Joint Office of Homeless Services

NWPP NORTHWEST PILOT PROJECT

Health and Housing

Exploring Health and Housing Initiatives and Opportunities….

1. Medicaid & HRSN Benefits : Bringing Healthcare Dollars to Housing
2. Connecting Housing to Healthcare: Medical Case Conferencing
3. Connecting Housing to Healthcare: Program Level Innovations
4. Q&A

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Medicaid and Housing

What is the Oregon Health Plan?

Medicaid

- Medicaid is the nation's public health insurance program for families. All states have Medicaid, but it can look different in each state.
- In Oregon we call Medicaid the *Oregon Health Plan (OHP).*
- Covered Services: Physical, Oral, Behavioral Health, Care Coordination and Substance Use Disorder treatment

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Medicaid and Housing

What is the Oregon Health Plan?

- People are eligible for the Oregon Health Plan based on their income or for other reasons.
- You can apply for OHP at any time.
- Federal rules set minimum standards related to eligibility and required benefits. But states can ask to **WAIVE** some federal rules to have more flexibility and offer the Oregon Health Plan to more people and cover more services than usually allowed.
- Every five years, Oregon must renew its agreement with the federal government around the Oregon Health Plan – proposing new changes and continuing existing programs. The federal government can accept or reject these proposals..

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Medicaid and Housing

In late September 2022, the Federal government announced its approval of Oregon's Medicaid waiver, which expanded Oregon Health Plan (OHP) coverage and empowered the state to use Medicaid funding for health-related social needs such as food and housing.

There are several key features of the waiver including:

- Extended OHP coverage for children up to age 6
- Health-related social needs coverage for certain food assistance
- Health-related social needs coverage for housing
- Health-related social needs coverage for climate

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Health Related Social Needs (HRSN)

Health-Related Social Needs Benefit

Climate Supports

Medically necessary devices:

- Air conditioners
- Heaters
- Air filtration devices
- Personal Power Supplies
- Refrigerators

Housing Supports

- Rent/temporary housing assistance for up to 6 months
- Utility assistance for up to 6 months
- Pre-tenancy and housing navigation support
- Tenancy sustaining services
- One-time transition and moving costs and deposits
- Medically necessary home accessibility modifications

Food Supports

- Nutrition counseling and education
- Medically-tailored meals, for up to 6 months
- Meals or pantry stocking for up to 6 months
- Fruit and vegetable prescriptions for up to 6 months

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HRSN Benefit Timeline

Note: Oregon Health Authority may adjust timelines for housing and food benefits as HRSN planning continues

OHA Update – Shared on 4/24

Eligibility for HRSN Housing Services on 11/1/24

Eligible Populations

Individuals who are OHP members
+ Meet the HUD definition of At-Risk of Homelessness
+ Need support to maintain their current housing

+

One Clinical Risk Factor

- Complex Behavioral Health Need
- Developmental Disability Need
- Complex Physical Health Need
- Need for Assistance with ADLs / IADLs or eligible for LTSS
- Interpersonal Violence Experience
- Adults 65 Years of Age or Older
- Children less than 6 years of age
- Repeated Emergency Department Use and Crisis Encounters
- Pregnant / Postpartum
- Young Adults with Special Health Care Needs

=

HRSN Housing Service

Potentially eligible for:

- Rent
- Utilities
- Utility arrears and set-set up
- Storage fees
- Tenancy Services
- Home remediation/ modifications (TBD)

Service specific eligibility are detailed in service definitions

OHA Update – Shared on 4/24

At Risk of Homelessness" HUD Definition, 24 CFR 91.5

At Risk of Homelessness

A. Have an annual income below 30 percent of median family income for the area, as determined by HUD

+ and

B. Not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section

+ and

C. **Meets one of the following conditions:**
(A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
(B) Is living in the home of another because of economic hardship;
(C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
(D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
(E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
(F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
(G) Otherwise **lives in housing that has characteristics associated with instability** and **an increased risk of homelessness**, as identified in the recipient's approved consolidated plan:

- People who are severely rent-burdened (50% or more of income on rent),
- face domestic violence,
- hold unstable employment,
- an increased risk of health issues,
- have a serious and persistent mental illness (SPMI),
- have criminal histories,
- are precariously housed (residents living in non-traditional and/or multiple family /"couch-surfing" situations who are vulnerable to being evicted or kicked out),
- have substance use disorders.

OHA Update – Shared on 4/24

Step 3, continued: HRSN Housing Services

HRSN Housing Services for November 1, 2024 include:

- Rent and utility services
- Utility arrears
- Utility set up (only if utilities have been shut off)
- Storage fees
- Tenancy services
- Home modifications and remediation: TBD
- Hotel/motel stays: TBD, potential for use with home modifications/remediation

! **6 months PER qualifying member**

*Health plan = Coordinated Care Organization or Open Card care coordination
HRSN= Health-Related Social Needs; OHP= Oregon Health Plan; CCO=Coordinated Care Organizations

Community Capacity Building Funding (CCBF)

Other key points

- You can still bill and utilize HRSN if you do not apply for CCBF
- HRSN applications are being considered as part of a landscape
- Healthshare has been developing this landscape in partnership with providers, counties and other partners

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Health Share of Oregon

Community Capacity Building Funds: Background and 2024 Goals

- Health Share has **10.77M** to award for 2024.
- This funding must **support the development of a provider network** for HRSN housing and food benefits.
- OHA developed the application questions, scoring rubric and budget template.
- Health Share developed and publicly shared funding priorities for 2024 and stated investments would be made in the following categories.
  - Network Managers/Hubs
  - Housing Providers ready to deliver supports on day 1 of benefit
  - Food Providers ready to deliver supports on day 1 of benefit
  - Organizations who want to grow their capacity

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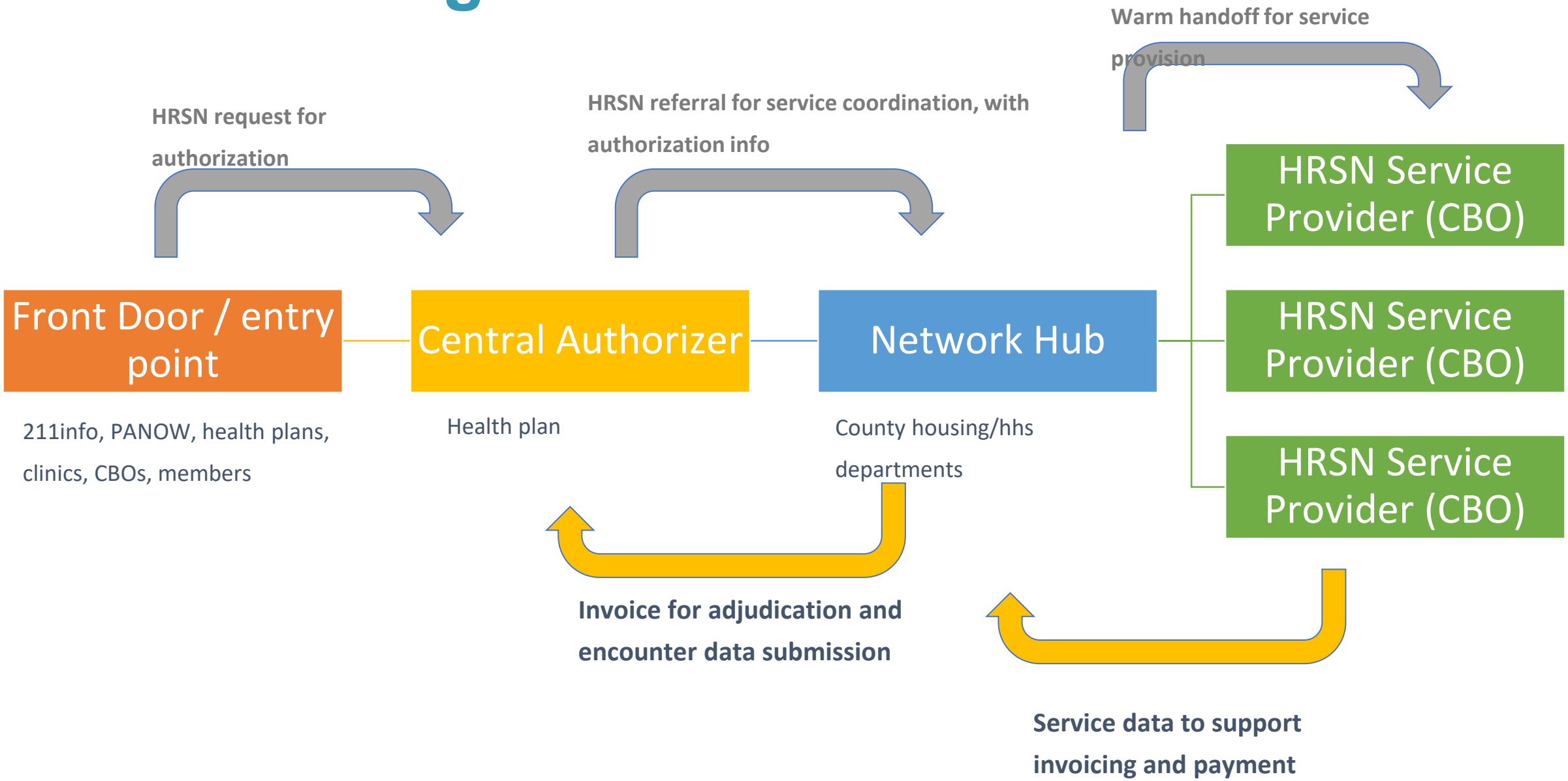
Health Share of Oregon

HRSN Housing Benefit Flow



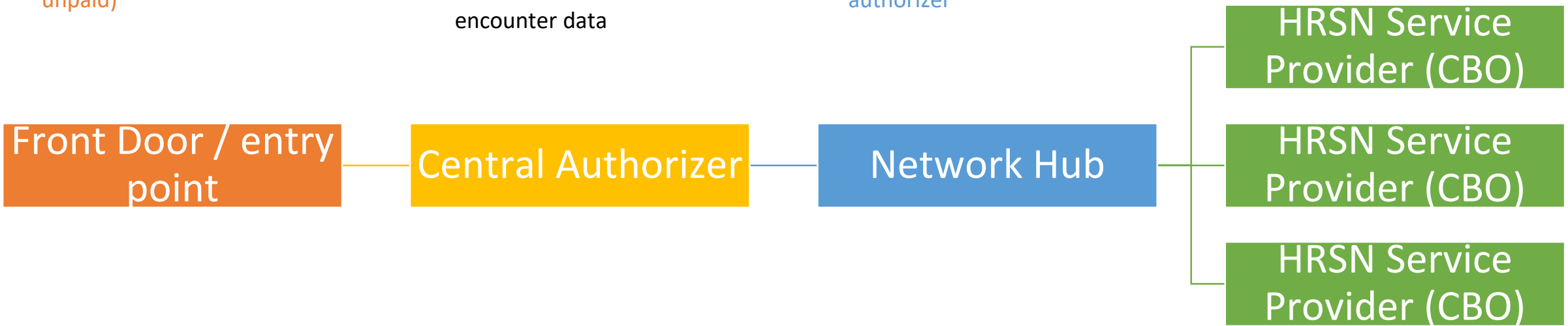
Functions

- Receive HRSN initial requests
- Screen for HRSN eligibility and follow up as needed
- Submit request to central authorizer or redirect to other resources
- Front door payment to: 211info, PANOW (other connectors unpaid)

- Receive HRSN requests
- Confirm eligibility and authorize. Follow up for more info as needed
- Establish person centered service plan
- Refer to network hub for HRSN service
- Follow up at 6 and 12 months
- Process invoices and submit encounter data

- Receive HRSN referrals and establish housing plan with members
- Refer to other HRSN service providers as needed
- Manage network – training, TA, monitor capacity
- Submit invoices to central authorizer

- Provide service as authorized
- Document services and submit data to network hubs



Why a HUB?

1. Identifies and avoids funding cliffs through coordination starting at screening and assessment
2. Promotes system alignment through policy and programming
3. Supports“no wrong door” vision
4. Potentially promotes equity through supporting smaller CBOs and culturally specific organizations

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How else can we coordinate…

1. Medical/Healthcare Case Conferencing
    a. Multnomah County will be launching a pilot program focused on Aging (over 65) people experiencing chronic homelessness with behavioral health needs
2. Work with Healthcare lead projects, like discharge planning innovations to understand opportunities for coordination and communication
3. Expand projects like FUSE that share data for analysis and targeted interventions
4. Exploring information sharing in multiple systems: data integration, MOUs, Business Associate Agreements, and ROIs

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Northwest Pilot Project (NWPP)

1. **Mission:** to offer opportunities for a life of dignity and hope to very low income seniors in Multnomah County by solving housing and transportation needs.
2. **Vision:** All low-income seniors have the opportunity to live in safe and affordable long-term housing.
3. **What We Do:** Housing placement and stabilization services to very low-income seniors in Multnomah County for over five decades.

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Current Landscape

Increasing client acuity limiting client housing options and impacting staff

Limited client access to behavioral health, substance use disorder, primary care

Urgency to address visible homelessness in policy forums

Clients eligible for OHP but may not be enrolled or engaged with health care system

Social service providers use workarounds to coordinate health care outside of the Medicaid system

Wages and workforce capacity impacting service delivery

Integration: Getting to what really matters

Opportunities for Transformation

- Regional Supportive Housing Service (SHS) funds
- Medicaid support for Health Related Social Needs (HRSN)

Goal: Craft a strategic vision for what integration means for Social Services providers

What would really help our clients and staff?

Looking Ahead: Future States

Future State 1 (Access to Care)**:** Identify which CCO/Health Plan or Fee-For-Service Contractor is responsible for administering OHP for each client .

Future State 2 (Case Conferencing) **:** Create a two-way referral system between social service providers and health systems that allows for joint accountability. Let's manage the health of our clients together through care coordination .

Future State 1: Access to Care

Streamlining Access to Care for OHP-Eligible Clients

Knowing the OHP benefit administrator (**CCO/Health Plan**) for each client would facilitate direct and timely contact for their health needs.

Defining **clear access pathways** could significantly enhance client reach to behavioral health care, substance use disorder treatment, and primary care services.

Proactively addressing healthcare needs as they arise could lead to **improved health outcomes** for clients.

Bridging silos to ensure comprehensive healthcare coverage, including essential support services for every client.

Future State 1: Access to Care (cont.)

Tools/Guidance to Facilitate Access to Care

* Explore **Business Associates Agreements**, **MOUs** and **ROIs**, or other information sharing tools, that allow Housing Services staff to better address client needs via coordination with health systems
* Allow for consultation with external experts (i.e. Intensive Care Coordination)

Future State 2: Multi-Sector Case Management

Potential Benefits of a Collaborative Referral System

- Establishing a **bilateral referral system** would enhance joint accountability and efficiency between social services and health systems.
- Co-defining **clear pathways** to inform health systems would ensure clients' chronic or acute needs are addressed effectively.
- Co-creating **designated entry points** for social workers would streamline referrals to all OHP-covered services, improving client care, while also being open to taking referrals from health systems.

Future State 2 (cont.): Multi -Sector Case Management

Opportunities & More…

- Co-developing a **referral mechanism** would facilitate smooth transitions for clients from medical care to housing and support critical healthcare needs.
- Develop and Troubleshoot models for **Case Conferencing** with medically complex clients
- NWPP/Project Access Now - **Housing and Health Integration Pilot**

Goals and Outcomes

Looking at the Big Picture of Integration Between Health and Housing

- What are the best ways to identify the health care insurer for OHP members and access care coordination?
- What are the best ways to communicate about client needs before there is an emergency?
- What are the best ways to track (waitlist) access to services (Behavioral Health/Substance Use) that are not readily available?

Integration between social services and health care is the only way to humanely address client needs.

Barriers to Consider

Health Care Workforce Challenges

HIPAA

Medicaid Billing Processes

Central Administrator needed to manage contracts/billing

Guidance from State: What is the process we need to follow and how does it change things (opportunities and problems)

Meaningful Cross-Sector Collaboration (Housing Service Providers, Jurisdictional Funders and Health Systems Partners) will stabilize our workforce and improve client outcomes.

Q&A

Let’s talk!

Feel free to put questions in the chat or raise your hand.