Attachment J
HRSN Infrastructure and Services Protocol

HRSN Services. In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions (STCs) this protocol provides additional detail on the requirements for the delivery of services for the Health-Related Social Needs (HRSN) program, as specifically required by STC 9.6(b). The state may claim FFP for the specified evidence based HRSN services identified in STC 9.2, (subject to the restrictions described below and the exclusions in STC 9.4). This protocol outlines the covered HRSN services, a process for identifying eligible individuals, a process for determining the services medically appropriate, and a description of the process for developing care plans based on assessment of need.

I. Member Eligibility.

a. Covered Populations. The following covered populations will be eligible to receive HRSN services provided that they also satisfy the applicable clinical and social risk criteria and the HRSN service is determined to be medically appropriate:

Covered Population	Population Description

Young Adults with Special Health Care Needs (YSCHN)	Including:
	• Members aged 19 to 26, with income up to 300% of the Federal Poverty Level (FPL), meeting at least one of the following criteria:
	  ◦ One or more complex chronic conditions as identified in the Pediatric Medical Complexity Algorithm (PMCA);
	  ◦ Serious emotional disturbance or serious mental health issue indicated by qualifying behavioral health diagnosis;
	  ◦ Diagnosed intellectual or developmental disability;
	  ◦ "Elevated Service Need" or functional limitations as determined by two or more affirmative responses to a screener; and
	  ◦ Starting no earlier than January 1, 2026, two or more chronic conditions as represented by a subset of the PMCA's non-complex chronic conditions.

Adults and youth discharged from an Institution for Mental Disease (IMD)	Including: • Members that were discharged from an IMD or qualifying non-IMD residential behavioral health setting in the last 12 months. • The state will determine based on licensure status the universe of facilities that will be considered qualifying non-IMD residential behavioral health setting for purposes of this definition. Eligibility must be determined within 12 months of discharge, and may extend for up to 12 months thereafter.
Adults and youths released from incarceration	• Including members released from incarceration within the past 12 months, including those released from state and federal prisons, local correctional facilities, juvenile detention facilities, Oregon Youth Authority closed custody corrections, and tribal correctional facilities.

	Eligibility must be determined within 12 months of discharge, and may extend for up to 12 months thereafter.
Youth involved with child welfare	Including members who are currently or have previously been: • In foster/substitute care; • Receiving adoption or guardianship assistance or family preservation services; or • The subject of an open child welfare case in any court.
Individuals transitioning to Dual Status	• Members enrolled in Medicaid that are transitioning to dual Medicaid/Medicare status. Members shall be included in this covered population for the 90 days (3 months) preceding the date Medicare coverage is to take effect and the 9 months after it takes effect. Eligibility must be determined within 9 months of transition and may extend for up to 12 months thereafter.
Individuals who are homeless or at risk of homeless	• Members who meet the definition of homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5.
Individuals with a high-risk clinical need in a region experiencing extreme weather	• Members who reside in an area where a significant weather event, such as unusually high or low temperatures, wildfires, or compromised air quality, is (i) currently taking place as determined by a federal, state, local, or tribal government authority or (ii) reasonably predicted to occur by a state or federal government authority such as the National Weather Service; and who also • Have a high-risk clinical need, defined to include members who: o Are Age 65 or over; o Homebound; o Need assistance with Activities of Daily Living or Instrumental Activities of Daily Living (ADL/IADL) o Receive long-term services and supports (LTSS); o Have physical or behavioral health conditions or disabilities that make them at greater health risk due to weather events such as significant heat or cold or poor air quality; o Are pregnant/postpartum up to 12 months; or o Are less than six years of age. Members that currently reside in a congregate care facility, community health facility, or other institutional setting are excluded from this covered population.

b. Medical Appropriateness. To ensure the services are medically appropriate, the state will require that individuals identified as in need of HRSN services meet the following clinical and social risk criteria. To qualify for a HRSN service, a member must:

i. Meet the eligibility criteria for one or more of the covered populations (described above in Section I.a);
ii. Have at least one of the following clinical risk factors;
iii. Have one of the following social risk factors; and
iv. Meet any additional eligibility criteria and requirements that apply in connection with the specific HRSN service (e.g., utility costs may only be provided for members who are also receiving rent/temporary housing).

Clinical Risk Factor	Risk Factor Description
Complex Behavioral Health Need	• An individual with a diagnosed or undiagnosed mental health condition, substance use disorder, that requires treatment and/or supports for the individual to achieve and maintain health goals and stability
Developmental Disability Need	• An individual with an intellectual disability or developmental disability[1] that requires services or supports for the individual to achieve and maintain care goals
Complex Physical Health Need	• An individual with a persistent, disabling, progressively or life-threatening physical health condition(s) requiring treatment for, stabilization, or prevention of exacerbation, ◦ Examples may include chronic conditions such as: congenital anomalies that adversely impact health or function, blindness, disabling dental disorders, chronic neurological diseases, chronic cardiovascular diseases, chronic pulmonary diseases, chronic gastrointestinal diseases, chronic liver diseases, chronic renal diseases, chronic endocrine diseases, chronic hematologic disorders, chronic musculoskeletal conditions, chronic infectious diseases, cancers, autoimmune disorders, immunodeficiency disorders or chronic immunosuppression
Needs Assistance with ADLs/IADLs or Eligible for LTSS	• An individual who needs assistance with one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) • An individual who receives or is determined eligible for Medicaid-covered long-term services and supports (LTSS) such as services through Oregon Department of Human Services' (ODHS) Aging and People with Disabilities (APD) or ODHS' Office of Developmental Disabilities Services (ODDS)
Interpersonal Violence Experience	• An individual who is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence

Repeated Emergency Department Use and Crisis Encounters	• An individual with repeated use of emergency department care (defined as two or more visits in the past 6 months or four or more visits in the past 12 months)
	• An individual with one crisis encounter in the past 6 months or two encounters in the past 12 months, defined to include:
	  ◦ Receipt of crisis/outreach team services;
	  ◦ Use of behavioral health mobile crisis, crisis respite services, or school behavioral health crisis services;

[1] As defined by OAR 411-320-0080

	○ Any length of stay in an adult or youth carceral setting; ○ Any length of stay in an emergency shelter; and, ○ Any length of stay in emergency foster care • An individual who was exited from a housing or behavioral healthcare program (e.g., shelter setting, day habilitation program, etc.) or from a school or an early childhood program in the past year
Pregnant/Postpartum	• An individual who is currently pregnant or up to 12 months postpartum
Children less than 6 years of age	• A child who is less than six years of age
Adults 65 years of age or older	• An adult who is 65 years of age or over
Young Adults with Special Health Care Needs	• An individual aged 19 to 26, with the following clinical risk factors defined in STC 4.6(a): • Have one or more complex chronic conditions as identified in the Pediatric Medical Complexity Algorithm (PCMA); • Have a serious emotional disturbance or serious mental health issue indicated by qualifying behavioral health diagnosis; • Have a diagnosed intellectual or developmental disability; • Have an "Elevated Service Need" or functional limitations as determined by two or more affirmative responses to a screener; or • Starting no earlier than January 1, 2026, have two or more chronic conditions as represented by a subset of the PMCA's non-complex chronic conditions as described in the New Initiatives Implementation Plan.

Social Risk Factor	Risk Factor Description
Housing-Related Needs	• An individual who: • Meets the definition of homeless or at risk of becoming homeless provided by HUD in 24 CFR 91.5; • Meets the definition of homeless children and youth provided the McKinney-Vento Act at 42 U.S.C. § 11434a(2); • Demonstrates a risk of losing current housing and lacks the resources or support networks to obtain other permanent housing; or, • Is exiting an institutional or congregate setting or system of care (such as a health care facility, a mental health facility, foster care or a youth facility or correction program or institution) without a stable clinically appropriate housing situation to return to or was homeless immediately prior to entering that institutional stay.
In Need of a Housing Service	• An individual who requires services to navigate, obtain, and sustain housing tenancy or create an accessible and healthy home environment

Nutrition-Related Needs	• An individual meeting the USDA definition[2] of marginal food security with one or two reported indications of food access problems or limitations—typically of anxiety over food sufficiency or shortage of food in the house. Little or no indication of changes in diets or food intake.
HRSN Device Needs	• An individual who has a need that will be aided by one of the following devices: air conditioners, heaters, air filtration devices, portable power supplies (PPSs), and refrigeration units.

c. **Publicly Maintained Criteria.** The state will maintain the clinical and social risk criteria detailed above on a public facing OHA webpage, and require that CCOs and FFS TPCs also maintain these criteria on a public facing webpage. The content will be updated if the criteria is changed.

II. HRSN Services

a. **Use of a Third-Party Contractor or Other Contracted Vendor.** OHA may contract with a third-party contractor (TPC) or other entity to perform service approval, care management, and other functions related to the administration of HRSN services for members covered under the FFS program (hereafter referred to as "FFS TPC"). The state will work with Tribal Government on a culturally responsive and specific HRSN service delivery approach for American Indian/Alaska Native (AI/AN) members.

b. **Providing culturally and linguistically appropriate services.** All HRSN services must be provided in a way that is culturally responsive and ensures meaningful access to language services. The state will require CCOs, and the FFS TPC to provide services in support of OHA's health equity goals, consistent with National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) to ensure language access across all services.

c. **Nonduplication of services.** No HRSN service will be covered that is found to be duplicative of a state or federally funded service or other HRSN service the member is already receiving.

d. **Covered HRSN Services.** The state will cover the following HRSN services as defined below:

Service	Description
Rent/temporary housing	Payment for housing stability for up to six months, including: 1. Rent payments for apartments, single room occupancy (SRO) units, single-family homes, multi-family homes, mobile home communities, accessory dwelling units

[2] *Definitions of Food Security* (2022). USDA Economic Research Service. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security

	(ADUs), co-housing communities, middle housing types, trailers, and manufactured homes; 2. Payments for short-term motel or hotel stays; 3. Payments for transitional and recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming; and, 4. Other appropriate settings, as approved by OHA. Payments must only be provided in connection with dwellings that meet state standards for safety, sanitation, and habitability. Rent/temporary housing is only available to individuals who are transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), correctional facilities, and acute care hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and youth transitioning out of the child welfare system including foster care.
Utility costs	Utility costs are limited to households receiving rent assistance/temporary housing and are available for up to six months. This assistance may include: 1. Recurring payments for utilities, including water, gas, electric, internet and phone(inclusive of land line phone service and cell phone service); 2. Payment for non-refundable, non-recurring utility set-up costs for utilities; or 3. Payment to resolve arrears related to unpaid utility bills and cover non-refundable, non-reoccurring utility set-up costs to restart the service if it has been discontinued.
Pre-tenancy and housing transition navigation services	Pre-tenancy and housing navigation services are flexible supports to individuals or households, or both individuals and households, to achieve their stability goals, as defined by them. These services include: 1. Working with the individual to develop a housing plan that supports the stated needs of the member and/or household to achieve their stability goals; 2. Reviewing, updating, and modifying the plan with the member to reflect current needs and preferences and address existing or recurring housing retention barriers; 3. Searching for housing and presenting options; 4. As needed, facilitating enrollment in the local Continuum of Care's Coordinated Entry System; 5. Assisting in completing housing applications and payment of any housing application or inspection fees;

	6. Assisting in obtaining identification and other required documentation (e.g., Social Security card, birth certificate, prior rental history); 7. Assisting in securing transportation to ensure access to housing options prior to transition and on move in day; 8. Ensuring that the living environment is safe and ready for move-in; 9. Assisting in arranging for and supporting the details of the move; 10. Engaging the landlord and communicating with and advocating on behalf of the member with landlords; 11. Providing supports to assist the member in communicating with the landlord and property manager; 12. Providing training and resources to assist the member in complying with the member's lease; 13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized; 14. Providing supports to assist the member in the development of independent living skills needed to remain housed (e.g., skills to maintain a healthy living environment, develop and manage a household budget, interact appropriately with neighbors or roommates, reduce social isolation, utilize local transportation, etc.); 15. Providing help with securing and maintaining entitlements and benefits that may be needed to obtain and maintain housing stability (e.g., TANF, WIC, SNAP, Social Security, Social Security Disability, and Veterans Affairs benefits); 16. Supporting housing stability by facilitation of the enrollment of individuals of the household in local school and college systems; 17. Providing connections to expert community resources to address issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions; or 18. Assisting individuals in gaining access to other necessary medical, disability, social, educational, legal, income-related tools and resources for housing, and other services.
Tenancy Sustaining Services	Services to assist individuals in maintaining housing stability. This assistance may include: 1. Engaging the landlord and communicating with and advocating on behalf of the member with landlords; 2. Providing supports to assist the member in communicating with the landlord and property manager;

	3. Providing training and resources to assist the member in complying with the member's lease; 4. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized; 5. Providing supports to assist the member in the development of independent living skills needed to remain housed (e.g., skills to maintain a healthy living environment, develop and manage a household budget, maintain relationships with neighbors or roommates, reduce social isolation, utilize local transportation, connect to needed behavioral health or other healthcare services, peer mentors or social supports, etc.); 6. Providing help with securing, utilizing, and maintaining entitlements and benefits that may be needed to obtain and maintain housing stability (e.g., TANF, WIC, SNAP, Social Security, Social Security Disability, and Veterans Affairs benefits); 7. Supporting housing stability by coordinating to facilitate the enrollment of individuals of the household in local school and college systems; 8. Providing connections to expert community resources to address issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions; or 9. Assisting individuals in gaining access to other necessary medical, social, educational, legal, and other services (e.g., connections to behavioral health treatment providers).
One-time transition and moving costs and housing deposits	One-time transition and moving costs necessary to establish a basic household such as: 1. Deposits needed to secure housing (i.e. security deposits); 2. First months and last month's rent as required by landlord for occupancy; 3. Set-up fees/deposits for utilities or service access and utility arrearages; 4. First month coverage of utilities, including water, gas, electric, internet and phone; 5. Moving and relocation expenses; 6. Services needed to secure the health and safety of the individuals in the dwelling, such as pest eradication and one-time cleaning prior to occupancy; 7. Pantry stocking at move in; or 8. Basic household goods and furniture, which may include appliances necessary for food consumption and

	cleaning, bedding, furnishings, and cleaning supplies, among other essential items.
Medically necessary home accessibility modifications and remediation services	The provision of medically necessary home accessibility modifications and remediation services to eliminate known home-based health and safety risks and ensure the occupants' health and safety in the living environment. • Accessibility modifications may include: ramps, rails, pathways, fencing, grip bars, among other modifications. • Home remediation services may include: cleaning supplies, pest eradication, carpet or mold removal, installation of washable curtains or synthetic blinds to prevent allergens, or lead abatement, amongst other services. • Weatherization assistance services may include: ceiling, wall, and floor insulation, energy-related minor home repairs, air infiltration reduction, furnace repair and replacement, or heating duct improvements.
Nutrition education	Any combination of educational strategies, accompanied by environmental supports, designed to motivate and facilitate voluntary adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being.
Medically tailored meals	Meals and meal kits tailored to support individuals with health-related condition(s) for which nutrition supports would improve health outcomes. This service includes: 1. An initial assessment with a Registered Dietitian Nutritionist (RD/RDN), or, if not available, a primary care provider, to develop a medically appropriate nutrition care plan; 2. The preparation and provision of the prescribed meals or meal kits consistent with the nutrition care plan, up to 3 meals a day, for up to 6 months; and 3. Regular re-assessment at least once every three months. Meals must be provided in accordance with national guidelines, such as the Dietary Guidelines for Americans, or evidence-based practice guidelines for specific chronic diseases and conditions. The service must follow food safety standards and consider an individual's personal and cultural dietary preferences.
Meals or pantry stocking	Meals or pantry stocking for children under 21, YSHCN, and pregnant individuals. May be up to 3 meals a day for up to 6 months. Meals and pantry stocking may be provided at the member or household level. Service must be provided in accordance with evidence-based nutrition guidelines and food safety standards. The service must also be person-centered, consider dietary preferences, and be culturally appropriate.

Fruit and vegetable prescriptions	Food service that helps individuals purchase fruits and vegetables from participating food retailers and farms, which may include but is not limited to grocery stores, farmers markets, farm stands, mobile markets, and community-supported agriculture (CSA) programs. Services may be provided at the member or household level. Services are limited to 6 months.
Medically necessary air conditioners, heaters, air filtration devices, portable power supplies, and refrigeration units	The provision, service delivery, and installation as needed of one or more of the following "home devices" (i.e., air conditioners, heaters, air filtration devices, portable power supplies and refrigeration units) to individuals for whom the device is needed for medical treatment or prevention. Examples of medical necessity would include, but not be limited to, the following: 1. Air conditioners for individuals at health risk due to significant heat; 2. Heaters for individuals at increased health risk due to significant cold; 3. Air filtration devices for individuals at health risk due to compromised air quality, and replacement air filters as needed; 4. Refrigeration units for individuals who lack a working refrigeration unit or a unit that meets their medical needs (e.g., because it has inadequate temperature controls to meet their medication storage needs, etc.); or, 5. Portable power supplies (PPS's) for individuals who need access to electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs that may compromise their ability to use medically necessary devices.
HRSN Outreach and Engagement, and Other Benefit Linkages	Activities may include: 1. Attempting to locate, contact, and engage individuals who may be eligible for HRSN services; 2. Using multiple strategies for engagement, including in-person meetings where the member lives, seeks care, or is accessible; community and street-level outreach; and mail, text, phone, and email; 3. Documenting outreach and engagement attempts, outcomes, and modalities; 4. Working with the member to provide the information necessary for assessment of HRSN service need, including through multiple engagements with the member as needed; 5. Determining whether the member is enrolled in the Fee for Service (FFS) program or a Coordinated Care

	Organization (CCO), and if a CCO which one, and then transmitting the partially or fully completed Eligibility and Service Need Form to the member's CCO or to the FFS program (or its designated third-party contractor) for eligibility determination and service authorization; 6. Helping the member to enroll, re-enroll, or maintain enrollment in Medicaid; 7. Providing help with securing and maintaining entitlements and benefits, such as TANF, WIC, SNAP, Social Security, Social Security Disability, and Veterans Affairs benefits, and other federal and state housing programs; 8. Assisting in obtaining identification and other required documentation (e.g., Social Security card, birth certificate, prior rental history) needed to receive benefits and other supports; 9. Connecting individuals to settings where basic needs can be met, such as access to shower, laundry, shelter, and food; or 10. Assisting individuals in gaining access to other necessary medical, peer, social, educational, legal, and other services.

III. **Provider Qualifications**

a. Service providers will be required to meet the following minimum qualification requirements:

i. Demonstrate the capacity and experience to provide HRSN services as described below:

1. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing.
2. Nutrition services providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety.
3. HRSN outreach and engagement and benefit linkages providers must have knowledge of principles, methods, and procedures of these services or comparable services meant to outreach to and engage the populations covered under the waiver and connect them to benefits and services to meet their needs.
4. Providers of medically necessary home devices during significant weather events (e.g., ACs during heat waves) must have knowledge and experience in providing such devices during significant weather events, including the ability to store devices and distribute them prior to or

during the event so that members have access to the devices when they need them most (i.e., while the event is taking place)

5. Providers of medically necessary devices at times other than during significant weather events must have the ability to timely and appropriately deliver devices to members' homes.
6. All HRSN services providers must:
    a. Demonstrate a readiness to serve as a HRSN provider for eligible populations;
    b. Demonstrate strong community relationships;
    c. Demonstrate the capacity to provide culturally and linguistically responsive and trauma-informed service delivery;
    d. Have appropriate business licensing or accreditation that meets state and industry standards, as needed;
    e. Demonstrate the ability to receive referrals through closed loop referral technology or an alternative mechanism such as email, regular mail, fax, or other mechanism, and to close the loop on referrals by reporting service delivery and delivery status;
    f. Demonstrate the ability to invoice for services as agreed upon with their contracted CCO/FFS TPC;
    g. Demonstrate a history of responsible financial stewardship and integrity; and,
    h. The ability to comply with all reporting and oversight requirements established by the state or CCO.

b. CCOs and the FFS program will be required to ensure that HRSN service providers meet and maintain compliance with these minimum qualification requirements.

IV. Member Identification and Assessment of Service Need.

a. Member Identification. The state will ensure individuals can be identified for HRSN services through many different pathways.

i. The following are examples of individuals and entities that will be expected to identify individuals in needs of HRSN services:
    1. Private and public housing service agencies and housing providers
    2. Nutrition service agencies and providers
    3. Correctional institutions
    4. Health care providers including but not limited to primary care providers, behavioral health providers, hospitals, and long-term services and supports (LTSS) providers
    5. State, local, and federal agencies who engage with Medicaid members
    6. Traditional health workers
    7. CCO care managers
    8. Child welfare workers and other case managers
    9. Other CBOs who engage with Medicaid members
    10. Individuals will also be permitted to self-refer for HRSN services

ii. The state may require CCOs or any TPCs used for the FFS program to conduct outreach and seek to engage in HRSN services specific populations or specific individuals identified by the state as a high priority. In addition, the state may require CCOs or any TPCs used for the FFS, to proactively identify members

who may be eligible for HRSN services or who may be the priority populations for HRSN services, as established by the state and in accordance with state-established guidelines.

iii. CCOs and, if applicable the FFS TPC, will be required to estimate the number of individuals they expect to serve each year with HRSN services, as well as report to the State on the actual number of individuals they do serve.

b. Assessment of Service Need.

i. The state will provide an Eligibility and Service Need Form that contains necessary information about individuals identified with a service need for an approval decision.

ii. An entity that identifies a member in need of HRSN services will work with the member or their guardian to complete the information in the Eligibility and Service Need Form and transmit it to the member's CCO or the FFS TPC. If the entity does not know whether the member is enrolled in the FFS program or a CCO, or which CCO the member is enrolled in, the entity may follow its preferred approach to connecting the member with appropriate resources, which may include calling the local CCO or CCOs, calling OHA member services, or seeing if there is relevant information in the Homeless Management Information System (HMIS).

iii. The transmission of the information in the Eligibility and Service Need Form to a CCO or the FFS TPC will take place through a closed-loop referral mechanism, preferably Community Information Exchange (CIE) if possible and if not, through an alternative system. CCOs and the FFS TPC will be required to establish processes for receiving the Eligibility and Service Need Form through pathways other than the CIE such as email, regular mail, and fax. These pathways must be made clear and accessible to members, CBOs, providers, and other potential entry points through information posted on the websites of each CCOs and FFS TPC and through other means.

iv. Entities may submit to a CCO or the FFS TPC a partially completed Eligibility and Service Need Form. It will be the responsibility of the CCO or FFS TPC to follow up with the member and, if needed and appropriate, the entity that submitted the form, to obtain the additional information needed to determine eligibility and authorize services. The CCO or FFS TPC will be required to document its attempts to collect the information needed to determine eligibility.

V. Service Approval

a. Upon receipt of the information in the Eligibility and Service Need Form, the CCO, Tribal Government, or the FFS TPC will determine whether the service may be authorized. The service approval will be based on the following criteria:

i. Confirmation that the member is enrolled in the Oregon Health Plan;

ii. Determination that the individual meets the eligibility criteria for one of the HRSN covered population groups;

iii. Determining what other services the individual is receiving or may be eligible to receive under Medicaid or other programs;

iv. Assessment of the individual's clinical and social needs (described above in Section I.b) that justify the medical appropriateness of the service; and,

v. Determination of the medically appropriate service duration, not to exceed twelve months for an initial authorization.

b. CCOs and the FFS TPC will be required to:

i. Notify the individual of approval or denial of the service and provide information about appeals and hearing rights; and

ii. Document the approval or denial of services through the closed loop referral technology; or chosen alternative system by the referring entity, ensuring a closed loop of the referral.

VI. Care Management and Service Plans

a. The CCOs/FFS TPC will conduct care management for individuals approved for HRSN services. The care management will include:

i. Developing the person-centered service plan (PCSP) with the member, with review at least every 12 months;

ii. Referring the member to a HRSN provider for the approved services, and supporting member choice of provider, ensuring member needs are met by the provider, and finding alternative providers if needed;

iii. Identifying other HRSN services the member may need;

iv. Determining what other services the individual is receiving or may be eligible to receive under Medicaid or other programs;

v. Coordinating with other social support services and care management the member is already receiving or becomes eligible for while receiving the HRSN service;

vi. Conducting reassessment for services prior to the conclusion of the service; and

vii. At a minimum, conducting a 6-month check-in to understand if HRSN services are meeting their needs, or if additional/new services are needed, if the service duration is longer than 6 months.

b. The CCO/FFS TPC care manager and the member will create the PCSP for the individual to obtain the HRSN service as approved by the CCO/FFS TPC. The PCSP will be in writing and developed with and agreed upon by the member.

i. The PCSP will include:

1. The recommended HRSN service;
2. The service duration;
3. The determination that the recommended service, unit of service, and service duration is medically appropriate based on clinical and social risk factors;
4. The goals of the service(s);
5. The follow-up and transition plan;
6. The CCO/FFS TPC care management team responsible for managing the member's HRSN services.

c. The care manager is required to have one meeting with the individual, either in person or by telephone or videoconference during the development of the PCSP. If efforts to have a meeting are unsuccessful, the care manager is required to document connection attempts, barriers to having a meeting, and justification for continued provision of service.

d. A parent, guardian, or caregiver of a child may receive an HRSN service on the child's behalf if the parent, guardian, or caregiver lives with the child and it is in the best interest of the child as determined through the PSCP.

VII. Conflict of Interest

a. To protect against conflict of interest and ensure appropriate separation of assessment, service planning, and service provision, the state will require that the CCO and FFS TPC perform the service authorization function and develop the PCSP 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 in subsection (b) and (c) below, or otherwise approved by OHA.

b. Assessment, service planning, and service provision for the service covering medically necessary air conditioners, heaters, air filtration devices, portable power supplies, and refrigeration units may be provided by: (i) CCOs and (ii) the state Medicaid agency program that provides medically necessary air conditioners and air filters to Medicaid members and other state residents, subject to protocols established by the state to ensure that assessment, service planning, and service provision are performed in accordance with all applicable requirements.

c. If the state contracts with Tribal organizations to perform HRSN service authorization and service planning for American Indian/Alaskan Native (AI/AN) enrolled in the state's FFS program, those Tribal organizations may also furnish HRSN services, subject to requirements established by the state to ensure that there is appropriate separation between assessment, service planning, and service provision to guard against conflict of interest.

VIII. Payment

a. After providing HRSN services to members who satisfy HRSN eligibility requirements, HRSN service providers will submit an invoice and additional required documentation to the member's CCO or the FFS TPC.

b. CCOs and the FFS TPC will reimburse HRSN service providers according to a fee schedule for HRSN services to be developed by the state, as detailed in the New Initiatives Implementation Plan.

c. CCOs and the FFS TPC may also pay HRSN services providers in advance for planned services, with the intent of conducting a reconciliation no less than annually to ensure services were rendered.