HHS/ CMS/ CMCS

December 6, 2023

2:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in listen-only mode until the question and answer session of today's conference. If you'd like to ask a question over the phone, you can dial Star 1.

I would like to inform all parties that today's call is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the conference over to Jackie Glaze. Thank you.

Jackie Glaze: Thank you and good afternoon and welcome everyone to today's Allstate Call In Webinar. I'll now turn to Anne Marie Costello, our Deputy Center Director, and she'll introduce our speakers for today and provide a few updates on RSV. Anne Marie?

Anne Marie Costello: Thanks Jackie, and hi everyone. And welcome to today's All State Call. First up Sara Harshman, from our Disabled & Elderly Health Programs Group will provide a quick update on monkeypox and a PREP Act.

Then we're excited to feature the 1115 framework for addressing health related social needs. Dan Tsai, our Center Director, will say a few words about our featured presentation.

Aditi Mallick and Lorraine Nawara, from CMCS will lead this presentation. We are also joined by Richard Cho, from HUD, who will outline the importance of partnerships with state and local housing agencies in successful implementation of allowable housing support under Medicaid programs.

Finally, Lori Coyner, from the state of Oregon, will provide the state perspective and an overview of Oregon's approach to health related social needs, including sharing some key implementation strategies and challenges. After (Lori) we'll open the lines to take your questions.

We'll use a Webinar for today's call so if you're not logged into the Webinar platform I suggest you do so now. But before we start our presentations I wanted to acknowledge that CMS knows the current surge of RSV cases is creating significant challenges for our family's, pediatricians and hospitals.

CMS has heard from national pediatric and children's hospital associations, but we know states are also hearing strong concerns from stakeholders. We've received many questions on Public Health Emergency flexibility for RSV.

We would like to remind states that the 1135 flexibility offered under the COVID-19 Public Health Emergency continue to be available to facilities and providers to use right now. For existing 1135 waivers states may continue to use any approved Medicaid 1135 flexibility and Medicare blanket waivers through the end of the COVID-19 Public Health Emergency for other needs conformant with the public health emergencies or natural disasters.

The new 1135 waivers, states may apply for new waivers, but must note that the waiver is needed due to the continuing consequences of COVID-19 and its

effects. So for example, noting that COVID is likely a confounding factor in response to RSV.

If you have any questions about RSV, and how to apply existing flexibility, please reach out to your state lead and CMS will provide technical assistance. And now I'll turn things over to Sara Harshman to share some information on monkeypox, Sara?

Sara Harshman: Great. Thank you, Ann Marie. As many of you may remember on September 13 we provided an overview of Medicaid and CHIP Mpox testing, treatment and vaccine coverage. If you missed that presentation, I encourage you to check out the slide deck posted on medicaid.com.

For more background, since that presentation, the secretary of HHS has amended the Public Readiness and Emergency Preparedness Act, also known as the PREP Act, to expand covered persons authorized to administer vaccines and therapeutics against the Mpox virus to include pharmacists, pharmacy technicians and pharmacy interns. These additional providers are subject to a number of conditions outlined in the declaration, including training and supervision and the requirement to provide vaccinations according to CDC and ACIP recommendations.

Next slide please. All states generally have flexibility to set Medicaid provider qualifications. The HHS PREP Act declarations preempt conflicting state laws.

Therefore, in cases where a MPOX vaccination is covered by Medicaid the state would be required to provide a pathway to reimburse pharmacists for MPOX vaccine administration when provided in accordance with PREP Act declaration provisions. It should also be noted that states will also have to

need federal requirements such as those that require that providers are enrolled as Medicaid providers and covering vaccinations for only eligible individuals.

For further reference we've linked a number of documents available that provide more background on Medicaid and CHIP coverage and Medicaid implications of the HHS PREP Act declarations. This slide deck will be posted on medicaid.gov shortly after this call.

And finally, as you may have seen, Secretary Becerra has announced that HHS does not expect the Mpox Public Health Emergency to be renewed after January 31, 2023. With that we will keep states updated on PREP Act implications in future All State calls. And with that quick update, I will turn it over to Dan.

Dan Tsai: Thanks, Sara. Good afternoon folks. We have an exciting presentation, I think, that we've gotten a ton of questions about.

Many of, you know that for quite some time, and then especially over the past 12 to 18 months, we, in the Medicaid community, have had a significance set of discussions around how and what is the role of Medicaid and really supporting what the right guardrails health equity, health outcomes, population health, especially as it relates to how to integrate and encompass health related social needs, things like housing supports, nutritional support, et cetera.

There is both clear literature around the impact of housing and nutritional and other health related social need stability around health outcomes. And also a ton of questions about how to bring a delivery system together. What's the right role in place for Medicaid around this and so on.

And so we have spent a substantial time at the federal level based on a range of proposals and work in the states to really help outline a federal framework around this. And some of these folks will have seen in what we worked with California on both in the 1115 demo approved at the end of last year as well as through in lieu of services.

This discussion won't touch that piece as much, although they're all kind of interrelated as one overall framework. We did a number of months ago, in collaboration with a number of states Oregon, Massachusetts, Arizona, and Arkansas really work through the federal framework on Medicaid for housing supports, nutritional supports, a range of things, what are the guardrails, what can Medicaid cover, what are the care delivery expectations, how does it intersect with things like budget neutrality, all of that.

We're excited for where we've landed and partnership with many folks at the federal level, at the state level and in the community. All of you I'm sure have read very detailed, long approval letters and STCs that went out to those states that explains many of the pieces, but obviously we've heard there's a lot of detailed technical pages. And so our team is going to do an overview of what are the main policy parameters that we have landed on from federal standpoint that really become available to any state that is interested in pursuing this.

So that's kind of the opener. We're excited. And I'll save the details for the team to go through shortly. So I'm going to pass it over to Aditi now. And we also have some other partners outside of CMS joining for this presentation as well, so Aditi?

Aditi Mallick: Thank you, Dan, and thank you everyone for joining today. This is a brief overview of what you can expect to hear from us today. And as you all know these slides will be posted after today's call.

Next slide please. We'll start with a bit of background, and this is building off of what Dan has said, I don't think it will be a surprise to folks call that many enrollees in Medicaid and CHIP face challenges related to health related social needs.

And folks may be familiar with the January 2021 State Health Official Letter that CMCS put out that describes opportunities to address the social determinants of health and health related social needs including, but not limited to things like access to nutritious food and affordable housing. There is a significant body of evidence that has shown that those challenges can lead to poor health outcomes, higher healthcare costs for the Medicaid and CHIP programs and worsening of health disparities.

The first pillar of CMS's strategic plan is to advance equity. And core to advancing equity is addressing health related social needs.

And we see doing that in this - the following three ways that you see there on the slide. First, is through changes to the care delivery system. And that's really a transition to a delivery system where states, managed care plans and providers, as part of their core responsibilities, are screening for health related social needs and acting to meet those needs.

Next is a transition on the quality measurement side where we're using a consistent measurement framework to create accountability around conducting HRSN sense screening and acting to meet or link beneficiaries or enrollees to services that meet those needs.

And third, which is really where we'll focus today, is the coverage of clinically appropriate, time limited, upstream health related social needs intervention. As was outlined in that January 2021 SMDL states can address health related social needs to a variety of Medicaid authorities.

Some parts of Title 19, in particular Sections 1915(c) and (i) in particular have long acknowledged the critical role of those upstream services in meeting the needs of certain Medicaid eligible populations, for example individuals with disabilities. And through recent 1915(b), and a lot of what we're here to talk about today, Section 1115 approvals California, Massachusetts, Oregon, Arizona, Arkansas, as was mentioned earlier, have begun to integrate health related social needs services into their State Medicaid programs through 1115 demonstration.

And that allows for a much more nuanced targeting of focused populations. And coverage of these HR fund services through 1115 authority comes with additional requirements and guardrails, that we'll outline later in this presentation, as well as a unique treatment with respect to budget neutrality calculations, that we'll also outline later in this presentation.

And I will underscore what's there at the bottom of this slide that we really are committed to supporting our state colleagues to address health related social needs. And in that vein have established a framework to evaluate state proposals to cover these services through 1115 demonstration.

Next slide please. Before we dive into that framework a bit of background on health related social needs and the importance of addressing them in particular in the Medicaid and CHIP program. Health related social needs, and the distinction to draw here is, health related social needs are really unique to an

individual. They're an individual's unmet, adverse social conditions that can contribute to poor health.

And that's things like what you see listed here, food insecurity, housing instability. And that can drive health disparities across demographic groups.

Those are related to, but distinct from, community level underlying social determinants of health which the WHO defines as the conditions in which people are born, grow, work, live, and age. And really a wider set of forces and systems that shape the conditions of their daily life and have very meaningful impacts on health.

There is extensive research that's indicated that the social determinants of health and associated health risk related social needs can account for as much as 50% of health outcomes. So there's a real strong case to be made for addressing health related social needs in the Medicaid program to help enrollees and members stay connected to coverage and access needed healthcare services. Recognizing that important link between health related social needs, healthcare coverage, and healthcare outcomes we are so excited to be sharing these new opportunities to support states in addressing health related social needs.

Next slide please. So here is the framework slide. So the idea here is that the coverage of targeted health related social needs services and supports can and must be done in a responsible way that promotes equity and coverage while maintaining program integrity, and to the extent possible, consistency. So the first part of this framework is to outline some of the covered services. Today, you'll hear us focus on nutrition and housing support, but please know that there are other services such as transportation that may be allowable through 1115 even though they're not explicitly covered here.

Next is service delivery and expectations around those services being medically appropriate determined by both clinical and social risk factors of an individual. That those services must be offered at the option of beneficiary and never required and would never disqualify a beneficiary from receiving other medical services.

And that there must be integration with existing social services. So as you'll see today for housing support integration with local public housing authorities and HUD services, and similarly on the nutrition side with SNAP programs.

Next is fiscal policy, and this includes the guardrails and treatment under budget neutrality. For those that are on the WebEx platform I will just read you these, so folks can internalize them a bit.

Expenditures cannot exceed 3% of the states annual total Medicaid spend. There is potential to fund infrastructure costs not to exceed more than 15% of the total health related social needs spend in the demonstration. And that those services are included in the without waiver baseline for budget neutrality purposes.

A key requirement here is that state spending on related social services, prior to the demonstration, must be maintained or increased. These are really not intended to supplant, but rather to support or compliment existing investments in other parts of the social safety net.

And lastly, the related requirements that particularly around rate payment reimbursement rate adequacy for primary care, behavioral health and OBGYN. And we'll get into greater detail on this in subsequent slides.

But the high level takeaway is that those rates must be at least 80% of Medicare rates and a requirement that four rates that in those categories that are the lowest that there be an increase by at least two percentage points by the third year of the demonstration. And all of this is alongside longstanding and established systematic monitoring and evaluation requirements, including reporting on quality and health equity measures.

Next slide please. So a bit more - now the coming three slides go into specific detail on nutrition supports and housing supports. So this slide on nutrition supports gives you a sense of the interventions that are allowable.

The nutrition support tier two four have been provided in limited scope under 1915 authority. And in particular, I think, important to note here is that under Section 115 Demonstration Authority can include up to three meals per day when other authorities were limited to two or less than a full regimen. These meals are to be provided in the home or private residents never to offset the cost of room and board in a congregate or institutional setting.

Another new benefit to highlight is the food and vegetable prescriptions for those who don't have access to fresh produce. Again, a time limited intervention not intended to supplant or replace other resources for food.

And similar to what you'll hear us talk about in the expected connections of housing agencies connections to existing and ongoing resources for nutrition supports are really critical for long-term support to enrollees. That again these services are a supplement rather than a supplementation of support services and that it is critical for state Medicaid agencies to be partnering with other state agencies and social service providers to ensure that beneficiaries experiencing food insecurity are connected to programs for the long-term.

Next slide please. This slide, and the next one, go over in a bit more detail the housing support. The 1115 housing supports are modeled after those allowable under 1915 and other HCBS authorities.

So again, these are not intended to be long-term supports or replacements for existing resources, and they are time limited in nature. And the structure of them is really designed to encourage state Medicaid agencies to partner with existing housing supports to prioritize targeted focused populations and develop pathways for permanent support.

So as you can see on the slide allowable services includes rent and housing costs for up to six months, respite services, day habilitation, sobering centers, pre-tenancy and tenancy supports and housing navigation services. And eligible individuals can include those, who for example, are in transition between an institutional setting in the community those who are experiencing homelessness or at risk of homelessness.

Next slide please. And again, similar to services available in 1915 authorities for those leaving institutions transition costs, home modifications are allowable under this 1115 authority, including medically necessary remediation services to ensure a healthy stable living environment.

Now that we've done an overview of some of those services, and the background, I'd like to turn it over to my colleague, Richard Cho, who is the senior advisor to the Secretary of Housing and Urban Development, to share a bit more about how exactly to do the integration with state and local housing agencies. Richard, over to you.

Richard Cho: Thank you so much, Dr. Mallick. Let me just say on behalf of everyone at HUD how excited we are not only about CMS's leadership in recognizing

housing's role as a health related social need, but also the growing number of states that are looking to adopt housing related services as covered services under their Medicaid programs.

You know, recently HUD provided states and communities with pretty significant resources, which they haven't had in a long time, to address homelessness as well as provide more affordable housing. And that comes in the form of vouchers as well as new dollars to actually build more affordable and supportive housing.

But what a lot of the states and communities have told us is that now the limiting factor to being able to address people's housing insecurity and homelessness is not rental assistance per se or capital to build more affordable housing, it's really funding to provide wraparound supportive services to help people find housing as well as maintain ongoing tenancy and housing. And so these housing related services covered under Medicaid programs is really key and something that we are very excited about.

But now as Dr. Mallick mentioned the key to success with Medicaid coverage of these housing related services is those partnerships with state and local housing agencies. That really can not only help Medicaid programs understand how to connect these new Medicaid covered housing related services to existing housing supports, but also may be key partners in helping with implementation.

There's really essentially three different roles that I think housing, state and local housing agencies, can play. One is to actually help coordinate the provision of the ongoing long-term rental assistance that public housing authorities and other providers of HUD programs can actually provide on a long-term basis to coordinate with some of the short-term supports.

The key with the coverage of short-term housing related costs such as short-term rental assistance or utility assistance is that they're really bridging to something. And that means that they need to bridge to long-term ongoing sources of rental assistance or housing. And that's where it's really important to work with state and local housing agencies to coordinate how Medicaid covered short-term rental assistance is structured in ways that can actually seamlessly bridge into the way that HUD rental assistance works.

Second, is that many of the same public housing authorities, as well as homeless services organizations that work as part of local continuation of care, they can also be some of the key providers who can provide the housing navigation, the pre-tenancy and the tenancy sustaining services that are now being covered by many states under 1115 waivers to - under their Medicaid programs.

And third I think many of the public housing authorities who currently administer housing choice vouchers, and other voucher programs, can also play a key role in administering short-term housing assistance. So they can actually be the ones who administer that on behalf of a state Medicaid agency as well as to help be the agency that help allocate the use of one-time transition costs or other moving costs.

I just want to repeat something that Dr. Mallick already mentioned which is that Medicaid covered housing support should supplement, but not substitute existing housing funds. So again the key to success is where the Medicaid covered housing supports work in coordination with HUD programs and other state and local housing programs or where they actually bridge and kind of transition seamlessly to those long-term rental assistance and housing programs.

On the next slide please. There - you - those of you who've been working with housing agencies may sometimes realize that there - there's quite a few different agencies at the state and local level. What I wanted to do here was just to provide sort of the four basic categories of the types of housing agencies at the state and local level that are really key to partnering with.

In nearly every state there is something called a State Housing Finance Agency. These are state chartered agencies sort of, not necessarily part of government, but kind of chartered by state government.

And their role is to help finance the development of affordable housing. And they may administer programs like the Low Income Housing Tax Credit Program, which is probably the largest federal source of resources to help create affordable housing, as well as administer bond programs at the state level where housing bonds are actually used - the proceeds of housing bonds are used to generate capital to develop more affordable housing.

State HFAs, as they're known, also administer a couple of key programs that really are important for the kind of populations that I believe would sort of qualify or benefit from housing related services under Medicaid programs. And one of those is the Home Investment Partnerships Program. It's a program that HUD provides. And the other is the Section 811 Supportive Housing Program that's specifically for people with disabilities especially for those transitioning out of institutional settings.

I think the other category of agencies are public housing authorities. There's about 3000 quasi public housing authorities across the country who play a couple of roles.

One is that they oversee and manage the federal public housing program, which most people are familiar with, but they also administer vouchers, the Housing Choice Voucher Program. And other special purpose vouchers such as the HUD VA Supportive Housing Program and most recently the Emergency Housing Voucher Program that HUD provided to communities.

And those are - those rental vouchers work where you know, a voucher is provided to an eligible household who then can lease up a private market apartment. And where that voucher pays the difference between 30% of that households income and the rent that is charged by that private landlord.

And so that's probably one of the most important sources of rental assistance in the country and where, in the case where people are being provided with short-term housing assistance, or either pre-tenancy or ongoing tenancy supports really the key is to transition them into a voucher program and housing, and where the short-term housing tenancy can potentially transition into a housing choice voucher.

In addition, there's probably thousands of municipal and county governments that have housing departments that either help finance the development of housing or often who coordinate and provide federal housing programs like home CDBG. Without getting into the details on those programs essentially city and county housing agencies are another set of partners.

And last, but certainly not least, are homeless services organizations that work as part of continuums of care. Continuums of care are essentially collaborative bodies that manage the way that homeless services are organized.

They also coordinate the use of the homeless assistance grants that HUD provides, also known as the Continuum of Care Program. And where they also

have coordinated entry systems that help determine who experiencing homelessness is being prioritized for connections to housing.

And so partnering with all four of those types of agencies will really be key. If I had to pick I would say that certainly PHAs and Continuums of Care, COCs as they're known, are probably two of the most important partners to state Medicaid programs.

Next slide. And I want to just end my proportion here with just a few key issues and considerations. I think, you know, the increasing trend of states covering housing as a health related social need could not come at a sooner time. Timing is everything.

As I mentioned at the beginning of my remarks most housing agencies across the country have been experiencing pretty severe resource scarcity for the last a few years. Right now, or at least before the beginning of the Biden Harris administration, most PHAs would report that only one out of every four or one of every five households were on a waiting list for a housing choice voucher would actually ever receive it.

And so through the American Rescue Plan, as well as most a recent Appropriations Act for FY '22 housing and homeless services agencies have experienced an influx of new housing resources. And again those are housing resources that provide rental assistance or capital to build housing they don't come with supportive services per se. And so Medicaid's coverage of these housing related wraparound supports tenancy sustaining supports is really critical and timely.

Second, is recognizing that PHAs, and Continuums of Care, they all have their own methods, and processes and systems for determining who is eligible for vouchers, or rental assistance or housing assistance. And they also have their own methods for determining who should receive priority given that there is still resource scarcity.

Public housing authorities maintain their waiting list. Homeless service organizations, the COCs I mentioned, have coordinated entry systems.

And so it's really important that as Medicaid programs begin to cover housing related supports and services that they're, you know, being mindful of those existing processes for who is being determined eligible for say a voucher or permits for a housing unit, and try to work to coordinate the way that who is determined to be eligible for Medicaid covered housing supports is mindful of those other processes.

And third is to ensure that when states are covering short-term housing assistance, for example the six months of rental assistance, that they're doing so in a way that makes it much easier for people to then transition to long-term rental assistance such as through a voucher. So for example if a state is covering up to six months of rental assistance it may be helpful to provide that rental assistance, that short-term rental assistance, in ways that mirrors the housing choice voucher program. In other words, following the same payment standards, ensuring that people who are being given short-term housing assistance are actually going to be eligible for a housing choice voucher based on their income.

And lastly, I just want to reiterate the point that collaboration and communication needs to be an ongoing process. Many of the states who have like Arizona, and Massachusetts, and Oregon who have adopted 1115 waivers

that -- and had approved 1115 waivers that cover housing related services -- they planned and designed those housing related supports in partnership with their housing agencies at the state and local level.

But the collaboration needs to not just stop at the point in which a 1115 waiver demonstration is approved, but needs to be ongoing as part of implementation. So I want to just reiterate the point that collaboration and communication needs to be ongoing.,

And that it's probably going to - there's probably going to be things that be worked out even after 1115 waivers approved to get to plan to implement, monitor, troubleshoot as well as modify processes. So with that, again, just want to reiterate how excited HUD is to be partnering with CMS to support CMS's leadership in covering housing as a health related social need. And with that I'll turn this back over to CMS.

Lorraine Nawara: Thank you. This is Lorraine Nawara. I will be sharing some additional details about how the requirements for 1115 demonstrations that include HRSN services.

So while this presentation contains the interventions that are known to be evidence based and allowable for approval under the 1115, it's not an all inclusive list. And CMS will review proposals that include additional services and evaluate those individual requests from states.

Any details about the evidence base for an additional service will be helpful in our review process. We'll talk more in depth about budget neutrality in the next few slides, but additional services not included here in presentation will require demonstration savings to fund. And as always we encourage states to reach out to their project officers to request pre-submission technical

assistance and ask any questions you may have about the submission and approval process.

Next slide please. Additional requirements for HRSN and 1115 demonstrations include a determination that services are medically appropriate. And that determination must be documented in the service plan.

States should propose their method for identifying individuals who need the services and detail the process to be used for service planning and the determination of medical appropriateness in their 1115 proposals, Beneficiary protections, similar to those currently required for home and community based services, are also required for individuals receiving HRSN services in 1115 demonstrations.

These protections include that the HRSN services must be optional. A person cannot be forced to use an HRSN service or to use an HRSN service before receiving another Medicaid covered service. And as mentioned before, the state must be working with long-term resources for housing and nutrition supports and not view the 1115 demonstration as a permanent or ongoing resource for these needs.

Next slide please. Along with the service package CMS has developed some guardrails and a budget neutrality construct for HRSN. HRSN services will have a spending cap. And the total HRSN expenditure authority cannot exceed 3% of state total annual Medicaid spend.

Additionally, expenditure authority for the HRSN infrastructure can be no more than 15% of the states total expenditure authority. So if the state received $100 in total expenditure authority for HRSN only 15 of those dollars could be used for infrastructure.

Allowable infrastructure costs should not supplant or replace existing funding and should be necessary to implement the HRSN services. This could include funding to develop or purchase the screening tool for HRSN services for IT systems improvement such as electronic referral systems, workforce development efforts like cultural competency or trauma informed care training, or outreach and education efforts specific to HRSN services.

For the purpose of budget neutrality HRSN services, identified earlier in the presentation, and the related infrastructure costs will be considered hypothetical. Meaning that savings are not needed to fund the services and infrastructure that states also can't accrue savings based on the provision of HRSN services. And as noted before any new intervention, not already defined here, will require the use of demonstration savings to fund and would not be considered hypothetical.

There's also a maintenance of effort requirement in that states must demonstrate that they have not shifted or cut funding to existing nutrition and housing supports based on the provision of HRSN through the demonstration. We understand that the full state budget is not within the control of the Medicaid agency and the CMS teams will work with states to develop the baseline of nutrition and housing funding for the purposes of the MOE.

Next slide please. In addition, in order to receive authority to provide HRSN services states will be expected to increase or maintain their rates for primary care, behavioral health and OBGYN services. If the total HRSN expenditure authority is at least $50 million, or 0.5% of the State total Medicaid spend, whichever is less.

The state Medicaid to Medicare rate ratios must be at least 80% for these services in both fee for service and managed care systems. If any rate ratio is less than 80%, in any of the categories, then the statements increase that rate by 2% by the start of year three of the demonstration

That the state had a rate ratio for primary care of 82% in their managed care system and 75% in a fee for service system. Only the fee for service rates for primary care would need to increase by 2% by year three of the demonstration. CMS will work with states to establish their Medicaid to Medicare ratios, define a procedure code set for each group of services and review states submitted data and calculations related to the rate increased requirements.

Next slide please. And finally, there are additional evaluation monitoring requirements for HRSN services. These include an implementation plan that describes a plan for and progress towards implementing HRSN services as well as additional reporting on health outcomes for individuals who receive the HRSN services.

States must evaluate whether HRSN services effectively address unmet needs, reduce the use of high-cost services like emergency room visits and improve health outcomes for beneficiaries. States must commit to reporting on health equity metrics stratified by ethnicity, language, geography, disability, status, sexual orientation, and gender identity.

CMS understands the difficulty states may have with gathering and reporting on these stratified metrics and will work with each state towards developing this reporting capacity. Again, please reach out to your project officers for additional information and assistance and exploring this new options for supporting health related social needs.

It's now my pleasure to turn it over to Lori Coyner, representing Oregon, to share the state perspective with an overview of Oregon's approach to HRSN services as well as their implementation strategies and challenges.

Lori Coyner: Thank you, Lorraine. I want to thank both CMS and HUD for all their support on our recent waiver authorities we received. Couldn't have done it without all of us putting our heads together to make this work, and so on behalf of Oregon we really appreciate it.

And I want to talk - I'm going to talk a little bit about how we structured who can receive benefits and then some highlights as was stated earlier about our implementation planning. So one of the things that Oregon focused on initially was thinking about transition groups.

And what we mean by that are people who are going through a transition in their lives. Often it can include disruption of Medicaid services or other types of services. And, you know, our focus was on these populations because we know that they have high need are - and are more likely to be in need of health related social needs just to get to baseline so that then they can start to manage their medical and behavioral health needs as well.

So I've - we have six different transition groups here who are the folks that will be eligible for these health related social needs services. So the first are people who are currently experiencing homelessness or at risk of homelessness.

The second is youths with special healthcare needs between the ages from 18 up to age 26. Youth who are child welfare involved and their families, obviously.

Older adults who are - have both Medicare and Medicaid health insurance, so our dual eligible populations. Particularly those people who are moving from Medicaid only to becoming a dual.

Adults and youths leaving the criminal justice system. And that includes both state level incarceration and county facilities. And finally adults leaving the Oregon State Hospital.

Next slide please. I can't highlight enough on what Richard was talking about in terms of needs for a partnership with state and local housing and homeless service agencies. You know, we are an agency that works primarily in Medicaid and public health.

And, you know, this movement into partnership between the health and behavioral health system with housing and nutrition services is going to take partnership in a lot of learning. So I'm going to start with that statement.

And the, you know, across these implementation strategies we're really having to think about, you know, how to identify individuals, how to do the outreach and referral, and engagement from a member centric viewpoint. And part of the need for that is around, you know, technology solutions that allow referrals and tracking of individuals between the different systems which will be new for us in Oregon.

These technology solutions are also needed to be able to have the housing providers and nutrition providers bill for services. So some of the big areas that we're, you know, working on right now is, you know, build - thinking about provider network.

And that's where this partnership between state and local housing becomes critical, you know, because we need to build on existing relationships that have been formed. We have a longstanding history with our coordinated care organizations working with what we call health related services, so they do have - many of them do have connections already with housing.

And really make some investments in building capacity of these housing providers to begin to act as a Medicaid service provider. And further that partnership between coordinated care organizations and community based organizations, you know, requires, you know, building on relationships that are already there, but expanding the capabilities around technology, around billing, about how to identify individuals and send the information back and forth.

And then also I - it's really new for us to, you know, have robust collaborations across our state agencies. And in particular we - we've been developing a strong partnership with Oregon Housing and Community Services. And we see that as a critical relationship and making this effort successful.

The other piece around that collaboration is thinking about, you know, how we prevent duplication of effort and services. So part of our commitment to CMS, and our waiver, was that we would not supplant services.

And as Richard from HUD said, you know, we see these, you know, the temporary rental assistance is an opportunity to cover members with housing so that they can then find permanent housing solutions, permanent types of connections to behavioral, physical and oral healthcare.

Next slide. I think it's covered, you know, a lot of these challenges, but I'll go through a few more in detail. So our community based organizations are not familiar with Medicaid billing, so that's going to take some readiness development as I mentioned earlier.

And across both our healthcare and community partner systems right now we're experiencing workforce challenges. I know that's a problem across the country, and so it's something that we have to spend our time thinking about how to be efficient and how to account for that. And also, you know, think about ways that we can build the workforce.

Again, there's infrastructure building needs around technology for data sharing and information utilization. We also committed to collecting and reporting back on data, you know, in terms of outcomes. And so that that whole system needs to be developed.

And there were some legislative acts to make this be a reality. And so if your states thinking about it then, you know, starting to have those conversations are important.

This is a complex package of benefits. It's something that Medicaid is, you know, new to in many cases. And so it does require us to partner with both state and local agencies in ways that we haven't before.

We also are building this system across both our managed care and fee for service systems. In Oregon we're about 80%, about 80% to 90%, 85% to 90% of our members at any one time are managed care, but we do have you know, a substantial number of fee for service members.

And then how to be responsive. So how do we center the member and their needs in this - in our development? How do we ensure that the services are culturally and linguistically appropriate and make sure that our diverse populations are receiving services in and having their needs met in the same way that, you know, everyone else does so that we have, you know, equity in the care that we deliver and the services that we provide as we build these health related services.

I think that's my last slide. And so I am going to turn this back over to Jackie Glaze for questions. Oh, and there are updates here. Feel free to look at our Web site. You can see our waiver. And there's many materials and multiple languages on what we're up to. Thank you.

Jackie Glaze: Thank you so much, Lori, Richard, Aditi and Lorraine for your presentation. So we're ready now to take your state questions.

We'll begin by using the chat function. I do see some questions already, so we'll go through those. And then we will move to the phone line. So I will transition to you (Ashley) now for those questions through the chat.

(Ashley): Thanks, Jackie. The first question says, "Can in lieu of services the use for HRSN under an existing 1115? And if so is a waiver amendment needed?"

Jackie Glaze: Lorraine, do you want to take that one?

(Judith): So this is (Judith). I'll jump in on that one. And we think we - if we have anybody from our managed care team on the phone I'm sure they could supplement as well.

But I think our response to that is, you know, the in lieu of services opportunity through managed care is yet another opportunity to address health related social needs through the managed care construct. So that is absolutely an option.

And, you know, there are a number of ways I think\ to explore that option. And so I would certainly suggest taking a look at that with our managed care team if that's an interest.

Where a state has its managed care authority in the demo we can certainly look at that in the demo, but we would do it sort of within the construct of the in lieu of services as authorized under the managed care rules. So, you know, I think there are a number of opportunities to address health related social needs, what Lorraine, and Aditi, and Lori have all talked about is, how we are offering one of those opportunities through 1115.

And we can certainly explore that with any states on the phone. And there are other ways to address health related social needs including the ILLS framework.

(Ashley): Great, thanks (Judith). The next question says, "Can you confirm did you say HRSN expenditures are capped at 3% of total Medicaid spend?"

Lori Coyner: Yes, that's correct.

(Ashley): Okay. Then you have a question that says, "When you say included in the without waiver baseline, does that mean you're increasing both the with and without waiver estimates and effectively making it, so a state doesn't have to find other cost savings to finance these expenses?"

Lorraine Nawara: Yes, that's exactly right. They're counted on just the with waiver and the without waiver side. So they balance out and there's no requirement that states use savings from other portions of the demonstration to fund these services.

And that's for those services that are already identified in this presentation. It's not related to any new unique state specific services that might be proposed.

(Ashley): Thank you. So we'll now move to the phone line. So operator, if you could please provide instructions to the participants on how to register their call - their question. And then we'll take some questions there.

Coordinator: Thank you. As a reminder, if you'd like to ask your question over the phone please dial Star 1, unmute your phone and record your name when prompted. Your name is just required, so we can introduce your question.

If you need to withdraw your question for any reason, please dial Star 2. Again that's Star 1 if you'd like to ask a question over the phone. Our first question comes from (Steven Costatino). Your line is now open.

(Steven Costatino): Thank you. And again I think this has been a wonderful development with CMS and appreciate the effort that was put into this.

Question on the definition on housing supports. And if it's more appropriate that this is a state CMS discussion, you know, I could defer to that as well.

But in terms of institutionalization and congregate care were there any specific definitions in terms of that? And I particularly reference individuals that potentially are in hospital settings, acute hospital settings, for long periods of time inappropriately because there's no access to housing or even those in a

homeless shelter for a long-term would those kinds of fit the definition? Are we kind of using a specific definition as it relates to those?

Aditi Mallick: This is, again happy to start, and then others please chime in. I think that that likely could fit. We're really envisioning this as, again a wraparound or a bridge.

And so individuals transitioning out of institutions sort of broadly defined as well as individuals who are medically fragile or at risk of homelessness, but no longer need, for example, a hospital level of care...

(Steven Costatino): Right.

Aditi Mallick: ...can face sort of unique barriers to housing that prevent community living. So I think the short answer to your question is certainly could consider some of the examples that you've raised of individuals who are in hospitals not due to medical reasons and need some bridge support to be able to live in the community.

(Steven Costatino): Thank you for that. That really clarifies it.

Coordinator: We have no further questions over the phone so far. As a reminder if you'd like to ask a question over the phone you can dial Star 1.

Jackie Glaze: Thank you. Back to you, (Ashley), for some additional questions through the chat.

(Ashley): Okay. thanks Jackie. So we have a question for Oregon. And it says, "Did Oregon change HUD/COC or Section 8 access rules? So people housed and

rent paid through Medicaid for six months are still eligible for affordable housing typically reserved for those actively experiencing homelessness."

Lori Coyner: So we did not make any change to HUD rules. This is Lori Coyner from Oregon.

(Ashley): Okay. Thanks, Lori. We have a question that has come in around unwinding from the public health emergency.

And it says, "We have a question about electronic notices and renewal packets specifically for individuals who opt into getting electronic notices under 435918 and fail ex parte review, meaning that we cannot renew them via the ex parte process, and we need more information from them. Can we opt to forego sending them a physical renewal packet and just send them an electronic notice that they need to go into their online account to do an electronic renewal without sending them a renewal packet?:

(Shannon): Hi. This is (Shannon).

Jackie Glaze: Oh, good (Shannon). I was just going to ask if anybody was someone who could answer, fabulous. Thank you.

(Shannon): Yes, I will get started and feel free to jump in. But this is (Shannon) in the Children and Adult Health Programs Group.

And so if an individual - if states unable to complete an ex parte renewal for an individual they must provide the individual with a renewal form. If you do have an individual, so individuals can choose to receive notices electronically, and if the individual elects to receive information electronically the state could

send the individual an electronic notice rather than mailing a paper renewal form first.

However, if the individual comes back and would like to receive that renewal form over paper then of course the state would need to make sure that they accommodate that request. But if the individual has not made such an election, and has not elected for electronic notices, then, you know, the state would need to go ahead and just send out the renewal form via mail.

(Ashley): Thanks, (Shannon). We have one more question that came in for CAP. And it, sorry I just lost it, it says, "Can CMS advise how states should be processing individuals received on a PARIS match? Are states able to terminate coverage if the out-of-state address has been confirmed via additional sources assuming the member does not respond to a request to verify residency?"

(Susan): Hi. This is (Susan) maybe I - oh was someone else jump in? Okay, I would say this state may not terminate if you have a PARIS match, and you reach out to the individual, and they don't respond.

If you - if the state is electing the FFCRA, I'm sorry, electing the increase (unintelligible) under the FFCRA. However, the interim final rule did permit states to terminate, based on a PARIS match, if state spent certain conditions such as checking other data sources and reaching out to the state in which the PARIS match shows they have other benefits. So there is - the option under (unintelligible) that states have to do additional work to be able to terminate under that option.

Jackie Glaze: Thank you. (Ashley). (Ashley), one more question and then we'll wrap up.

(Ashley): Yes, the last question says, "At the beginning of the call did I hear correctly that the PHE can now be expected to end January 31, 2023?"

Sara Harshman: Hi. This is Sara. The Mpox Public Health Emergency.

Jackie Glaze: Monkeypox, Sara, let's just be clear it's the monkeypox.

Sara Harshman: Yes, yes. It's the, yes, monkeypox Public Health Emergency is expected to end January 31. That is right.

Jackie Glaze: Thank you, Sara. So in closing we'd like to thank the team for their presentations today. Looking forward we will provide the date, the topic and the invitation for the next call. So that will be forthcoming.

If you do have questions in the interim please reach out to us, your state leads or bring your questions to the next call. So we thank you for participating. Thank you for your questions, and we hope everyone has a great afternoon. Thank you.

Coordinator: That concludes today's conference. Thank you all for participating. You may disconnect this time.

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