

OREGON| 2021

MEDICAID SUPPORTIVE HOUSING SERVICES

Crosswalk



About Health Share of Oregon

Health Share of Oregon (Health Share) is a Coordinated Care Organization or CCO that operates as a Medicaid health plan and community leader in building health and well-being for persons in Clackamas, Multnomah and Washington Counties in Oregon. The Oregon Health Plan (OHP) is the state's Medicaid program, which provides medical, dental, mental health and substance abuse services to persons who qualify. Health Share was founded by 11 health and social service agencies that served as board members. Founding agencies include Central City Concern a nationwide leading supportive housing agency, Kaiser Permanente, Adventist Health Portland, Providence Health and Services and the tri-county partners. With 370,000 members, they are the largest CCO in the state. Their mission is to partner with communities to achieve ongoing transformation, health equity and the best possible health for each individual. Learn more about Health Share at <https://www.healthshareoregon.org/>.

About Corporation for Supportive Housing (CSH)

CSH is the national champion for supportive housing, demonstrating its potential to improve the lives of highly impacted individuals and families by helping communities create over 335,000 homes with supportive services for people who need them. CSH funding, expertise and advocacy have provided nearly \$1 billion in direct loans and grants for supportive housing across the country. Building on nearly 30 years of success developing multi and cross-sector partnerships, CSH engages systems to invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources and ensure a better future for everyone. CSH advances solutions that use housing as a platform for services to improve the lives of highly impacted people, maximize public resources and build healthy communities. Visit us at www.csh.org.

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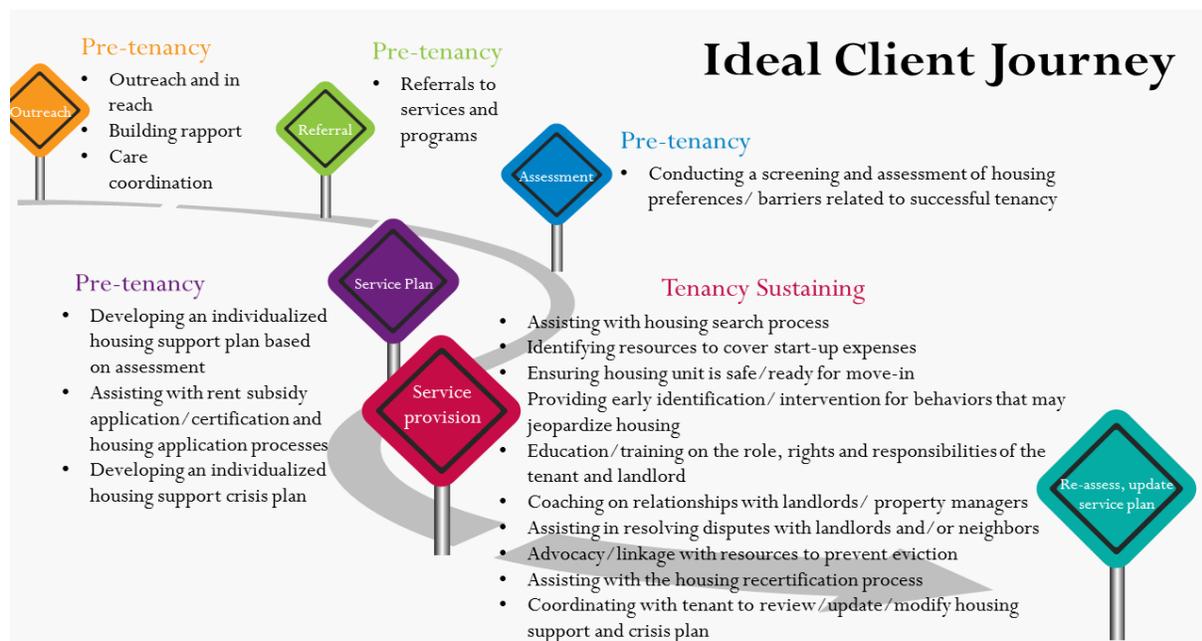
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Introduction

On January 7, 2021, the Centers for Medicare and Medicaid Services (CMS) sent a letter to State Health Officials (SHO) outlining opportunities under Medicaid to better address social determinants of health (SDOH) with the intention of supporting states in designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs.¹ Recognizing the positive impacts of supportive housing for a subset of Medicaid beneficiaries who need stable housing and better access to healthcare, Health Share sees the potential of supportive housing to improve population health outcomes, build health equity and address homelessness and housing instability in its communities.

Health Share’s leadership recognizes the opportunity to further integrate supportive housing services into Medicaid. Health Share contracted with CSH to complete this Medicaid Supportive Housing Services Crosswalk to determine the degree to which Oregon’s Medicaid program, also known as OHP, currently aligns with supportive housing services in policy and practice and where gaps would need to be addressed to ensure that the most impacted beneficiaries can live in their own homes and communities with stability and autonomy. CSH has analyzed more than a dozen state Medicaid plans, comparing services offered and populations covered with the services provided in [high-quality](#) supportive housing. CSH has also assisted multiple states in creating new Medicaid benefits for supportive housing services, referred to throughout this document as pre-tenancy and tenancy support services. The purpose of this Crosswalk is to highlight how Medicaid can make healthcare and housing more accessible for highly-impacted Medicaid beneficiaries. The graphic in Figure 1 below, highlights what this ideal journey could look like for these Oregonians.



¹ [Social Determinants of Health \(SDOH\) State Health Official \(SHO\) Letter \(medicaid.gov\)](#)

The Crosswalk is organized in four parts:

- 1) Background on Supportive Housing
- 2) Overview of Medicaid
- 3) Crosswalk Findings
- 4) CSH Recommendations

PART ONE: BACKGROUND ON SUPPORTIVE HOUSING

I. Supportive Housing

Supportive housing combines affordable housing with intensive tenancy support services and care coordination to help people who face the most complex challenges live with stability, autonomy, and dignity. People who benefit from supportive housing include people experiencing chronic homelessness² (extended periods of homelessness and one or more disabling conditions), people who live in public institutions and licensed residential settings because of the lack of the affordable housing with tenancy supports in their communities and people who cycle between homelessness and these settings.

A federally recognized evidence-based practice,³ research demonstrates that supportive housing provides housing stability, improves health outcomes and reduces public system costs. Supportive housing is not affordable housing with resident services. It is a specific intervention that employs the principles of Housing First and consumer choice in service delivery, and it provides specialized tenancy support services with low staff-to-client ratios of 1:10 or 1:15.

The **housing** in supportive housing is deeply affordable. Tenants pay thirty percent of their incomes toward rent and utilities. Subsidies pay the remaining cost of operating the housing. Supportive housing is independent like any other rental housing and requires a lease with full tenancy rights and responsibilities. It is a platform from which tenants can engage in health related and other supportive services to improve their lives. The core **services** in supportive housing are pre-tenancy (outreach, engagement, housing search, application assistance, and move-in assistance) and tenancy sustaining services (landlord relationship management, tenancy rights and responsibilities education, eviction prevention, crisis intervention, and subsidy program adherence). In addition, the service providers working in supportive housing connect tenants to primary and behavioral healthcare and other community resources to help them thrive. Services such as counseling, peer supports, independent living skills, supported employment, end of life planning and crisis supports are also provided to residents by supportive housing service providers and/or their community partners.

In June 2021, CSH coordinated and completed a [FUSE](#) effort in Multnomah County in partnership with Health Share, the Local Public Safety Coordinating Council, the Multnomah County Sheriff's Office and the Joint Office on Homeless Services to determine the frequency that emergency and in-patient healthcare services and jails were used in response to people experiencing homelessness and housing instability as

² [HUD's Definition of Homelessness: Resources and Guidance - HUD Exchange](#)

³ SAMHSA Supportive Housing Evidence Based Toolkit. <https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509>

compared to those living in supportive housing. Most significantly, the findings showed that supportive housing is a game changer in its ability to reduce crisis and institutional responses for people experiencing homelessness including:

- Over 400 fewer jail bookings
- Over 500 fewer in-patient psychiatric stays
- Over 17,000 fewer Emergency Department visits
- Over 5,000 fewer avoidable Emergency Department visits
- Over 200 fewer hospitalizations

These findings illustrate that supportive housing is one of the most effective ways to decrease avoidable over-spending on emergency health services and reduce the criminalization of people in need of accessible housing and healthcare.

Financing supportive housing requires “three legs of a stool,” 1) capital funds to build apartment buildings, 2) rental assistance to supplement the rents that tenants with extremely low incomes can pay and 3) services to support tenants in accessing housing and healthcare so that they can thrive in their communities. Most states and localities do not have the resources to take this intervention to scale. A lack of sustainable services funding often delays the creation of new supportive housing. Funding for services has historically come in the form of short-term grants and contracts attempting to address long-term needs. Instead of using these funds to create more housing, communities use a significant portion of these limited resources to pay for the tenancy supports in supportive housing that could instead be covered by Medicaid.

II. The Need for Supportive Housing in Oregon

A subset of Medicaid beneficiaries in Oregon have critical, unmet housing and healthcare needs. Many of these highly impacted people are aging or living with multiple chronic physical and behavioral health conditions, including severe mental illness, substance use disorders, functional impairments, and other disabilities. They have extremely low incomes (0-30% Median Family Income or MFI or \$0 to \$17,050 for an individual and \$21,900 for a family of three) and are unable to afford the rents in Oregon without a subsidy. These beneficiaries experience housing instability, homelessness and/or are cycling through multiple social service systems, acute care settings and institutions.

Despite significant public sector investments in long-term care facilities, jails, shelters, residential treatment facilities and hospitals, these individuals are not receiving the care they need, and therefore, their health and well-being are not improving. Instead, they experience expensive and often preventable institutionalization, lack of access to primary care, and lack of integrated services addressing their complex care needs. While these residents represent a small percentage of the total state population, the State makes disproportionately large investments in the systems most accessible to them without addressing their needs or those of their communities.

To better understand the supportive housing need in Oregon, CSH used publicly available state and local data to predict the need across a variety of subpopulations.⁴ As of 2019, Oregon was predicted to need an additional 12,472 supportive housing apartments. The five largest populations needing supportive housing include: adults experiencing chronic homelessness, those returning from incarceration, older adults (65 and older), individuals with intellectual and developmental disabilities and transitional aged youth (TAY) (when combining unaccompanied, justice-involved and child welfare TAY). (The analysis is limited to systems that collect data on housing and housing related questions.)⁵

When disaggregated by race, the need for supportive housing demonstrates institutionalized racism inherent in the barriers to affordable housing and person-centered healthcare services. CSH’s Racial Disparities and Disproportionality Index (RDDI) shows disparity indices calculated by comparing racial groups’ rates of representation in a public sector system with their representation in the population at large. Figure 2 below illustrates the likelihood of a group experiencing system involvement in Oregon compared to all other groups. For Oregon, the RDDI illustrates racial disparities in the involvement in multiple systems, especially for Black and American Indian/Alaska Native individuals. For example, Black and American Indian/Alaska Native individuals are much more likely to experience chronic homelessness than all other households (with indices of 3.2 and 3.9, respectively). Similar disparities are seen in multiple populations’ experiences of homelessness (e.g., non-chronic, families and youth) as well as other systems such as Child Welfare, Veterans and Mental Health institutions). Moreover, Black youth are eight times more likely to experience involvement in the justice system and American Indian/Alaska Native individuals are seven times more likely to experience involvement in the substance use system.

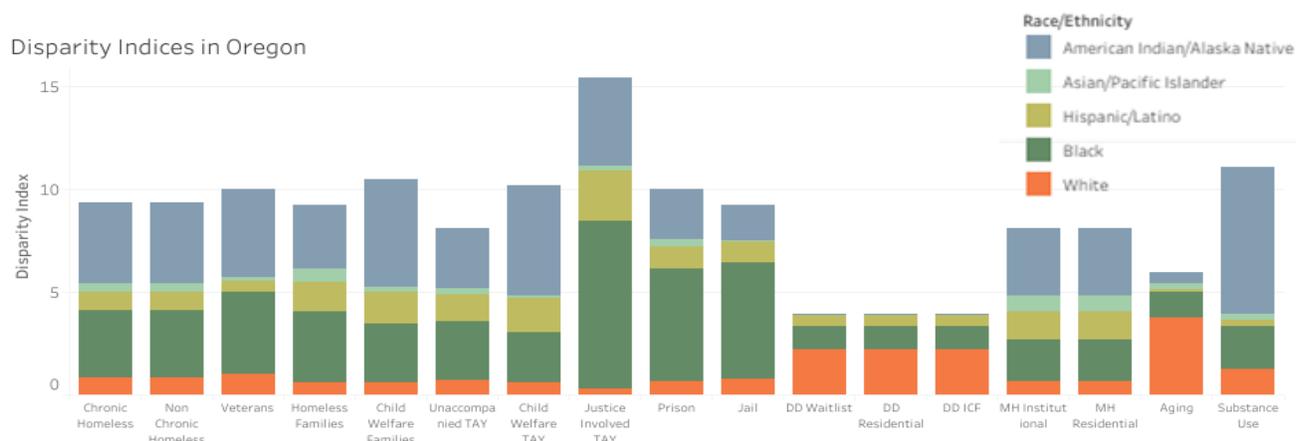


Figure 2: Disparity Indices in Oregon, CSH RDDI Results

⁴ CSH Supportive Housing Needs in the United States. <https://www.csh.org/supportive-housing-101/data/>

⁵ Find detailed data reports on the supportive housing need for each population, total figures, and research references and citations at <https://www.csh.org/supportive-housing-101/data/>.

To create its founding documents around the SDOH, OHA engaged in a statewide community engagement process to establish priorities for a report.⁶ The most pressing issue considered in the exacerbation of illness was a lack of safe and affordable housing. The experience of homelessness is further recognized as both a cause and effect of trauma and is known to make one more vulnerable to disease, injury, victimization and assault. The impact of the experience of homelessness and housing instability on mental and physical health is increasingly being recognized by healthcare leaders around the nation, and the report developed by OHA following that stakeholder process establishes Oregon as a leader these efforts.

The impact of a lack of affordable housing is also demonstrated in the number of people experiencing homelessness. Every year, communities across the nation who receive homelessness assistance funds from the federal Department of Housing and Urban Development (HUD) are required to conduct a count of people experiencing



Figure 3: 2019 Oregon PIT Count Data

homelessness, known as the Point in Time (PIT) count. Continuum of Care (CoCs) can opt to do street counts every other year. (Some communities in Oregon, did not participate in the 2021 count due to COVID.) Oregon PIT counts and national reports about the data highlight trends in the number of people experiencing homelessness as well as the disproportionate representation of people of color. Figure 3, copied from OHCS’s website, reflects the 2019 PIT count.⁷ OHCS notes that between 2015 and 2019, homelessness increased 19% across the state while unsheltered homelessness increased 37% in the same time period. Twenty-five percent of people experiencing homelessness are living in the Portland Metro Area.

People of color across various racial and ethnic groups experience homelessness disproportionately according to OHCS.⁸ As illustrated in Figure 4 below (also copied from OHCS), Black Oregon residents are 1.6% of the state’s population but 6% of those experiencing homelessness. Native American’s are 2% of the population but 5% of those experiencing homelessness.⁹ When supportive housing services are provided by culturally specific organizations and programs, they can be a powerful tool in addressing racial disparities in health, economic mobility, and homelessness.

⁶ <https://www.oregon.gov/oha/PH/ABOUT/Documents/sha/sha-social-determinants-of-health.pdf>

⁷ <https://public.tableau.com/profile/oregon.housing.and.community.services#!/vizhome/2019Point-in-TimeDashboard/Story1>

⁸ <https://public.tableau.com/profile/oregon.housing.and.community.services#!/vizhome/2019Point-in-TimeDashboard/Story1>

⁹ https://public.tableau.com/shared/TCDQTGP6F?:display_count=y&:origin=viz_share_link

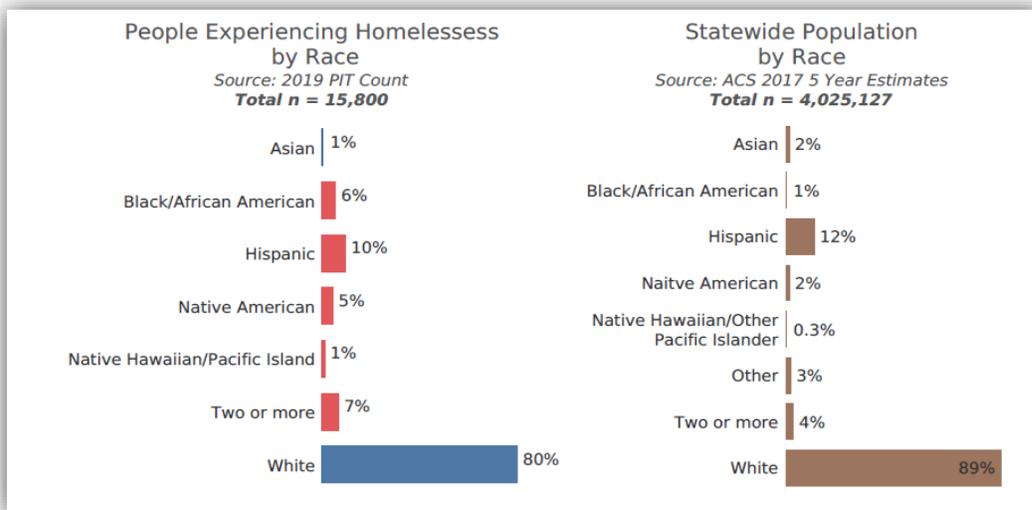


Figure 4: People Experiencing Homelessness (2019) and Statewide Population

III. Related Housing and Service Programs in Oregon

Several local and State initiatives are underway to make a dent in the supportive housing need in Oregon. Following are a few key examples:

In the Portland Metro area, which includes Clackamas, Multnomah and Washington Counties, Kaiser Permanente and regional leadership supported the development of Metro 300, a 3-county initiative to house 300 homeless and medically vulnerable seniors by the end of 2020.¹⁰ This investment initiated the implementation of the Regional Supportive Housing Impact Fund or (RSHIF).¹¹ The fund is utilizing a collective impact approach to create the networks, partnerships, systems and investments needed to ensure that people who are in acute care or institutional settings have access to and resources for supportive housing.

In the same tri-county region, where Health Share members live, the new Metro Supportive Housing Services (SHS) Program will provide \$250 million a year for 10 years.¹² The focus population of initial implementation are people who experience long-term or frequent homelessness and have complex health needs. Seventy-five percent of the funding is slated to be directed to this population. The SHS program is primarily supporting services and rent assistance. Coordinating Medicaid with this, especially for services, is critical to ensuring that providers in the region take advantage of all the resources that would be available for similar populations that will benefit from both funding sources.

In addition, in the past year Oregonians passed Measure 110, or the Drug Addiction Treatment and Recovery Act. In addition to reducing penalties for possession, it provides the framework for funding from

10 <https://about.kaiserpermanente.org/community-health/news/housing-300-portland-metro-area-seniors-in-2020>

11 <https://www.csh.org/resources/regional-supportive-housing-impact-fund-strategic-framework/>

12 <https://www.oregonmetro.gov/public-projects/supportive-housing-services/taxes-and-funding>

Oregon’s marijuana tax to develop a large scale additional substance use disorder (SUD) treatment system for people with a focus on serving communities of color.¹³ These new treatment resources, including residential substance use care will also serve people experiencing housing instability or homelessness and many persons will benefit from supportive housing to thrive in communities after receiving residential care.

PART TWO: OVERVIEW OF MEDICAID

I. The Medicaid Program

Medicaid is public health insurance that pays for essential medical and medically-related services for people with low-incomes. Statutorily, Medicaid insurance cannot pay for room and board or housing related costs. Medicaid’s ability to reimburse for services starts with a determination as to whether an individual is Medicaid eligible and if so, if they are enrolled in the Medicaid program.

CMS oversees all state Medicaid plans. A Medicaid “State Plan” is the contract between a state and the federal government. It defines the services, populations and payment rates that are part of the state’s Medicaid program. All state plans cover certain mandatory benefits as determined by federal statute. States and CMS can also agree to cover additional benefits designated as ‘optional’ in federal statute.¹⁴ For example, Oregon has a variety of peer-delivered services (PDS) that are optional state services for persons with mental health and/or substance use disorders. Oregon also offers targeted case management (TCM) for persons with HIV, pregnant women with substance use disorders and child welfare involved youth.

States can make changes to their Medicaid State Plan by applying to CMS for a state plan amendment (SPA) or to waive certain provisions of the Social Security Act that governs Medicaid regulations (a Waiver). Medicaid authorities are commonly known by their federal statute section number. Examples of authorities that can help states address housing as a SDOH include:

- 1115 Medicaid Waivers allow for state demonstration programs to pilot innovative services, serve new populations, or test payment structures.
- 1915(c) Waivers and 1915(i) SPAs: Among other benefits, States can use these authorities to provide Home and Community Based Services (HCBS) for specific populations (seniors with functional impairments, adults with severe physical disabilities, individuals with severe or persistent mental illness, individuals with developmental disabilities, children with special health care needs and people living with traumatic brain injuries). These services are intended to help beneficiaries remain in their own homes and communities for as long as possible, rather than requiring that they move into institutions to receive the level of care they need.¹⁵

¹³ <https://www.oregon.gov/oha/HSD/AMH/Pages/Measure110.aspx>

¹⁴ For more detail on mandatory and optional Medicaid benefits - <https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html>

¹⁵ <https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>

States can reimburse providers directly for services in a Fee for Service (FFS) structure or they can contract with managed care organizations (MCOs) to establish a provider network and manage payments to those providers. States contract with MCOs primarily on a per member, per month (PMPM) basis. This shifts the financial risk onto the MCOs. While MCOs may have greater flexibility than state governments to contract for provider services, they may also at times need to limit the services they cover to stay within their budget. States and MCOs establish agency licensing and credentialing requirements and staff qualifications that determine which providers can receive Medicaid reimbursement.

Indian Health Service (IHS), another agency within the federal Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The federal government provides 100% payment for services provided to American Indian and Alaska Natives receiving healthcare in IHS facilities, which include Tribal Contract or Compact Health Centers that deliver outpatient healthcare programs and Urban Indian Health Centers, which are designated Federally Qualified Health Centers that provide comprehensive primary care and related services. These facilities are owned or leased by Urban Indian organizations and receive grant and contract funding through Title V of the Indian Health Care Improvement Act.

II. Medicaid in Oregon

In Oregon, the Oregon Health Policy Board¹⁶ oversees OHA,¹⁷ which is the state Medicaid Agency that manages OHP.¹⁸ OHA also administers behavioral health, public health, women, infants and children and health policy and includes divisions such as fiscal and operations, health policy and analytics and the Oregon state hospital.

Beginning in August 2012, OHA used an 1115 Waiver to replace the traditional managed care system in Oregon with 16 CCOs-- networks of physical, mental, and oral health providers. Most counties in Oregon have a single CCO, but some urban areas have more than one. Some CCOs are collaborations between existing MCOs and mental health organizations. Other models can be used as long as the entity can assume financial risk and meet the established criteria on coordination of care, governance, and other requirements.

The vision for the CCO model is to achieve the triple aim of better health, better care and lower costs by focusing on prevention and helping people manage chronic health conditions. This helps reduce unnecessary emergency room visits and gives people support to be healthy. They are designed to be a 'one stop shop' for healthcare related referrals and provider network development, and they collaborate closely with counties and nonprofit agencies that deliver social services that address the SDOH. OHA prioritizes addressing health inequities using a wide variety of strategies, including flexibility for CCOs to fund health related services (HRS). HRS are a broad array of potential services that improve health, both

¹⁶ <https://www.oregon.gov/oha/OHPB/Pages/index.aspx>

¹⁷ <https://www.oregon.gov/oha/Pages/index.aspx>

¹⁸ <https://www.oregon.gov/oha/HSD/OHP/Pages/index.aspx>

on an individual basis and/or community wide, and OHA has highlighted how this mechanism can be used for services in supportive housing.¹⁹

Most Oregon residents are assigned to a CCO. Many in a number of urban counties, have a choice of CCOs.²⁰ More than 90% of the beneficiaries OHP covers are served by CCOs. The remainder are covered by OHP under an FFS program. Health Share is a CCO covering three counties in the Portland Metro Region, Clackamas, Multnomah and Washington²¹. In the tri-county area, Trillium Community Health Plan, Inc. (a subsidiary of Centene Corporation) is also designated as a CCO by OHA.

The state's Office of Aging and People with Disabilities administers the State's Long Term Services and Supports (LTSS) program that serves over 35,000 people per year.²² This office administers Medicaid funded programs, Older Americans Act and State aging funding. Together these programs serve over 227,000 persons a year.²³ LTSS programs, including HCBS, remain in an FFS delivery system though members enrolled in LTSS services can also be CCO members. The State's model aims to integrate access to senior services including LTSS into a single site visit option, primarily through the Area Agencies on Aging.

Behavioral Healthcare is led by OHA's Health Systems Division (HSD). HSD's vision is of a Healthy Oregon "where mental health disorders and addiction to substances or gambling are prevented through education, early intervention and access to appropriate health care."²⁴ Mental healthcare is bifurcated between the CCO's administration of out-patient behavioral health services and counties, which operate as local behavioral health authorities. Counties provide localized care through the CHOICE program, which has a goal of prioritizing community-based recovery supports.²⁵ To assist in that end, the State's mental health website offers an affordable housing inventory that integrates information from across the affordable housing sector in the state.²⁶ Counties have the option of delivering housing supports or even rental subsidies using their CHOICE funding. Multnomah and Washington Counties have a limited number of supportive housing programs for the people they serve. Clackamas County does not fund rental subsidies. All counties operate traditional, state-licensed congregate and group-home residential settings called adult foster homes, adult residential treatment facilities, and adult residential treatment homes.²⁷ Lengths of stay in these sites was reported to be commonly over 90 days though counties did not have easily accessible data on service models, residential agreements, or outcomes for these facilities. The state also continues to operate a state psychiatric facility, though most residents are mandated to care

¹⁹ <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-Guide-Housing.pdf>

²⁰ <https://www.oregon.gov/oha/OHPB/CCODocuments/Coordinated-Care-Organization-2.0-Service-Areas.pdf>

²¹ <https://www.healthshareoregon.org/>

²² <https://www.oregon.gov/DHS/SENIORS-DISABILITIES/LTC/CMS/Pages/LTSS.aspx>

²³ https://nci-ad.org/upload/state-reports/OR_2017-2018_NCI-AD_state_report_w_Medicaid_Avg_FINAL_ORseal.pdf

²⁴ <https://www.oregon.gov/oha/HSD/AMH/Pages/About-Us.aspx>

²⁵ <https://www.oregon.gov/oha/HSD/AMH/Pages/Choice-Model.aspx>

²⁶ <https://www.oregon.gov/oha/HSD/AMH/Pages/Affordable-Housing.aspx>

²⁷ <https://www.oregon.gov/oha/HSD/AMH-LC/Pages/RT.aspx>

there by the judicial system.²⁸ The State and the US Department of Justice have a voluntary agreement, reached in 2012 to ensure that the state is compliant with its Olmsted obligations to ensure community care for persons with serious and persistent mental illness.²⁹

State-wide, 24 tribes or tribal organizations have contracted to assume responsibility for providing health care for American Indians and Alaska Natives, and there are 21 Indian and Tribal Health Service Clinics. Healthcare at these clinics includes direct health services as well as system, community and tribal support. Only Multnomah County has an Urban Indian Health program,³⁰ which is operated by NARA, a nonprofit and funded through a mix of IHS and other grants.³¹

PART THREE: CROSSWALK FINDINGS AND ANALYSIS

I. Materials Reviewed for the Crosswalk

This Crosswalk concentrates on Oregon’s Medicaid services that address the healthcare needs of beneficiaries with functional impairments who are likely to be impacted by housing instability, homelessness, and/or unnecessary institutionalization. The Crosswalk considers two primary sources of information in determining the degree to which OHP covers supportive housing services in policy and practice: 1) A review of the State Plan and other relevant documents, and 2) Interviews with providers who serve these populations.

For the document review, CSH reviewed the following materials in spring of 2021. Please note that OHA staff reported that housing related services were added to the 1915(c) waiver and the 1915(i) State Plan services for persons with serious behavioral health needs that were not reviewed and are not a part of this analysis beginning in 2022. The reviewed materials include:

- 1) Oregon State Medicaid Plan³²
- 2) Oregon’s 1115 Medicaid Waiver that created the CCO system³³
- 3) Oregon’s approved 1115 SUD demonstration Waiver³⁴
- 4) Oregon’s Home and Community Based Waivers and SPAs for persons with intellectual and developmental disabilities and persons who are aging with functional impairments or who are physically disabled, including:
 - A) 1915(c) for individuals with Intellectual or Developmental Disabilities³⁵

²⁸ <https://www.oregon.gov/oha/osh/pages/index.aspx>

²⁹ <https://www.oregon.gov/oha/HSD/BHP/Documents/USDOJ%20Agreement%20Letter%202012.pdf>

³⁰ <https://www.oregon.gov/oha/HPA/HP-PCO/Documents/IndianTribalHealthClinics.pdf>

³¹ <https://www.naranorthwest.org/>

³² <https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/Medicaid-State-Plan.pdf>

³³ <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-plan-2-ca.pdf>

³⁴ <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-sud-demo-ca.pdf>

³⁵ <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82981>

- B) Case Management for those who are aging or physically disabled³⁶
- D) Oregon’s Community First Choice 1915(k) SPA³⁷
- 5) Oregon Health Authority guidance on Social Determinants of Health³⁸, Health-Related Services³⁹ and Health Related Services SDOH Guide⁴⁰
- 6) Health Share’s 2020 contract as a CCO⁴¹

The purpose of the provider interviews is to inform where alignment and gaps exist between supportive housing services and OHP in practice. CSH interviewed six service providers across the Tri-County region served by Health Share. Some provide only supportive housing services and some provide both services and housing. Two did not have experience with Medicaid, and four seek Medicaid for reimbursement of the services they provide. The interviews included a series of questions about the funding and operations of their programs, their understanding of Medicaid reimbursement for supportive housing services, and their perceptions of Medicaid Assistance alignment with supportive housing services. CSH also sought to understand the array of services that supportive housing service providers are currently offering to tenants, regardless of funding source.

II. Findings from the State Plan and Document Review

To determine the degree to which Medicaid currently references one or more supportive housing services, CSH cross-walked the services provided in quality supportive housing with key provisions of the Oregon State Medicaid Plan and related authorities for the population groups noted above. Figure 5 below notes where these key services are referenced in the State Plan.

Figure 5: Supportive Housing Services Referenced in the OHP	
Supportive Housing Service	State Plan and Authorities Where the Service is Mentioned
<i>Pre-Tenancy Supports</i>	
Outreach and In-reach services	PDS, TCM for various Populations, CFC 1915(k) Community Transition Services, Rehabilitative Mental Health Services, Health Related Services
Assessment of housing preferences/ barriers related to tenancy	PDS, TCM for various Populations, CFC 1915(k), Rehabilitative Mental Health Services
Identification of resources to cover moving and start-up expenses	PDS, TCM for various Populations, CFC 1915(k) Community Transition Services, Health Related Services

³⁶ https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/OR_APD-Case-Management-Freedom-of-Choice-Waiver_OR-11.pdf

³⁷ <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-12-14-179.pdf>

³⁸ <https://www.oregon.gov/oha/PH/ABOUT/Documents/sha/sha-social-determinants-of-health.pdf>

³⁹ <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-Guide-Housing.pdf>

⁴⁰ <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-SDOH-E-Guide.pdf>

⁴¹ <https://www.oregon.gov/oha/OHPB/CCODocuments/Health-Share-Oregon-Oct19-Dec24-signed.pdf>

Ensuring housing unit is safe and ready for move in	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k), Health Related Services
Assistance with move-in arrangements	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k) Community Transition Services, Health Related Services
Assist with housing search and completing housing applications	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k) Community Transition Services, Rehabilitative Mental Health Services, Health Related Services
<i>Tenancy-sustaining Services</i>	
Development of housing support crisis plan	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k), Rehabilitative Mental Health Services, Health Related Services
Eviction prevention planning & coordination	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k) Skill Building, Rehabilitative Mental Health Services, Health Related Services
Development of re-housing plan: ongoing services to re-house	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k) Skill Building, Rehabilitative Mental Health Services, Health Related Services
Early identification/intervention for behaviors that may jeopardize housing	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k) Skill Building, Rehabilitative Mental Health Services, Health Related Services
Education/training on tenant and landlord rights and responsibilities	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k) Skill Building, Rehabilitative Mental Health Services, Health Related Services
Coaching on developing/maintaining relationships with landlords/property managers	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k) Skill Building, Rehabilitative Mental Health Services, Health Related Services
Assistance resolving disputes with landlords and/or neighbors	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, Rehabilitative Mental Health Services, Health Related Services
Advocacy/linkage with community resources to prevent eviction	PDS, TCM for various Populations, CFC 1915(k) Support System Activities, Health Related Services

Assistance with credit repair activities and skill building	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k) Support System Activities, Rehabilitative Mental Health Services, Health Related Services
Assistance with housing recertification process	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k) Support System Activities, Rehabilitative Mental Health Services, Health Related Services
Coordination with tenant to review/update/modify housing support plan and eviction prevention plan	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k) Skill Building, Rehabilitative Mental Health Services, Health Related Services
Housing stabilization services	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, Rehabilitative Mental Health Services, Health Related Services
Continued training on being a good tenant and on-going support with activities related to household management	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k) Skill Building, Rehabilitative Mental Health Services, Health Related Services
Housing focused care coordination with other community providers	PDS, TCM for various Populations, HCBS Behavioral Rehabilitation, CFC 1915(k) Skill Building, Rehabilitative Mental Health Services, Health Related Services

In an effort to quantify the degree to which these services are referenced in the State Plan and accompanying authorities, CSH tallied the number of pre-tenancy and tenancy-sustaining services that are noted in OHP’s policy documents. Figure 6 below represents the percentage of coverage.

- Services that appear explicitly in policy documents and read as though they are accessible without barriers are reflected as “covered” in blue.
- Services that theoretically could be delivered as part of an existing, broadly-defined Medicaid service but are not explicitly mentioned in the service definitions are noted in orange as “inconclusive.”
- Services that are not referenced at all are depicted in gray as “not covered.”

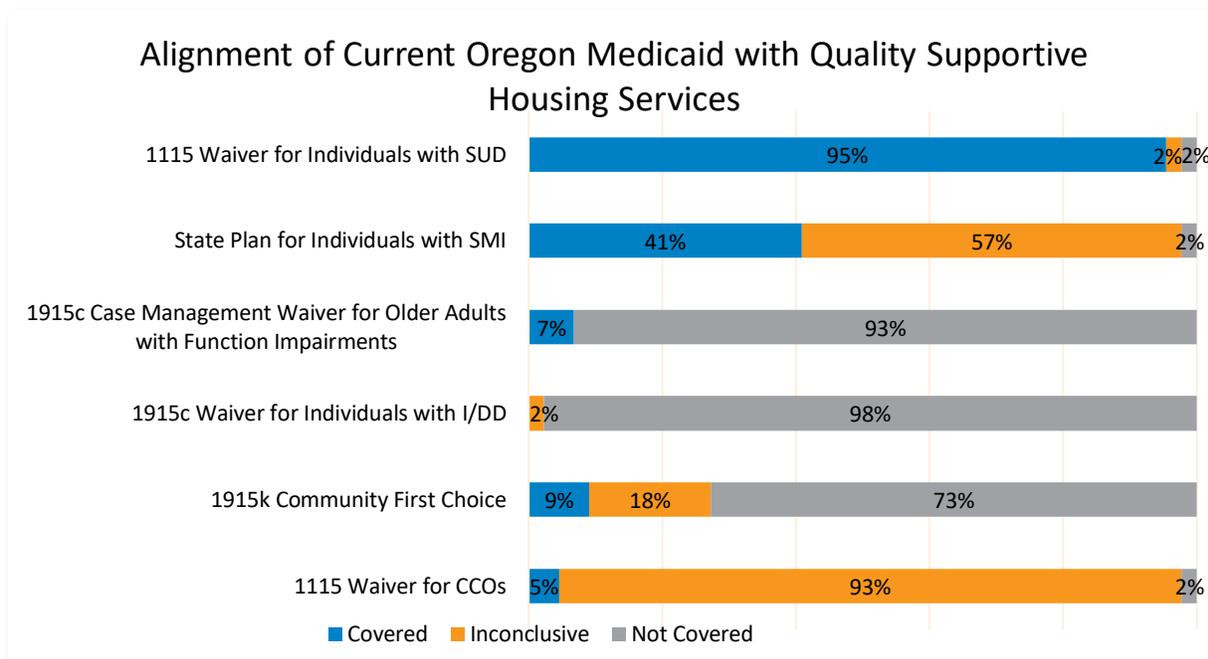


Figure 6: Percentage of Supportive Housing Services Covered by State Plan or Authority

Following is a brief description of the ways in which each of the authorities above do or do not align with supportive housing services.

1. 1115 Waiver for Individuals with substance use disorders (SUD)

Oregon’s 1115 SUD demonstration program received CMS approval on April 8th, 2021. This program includes the vast majority of services required to deliver high-quality supportive housing. In fact, it is the most aligned Medicaid authority that CSH has found in its analyses nationwide of Medicaid services and quality supportive housing.

2. State Plan Provisions for Individuals with SMI

Oregon has integrated the administration of out-patient mental health and substance use services for over a decade. As such, it is presumed that *some* beneficiaries with SMI (those with co-occurring disorders) will receive supportive housing services under the SUD Waiver. The State Plan theoretically covers an array of in-depth pre-tenancy and tenancy-sustaining services that individuals with SMI may need in order to live independently in their communities. For example, it includes Mental Health Rehabilitative Services such as Assertive Community Treatment (ACT) teams and other skills building activities. If stable housing is a goal on an individual’s treatment plan, then many of the services in supportive housing could be billable services. The State Plan also includes PDS focused on community integration and behaviors that lead to stable housing, which would also be billable services. However, the nature of the services described in the plan suggest that they are not likely to be provided in practice because in CSH’s experience, if states do not explicitly call out these services in State Plan service definitions, set rates for them, and offer training and support on these activities, they seldom occur in practice.

3. 1915c Case Management Waiver for Older adults with functional impairments

CSH found very limited alignment between OHP's 1915(c) Case Management Waiver for the aging population and quality supportive housing services. This benefit is primarily meant to develop the Person-Centered Plan for recipients of the Waiver.

4. 1915c Waiver for Individuals with intellectual and developmental disabilities (I/DD).

CSH similarly found very limited alignment between the state's 1915c Waiver for individuals with intellectual and developmental disabilities and quality supportive housing services.

5. 1915k Community First Choice

For those in the aging population with functional impairments, the HCBS waiver offered little to no opportunity for services to align with supportive housing services. The one service that showed the greatest potential for some service coordination was within case management services.

6. 1115 Waiver for CCOs

The CCO model is designed to transcend what managed care can do by adding flexibility and innovation to the coordination of care with special attention to the SDOH. CCOs can create new ways of delivering care that address the health and well-being of individuals before they turn into major health crises, which would suggest an opportunity to promote supportive housing services. Methods for doing so could involve drawing on incentive payments, using other reinvestment opportunities, and/or establishing more defined services through HRS. HRS are a broad array of potential services designed to improve individual and community health, and OHA has highlighted how this mechanism can be used for services in supportive housing.⁴² Similar to an in-lieu-of-services payment mechanism, CCOs can choose to offer non-Medicaid plan covered services that promote health via HRS, but there are no designated fund sources for these services.

III. Findings from Provider Interviews

Two prominent themes emerged from CSH's interviews with providers of supportive housing services.

- Providers are not receiving Medicaid reimbursement for a large amount of healthcare services they deliver, especially pre-tenancy and tenancy-sustaining services and care coordination, where eligible.
- Providers are concerned about being able to provide supportive services to all who need them given current funding structures and the lack of system-wide coordination.

Other key themes included:

- For providers who are authorized to seek Medicaid reimbursement, uncertainty about how to bill for pre-tenancy and tenancy-sustaining services when they are not explicitly described in Medicaid policy
- For providers who are not authorized to seek Medicaid reimbursement, a desire to learn how to do so mixed with reservation and concerns around the infrastructure and capacity required and the potential for this to shift organizational culture toward a focus on billing and documentation at the expense of meeting tenant needs

⁴² <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-Guide-Housing.pdf>

- A desire to learn how to seek reimbursement under the new 1115 SUD Waiver generally and specifically how this will impact current coordination of care, staffing models and billing structures, especially those that relate to FQHC encounters
- A desire to maintain flexible dollars along with Medicaid reimbursement in order to maintain the quality and variety of services they offer
- A lack of funding for the significant amount of care coordination provided, especially for those transitioning from institutional or residential care to independent living
- Employing people with lived experience who may not have credentials or are supervised by clinical staff required for Medicaid reimbursement. (Many providers expressed the importance and value of hiring individuals with lived expertise as a way to ensure that services are person-centered and reflect real-world experiences and strategies that are relatable to their service population, and they do not believe that Medicaid currently allows for this to happen)
- Ensuring that services are addressing racial equity and improving access to care for all qualified individuals. Some providers thought the ability to hire medical professionals would help address these issues including the lack of trust many of their clients and tenants have with seeking help from external, community partners.
- Barriers to providing services that can only be funded after a service occurs via reimbursement or after an individual has signed a treatment plan, or enrolled in a program
- Lack of funding for initial program startup expenses that are not yet reimbursable such as electronic health records, harm reduction supplies, and staff salaries and training before reimbursement begins.
- A need for funding for lighter-touch services for tenants who do not qualify for Medicaid or receive services through IHS
- Difficulty tracking and braiding the requirements of the multiple, siloed sources of funding they receive and a desire for support from the system level in braiding these funds together so that they can focus on delivering services
- Finding ways to coordinate with each other despite lack of resources. For example, some behavioral health providers and supportive housing providers have (or have had) programs that include a collaborative approach to providing services. However, due to limited funding streams or challenges in supporting or funding the coordination activities, this work is not always sustainable or possible at scale.

IV. Summary and Analysis

Based on the two key data sources: The State Plan document review and provider interviews, it is clear that Oregon has a strong commitment to improving healthcare for people with complex needs. In the time to review the document, OHA has added housing support related services for two additional populations, persons with serious mental illness and those who meet nursing home criteria and are aging and physically disabled. The CCO model itself demonstrates this at the structural level with flexibility and a mission for addressing the triple aim through innovation. When drilling down to the core services in supportive housing, pre-tenancy and tenancy-sustaining services from a policy perspective, one glowing example stands out, the 1115 SUD Waiver. This Waiver's description of services is exemplary and will change the paradigm for beneficiaries with SUD who need supportive housing. These services will likely serve individuals with a wide range of other health challenges and by default, can serve a large number of individuals who need supportive housing. However, for those without SUD, only the 1115 CCO Waiver's reference to HRS and the provisions of State Plan mental health rehabilitative services and PDS offer

room for authorizing and delivering supportive housing services. Yet they do not do so in a way that is robust enough to ensure these services are delivered at the case ratios proven to increase housing stability, and they lack the intensive focus needed. Without service definitions and established rates for these services within their larger policies, attempts at service delivery will not likely be sufficient to help beneficiaries get housed and stay housed. If a CCO or the State were to tease them out of HRS and/or rehabilitative services would take a concerted effort to define services, set rates, and train providers on how to deliver them. It should be noted that the SUD Waiver will also require a dedicated commitment to implementation, including comprehensive provider training. Providers who understand and are experienced in delivering supportive housing services but who are currently not able to seek Medicaid reimbursement will need training and support in becoming Medicaid billers. They and providers already authorized to bill Medicaid will need training and support to deliver high-quality supportive housing services, especially for members who are transitioning from institutional and inpatient settings to community-based supportive housing, which ensures the benefit produces positive tenant outcomes.

At the system level, new federal, state and local resources offer the potential to create new, deeply affordable housing for Oregonians with complex healthcare needs experiencing homelessness, housing instability and unnecessary institutionalization. When paired with Medicaid supportive housing services, these resources could also provide the supplemental service funding and capacity-building grants providers seek to expand their services. Specifically, the opportunity to coordinate OHP's new SUD Waiver services with new funding in the Metro region could provide thousands of people the opportunity to move back into their own homes and communities permanently. These resources will need to be more intentionally integrated at the system level so that public entities can ensure their funds are leveraged as strategically as possible and providers can focus on the work of helping people obtain and maintain housing.

PART FOUR: RECOMMENDATIONS

CSH's recommendations aim to support Health Share and OHA in acting on recent CMS guidance to further address housing as a SDOH in order increase access to healthcare, improve health, and lower system costs.⁴³ The Crosswalk takes a comprehensive look at the OHP to determine the degree to which it does or does not provide pre-tenancy and tenancy-sustaining services. The first recommendation is for OHA to establish a supportive housing services benefit for a broader array of populations who need these services. The following recommendations offer ways that OHA and Health Share can ensure the success of this benefit by engaging in a comprehensive state-wide approach to funding and tracking outcomes in supportive housing.

- I. Expand the pre-tenancy and tenancy-sustaining services included in the State's 1115 Waiver for all who need these services to live in their communities.**

⁴³ <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>

The State's recently-approved 1115 Waiver for SUD offers exemplary descriptions of the pre-tenancy and tenancy-sustaining services needed for all individuals with complex health conditions experiencing or at risk of housing instability, homelessness and unnecessary institutionalization. The state reports recently adding these services also for persons with serious mental illness and who are aging and disabled and meet criteria for nursing home placement. These are excellent steps forward. To fully address these needs state-wide, supportive housing services should also be explicitly included in the OHP for all who need them, such as aging or those with intellectual disabilities or justice involved populations.

In order to include these services and populations, OHA would need to seek a new SPA or Waiver from CMS. CMS indicated in its January 7th SHO letter that its financial participation is available for the provision of these services under certain federal authorities. CSH recommends pursuing one of two commonly-used authorities to include pre-tenancy services and tenancy sustaining services, the 1915(i) SPA or an 1115 Waiver.

The 1915(i) is an optional state plan benefit that allows states to provide HCBS to individuals who meet state-defined needs-based criteria that are less stringent than institutional criteria. States may target the benefit to a specific population based on functional impairments, age, disability, diagnosis, and/or Medicaid eligibility. Needs-based criteria may include, but cannot only include, state-defined risk factors, such as risk of or experiencing homelessness. States have the option to cover any services necessary to live in the community. Minnesota⁴⁴ and North Dakota⁴⁵ have been approved for these services under 1915(i) SPAs, and Connecticut⁴⁶ and Illinois⁴⁷ have submitted to CMS for SPAs that offer housing support services.

Oregon's experience with the 1115 Waiver for individuals with SUD would provide a helpful template for using this authority to provide these same services to a broader array of populations. CMS requires that a demonstration projects under section 1115(a) of the Act be budget neutral to the federal government, and States are expected to conduct independent and robust evaluations of the demonstration. It is important to note that CMS currently will not approve a demonstration providing coverage of services consistent with those authorized under section 1915(i) unless the state agrees to adhere to programmatic requirements of individual assessments of need with respect to those services. Washington State and Hawaii are examples of two neighboring states using 1115 Waivers to implement pre-tenancy and tenancy-sustaining services through Medicaid.

A core element of acknowledging housing-related services as healthcare services is changing the paradigm of access to care. In traditional healthcare structures, beneficiaries are required to seek out

⁴⁴ <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-18-0008.pdf>

⁴⁵ <https://www.medicaid.gov/medicaid/spa/downloads/ND-20-0010.pdf>

⁴⁶ <https://portal.ct.gov/DSS/Health-And-Home-Care/Connecticut-Housing-Engagement-and-Support/Connecticut-Housing-Engagement-and-Support-Services---CHES>

⁴⁷ <https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/1915iapplication.aspx>

services and go to clinics to receive them. Individuals who need supportive housing need the opposite- they need the services to come to them. Service delivery must be engaging and coordinated in order to build trust and support major life transitions. Therefore, these services or potential funding must include an outreach and engagement component to ensure they reach the people that need them most.

CSH further suggests that Health Share and OHA consider exploring supported employment benefit. An evidence-based practice, the Individual Placement Service (IPS) model assists beneficiaries in moving beyond housing stability into services that enable them to thrive. Washington State has seen expansive enrollment in its supported employment program, and providers have found it to be an excellent engagement opportunity for beneficiaries seeking both supported employment and supported housing.

II. Coordinate local and state funding for tenancy supports that Medicaid cannot provide.

CMS requires that Medicaid resources do not duplicate other available funding streams and that Medicaid aligns with other programs and fills gaps where appropriate. CSH estimates that robust Medicaid-covered supportive housing services will address approximately 80% of the need for supportive housing services. The other 20% should be covered by flexible grants and contracts to address the clearly-delineated gaps, including:

- Outreach and engagement
- Benefits navigation
- Services for people who are not able to be immediately Medicaid enrolled
- Services for people who are not eligible for Medicaid or who are working on their citizen documentation
- Warm hand-off to ensure coordination of services and care if a person changes CCOs
- Services provided by agencies that provide culturally-specific services that do not have the capacity to become Medicaid billing agencies and/or to partner with those that are.

III. Support implementation with capacity-building grants and training.

As indicated by multiple providers interviewed for the Crosswalk, the prospect of becoming a Medicaid billing entity has pros and cons. Certainly the potential for sustained investment in services at rates that allow for 1:15 caseload sizes and living wages for staff is highly appealing and would allow many providers to deliver higher-quality services at scale. At the same time, nonprofit supportive housing and homeless service providers have been successful in addressing the needs of Oregonians that have been rejected and forgotten by public systems for so long because they have the flexibility to truly meet them where they are. CSH recommends the State of Oregon consider how best to leverage the knowledge and capacity of its current supportive housing services network to address the needs of priority populations while training providers who are skilled in population-specific services in the intricacies of pre-tenancy and tenancy-sustaining services. In addition to enhancing the overall services funding package for these providers as indicated above, the State, Health Share, and other CCOs will need to provide capacity-building grants and training to providers who provide culturally-specific services and for those who understand Medicaid but who are learning how to deliver supportive housing services for the first time.

Existing nonprofit providers will need assistance with activities such as purchasing an electronic health record, analyzing current activities for billing potential, and significant startup costs for staffing, supervision, and offices. Standards, when developed, need to be supported via training for the workforce both on the roll out of standards and to ensure sustained quality supportive housing services. Agencies that are proficient in billing Medicaid for reimbursement of other services will need training in the nuances of rapport-building and working with the housing system. A goal for all state supportive housing projects should be an inclusion of peer support specialists in every supportive housing project statewide. Current quality supportive housing providers and people with lived expertise could be the training partners in this endeavor.

IV. Coordinate Medicaid benefits with local and state housing and service resources at the system level.

As noted by providers, access to affordable housing is equally a great need for people with complex care needs. Oregon has historically and continues to make significant investments in housing and services, but based on provider experiences, these investments are not well-coordinated between the homeless, behavioral health, and aging systems. When coordination is not extensive enough at the system level, the burden of coordinating care falls to the individual in need of care or the provider. Counties, OHA and OHCS have positive examples of where this type of coordination is happening well, including the recently completed Health and Housing Institute, the Supportive Housing Institute, and alignment between the State's Qualified Allocation Plan (QAP) for Low income Housing Tax Credits and the CCOs' Community Health Improvement Plan.⁴⁸ Building upon these types of initiatives will be necessary for successful benefit implementation, and as-noted, new resources in the Portland Metro area provide an excellent opportunity for Health Share to take a lead role in this coordination.

V. Ensure quality.

In his work on the FUSE project, Dr. Frank Franklin, Ph.D., JD, M.PH. and Director of Community Epidemiology Services at the Multnomah County Health Department wisely noted that all system change needs to be data and systems driven. CMS strongly encourages states to build in continuous evaluations of any services, interventions, or initiatives intended to address SDOH and to make changes as needed and allowable under federal requirements. Data and systems driven partnerships commonly have the greatest impact at the person and cost level. If data is available broken out by race and ethnicity, those partnerships can also assist a state to address the health and housing disparities in the state.

Beyond the Crosswalk, cross-sector opportunities exist to develop policy goals, determine implementation priorities, and develop cross sector partnerships based upon new federal, state and local housing opportunities and other next steps. CSH recommends that OHA and DHS develop collective goals and standardized reporting for supportive housing service delivery and housing across State departments

⁴⁸ <https://www.nashp.org/five-states-break-down-interagency-silos-to-strengthen-their-health-and-housing-initiatives/#toggle-id-3>

and in partnership with local municipalities and providers. This will be especially important in ensuring the success and collective leveraging of a new OHP benefit, significant new federal resources coming into the State, and the funding for supportive housing available in the Metro area. Providers will need training and supports in learning and measuring their work against a set of state-wide standards such as CSH's [Dimensions of Quality Supportive Housing](#). Training programs, learning circles, guidance from people with lived expertise and professional technical assistance will be needed to ensure successful implementation. Examples of common measures could include:

- Need for supportive housing
- Number of persons served, disaggregated by race and ethnicity
- Length of time from referral to lease up in housing
- Impact on housing stability, reasons for exiting housing, and destinations upon exit
- Impact on standard health related outcomes and health care costs
- Changes in racial disparities

VI. Develop a pilot program while applying to CMS for a SPA or Waiver.

As a CCO, Health Share's staff can see clearly where a lack of housing supports are putting a subset of its members at risk of even greater health challenges. As OHA explores CMS approval on a benefit to serve individuals with SMI, older adults with functional impairments, and persons with ID/DD, Health Share could develop a pilot to start the delivery of pre-tenancy and tenancy-sustaining services using HRS. CSH does not recommend that the pilot be implemented as a demonstration program to prove the case for a state-wide benefit. The case is clear. However, similar to a pilot light, Health Share could ignite the work of defining eligibility criteria and services so that state-wide implementation can move quickly upon CMS approval. A pilot would also offer the opportunity for Health Share and OHA to begin examining the impact of housing-related services on transitions out of high levels of care and into the community as well as the impact of providing services based on need (functional limitations) rather than specific diagnoses.

Conclusion

CSH applauds Health Share, OHA, and their partners at OHCS for their efforts to more effectively align the health and housing sectors and for their emphasis on increasing supportive housing services capacity and quality in the state. The state has clear building blocks for better serving its most impacted residents who currently fall through the cracks. In line with the goals of the State's plan to address SDOH and health disparities, this report offers a thorough analysis that confirms the need for a supportive housing services benefit for a broader set of Medicaid beneficiaries. Creating this benefit, building provider capacity, and focusing on state-wide housing and services coordination would drive changes that would be beneficial to the State, local jurisdictions, providers and Oregon residents who are most in need.