Attachment L
New Initiatives Implementation Plan

New Initiatives Implementation Plan. In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions (STCs), the New Initiatives Implementation Plan provides additional detail on the strategic approach to implementing Young Adults with Special Healthcare Needs (YSHCN), Health Related Social Needs (HRSN) Infrastructure, HRSN Services, and Continuous Eligibility, including timelines for meeting critical implementation stages and milestones, as applicable, to support successful implementation.

I. New Initiatives Implementation Approach and Timeline. The State will phase-in the implementation of key initiatives over the course of the demonstration. Information for each initiative as required in the STCs is included below.

a. Continuous Eligibility Implementation Activities and Timeline

i. The state's continuous eligibility policy became effective on July 1, 2023, and went live in the OregonEligibility (ONE) system on July 20, 2023. New CE policy grants continuous eligibility for children up to age six, and for 24-months of continuous coverage for children and adults over age six.

ii. The continuous eligibility policy applies to all individuals who experienced a renewal as a result of the end of the Public Health Emergency, or newly applied and were found eligible as of April 1 forward, and are still eligible and receiving benefits on July 1, 2023. The state will apply the continuous eligibility period for anyone who meets those criteria by establishing a continuous eligibility begin-date based on their renewal or initial application date. For example, if an adult was renewed in May 2023 and is still eligible on July 1, 2023, the state will begin the 24-month continuous eligibility period for this adult in May 2023.

iii. Systems updates, which went live on July 20, 2023, will automatically identify individuals who are undergoing their post-PHE renewal or newly applying and assign a continuous eligibility period to those individuals. At this time, the system will assign both a continuous eligibility period, and the renewal date will still reflect a 12-month period. There will be a second phase of systems updates in early 2024 that will deploy the system functionality to assign case renewal dates based on continuous eligibility periods present on the case.

b. Health Related Social Needs Implementation Activities and Timeline

i. *DY 21 – DY 22*: Procurement of Essential Vendors

1. The state will procure vendors necessary to deliver HRSN services. Throughout the first two years of the demonstration, the state will procure the following vendors:
    a. *Third-Party Contractor for FFS HRSN Operations:* The Third-Party Contractor (TPC) will support the HRSN

service delivery model for the Fee-For-Service (FFS) population, and may serve as a resource to CCOs should they choose to sub-contract key contractual obligations related to HRSN service delivery as detailed in contracts with Oregon Health Authority. Key activities for the TPC may include:

i. Building a network of HRSN service providers
ii. Providing support and TA to HRSN service providers
iii. Proactively screening for members who may be eligible to receive HRSN services
iv. Accepting referrals from state agencies, providers, community-based organizations, and other entities, for individuals who may be eligible to receive HRSN services
v. Conducting eligibility determination and service authorization
vi. Developing the person-centered service plan
vii. Referring the eligible individual to an appropriate HRSN service provider
viii. Providing care coordination and HRSN care management
ix. Accepting invoices from HRSN providers and verifying invoices are payable
x. Facilitating payment to HRSN providers
xi. Collecting data from HRSN providers and submitting data to OHA for monitoring and reporting
xii. Ensuring provision of services is culturally appropriate and trauma informed

b. The state may also enter into agreements with Tribal organizations to perform for FFS members who are also American Indian/Alaskan Native (AI/AN) HRSN service authorization and related functions that will be performed by the TPC for non-AI/AN FFS members.
c. *Administration of HRSN Infrastructure*: The state intends to carry out the essential administrative functions related to HRSN infrastructure disbursement and monitoring in partnership with another contracted entity (e.g., CCOs)*(see Attachment J for additional detail on roles and responsibilities).*
d. *Community Information Exchange for HRSN Service Delivery:* The state intends to procure Community

Information Exchange (CIE) vendor(s) to support statewide HRSN screening and referral data sharing for FFS members. These vendors are likely to be aligned with those CIE vendors providing the HRSN data sharing supports to CCOs. Over the course of the demonstration, HRSN providers throughout the state will use CIE to support HRSN data sharing. See Section II.a for additional details on the state's approach to data sharing.

e. The state may also consider procuring one or more Network Managers to support the development and oversight of adequate HRSN Provider networks across the state.

ii. ***DY 21 through DY 25:*** **Build Community Capacity and Award HRSN Infrastructure Funding**

1. In the initial years of the demonstration, the state will focus efforts on capacity building for key entities, (e.g., HRSN providers), to begin delivering HRSN services starting in Calendar Year (CY) 2024. Infrastructure funding disbursement is intended to be "front loaded" in the first half of the demonstration (i.e., DY 21-23), tapering off in the final years (i.e., DY 24-DY 25). In particular, the state intends to conduct the following activities either itself or via a contracted entity (e.g., CCOs):
    a. Receive input from the nine federally recognized Tribes, HRSN and community partners on infrastructure funding design and process;
    b. Conduct outreach and education to providers interested in delivering HRSN services on available infrastructure funding and requirements to becoming a HRSN provider;
    c. Provide technical assistance (TA) and support to providers interested in delivery of HRSN services to submit an application to receive infrastructure funding;
    d. Review the submitted applications and award infrastructure funding, as detailed in Attachment J; and,
    e. Monitor and oversee the use of infrastructure funding, as detailed in Attachment J.

iii. ***DY 22- DY 25*****: Phased Implementation of HRSN Services**

1. Beginning in CY 2024, eligible individuals will be able to receive HRSN services. All members must meet eligibility criteria as set forth in Attachment J: HRSN Services Protocol. Additionally service specific eligibility will apply as detailed in STC 9.2(a). The state intends to phase-in services on the following timeline:
    a. No sooner than January 2024:
        i. The following services for all eligible populations:

1. Medically necessary air conditioners, heaters, air filtration devices, portable power supply (PPS), and refrigeration units as needed for medical treatment and prevention
2. HRSN outreach, education and other benefit linkages[1]

b. No sooner than November 2024:
   i. The following services for populations "at risk of homelessness":
      1. Rent/temporary housing
      2. Utility costs
      3. Pre-tenancy and housing transition navigation services
      4. Tenancy sustaining services
      5. One-time transition and moving costs
      6. Housing deposits
      7. Medically necessary home accessibility modifications and remediation services
c. No sooner than January 2025:
   i. The following services for all qualifying individuals:
      1. Nutrition counseling and education
      2. Medically-tailored meals
      3. Meals or pantry stocking
      4. Fruit and vegetable prescriptions
d. At a date to be determined by the state based on HRSN service delivery experience in the initial DYs:
   i. All HRSN services fully phased-in for all eligible populations.

c. Young Adults with Special Healthcare Needs (YSHCN)

i. As part of the YSHCN initiative, the state intends to implement an expanded OHP YSHCN eligibility and an expanded OHP benefit for individuals in this eligibility category.

ii. The state developed a YSHCN Policy Oversight Team to oversee key policy decisions needed to operationalize YSHCN eligibility, benefit expansion and enrollment in OHP. The team will focus on two distinct scopes of work, including:

1. YSHCN Eligibility: Initial priority is to finalize a final list of behavioral health conditions and codes for YSHCN eligibility

[1] The state may opt to launch this service separately and at a later date from the roll-out of the medically necessary devices service.

related to the second approved waiver criteria: *(see also, Section iii.1.a; and Section iv below for more information on Eligibility)*

a. **STC 4.6.a.ii: Have a serious emotional disturbance or serious mental health illness.**

2. YSHCN Screening and Enrollment: Focus will be on developing a recommendation for a finalized screening tool and enrollment process that is culturally and linguistically responsive, based on review of the Child and Adolescent Health Measurement Initiative's (CAHMI) Children and Special Health Care Needs (CSHCN) Screener. This process will operationalize the pathway to qualify for YSHCN via the fourth approved waiver criteria:
    a. **STC 4.6.a.iv: Have an "Elevated Service Need" or functional limitations as determined by two or more affirmative responses to a screener**, modeled after the Child and Adolescent Health Measurement Initiative (CAHMI)'s "Children with Special Health Care Needs" (CSHCN) Screener.

iii. YSHCN Eligibility and Enrollment Framework

1. The YSHCN Policy Oversight Team is suggesting three pathways to YSHCN eligibility:
    a. Passive identification and enrollment (data-confirmed eligibility): Health care utilization data are automatically screened for young adults currently enrolled in OHP and nearing their 19th birthday
        i. Utilization matching the PMCA or identified behavioral health diagnostic codes *(see Section I.c.ii.1)* would trigger eligibility for YSHCN coverage as defined by **STC 4.6.a.i - .ii**
        ii. Programmatic eligibility: young adults with a diagnosed intellectual or developmental disability are automatically eligible for YSHCN coverage as defined by **STC 4.6.a.iii**
        iii. Operationalizing: Contractor to review claims data from MMIS, APAC and/or a combination of these sources. young adults flagged in systems for auto-enrollment upon 19th birthday.
    b. Hybrid identification (targeted screening): Certain scenarios activate further YSHCN screening via CSHCN screener to determine eligibility
        i. Defined service utilization patterns or diagnostic information (e.g. certain pre-determined conditions) that do not fully establish eligibility

ii. Members of OHA-prioritized populations are automatically screened, e.g. former foster youth eligible for Medicaid from out-of-state, young adults in carceral settings; and/or
iii. Certain answers to selected, related questions on ONE application

c. Referral and self-attested eligibility: Identification of settings more likely to refer and create referral pathways; self-attested YSHCN eligibility via adapted CHSHCN screener
   i. OHA to identify settings more likely to support or serve YSHCN (e.g. young adults -specific settings including schools, juvenile justice settings, other) and provide education on eligibility to providers & professionals (e.g. case coordinators) to assist in identification of eligible young adults
   ii. Youth complete/partners support y young adults to complete CSHCN screener; two or more affirmative answers signal YSHCN eligibility.
   iii. OHA proposes screener-identified eligibility will function as self-attested eligibility for the purposes of YSHCN. Standard eligibility factors (e.g. income, age) will still go through agency verification processes.
      1. Ensures equitable access with varying health care data availability (such as former foster youth from out-of-state vs. in-state)
      2. Reduces barriers to entry, particularly at launch of the program
      3. Shortens timeline from screening to eligibility determination, improving equity between passive and referral enrollment pathways
      4. Lowers administrative burden for Tribal Governments, CCOs, other contracted entities, and OHA
      5. Risk of false self-attestation perceived to be low

iv. The timeline and approach will ensure the state collaborates with key partners throughout the design and moving into the implementation of the expanded eligibility and benefit beginning January 2025. The planning and design process will include:
   1. Throughout 2023:

a. Assemble and consult a clinician and advocate panel to inform final set of behavioral health conditions and diagnostic codes for YSHCN eligibility
b. Finalize review of CAHMI screener to determine cultural and linguistic appropriateness, including family and young adult engagement
c. Finalize policy questions to inform systems changes and launch systems changes to state systems for claims, eligibility and enrollment (MMIS, ONE Eligibility, and Legacy)
d. Conduct health equity impact assessment on key policy and program decisions
e. Develop contract requirements for a data contractor responsible for ongoing mining of claims data for young adults with qualifying conditions for YSHCN (i.e. applying the Pediatric Medical Complexity Algorithm and any supplemental behavioral health condition codes)
f. Begin financial modeling for CCO contracts

2. Throughout 2024:
    a. Update CCO contracts as needed for CY 2025
    b. Continue implementation of, and finalize, systems changes
    c. Identify and implement needed changes to Oregon Administrative Rules, including Tribal Consultation
    d. Provide education to, and engage with, partner agencies, providers, and members of the public about YSHCN
    e. Secure data contract for claims mining
    f. Run the Pediatric Medical Complexity Algorithm (PMCA) and set flags for individuals who will be eligible on January 1, 2025

II. Data Sharing and Key Partnerships

a. Data Sharing

i. *Overview:* The state will work with CCOs and community partners on an approach to data sharing that meets entities where they are today and supports them toward uptake and the use of shared systems. Closed loop referral technology will provide a mechanism to conduct closed loop referrals and service provision between HRSN providers, the FFS TPC (described above) and CCOs. Data sharing between these entities may include general SDOH screenings, Eligibility and Service Need Form, person-centered service plan, and HRSN service referral and delivery status. The state will work with these entities to phase in the use of closed loop referral technology based on readiness and appropriateness, over the course of the demonstration. Today, all CCOs currently sponsor

closed loop referral technology use for their service region through the use of two CIE technology vendors. The state intends to contract the same two vendors and provide access to the closed loop referral technology for the TPC to ensure statewide access for members in FFS. OHA will contract to have access to all Medicaid member data related to CIE for analytics purposes.

ii. *Background:* From May through July 2022, the state engaged 99 CBOs statewide to understand views and experiences with CIE and solicit input to inform the state's approach to accelerate, support, and improve statewide CIE efforts.[2] As a result of this work and a CIE Workgroup of key partners in 2022, the state recommended that CBOs should be incentivized, rather than required, to use CIE.[3,4]

iii. *Approach:* The state, either itself or via a contractor, will incentivize HRSN providers to utilize the closed loop referral technology by offering infrastructure funds to support use of, training on and connection to closed loop referral technology. Further, the state will require CCOs to support and incentivize HRSN providers with closed loop referral technology uptake as part of the CCOs' contractual obligation with the state. The state will support the statewide provision of TA, education, and communities of practice for HRSN providers throughout the duration of the demonstration to ensure a consistent space to support providers with closed loop referral technology uptake.

1. The state will allow for exceptions for HRSN providers to use closed loop referrals as there may be situations where it is not feasible for the providers to participate and may impact equitable access to services for some members (e.g., monolingual non-English speaking HRSN providers). HRSN providers will be expected to use alternative modes to communicate about the status of referrals, services delivered and other required data elements.
2. The state will require CCOs to develop a plan for and report progress on supporting and incentivizing the adoption of closed loop referrals specifically as part of their overall Health IT Roadmaps.[5] This plan will need to include the CCO's approach to outreach, education, and incorporating feedback from HRSN providers. CCOs will also be required to ensure their plan for supporting closed loop referral technology adoption aligns with the SDOH: Social Needs Screening and Referral incentive measure.[6]

[2] CIE_Community_Engagement_Findings_and_Recommendations.pdf (oregon.gov)
[3] CIEWG_PrelimRecs.SupportforCBOstoParticipateinCIE.pdf (oregon.gov)
[4] https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/HB4150FinalReport.SupportingStatewideCIE.pdf
[5] Oregon's CCOs are required to submit Health IT Roadmaps to OHA each year outlining their strategies to accomplish Health IT goals. Redacted roadmaps are available at https://www.oregon.gov/oha/HPA/OHIT/Pages/HITAG.aspx
[6] https://www.oregon.gov/oha/hpa/dsi-tc/pages/sdoh-metric.aspx

3. The state intends to support closed loop referral technology uptake amongst HRSN providers and other entities participating in the HRSN initiative.

iv. *Reporting on HRSN-Related Data*. The state will require HRSN partners, including, for example: CCOs, FFS TPC, HRSN providers and others to maintain and report on key data elements related to HRSN service delivery. Key data elements will include, at a minimum:
   1. Demographic information on members receiving HRSN services
   2. Number of members currently receiving an HRSN service (listed by service)
   3. Number of members denied for HRSN services (listed by service)
   4. Number of members who have been referred to an HRSN provider
   5. Data to support evaluation of HRSN program, including, for example:
      a. Data on improvements in member health-related resource needs.
      b. Data on member health outcomes, if applicable
   6. Other data required by the state

v. Partners will be required to use strategies to meet these requirements which may include the need to modify existing methods to track the information above or develop new strategies to meet these requirements.

b. Key Partnerships and Approach to Soliciting Community Partner Feedback

Cross-sector and community-based partnerships are essential to the successful delivery of HRSN services to eligible members and promotion of health equity. The state has developed the following approach to engaging with and incorporating input from impacted partners, including HRSN providers, CCOs, members and others.

i. *Partner and Community Engagement Strategy:* The state has developed a strategy to ensure engagement across a diverse set of key partners involved in the design and implementation of HRSN services. OHA developed this strategy in partnership with sister agencies OHCS and ODHS to identify key partners and develop an effective engagement approach. As part of this focused engagement approach, the state will work with distinct audiences, including:
   1. Tribal governments and AI/AN members
   2. Contract holders (i.e. CCOs and FFS entities)
   3. Direct HRSN service providers (i.e. housing and nutrition CBOs)
   4. Oregon Health Plan members
   5. Others, as identified through continued engagement efforts by the state

ii. *CCO Partnership:* Through the current provision of related initiatives (e.g., health-related services (HRS)), CCOs have developed robust

provider networks, partnerships, and expertise in several areas, including, for example:

1. Care coordination, navigation and case management activities
2. Food services and supports, including vouchers, meal delivery, and farmers' markets
3. Housing services and supports, including temporary housing or shelter, utilities, critical repairs, air conditioners, items to improve mobility, and environmental remediation
4. Trauma-informed services and supports across sectors

iii. The state will support CCOs in building upon these existing networks, partnerships, and resources to now provide HRSN in addition to the continuation and coverage of HRS.

iv. The state will require CCOs to have networks of HRSN providers to sufficiently meet the needs of their members for nutrition and housing services, including culturally and linguistically appropriate and responsive services.

1. To inform this design, the state has and will continue to engage with CCOs on a regular basis through forums such as the:
    a. Regular meetings with CCOs specifically related to HRSN
    b. Monthly Operations Collaborative
    c. Monthly CCO Contracts Group
    d. Rate Workgroup

v. *Climate Specific Partnerships:* The state has been working with vendors since 2021 to establish partnerships for the purchase and distribution of air conditioners and air filtration devices to older and at risk Oregonians to protect their health and well-being in the event of extreme heat and wildfire smoke. The state will build on these partnerships to expand the types of devices and formalize the distribution processes to deliver these services to eligible populations.

III. Partnerships with State and Local Entities

a. The state intends to develop robust partnerships with other state and local agencies to help assist Medicaid members in obtaining non-Medicaid funded supports related to housing and nutrition, upon the conclusion of temporary Medicaid payment via the HRSN services program.

i. Medicaid is not intended to cover the cost of social supports for individuals in perpetuity. The state will develop strong partnerships state and local entities that prepare a pathway to providing whole person care in a sustainable way.

ii. The HRSN program provides an opportunity to formalize existing and develop new partnerships between the Medicaid delivery system and other federal, state and local initiatives that support improved health and wellbeing.

b. At a minimum, the state will undertake the following efforts to develop partnerships with key entities listed below:
    i. **Continuums of Care**. The state has active Continuums of Care (CoCs) that develop locally appropriate strategies to end homelessness. Throughout the demonstration, the state seeks to formalize partnerships between the Medicaid delivery system and CoCs. For example, the state will encourage CCOs to be active partners by joining the board, attending meetings, or joining sub-committees of their local CoC to build the relationships with their local housing partners. The state, in partnership with other entities, including CCOs and CoCs, will consider opportunities to support identification of additional housing resources that members may require, and to provide a more sustainable funding source for ongoing services beyond what is covered under Medicaid. As part of this partnership, the state is exploring ways to support CCOs to connect to the Homeless Management Information System (HMIS) in a way that preserves informed consent and creates mechanisms for sharing sensitive data cross-sectors. Additionally, the state will encourage CCOs to have their care coordinators, and intensive care coordinators become Coordinated Entry (CE) access points, along with any other member facing positions the CCO may have that could serve as a connection to CE. State convenings on HMIS data sharing are underway and will continue as part of this effort. The state intends to pursue these partnerships in advance of launching the housing services, in July 2024.
    ii. **Local Public Housing Authorities.** The state will seek to formalize and oversee partnerships between OHA and 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 HRSN or other Medicaid initiatives, including through partnerships with CCOs , the FFS TPC staff, local housing authorities and others. For example, CCO care coordination staff can 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 pursue these partnerships in advance of launching housing services, in July 2024.
    iii. **Supplemental Nutrition Assistance Program (SNAP) and Women, Infants and Children (WIC).** Oregon Health Authority works closely with the Oregon Department of Human Services (ODHS), which is the state department that administers SNAP. OHA administers the WIC program. The launch of the HRSN initiative provides the opportunity for more close coordination between the state agencies to maximize enrollment in federal and state programs. Through these partnerships, the state will identify opportunities to ensure eligible individuals are

seamlessly enrolled in other federal and state programs for which they are eligible—including SNAP and WIC. Efforts to promote these connections include identifying opportunities in the HRSN design to establish requirements for CCOs, HRSN providers and others, that support the goal of connecting members to SNAP, WIC and/or other federal and state programs for which they are eligible. The state intends to pursue these partnerships by the launch of the full suite of nutrition services, in January 2025.

IV. Information Technology Infrastructure

a. The state will ensure appropriate updates to existing IT infrastructure to support and promote the successful delivery and monitoring of HRSN services.
    i. Specifically, the state is updating state eligibility systems to reflect the eligible HRSN populations and services, as well as updates to the Medicaid Management Information System (MMIS) to appropriately support encounter information for payment processing.
    ii. There is a process underway for identifying required data elements for encounter files to enable actual reporting of HRSN services delivered by the CCO or FFS.
    iii. The state intends to develop a plan to enable data exchanges between various systems and state agencies to make sure that HRSN services are only offered when eligible individuals are not covered under other state programs.
    iv. The state is building a technology roadmap to outline all system requirement changes needed to track and report on HRSN services.

b. **Infrastructure for Invoicing for HRSN Services Delivered**. HRSN providers will be required to send invoices for the delivery of authorized HRSN services to either the CCO or the FFS TPC, based on the member.
    i. For CCOs, the CCO will be responsible for processing the invoice and issuing the payment to the HRSN provider. CCOs will generate an encounter for the service provided and send encounter data to the state.
    ii. For FFS, the TPC will be required to process the invoice and generate Electronic Data Interchange (EDI) claims transactions that are sent to the state. The state will use MMIS to ingest encounter information from the FFS TPC and draw on those encounters for payment processing. The state is developing appropriate systems to ensure encounters can be reviewed, revised if needed, and accepted or denied.

c. **Monitoring and Oversight**. The state will require HRSN partner, including CCOs, HRSN providers and others—to maintain program integrity standards in the HRSN program, leveraging existing or new IT infrastructure to conduct activities, including, for example:
    i. Tracking payments to HRSN providers for HRSN services delivered and monitoring for outliers;

ii. Conducting invoice analysis to avoid payment irregularities (e.g., over or underpayment);
iii. Conducting quarterly accounting on HRSN services delivered;
iv. Performing visit verifications to ensure individuals received the HRSN services for which they were authorized to receive; and,
v. Other activities required by the state.

d. The state is developing a plan to make sure that data is available for outcomes and CMS reporting, including data from other state agencies.
e. The state is continuing to explore future data integrations and connections that will create a sustainable statewide system, including infrastructure for a statewide consent tool.

V. SNAP, WIC, TANF, and Housing Assistance Program Enrollment. The state will use a multi-faceted approach to improve the share of beneficiaries enrolled in SNAP, WIC, TANF and other federal and state housing assistance programs ("key benefits").

a. Policies to Support Key Benefit Enrollment for Members Receiving HRSN Services. As described below, the HRSN services member journey is being designed to ensure the members receiving HRSN services are also applying for and maintaining other key benefits for which they may be eligible.

i. **Included on the Eligibility Screening and Need Form.** This form will include a section on whether a member is enrolled in, or interested in enrolling in key benefit programs, to be completed by the identifying entity or CCO/TPC as applicable.
ii. **Required as a Component of the Person-Centered Service Plan (PCSP).** First, the state will leverage CCOs and the FFS TPC to support member enrollment in key benefit programs through the person-centered service planning process. As part of the process, CCOs and the TPC will be required to review the key benefit information provided as part of the member's Eligibility and Service Need Form and then as needed, inquire further about the member's enrollment in key benefit programs in person, by phone, or through follow-up with the identifying entity. In its telephonic or in-person contact with the member, the CCO/TPC will be expected to confirm the information it has gathered to date about the member's enrollment in key benefits, and then include as a required element of the PCSP, a plan for supporting or maintaining the member's enrollment in key benefits for which the member is likely eligible.
iii. **Supporting Referrals for Key Benefit Application Assistance.** Upon a determination of member likelihood to meet eligibility criteria and interest in applying for key benefits, the CCO/TPC care manager shall make referrals to help the individual apply for benefits. The state expects that referrals will be made to the local ODHS office (for TANF and SNAP) and the local WIC office, as well as other organizations that can assist an individual, or direct an individual to assistance, for the

eligibility and enrollment process, such as 211, and other community partners including, but not limited to, HRSN contracted providers. In determining the appropriate referral, the CCO/TPC shall consider, first and foremost, the organization who is most likely to succeed in engaging with the member and supporting their enrollment in key benefit programs, such as an organization that has a trusted relationship with the member, is culturally and linguistically responsive, or that is or will be providing other services to meet the member's needs (whether HRSN waiver services or not). The CCO/TPC care manager will be required to follow up with the member on any referral and provide additional referrals or direct support as needed to facilitate the member's application for key benefits. If the member's application is deemed incomplete or denied, the care manager will be expected to ensure the member receives assistance, including by referral to an organization that can provide the assistance as needed, to submit any missing information or appeal the denial, if the member wishes to pursue an appeal. All efforts to connect the member to key benefits must be documented in the PCSP. As part of its oversight of CCO/TCP administration of HRSN services, OHA will require CCO/TPC reporting on compliance with these requirements, conduct its own monitoring activities (e.g., spot audits), and where significant deficiencies are found, require corrective action by the CCO/TPC.

iv. **Included as An Element of Several Covered HRSN Services.** To support key benefit enrollment, providing help with securing, utilizing, and maintaining benefits will be included in the HRSN service definitions and rate development for the following HRSN services:
    1. Pre-tenancy and housing transition navigation services,
    2. Tenancy sustaining services, and
    3. Outreach, engagement, and benefit linkages service

b. **Supporting Key Benefit Enrollment for All Medicaid Members.** The state will also seek to implement other policies designed to ensure that all Medicaid members, whether receiving HRSN services or not, have the appropriate supports needed to learn about and apply for the key benefits they need. Policies being implemented, developed, or under consideration include the following:

i. **Seeking Authorization for Application Assistors to Assist with Medicaid *and* SNAP.** The state is developing and seeking authorization for a pilot program from Food and Nutrition Services (a program of the United States Department of Agriculture) to offer help to individuals applying for SNAP. For the pilot, forty (40) contracted Medicaid application assistors would have the option to attend additional training to provide application help for SNAP applicants. Additionally, the twelve (12) contracted SNAP outreach organizations would have the option to help SNAP and/or Medicaid applicants access these benefits.

ii. **Enhanced Training Requirements for CCOs/TPC.** The state may consider requiring that CCO/TPC care managers receive training on how to help members in completing the written unified application for SNAP and TANF; support a member in real-time in connecting with 211 and working with the appropriate assistor to apply for key benefits and enroll in the local CoC's coordinated entry system (if available through 211); or submit a request online through the WIC site so that the member receives a call back to support WIC enrollment.

iii. **Learning Collaboratives.** The state may also consider hosting learning collaboratives for CCOs and the TPC with contracted HRSN providers, relevant state agencies, and other partners to share learnings on best practices in engaging with members to support their success in applying for and obtaining key benefits.

iv. **Member Input.** The state may consider requiring that CCOs use their Community Advisory Councils to seek input on how they can more effectively support members in connecting to key benefits, and report back on the feedback received through the discussions, and how the CCO plans to respond to this feedback, as part of their required reporting to the state on their advisory committees' activities.

c. **Data Tracking and Monitoring**

i. **Current Data Warehouses for Key Benefits**. Currently, enrollment information for Medicaid, TANF, and SNAP is housed in Oregon's unified Oregon Eligibility (ONE) system. Information on WIC enrollment is housed in a separate state database, and information on receipt of housing assistance in separate local versions of HMIS, held by the state's eight continuums of care. On a quarterly basis, the local Community Action Agency and CoCs share OHCS funded data with OHCS for inclusion in a statewide database.

ii. **Cross-Program Data Matching.** To support the state's effort to track and increase the share of Medicaid enrollees who are enrolled in key benefits, the state will conduct an annual cross-program data matching analysis to identify Medicaid enrollees who are likely eligible for but not enrolled in key benefits. The analysis will be conducted by the Integrated Client Services (ICS) division of the Oregon Office of Forecasting, Research, and Analysis (OFRA), an office that supports both OHA and the Oregon Department of Human Services (ODHS) ICS has experience and expertise in creating integrated data sets that involve cross-program data matching for State programs, including Medicaid, TANF, and WIC. ICS currently receives nutrition program enrollment information monthly and has an established process for obtaining the necessary data permissions, collecting and warehousing the data,, producing the data results, and sharing it with the state agencies that contributed data for the analysis results. While OHCS and HMIS data is

not currently available to ICS, OHA plans to partner with ICS in developing a strategy for using any data that can be obtained to track Medicaid member enrollment in state and federal housing assistance programs.

VI. Continuous Eligibility Member Verification

a. Beneficiary-Reported Information and Periodic Data Checks

i. The state will ensure that beneficiaries can make timely and accurate reports of any changes in circumstances, including changes to state residency or income. Beneficiaries will be able to report this information

ii. On at least an annual basis, the state will continue to verify residency, and confirm the individual is not deceased for all beneficiaries.

iii. To verify residency:

1. Subject to final approval from CMS, the state intends to use the quarterly Public Assistance Reporting Information Systems (PARIS) report to check which individuals are receiving concurrent benefits in another state.
2. Drawing on the PARIS report, the state will continuously analyze the quarterly PARIS report and confirm with other states that these individuals have applied and attested to being a resident in another state. If confirmed, eligibility for the Oregon Health Plan (OHP) will be terminated. If the state is unable to confirm, the individual will remain on OHP.

iv. To verify if a member is deceased:

1. The state will continue to use the same process and systems in place today. The OregonEligibility (ONE) system interfaces with the State Data Exchange (SDX), Beneficiary Earnings and Data Exchange (BENDEX) and Vital Stats databases to receive and track information related to the death of a member, and terminate coverage effective on the date of death.
2. Additionally the state receives a “Death File Report” from the Social Security Administration, which serves as a secondary check to the file received from SDX.
3. The state also received a “Do No Pay” report, which is a compilation from the American InfoSource, the SSA Death Master File, the Department of Defense Death Data, and the Department of State Death Data. The state uses this file as another check for records in the ONE system.
4. Once a month, the Medicaid Management Information System (MMIS) interfaces with data from the state Public Health Division. This interface automatically adds death date indicators in MMIS for deaths that occurred in the previous month, which leads to CCO disenrollment and initiates the prorated recoupment process.

b. Annual Updates to Beneficiary Information

i. The state clearly communicates reporting requirements, including updates to residential and mailing address and other contact information, on all eligibility correspondence with applicants and beneficiaries. Beneficiaries may report such changes online, in person, by telephone or by mail.

ii. The state will rely on this, in coordination with information available from resources described above, to maintain accurate beneficiary contact information. Additionally, reported changes relating to other OHA or ODHS benefits (SNAP, TANF, ERDC, etc.) will be considered for medical beneficiaries.

VII. HRSN Rate Methodologies

a. OHA to submit to CMS at least 60 days prior to implementation.

VIII. MOE

Commented [MF1]: CMS: This will be sent separately 60 days prior to launch of any HRSN service, per the STCs

Commented [MF2]: CMS: This was already submitted to CMS, per the STCs.