innovation Accelerator Program (IAP): Alignment with CHP Proposal**

Oregon was selected to participate in two Medicaid Innovation Accelerator Programs (IAPs), sponsored by the Centers for Medicare and Medicaid Services (CMS). These programs consist of a series of webinars, tools, and technical assistance designed to assist participating states in leveraging Medicaid dollars to pay for housing supports, and to better align efforts between state and local service and housing agencies. The initiatives through the IAP program serve to complement Oregon’s CHP planning efforts.
Through the IAP, Oregon will develop a “State Action Plan” and framework to help forge a closer partnership between Oregon’s housing and Medicaid agencies that will prepare the state to launch the CHP Pilot Program in July 2017.
<table>
<thead>
<tr>
<th>Pilot Domain14</th>
<th>Program</th>
<th>Partners</th>
<th>Program Goals and Potential Measures</th>
<th>Target Populations</th>
<th>List of Services</th>
</tr>
</thead>
</table>
| Homelessness Prevention/Transitions of Care | Select one program (at minimum): | • Lead entity:  
  o CCOs  
  o Tribes or I/T/Us  
  • Additional partners:  
    o Local hospital(s)  
    o County health departments  
    o State Hospital  
    o County Jails and Oregon Department of Corrections  
    o Care management entities  
    o Affordable housing providers  
    o Community-based organizations (CBOs) focused on health equity | • Reductions in ED use and psychiatric acute care hospitalizations  
• Decreases in inpatient admissions and total hospital days  
• Increases in primary care and behavioral care use including medications | Individuals with:  
• Repeated incidents of avoidable emergency use or hospital admissions, or nursing facility placement; or  
• Two or more chronic conditions; or  
• Mental health and/or substance use disorders; or  
• History of or current homelessness and/or at risk of being homeless, including:  
  o Pre-adjudicated criminally justice involved  
  o Oregon State Hospital (OSH) patients  
  o Dual eligibles  
  o Tribal members | • Ensuring that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health  
• Ongoing assessment of medical, mental health, substance use disorder or dental needs  
• Case management and coordinating the access to and provision of services from multiple agencies  
• Establishing service linkages with community providers, such as transportation for CHP enrollees in rural communities. |

14 CHP pilots must provide services across all three domains.
<table>
<thead>
<tr>
<th>Pilot Domain</th>
<th>Program</th>
<th>Partners</th>
<th>Program Goals and Potential Measures</th>
<th>Target Populations</th>
<th>List of Services</th>
</tr>
</thead>
</table>
| Housing Transition Services | Pre-tenancy support services that aid an individual’s ability to prepare for and transition to housing | • Lead entity:  
  o CCOs  
  o Tribes or I/T/Us  
• Additional partners:  
  o Primary, behavioral and SUD providers  
  o Local hospital(s)  
  o Local housing agencies  
  o City and county agencies  
  o Affordable housing providers  
  o CBOs focused on health equity | • Reductions in ED use and psychiatric boarding  
• Decreases in inpatient admissions and total hospital days  
• Decreased discharges to secure residential treatment facilities  
• Increase in transitions from recovery to permanent housing settings  
• Increase in access to care and quality of care after moving into housing | • Tenancy screening and assessment  
• Assistance with housing searches and applications, move-in assistance, short-term expenses such as security deposits, other landlord-required rental or lease costs  
• Moving costs, basic furnishings, food and grocery supports  
• Adaptive aids and environmental modifications  
• Housing support crisis plan and intervention services  
• Care coordination services with medical homes, behavioral health and SUD providers, including transportation to medical appointments for CHP enrollees in rural communities. | • Tenancy rights/responsibilities education; coaching in maintaining relationships with landlords  
• Eviction prevention (paying rent on time, conflict resolution, lease behavior requirements) |
| Tenancy Sustaining Services | Services that support the individual in being a successful tenant in his/her housing arrangement and thus able to | • Lead entity:  
  o CCOs  
  o Tribes or I/T/Us  
• Additional partners:  
  o Primary, behavioral and SUD providers  
  o Local hospital(s)  
  o Local housing agencies | • Reductions in ED use  
• Decreases in inpatient admissions and total hospital days  
• Increases in primary care and behavioral health |
<table>
<thead>
<tr>
<th>Pilot Domain</th>
<th>Program</th>
<th>Partners</th>
<th>Program Goals and Potential Measures</th>
<th>Target Populations</th>
<th>List of Services</th>
</tr>
</thead>
</table>
| housing      | sustain tenancy including permanent supportive housing and family housing | o City and county agencies  
               |                                                                          | o Affordable housing providers  
               |                                                                          | o Other community based entities  
               |                                                                          | o CBOs focused on health equity | Retention in housing unit for 12 months or longer  
               |                                                                          | Reductions in eviction rates.  
               |                                                                          | Increase in percentage of individuals that access employment and benefits services  
               |                                                                          | Increase in the percentage of individuals who transition to affordable housing (market rate housing/community housing placement)  
               |                                                                          | Increase in self-sufficiency among those served |                   | Utilities management (e.g. help with paying monthly bills)  
               |                                                                          | Crisis interventions and linkages with community resources to prevent eviction when housing is jeopardized  
               |                                                                          | Utility assistance (e.g. financial assistance to pay utility bills)  
               |                                                                          | Linkages to education/job training, employment  
               |                                                                          | Care coordination services with medical homes, behavioral health and SUD providers |                   |