DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

February 1, 2024

Vivian Levy
Medicaid Director
Oregon Health Authority
500 Summer Street NE, E35
Salem, OR 97301

Dear Director Levy:

Oregon submitted a draft its Health Related Social Needs (HRSN) Services Protocol on August 31, 2023, in accordance with the special terms and conditions (STC), specifically, STC 9.6. The Centers for Medicare & Medicaid Services (CMS) is approving the protocol, as an attachment to the STCs for Oregon's section 1115 demonstration project entitled, "Oregon Health Plan (OHP)" (Project No. 11-W-00415/10;21-W-00073/0), effective through September 30, 2027. A copy of the approved attachment is enclosed and will be incorporated into the STCs as Attachment J.

This approval is conditioned upon compliance with the previously approved STCs, which set forth in detail the nature, character, and extent of anticipated federal involvement in the project. In addition, as stipulated in the STCs, the state must continue conducting monitoring and evaluation of all HRSN-funded initiatives.

We look forward to our continued partnership on the OHP section 1115 demonstration. If you have any questions, please contact your CMS project officer, Felicia Pailen. Felicia can be reached by email at Felicia.Pailen@cms.hhs.gov.

Sincerely,

[redacted]

Andrea J. Casart
Director
Division of Eligibility and Coverage Demonstrations

cc: Nikki Lemmon, State Monitoring Lead, Medicaid and CHIP Operations Group

Enclosures: Attachment J: Protocol for HRSN Services

Attachment J
HRSN Services Protocol

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

I. Member Eligibility.

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

Covered Population	Population Description
Young Adults with Special Health Care Needs (YSCHN)	Including: • Members aged 19 to 26, with income up to 300% of the Federal Poverty Level (FPL), meeting at least one of the following criteria: • One or more complex chronic conditions as identified in the Pediatric Medical Complexity Algorithm (PMCA); • Serious emotional disturbance or serious mental health issue indicated by qualifying behavioral health diagnosis; • Diagnosed intellectual or developmental disability; • "Elevated Service Need" or functional limitations as determined by two or more affirmative responses to a screener; and • Starting no earlier than January 1, 2026, two or more chronic conditions as represented by a subset of the PMCA's non-complex chronic conditions.
Adults and youth discharged from an Institution for Mental Disease (IMD)	Including members who were discharged from an IMD in the last 12 months. Eligibility must be determined within 12 months of discharge.
Adults and youths released from incarceration	Including members released from incarceration within the past 12 months, including those released from state and federal prisons, local correctional facilities, juvenile detention facilities, Oregon Youth Authority closed custody corrections, and tribal correctional facilities. Eligibility must be determined within 12 months of discharge.

Youth involved with child welfare	Including members who are currently or have previously been: • In foster/substitute care; • Receiving adoption or guardianship assistance or family preservation services; or • The subject of an open child welfare case in any court.
Individuals transitioning to Dual Status	Members enrolled in Medicaid that are transitioning to dual Medicaid/Medicare status. Members shall be included in this covered population for the 90 days (3 months) preceding the date Medicare coverage is to take effect and the 9 months after it takes effect. Eligibility must be determined within 9 months of transition.
Individuals who are homeless or at risk of homeless	Members who meet the definition of homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5.

b. **Medical Appropriateness.** To ensure the services are medically appropriate, the state will require that individuals identified as in need of HRSN services meet the following clinical and social risk criteria. To qualify for a HRSN service, a member must:
   i. Meet the eligibility criteria for one or more of the covered populations (described above in Section I.a);
   ii. Have at least one of the clinical risk factors. The Climate Device-specific clinical risk factors and associated Outreach and Engagement services are listed in the appendix in Table 1. The HRSN clinical risk factors for housing, nutrition, and outreach and engagement broadly are listed in the appendix in a second Table 2.;
   iii. Have one of the following social risk factors; and
   iv. Meet any additional eligibility criteria and requirements that apply in connection with the specific HRSN service (e.g., utility costs may only be provided for members who are also receiving rent/temporary housing).

c. **Clinical Risk Factors.** In order to receive a Climate Device or Outreach and Engagement services at launch, individuals must meet one of the climate device specific clinical risk factors listed in the appendix. To receive a Housing, Nutrition, or Outreach and Engagement services, individuals must meet one of the HRSN clinical risk factors listed in the appendix based on assessment and included in the individuals plan of care.

Social Risk Factor	Risk Factor Description
Housing Related Need	• An individual who: Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5; or ○ Requires a clinically appropriate home modification/remediation service.

Nutrition-Related Needs	• An individual meeting the USDA definition[1] of low food security.
HRSN Device Needs	• An individual who resides in their own home or non-institutional primary residence and for whom an air conditioner, heater, air filtration device, portable power supply (PPSs), and/or refrigeration units for medications is Clinically Appropriate as a component of health services treatment or prevention.

d. **Publicly Maintained Criteria.** The state will maintain the clinical and social risk criteria detailed above on a public facing OHA webpage, and require that CCOs and FFS TPCs also maintain these criteria on a public facing webpage. The content will be updated if the criteria is changed. Any changes must be approved by CMS prior to posting.

II. HRSN Services

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

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

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

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

Service	Description

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

Rent/temporary housing	Payment for rent and/or short-term, temporary stays for up to six months, including: 1. Rent payments for apartments, single room occupancy (SRO) units, single-family homes, multi-family homes, mobile home communities, accessory dwelling units (ADUs), co-housing communities, middle housing types, trailers, manufactured homes; manufactured home lots, motel or hotel when it is serving as the member's primary residence, transitional and recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming. Eligible costs include: • Rent payment (past due or forward rent) • Storage fees • Renter's insurance if required by the lease • Landlord paid utilities that are part of the rent payment and not duplicative of other HRSN utility payments Payments must only be provided in connection with dwellings that meet maintenance regulation code within the local jurisdiction for safety, sanitation, and habitability. Rent/temporary housing is only available to individuals who are transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), correctional facilities, and acute care hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and youth transitioning out of the child welfare system including foster care.

Utility costs	Utility costs are limited to households receiving rent assistance/temporary housing and are available for up to six months. This service provides payment for: 1. Recurring utilities 2. Non-refundable, non-recurring utility set-up costs for utilities or restart costs if the service has been discontinued, and up to six months of arrears related to unpaid utility bills This service will cover expenses for the following types of utility payments: o Garbage o Water o Sewage o Recycling o Gas o Electric o Internet o Phone (inclusive of land line phone service and cell phone service)
Pre-tenancy and housing transition navigation services	Pre-tenancy and housing navigation services are supports to individuals or households, or both individuals and households, to achieve their stability goals, as defined by them. These case management/coordination services include: 1. Working with the individual to develop a housing plan that supports the stated needs of the member and/or household to achieve their stability goals; 2. Reviewing, updating, and modifying the plan with the member to reflect current needs and preferences and address existing or recurring housing retention barriers; 3. Searching for housing and presenting options; 4. As needed, facilitating enrollment in the local Continuum of Care's Coordinated Entry System; 5. Assisting in completing housing applications and payment of any housing application or inspection fees;

	6. Assisting in coordinating transportation to ensure access to housing options prior to transition and on move in day; 7. Ensuring that the living environment is safe and ready for move-in; 8. Assisting in arranging for and supporting the details of the move; 9. Engaging the landlord and communicating with and advocating on behalf of the member with landlords; 10. Assist the member in communicating with the landlord and property manager; 11. Providing training and resources to assist the member in complying with the member's lease; 12. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized; 13. Providing supports to assist the member in the development of independent living skills needed to remain housed (e.g., skills to maintain a healthy living environment, develop and manage a household budget, interact appropriately with neighbors or roommates, reduce social isolation, utilize local transportation, etc.); 14. Supporting housing stability by facilitation of the enrollment of individuals of the household in local school and college systems; or 15. Coordinating referrals for access to other necessary medical, disability, social, educational, legal, income-related tools and resources for housing, and other services.
Tenancy Sustaining Services	Services to assist individuals in maintaining housing stability. This assistance may include: 1. Engaging the landlord and communicating with and advocating on behalf of the member with landlords; 2. Providing supports to assist the member in communicating with the landlord and property manager;

	3. Providing training and connections to resources to assist the member in complying with the member's lease; 4. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized; 5. Assist the member in the development of independent living skills needed to remain housed (e.g., skills to maintain a healthy living environment, develop and manage a household budget, maintain relationships with neighbors or roommates, reduce social isolation, utilize local transportation, connect to needed behavioral health or other healthcare services, peer mentors or social supports, etc.); 6. Supporting housing stability by coordinating to facilitate the enrollment of individuals of the household in local school and college systems; or 7. Coordinating referrals for other necessary medical, social, educational, legal, and other services (e.g., connections to behavioral health treatment providers).
One-time transition and moving costs and housing deposits	One-time transition and moving costs necessary to establish a basic household such as: 1. Deposits needed to secure housing (i.e. security deposits); and first months and last month's rent as required by landlord for occupancy; 2. Utility set-up fees/deposits and up to six months of unresolved utility arrearages if necessary to set up services in new residence; and first month coverage of utilities, including water, garbage, sewage, recycling, gas, electric, internet and phone (inclusive of land line phone service and cell phone service); 3. Relocation expenses; 4. Pantry stocking at move in; or Basic household goods and furniture, which may include appliances necessary for food consumption, bedding,

	furnishings, cribs, bathroom supplies, and cleaning supplies

Medically necessary home accessibility modifications and remediation services	The provision of medically necessary home accessibility modifications and remediation services to eliminate known home-based health and safety risks and ensure the occupants' health and safety in the living environment. • Accessibility modifications may include: ramps, hand rails, pathways, grip bars, electric door openers, widening of doorways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, non-skid surfaces, sound proofing, overhead track systems, among other modifications necessary for access, health, and safety, subject to OHA approval. • Home remediation services may include: chore services (inclusive of heavy housecleaning, removal of hazardous debris or dirt, and removal of yard hazards), pest eradication, carpet or mold removal, installation of washable curtains or synthetic blinds to prevent allergens.
Nutrition Education	Any combination of educational strategies designed to motivate and facilitate voluntary adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being. This service may consist of the following: 1. Provision of nutrition education or information to an individual or group that offers evidence based or evidence informed strategies on adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being and guidance on food and nutrition resources. 2. Meal preparation education in an individual or group setting. Nutrition education services may be supplemented with handouts, take-home materials, and other informational resources that support nutritional health and well-being. This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.

Assessment for Medically Tailored Meals	Initial assessment with a Registered Dietitian Nutritionist (RDN) (preferred), or, if not available, a primary care provider, to develop a medically appropriate nutrition care plan for the HRSN "Medically Tailored Meals" service. This service also covers a reassessment, if needed, to understand whether the delivery of a service is meeting the member's needs.
Medically Tailored Meals	Meals tailored to support individuals with health-related condition(s) for which nutrition supports would improve health outcomes. This service includes: 1. The preparation and provision of the prescribed meals consistent with the nutrition care plan, up to 3 meals a day, for up to 6 months; and 2. Delivery of the meal. Each meal must contain sufficient food to support approximately one-third of an individual's daily nutritional need as indicated by the Dietary Reference Intakes and Dietary Guidelines. The meal may also include an accompanying fluid/drink and/or a supplementary food item to support meeting a member's nutrition needs between meals if medically appropriate (for example, to provide access to fluids and/or support taking medication accompanied by food). Meals may consist of fresh or frozen food. If a member is receiving 3 medically tailored meals/day, the member may not concurrently receive pantry stocking, meals, or and food prescriptions simultaneously. The service must: • Be provided in accordance with nutrition-related national guidelines, such as the Dietary Guidelines for Americans, or evidence-based practice guidelines for specific chronic diseases and conditions. • Follow food safety standards. • Consider an individual's personal and cultural dietary preferences.
Meals	Receipt of prepared hot foods, meal kits or restaurant meals to supplement HRSN "Pantry Stocking" for members who require additional food supports, in particular for but not limited to supporting members' engagement with healthcare or other supportive services. This service may also be provided in place of HRSN "Pantry Stocking" for members who do not have the means to prepare or store groceries (e.g., individuals who are

	unhoused). Member may pick up food from food retailer or have food delivered to the Member's home or private residence, if delivery service is available. This service must be consistent with the nutrition care plan and is available for up to 3 meals a day, for up to 6 months.[2] This service may: • Take into account a member's household size • Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases • Be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.
Pantry Stocking	This service allows a Member to purchase an assortment of foods aimed at promoting improved nutrition for the member. Member may pick up food from food retailer or have food delivered to the Member's home or private residence, if delivery service is available. This service must be consistent with the nutrition care plan and is available for up to 3 meals a day, for up to 6 months.[2] Examples of allowable foods include: • Fruits and vegetables; • Meat, poultry, and fish; • Dairy products; • Breads and cereals; • Snack foods and non-alcoholic beverages; and • Seeds and plants, which produce food for the household to eat. This service may: • Take into account a member's household size • Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases

[2] This intervention may be renewed for additional 6-month periods if the state determines the beneficiary still meets the clinical and needs-based criteria

	• Be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.

Fruit and Vegetable Prescriptions	This service allows a Member to purchase fruits and vegetables from participating food retailers and farms. Fruits and vegetables available for purchase through this service may be fresh, frozen, or canned. Member may pick up food from food retailer or have food delivered to where the Member resides, if delivery service is available. This service is limited to 6 months and must be tailored to health risk, certain nutrition-sensitive health conditions., and/or demonstrated outcome improvement. This service may: • Take into account a member's household size for children, YSHCN, and pregnant individuals using the SNAP definition of a household to determine the benefit level for these beneficiaries. Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases • Be provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection This service must: • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.

Medically necessary air conditioners, heaters, air filtration devices, portable power supplies, and refrigeration units	The provision, service delivery, and installation as needed of one or more of the following "home devices" (i.e., air conditioners, heaters, air filtration devices, portable power supplies and refrigeration units) to individuals for whom such equipment is Clinically Appropriate and medically necessary as a component of health services treatment or prevention for a climate-device specific medical indication (see details in Appendix). Examples include the following: 1. Air conditioners for individuals at health risk due to significant heat; 2. Heaters for individuals at increased health risk due to significant cold; 3. Air filtration devices for individuals at health risk due to compromised air quality, and replacement air filters as needed; 4. Refrigeration units for individuals who lack a working refrigeration unit or a unit that meets their medical needs (e.g., because it has inadequate temperature controls to meet their medication storage needs, etc.); or, 5. Portable power supplies (PPS's) for individuals who need access to electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs that may compromise their ability to use medically necessary devices.
HRSN Outreach and Engagement, and Other Benefit Linkages	Activities may include: 1. Attempting to contact and engage individuals who belong to one or more HRSN Covered Populations and who may be eligible for HRSN services; 2. Using multiple strategies for engagement, including in person meetings where the member lives, seeks care, or is accessible; community and street-level outreach; and mail, text, phone, and email; Using multiple strategies for engagement, including in- person meetings where the member lives, seeks care, or is accessible; community and street-level outreach; and mail, text, phone, and email; 3. Documenting outreach and engagement attempts, outcomes, and modalities; 4. Working with the member to provide the information necessary for assessment of HRSN service need, including through multiple engagements with the member as needed; 5. Determining whether the member is enrolled in the Fee for Service (FFS) program or a Coordinated Care Organization (CCO), and if a CCO which one, and then

	transmitting the partially or fully completed HRSN Request Template (described below) to the member's CCO or to the FFS program (or its designated third-party contractor) for eligibility determination and service authorization; 6. Helping the member to enroll, re-enroll, or maintain enrollment in Medicaid; 7. Providing help with securing and maintaining entitlements and benefits, such as TANF, WIC, SNAP, Social Security, Social Security Disability, and Veterans Affairs benefits, and other federal and state housing programs; 8. Assisting in obtaining identification and other required documentation (e.g., Social Security card, birth certificate, prior rental history) needed to receive benefits and other supports; 9. Connecting individuals to settings where basic needs can be met, such as access to shower, laundry, shelter, and food; or 10. Providing members who may have a need for medical, peer, social, educational, legal, and other related services with information and logistical support necessary to connect them with the needed resources and services. 11. Providing application assistance and coverage of state and federal benefit programs' application fees as required for the services and activities listed above.

III. **Provider Qualifications**

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

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

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

including the ability to store devices and distribute them prior to or during the event so that members have access to the devices when they need them most (i.e., while the event is taking place)

5. Providers of medically necessary devices at times other than during significant weather events must have the ability to timely and appropriately deliver devices to members' homes.
6. **HRSN Provider Experience and Expertise**: All HRSN services providers are expected to meet certain qualifications that ensure they are capable of providing high-quality services to qualifying members as well as have culturally specific expertise to connect with members of priority populations. Qualifications may include, for example:
    a. Maintain sufficient hours of operation and staffing to serve the needs of HRSN participants.
    b. Demonstrate their capabilities and/or experience with effectively serving at least one "priority population," as determined by the state. HRSN Providers may demonstrate these capabilities and/or experience through, for example:
        1 Providing letter(s) of support from community members being served or other entities in the community, describing the HRSN Provider's presence in the community and impact on individual community members and/or the community as a whole.
        2 Submitting an annual report or similar document that describes the HRSN Provider's relevant capabilities and activities
        3 Other methods deemed appropriate by the CCO or FFS TPC.
        4 Demonstrate that it has qualified service delivery and administrative staff, as determined at CCO or FFS TPC discretion.
    c. The ability to comply with applicable federal and state laws.
    d. The capacity to provide culturally and linguistically appropriate, responsive and trauma-informed service delivery, including by ensuring their ability to:
        1 Adhere to federal and state laws and requirements related to ensuring communication and delivery of services to Members with diverse cultural and ethnic backgrounds
        2 Meet cultural needs of the community for whom it provides services
        3 Provide documentation of how cultural responsiveness and trauma informed care trainings are impacting organizational policies and staff practices
        4 Document efforts to recruit and employ staff who reflect the HRSN Provider's region's Medicaid population, including individuals with similar demographics, lived

experience, background and language fluency to the greatest extent possible.

e. A history of responsible financial stewardship and integrity via a CCO-conducted audit and/or recent annual financial reports.

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

IV. Member Identification and Assessment of Service Need.

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

i CCOs and the FFS TPC will ensure multiple pathways for individuals to be identified as being enrolled in Medicaid, belonging to an HRSN Covered Population, and potentially having one or more HRSN Service needs. Pathways for Member identification must include:

1. CCOs/FFS TPC proactively identifying Members through a review of Contractor's encounter and claims data;
2. Contracting with HRSN Service Providers to conduct HRSN Outreach and Engagement to identify Members and make HRSN Recommendations (described further below);
3. Engaging with and receiving HRSN Recommendations from organizations other than HRSN Service Providers (called "HRSN Connectors"); and
4. Accepting Members' self-referral.

ii. The following are examples of individuals and entities that may serve as HRSN Connectors and will have a pathway to identify individuals in need of HRSN services:

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

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

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

b. HRSN Requests.

i. The state will provide an HRSN Request Template that contains necessary information about individuals identified with a service need for an approval decision. HRSN Connectors that recommend individuals to receive HRSN services may use the State-developed HRSN Request Template or another tool of their choosing, so long as it captures the following information:
   1. The name and contact information for the individual being recommended for HRSN services
   2. Identification of one or more HRSN Service needs the individual may need

ii. Other information that may be documented in the HRSN Request includes confirmation of OHP Medicaid enrollment and confirmation of enrollment a particular CCO/FFS Medicaid as well as any other information regarding the individuals potential HRSN eligibility. All HRSN Recommendations must include a statement that the recommended individual desires to take part in further HRSN eligibility determination process.

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

iv. The transmission of the information in the HRSN Request Template to a CCO or the FFS TPC can occur through a variety of delivery methods including, but not limited to email, fax, mail personal delivery or any other reasonable delivery method. These pathways must be made clear and accessible to members, CBOs, providers, and other potential entry points through information posted on the websites of each CCOs and FFS TPC and through other means.

v. HRSN Connectors may submit to a CCO or the FFS TPC a partially completed HRSN Request Template. It will be the responsibility of the CCO or FFS TPC to follow up with the member and, if needed and appropriate, the entity that submitted the form, to obtain the additional information needed to determine eligibility and authorize services. The CCO or FFS TPC will be required to document its attempts to collect the information needed to determine eligibility.

V. Eligibility Determination and Services Approval

a. Upon receipt of the information regarding the individual's HRSN needs, the CCO, Tribal Government, or the FFS TPC will use reasonable efforts to obtain all other information

necessary to 1) determine whether the individual is eligible for HRSN and 2) to authorize the appropriate services. The CCO/FFS TPC reasonable efforts must include:

a. using the information included in CCO's/FFS TPC's own records,
b. obtaining only the relevant information from the Member, and when permitted by the Member,
c. obtaining the relevant and appropriate information from the HRSN Connector.

a. If, after completing the HRSN eligibility determination and documenting all the required information in, the Member meets all of the criteria for being HRSN eligible, the CCO/FFS TPC must authorize the identified HRSN Services need as expeditiously as possible. The service approval will be based on the following criteria:

i. Confirmation that the member is enrolled in the Oregon Health Plan;
ii. Determination that the individual meets the eligibility criteria for one of the HRSN covered population groups;
iii. Determining what other services the individual is receiving or may be eligible to receive under Medicaid or other programs;
iv. Assessment of the individual's clinical and social needs (described above in Section I.b) that justify the medical appropriateness of the service; and,
v. Determination of the medically appropriate service duration, not to exceed twelve months for an initial authorization.

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

i. Notify the individual of approval or denial of the service and provide information about appeals and hearing rights.
   i CCOs and the FFS TPC shall notify all individuals who have undergone an HRSN Service authorization or denial as expeditiously as the circumstances require, not to exceed fourteen (14) calendar days from the date of, as applicable and appropriate, authorization or denial. CCOs and FFS TPC will follow individual preferences for method of communication (e.g., e-mail, phone call, etc.).
   ii Individuals who are denied HRSN Services or are authorized for HRSN Services but such authorization is limited in scope, amount, or duration, have Grievance and Appeal rights.
ii. Document the approval or denial of services through the closed loop referral technology; or chosen alternative system by the referring entity, ensuring a closed loop of the referral.

VI. Care Management and Service Plans

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

i. Developing the person-centered service plan (PCSP) with the member, with review at least every 12 months;
ii. Referring the member to a HRSN provider for the approved services, and supporting member choice of provider, ensuring member needs are met by the Provider, including through regular communication with the individual and HRSN Provider delivering the service, and finding alternative providers if needed;
iii. Identifying other HRSN services the member may need;

iv. Determining what other services the individual is receiving or may be eligible to receive under Medicaid or other programs;
v. Coordinating with other social support services and care management the member is already receiving or becomes eligible for while receiving the HRSN service;
vi. Conducting reassessment for services prior to the conclusion of the service; and
vii. At a minimum, conducting a 6-month check-in to understand if HRSN services are meeting their needs, if additional/new services are needed if the service duration is longer than 6 months, or if HRSN services are duplicating other services they are receiving.

b. The CCO/FFS TPC care manager and the member will create the PCSP for the individual to obtain the HRSN service as approved by the CCO/FFS TPC. The PCSP will be in writing and developed with and agreed upon by the member.
i. The PCSP will include:
1. The recommended HRSN service;
2. The service duration;
3. The determination that the recommended service, unit of service, and service duration is medically appropriate based on clinical and social risk factors;
4. The goals of the service(s);
5. The follow-up and transition plan;
6. The CCO/FFS TPC care management team responsible for managing the member's HRSN services.

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

d. The PCSP must be contained within the same document as the individual's Care Plan, outlined in Oregon Administrative Rule.

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

VII. Conflict of Interest

a. To protect against conflict of interest and ensure compliance with HCBS conflict of interest standards, the state will require that the CCO and FFS TPC perform the service authorization function and develop the PCSP and prohibit the subcontracting of such functions where that would result in a single entity conducting the assessment, service planning, and service provision, except as provided in subsection (b) and (c) below, or otherwise approved by OHA.

b. Assessment, service planning, and service provision for select services may be provided by: (i) CCOs and (ii) the FFS TPC, subject to protocols established by the state to ensure that assessment, service planning, and service provision are performed in a manner that guards against conflicts of interest in accordance with all applicable requirements.

c. If the state contracts with Tribal organizations to perform HRSN service authorization and service planning for American Indian/Alaskan Native (AI/AN) enrolled in the state's FFS

program, those Tribal organizations may also furnish HRSN services, subject to protocols established by the state to ensure that assessment, service planning, and service provision are performed in a manner that guards against conflict of interest in accordance with all applicable requirements.

VIII. Payment

- **a.** After providing HRSN services to members who satisfy HRSN eligibility requirements, HRSN service providers will submit an invoice and additional required documentation to the member's CCO or the FFS TPC.
- **b.** CCOs and the FFS TPC will reimburse HRSN service providers according to a fee schedule for HRSN services to be developed by the state, as detailed in the New Initiatives Implementation Plan.
- **c.** CCOs and the FFS TPC may also pay HRSN services providers in advance for select services, with the intent of conducting a reconciliation no less than annually to ensure services were rendered.

Appendix: Climate Device Specific, Housing/Nutrition, and Related Outreach and Engagement Clinical Risk Factor Criteria

Guidance: In consideration of prioritization for outreach, health plans should consider priority populations, members with unstable or severe symptoms, members with more than one of these conditions, and individuals at the extremes of age. In addition, health plans should consider other medical conditions for review by exception including hyperthyroidism, autoimmune conditions, immunosuppression, fluid/electrolyte/acid base conditions, use of medication that impacts thermoregulation, etc.

In addition, health plans will utilize different outreach methods depending on the population they are contacting, ranging from low intensity outreach (e.g., general information across MyChart) to high intensity outreach (e.g., text messages, phone calls, etc.).

Table 1. Climate Device-Specific and Related Outreach and Engagement Clinical Risk Factors (Condition must have been active in the past 12 months. Members must meet age or pregnancy criteria at the time of eligibility determination, as relevant.)	**Eligible Climate Device**
Schizophrenia spectrum and other psychotic disorders	Air Conditioner, Air Filtration Device, Heater
Bipolar and related disorders	
Major depressive disorder with an acute care need in the past 12 months including a suicide attempt, crisis services utilization (emergency department, mobile crisis team, etc.), acute psychiatric hospitalization, or residential treatment.	
One or more of the following substance use disorders: alcohol use disorder, hallucinogen use disorders, inhalant use disorder, opioid use disorder, stimulant use disorder	
Major neurocognitive disorders	
Chronic lower respiratory condition including chronic obstructive pulmonary disease (COPD), asthma requiring regular use of asthma controlling medications, restrictive lung disease, fibrosis, chronic bronchitis, bronchiectasis	
Chronic cardiovascular disease, including cerebrovascular disease and heart disease	
Spinal cord injury	
In-home hospice	
Any sensory, physical, intellectual, or developmental disability that increases health risks during extreme climate events	
Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the following: • Heat stroke or heat exhaustion • Hypothermia, frostbite, or chilblains • Malnutrition • Dehydration • Child maltreatment as defined by the CDC (https://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf)	

• Is a child with a special healthcare need (CYSHCN) as defined by HRSA (https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn#i) • An acute or chronic respiratory condition • A respiratory or gastrointestinal infectious disease, or becoming febrile with an infectious illness • Low birth weight of <2500 grams	
Pregnant and currently has, has a history of, or is at risk for at least one of the following: • Heat stroke or heat exhaustion • Hypothermia, frostbite, or chilblains • An acute or chronic respiratory condition • Infection • High-risk pregnancy as defined by the NIH (https://www.nichd.nih.gov/health/topics/high-risk/conditioninfo) • History of previous pregnancy, delivery, or birth complication including gestational diabetes, preeclampsia, preterm labor, preterm birth, placental abruption, newborn low birth weight, stillbirth • Abuse or interpersonal violence • Malnutrition • Hyperemesis gravidarum and other causes of dehydration • Maternal low birth weight of <2500 grams • Multiple pregnancy • Mental health condition	
Adult 65 years and older and currently has, has a history of, or is at risk for at least one of the following: • Heat stroke or heat exhaustion • Hypothermia, frostbite, or chilblains • Malnutrition • Dehydration • Currently taking medications that impact heat tolerance, including for upper respiratory infections, allergies, COPD, muscle spasms, blood pressure, diuresis, diarrhea, constipation, anti-inflammation, mental health conditions, and sleep • Abuse or neglect • A respiratory or gastrointestinal infectious disease, or becoming febrile with an infectious illness • Mental health condition • Two or more chronic health conditions	
Chronic kidney disease	Air Conditioner, Heater
Diabetes mellitus, requiring any medication, oral or insulin	
Multiple sclerosis	
Parkinson's disease	
Previous heat-related or cold-related illness requiring urgent or acute care, e.g. emergency room and urgent care visits	

Individual requires home oxygen use: home oxygen, oxygen concentrators, home ventilator	Air Filtration Device
Individual uses medications requiring refrigeration. Examples include: • Medications for diabetes mellitus, glaucoma, and asthma; • TNF inhibitors	Mini-refrigerator
Enteral and parenteral nutrition	
Individual needs durable medical equipment (DME) requiring electricity for use. Examples include but are not limited to: • Oxygen delivery systems, including concentrators, humidifiers, nebulizers, and ventilators • Intermittent positive pressure breathing machines • Cardiac devices • In home dialysis and automated peritoneal dialysis • Feeding Pumps • IV infusions • Suction pumps • Power wheelchair and scooter • Lift systems and electric beds • Breast pumps for first 6mo post-partum • Other DME medically required for sustaining life	Portable Power Supply
Individual requires assistive technologies requiring electricity necessary for communication or ADLs.	
Other conditions approved by medical exception in an individual review for medical exception aligned with OHA's Medical Management Committee Process and CCO exception review process	Any of the above devices

Table 2. Housing, Nutrition, and Related Outreach and Engagement Clinical Risk Factors

HRSN Clinical Risk Factor	Risk Factor Description
Complex Behavioral Health Need	• An individual with a persistent, disabling, progressive or life-threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals.
Developmental Disability Need	• An individual with an Intellectual Disability or Developmental Disability (as defined by OAR 411-320-0080) that requires services or supports to achieve and maintain care goals.

Complex Physical Health Need	• An individual with a persistent, disabling, progressively or life-threatening physical health condition(s) requiring treatment for stabilization or prevention of exacerbation. • Examples may include chronic conditions such as: congenital anomalies that adversely impact health or function, blindness, disabling dental disorders, chronic neurological diseases, chronic cardiovascular diseases, chronic pulmonary diseases, chronic gastrointestinal diseases, chronic liver diseases, chronic renal diseases, chronic endocrine diseases, chronic hematologic disorders, chronic musculoskeletal conditions, chronic infectious diseases, cancers, autoimmune disorders, immunodeficiency disorders or chronic immunosuppression
Needs Assistance with ADLs/IADLs or Eligible for LTSS	• An individual who needs assistance with one or more Activities of Daily Living (ADLs) as defined in OAR 411-015-0006 or Instrumental Activities of Daily Living (iADLs) as defined in OAR 411-015-0007; or • Receives or are determined eligible for Medicaid-funded Long-Term Services and Supports (LTSS) provided by the Oregon Department of Human Services (ODHS) Office of Aging and People with Disabilities (APD) or ODHS Office of Developmental Disabilities Services (ODDS), as defined in 410-141-3500.
Interpersonal Violence Experience	• An individual who is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence
Repeated Emergency Department Use and Crisis Encounters	An individual: • With repeated use of emergency department care (defined as two or more visits in the past six months or five or more visits within the past 12 months); • With two or more crisis encounters in the past six months or five or more crisis encounters in the past 12 months, which represent an exacerbation of mental health distress, defined to include: receipt of crisis/outreach team services; use of behavioral health mobile crisis, crisis respite services, or school behavioral health crisis services; any length of stay in an adult jail or youth detention facility; or any length of stay in emergency foster care.
	• Who was exited from a housing or behavioral healthcare program (e.g., shelter setting, day habilitation program, etc.) or from a school or an early childhood program in the past 12 months due to behaviors that are likely manifestations of a behavioral health condition, significant life stress, adversity, or trauma.
Pregnant/Postpartum	An individual who is currently pregnant or up to 12 months postpartum and currently has, has a history of, or is at risk for at least one of the following: • Infection

	• High-risk pregnancy as defined by the NIH (https://www.nichd.nih.gov/health/topics/high-risk/conditioninfo) • Pregnancy-related death • History of previous pregnancy, delivery, or birth complication including gestational diabetes, preeclampsia, hyperemesis gravidarum, preterm labor, preterm birth, placental abruption, newborn low birth weight, stillbirth • Abuse or interpersonal violence • Malnutrition • Maternal low birth weight of <2500 grams • Multiple pregnancy • A mental health condition or substance use disorder, including a postpartum mental health condition • Significant life stress, adversity, or trauma •
Children less than 6 years of age	A child who is less than six years of age and currently has, has a history of, or is at risk for at least one of the following: • Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition • Child maltreatment as defined by the CDC (https://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf) • Is a child with a special healthcare need (CYSHCN) as defined by HRSA (https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn#i) • Low birth weight of <2500 grams • Mental health condition • Significant life or family stress, adversity, or trauma
Adults 65 years of age or older	An adult who is 65 years of age or over and currently has, has a history of, or is at risk for at least one of the following: • Two or more chronic health conditions • Social isolation placing the individual at risk for early death, neurocognitive disorders, sleep disruption, cardiovascular disease, and elder abuse • Malnutrition • Dehydration • Abuse or neglect • Significant life adversity stress, adversity, or trauma

Young Adults with Special Health Care Needs	An individual aged 19 to 26, with the following clinical risk factors defined in STC 4.6(a): • Have one or more complex chronic conditions as identified in the Pediatric Medical Complexity Algorithm (PCMA); • Have a serious emotional disturbance or serious mental health issue indicated by qualifying behavioral health diagnosis; • Have a diagnosed intellectual or developmental disability; • Have an "Elevated Service Need" or functional limitations as determined by two or more affirmative responses to a screener; or • Starting no earlier than January 1, 2026, have two or more chronic conditions as represented by a subset of the PMCA's non-complex chronic conditions as described in the New Initiatives Implementation Plan.

Target Populations	**Housing Services**						
	Rent/temporary housing for up to 6 months	Utility costs	One-time transition and moving costs	Housing deposits to secure housing	Pre-tenancy and tenancy sustaining services	Housing transition navigation services	Medically necessary home accessibility modifications and remediation services
Youth with Special Health Care Needs (YSHCN) ages 19-26			X	X	X	X	X
Adults and youth discharged from an IMD	X	X	X	X	X	X	X
Adults and youth released from incarceration, including prisons, local correctional facilities, and tribal correctional facilities	X	X	X	X	X	X	X
Youth involved in the child welfare system, including youth transitioning out of foster care;	X	X	X	X	X	X	X
Individuals transitioning from Medicaid-only to dual eligibility status			X	X	X	X	X
Individuals who are homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	X	X	X	X	X	X	X

**Meals or pantry stocking are available to individuals within the transition populations who are children under 21, YSHCN, or pregnant.*

Target Populations	Nutrition Services				Climate Supports
	Nutrition counseling and education, including on healthy meal preparation	Medically-tailored meals, up to 3 meals a day delivered in the home or private residence, for up to 6 months	Meals or pantry stocking*	Fruit and vegetable prescriptions, for up to 6 months	Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units
Youth with Special Health Care Needs (YSHCN) ages 19-26	X	X	X	X	X
Adults and youth discharged from an IMD	X	X	X	X	X
Adults and youth released from incarceration, including prisons, local correctional facilities, and tribal correctional facilities	X	X	X	X	X
Youth involved in the child welfare system, including youth transitioning out of foster care;	X	X	X	X	X
Individuals transitioning from Medicaid-only to dual eligibility status	X	X	X	X	X
Individuals who are homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	X	X	X	X	X

**Meals or pantry stocking are available to individuals within the transition populations who are children under 21, YSHCN, or pregnant.*

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Rent/temporary housing for up to 6 months	Individuals transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), correctional facilities, and acute care hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and youth transitioning out of the child welfare system including foster care.	An individual who: - Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs
Utility costs	Limited to those receiving Rent/Temporary housing	An individual who: - Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs
One-time transition and moving costs	All HRSN Services Populations	An individual who: - Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Housing deposits to secure housing	All HRSN Services Populations	An individual who: - Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs
Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention	All HRSN Eligible Populations	An individual who: - Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Housing transition navigation services	All HRSN Eligible Populations	An individual who: - Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs
Medically necessary home accessibility modifications and remediation services	All HRSN Eligible Populations	An individual who requires a clinically appropriate home modification/remediation service	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Nutrition counseling and education, including on healthy meal preparation	All HRSN Eligible Populations	An individual meeting the USDA definition of low food security[1]	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs
Medically-tailored meals, up to 3 meals a day delivered in the home or private residence, for up to 6 months	All HRSN Eligible Populations	An individual meeting the USDA definition of low food security[1]	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs
Meals or pantry stocking	Children under 21, YSHCN, and pregnant individuals who are also in an HRSN - eligible population	An individual meeting the USDA definition of low food security[1]	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Fruit and vegetable prescriptions, limited to 6 months, tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement	All HRSN Eligible Populations	An individual meeting the USDA definition of low food security[1]	Complex Behavioral Health Need Developmental Disability Need Complex Physical Health Need Needs Assistance with ADLs/IADLs or Eligible for LTSS Interpersonal Violence Experience Repeated Emergency Department Use and Crisis Encounters Pregnant/Postpartum Children less than 6 years of age Adults 65 years of age or older Young Adults with Special Health Care Needs

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

Clinical Risk Factor	Clinical Criteria Detail
Complex Behavioral Health Need	An individual with a persistent, disabling, progressive or life-threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals.
Developmental Disability Need	An individual with an Intellectual Disability or Developmental Disability (as defined by OAR 411-320-0080) that requires services or supports to achieve and maintain care goals.
Complex Physical Health Need	An individual with a persistent, disabling, progressively or life-threatening physical health condition(s) requiring treatment for stabilization or prevention of exacerbation. Examples may include chronic conditions such as: congenital anomalies that adversely impact health or function, blindness, disabling dental disorders, chronic neurological diseases, chronic cardiovascular diseases, chronic pulmonary diseases, chronic gastrointestinal diseases, chronic liver diseases, chronic renal diseases, chronic endocrine diseases, chronic hematologic disorders, chronic musculoskeletal conditions, chronic infectious diseases, cancers, autoimmune disorders, immunodeficiency disorders or chronic immunosuppression
Needs Assistance with ADLs/IADLs or Eligible for LTSS	An individual who needs assistance with one or more Activities of Daily Living (ADLs) as defined in OAR 411-015-0006 or Instrumental Activities of Daily Living (iADLs) as defined in OAR 411-015-0007; or Receives or are determined eligible for Medicaid-funded Long-Term Services and Supports (LTSS) provided by the Oregon Department of Human Services (ODHS) Office of Aging and People with Disabilities (APD) or ODHS Office of Developmental Disabilities Services (ODDS), as defined in 410-141-3500.
Interpersonal Violence Experience	An individual who is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence
Repeated Emergency Department Use and Crisis Encounters	An individual: - With repeated use of emergency department care (defined as two or more visits in the past six months or five or more visits within the past 12 months); - With two or more crisis encounters in the past six months or five or more crisis encounters in the past 12 months, which represent an exacerbation of mental health distress, defined to include: receipt of crisis/outreach team services; use of behavioral health mobile crisis, crisis respite services, or school behavioral health crisis services; any length of stay in an adult jail or youth detention facility; or any length of stay in emergency foster care. - Who was exited from a housing or behavioral healthcare program (e.g., shelter setting, day habilitation program, etc.) or from a school or an early childhood program in the past 12 months due to behaviors that are likely manifestations of a behavioral health condition, significant life stress, adversity, or trauma.

Clinical Risk Factor	Clinical Criteria Detail
Pregnant/Postpartum	An individual who is currently pregnant or up to 12 months postpartum and currently has, has a history of, or is at risk for at least one of the following: - Infection - High-risk pregnancy as defined by the NIH (https://www.nichd.nih.gov/health/topics/high-risk/conditioninfo) - Pregnancy-related death - History of previous pregnancy, delivery, or birth complication including gestational diabetes, preeclampsia, hyperemesis gravidarum, preterm labor, preterm birth, placental abruption, newborn low birth weight, stillbirth - Abuse or interpersonal violence - Malnutrition - Maternal low birth weight of <2500 grams - Multiple pregnancy - A mental health condition or substance use disorder, including a postpartum mental health condition - Significant life stress, adversity, or trauma
Children less than 6 years of age	A child who is less than six years of age and currently has, has a history of, or is at risk for at least one of the following: - Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition - Child maltreatment as defined by the CDC (https://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf) - Is a child with a special healthcare need (CYSHCN) as defined by HRSA (https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn#i) - Low birth weight of <2500 grams - Mental health condition - Significant life or family stress, adversity, or trauma
Adults 65 years of age or older	An adult who is 65 years of age or over and currently has, has a history of, or is at risk for at least one of the following: - Two or more chronic health conditions - Social isolation placing at risk for early death, neurocognitive disorders, sleep disruption, cardiovascular disease, and elder abuse - Malnutrition - Dehydration - Abuse or neglect - Significant life adversity stress, adversity, or trauma

Clinical Risk Factor	Clinical Criteria Detail
Young Adults with Special Health Care Needs	An individual aged 19 to 26, with the following clinical risk factors defined in STC 4.6(a): - Have one or more complex chronic conditions as identified in the Pediatric Medical Complexity Algorithm (PCMA); - Have a serious emotional disturbance or serious mental health issue indicated by qualifying behavioral health diagnosis; - Have a diagnosed intellectual or developmental disability; - Have an “Elevated Service Need” or functional limitations as determined by two or more affirmative responses to a screener; or - Starting no earlier than January 1, 2026, have two or more chronic conditions as represented by a subset of the PMCA’s non-complex chronic conditions as described in the New Initiatives Implementation Plan