

# Oregon Health Plan Health-Related Social Needs Provider Training

## Climate and Outreach & Engagement Support

**1115** **MEDICAID WAIVER**  
IMPLEMENTATION PROJECT | OREGON

Oregon  
**Health**  
Authority



# Zoom Meeting Tips



Use the **chat function** to submit your questions.

- We will work to make this work session as interactive as possible and are saving the chat.
- If you would prefer to ask your question verbally, please raise your hand.



This webinar is being **recorded**.

- It will be shared on our OHA 1115 Waiver webpage following the conclusion of the presentation.



For **live captioning**, please click on the “cc” button located at the bottom of your screen or click the link provided for Spanish captioning.



For **live interpretation guidance**, please click on the “Interpretation” button and choose either English or Spanish.



# Agenda

- Oregon Health Plan Overview
- Health-Related Social Needs (HRSN) Overview
- HRSN Service Provider Enrollment
- HRSN Eligibility and Authorization
- Invoicing
- Enrollment Next Steps
- Electronic Funds Transfer and Payments
- Q&A

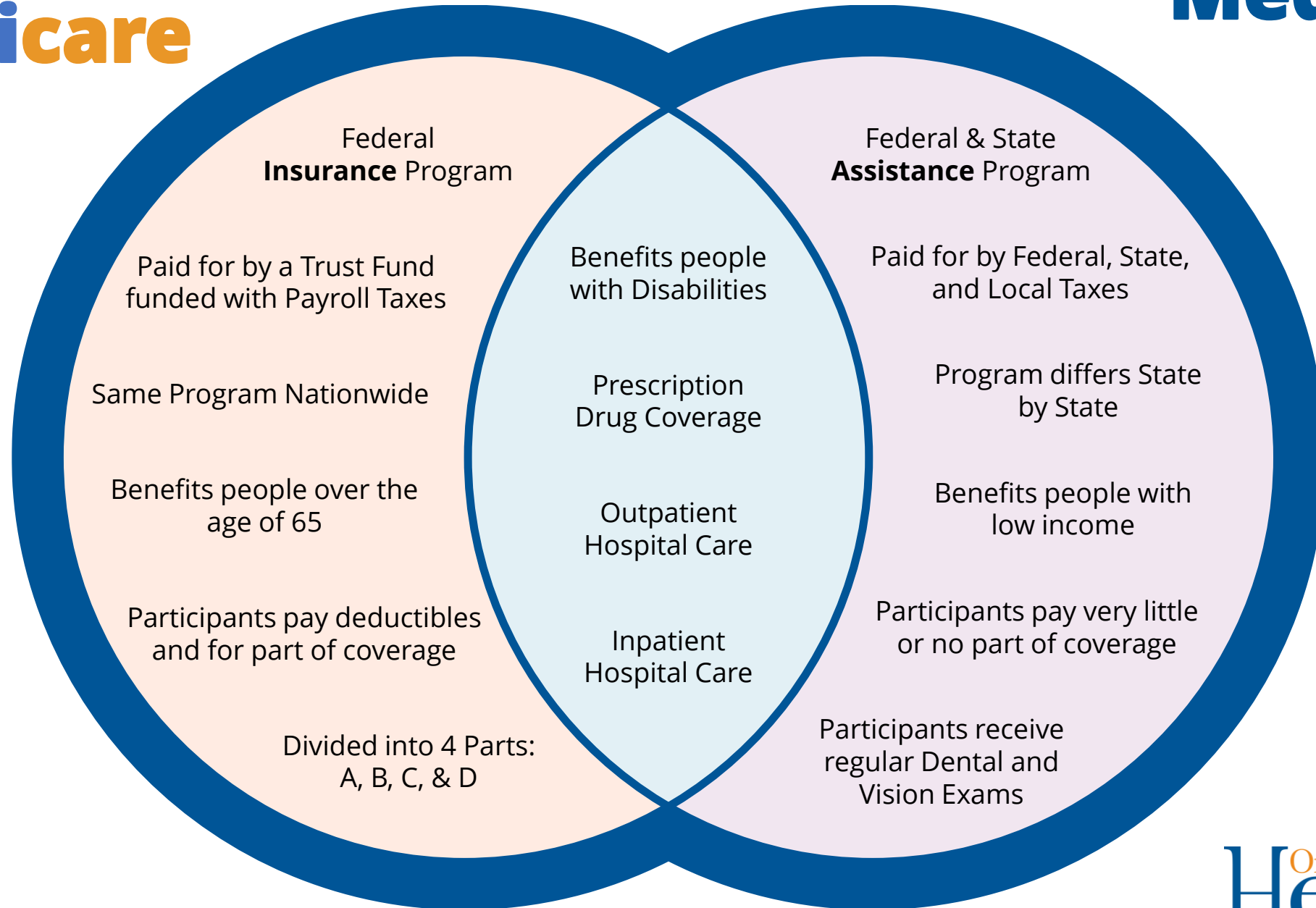
# Medicaid/Oregon Health Plan Overview

Jessica Deas  
Oregon Health Authority



# Medicare

# Medicaid



# What is the Oregon Health Plan?

## Medicaid

Medicaid is the nation's public health insurance program for families. In Oregon we call it the Oregon Health Plan (OHP).

## Oregon Health Plan

The Oregon Health Plan (OHP) is free health coverage available to individuals – children, teens, and adults – who live in Oregon and meet income and other criteria. You can apply for OHP at any time during the year.



# Coordinated Care Organization or Open Card?

## Coordinated Care Organization (CCO)

A Coordinated Care Organization (CCO) is a local organization that helps some Oregon Health Plan (OHP) members use their benefits. CCOs are made up of all types of health care providers in a community. They work together to care for OHP members in an area or region of the state.

## Open Card (also known as Fee for Service or FFS)

Open Card is OHP covered by the Oregon Health Authority (OHA). When the member is not enrolled in a coordinated care organization (CCO), they are an Open Card member and OHA pays for their care directly.

# How many Oregonians have OHP?

| County       | Medicaid Recipients |
|--------------|---------------------|
| Baker        | 6,661               |
| Benton       | 23,027              |
| Clackamas    | 110,126             |
| Clatsop      | 15,307              |
| Columbia     | 16,616              |
| Coos         | 28,555              |
| Crook        | 10,871              |
| Curry        | 9,690               |
| Deschutes    | 62,265              |
| Douglas      | 48,923              |
| Gilliam      | 793                 |
| Grant        | 2,586               |
| Harney       | 3,230               |
| Hood River   | 8,907               |
| Jackson      | 94,137              |
| Jefferson    | 12,716              |
| Josephine    | 44,448              |
| Klamath      | 33,016              |
| Lake         | 3,548               |
| Lane         | 138,459             |
| Lincoln      | 21,184              |
| Linn         | 52,422              |
| Malheur      | 16,885              |
| Marion       | 143,245             |
| Morrow       | 5,630               |
| Multnomah    | 288,682             |
| Out-of-State | 1,024               |
| <b>Total</b> | <b>1,495,833</b>    |

As of January 2024, 1,495,833 Oregonians are enrolled in the Oregon Health Plan.

Of those members, 128,291 utilize Open Card Benefits.

Oregon's [Medicaid Monthly Population Report](#) is an interactive dashboard that shows this and other reports.

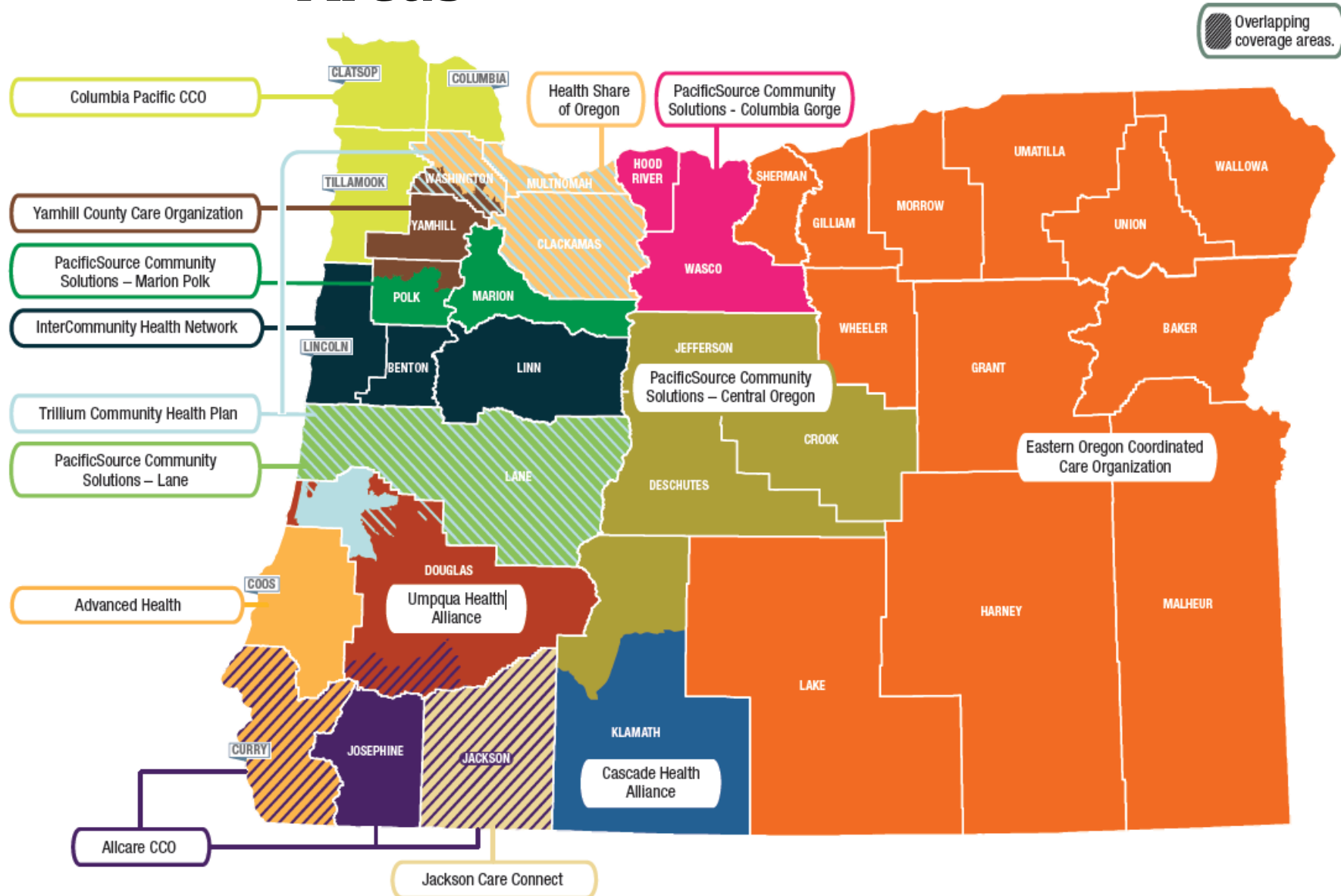


# As of January 2024, how many Oregonians were enrolled in each CCO?

## CCO Totals for Physical Health, OHP & CAK/HOP

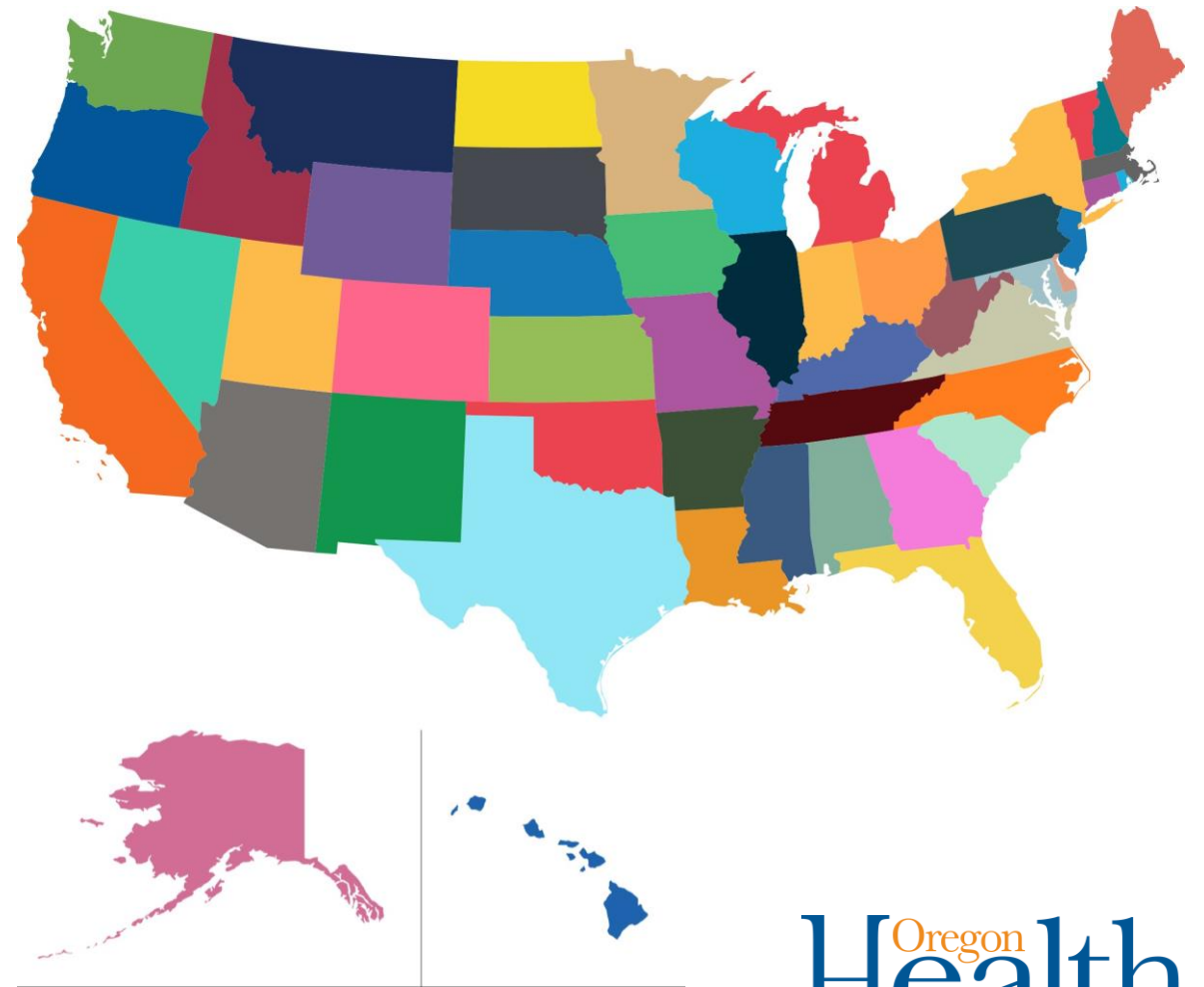
|                                  |                  |
|----------------------------------|------------------|
| ADVANCED HEALTH                  | 27,185           |
| ALLCARE CCO                      | 64,145           |
| CASCADE HEALTH ALLIANCE          | 25,866           |
| COLUMBIA PACIFIC                 | 36,262           |
| EASTERN OREGON CCO               | 74,593           |
| HEALTH SHARE OF OREGON           | 441,627          |
| INTERCOMMUNITY HEALTH NETWORK    | 82,306           |
| JACKSON CARE CONNECT             | 63,951           |
| PACIFICSOURCE CENTRAL            | 75,133           |
| PACIFICSOURCE GORGE              | 17,874           |
| PACIFICSOURCE LANE               | 90,324           |
| PACIFICSOURCE MARION POLK        | 149,090          |
| TRILLIUM COMM HLTH PLAN TRI-COUN | 54,584           |
| TRILLIUM COMMUNITY HEALTH        | 35,300           |
| UMPQUA HEALTH ALLIANCE           | 37,615           |
| YAMHILL COMMUNITY CARE           | 35,972           |
| <b>TOTAL</b>                     | <b>1,311,827</b> |

# Coordinated Care Organization Service Areas



# What is a 1115 Medicaid Waiver?

- The federal government has a **standard set of rules each state must follow** to get funds for Medicaid.
- States can ask the **federal government for permission to change** their Medicaid rules.
- Oregon's most recent 1115 Medicaid Waiver includes **health related social needs (HRSN) services** available as an OHP covered benefit.



# Health Related Social Needs Overview

Jessi Wilson  
Oregon Health Authority



# What are Health-Related Social Needs?



**Health-Related Social Needs (HRSN):** The **social and economic needs that impact an individual's ability** to maintain their health and well-being. For example, affordable housing and utilities, access to diverse, healthy foods, and support accessing benefit programs.



## **HRSN services that will be provided:**

- Climate-related needs (03/2024)
- Outreach & Engagement (03/2024)
- Housing support (11/2024)
- Nutrition support (01/2025)

# HRSN-Specific Funding Components

- **\$119 million** approved for grants for infrastructure and capacity building called **Community Capacity Building Funds** to HRSN providers (e.g., community-based organizations, social service agencies, tribal providers, others).
- **\$904 million** available for **HRSN services** to eligible individuals, including:



**Climate  
Supports**



**Outreach &  
Engagement**



**Housing  
Supports**



**Nutrition  
Supports**

# HRSN Service Member Eligibility



To qualify for a HRSN service, an individual must:

- Be a current **OHP member**; AND
- Be a member of an **eligible population**; AND
- Meet the individual service **clinical and social risk criteria**.

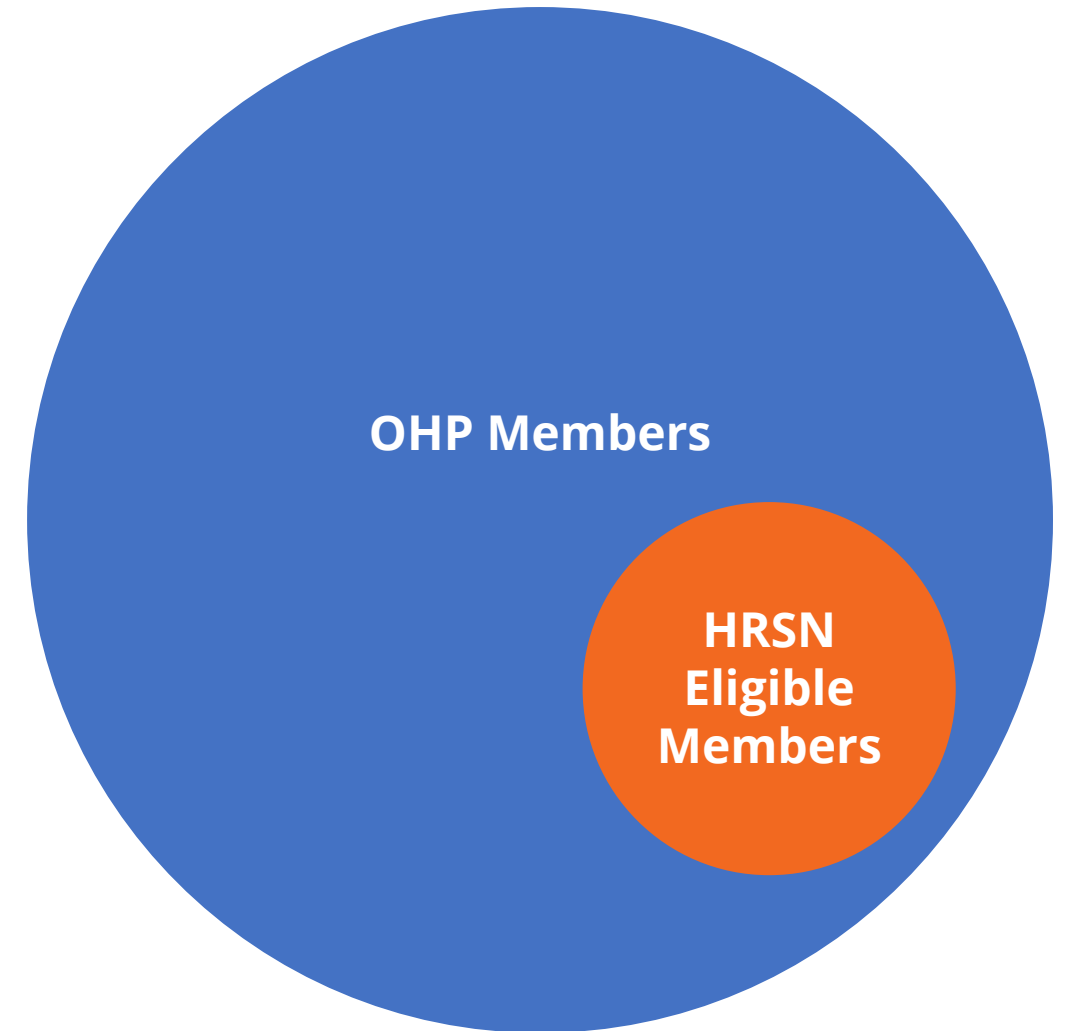


## Important Notes

- To be eligible, individuals cannot be receiving the same service through state-, local-, or federally-funded programs.
- There may be additional eligibility criteria for specific HRSN services.

# HRSN Service Eligible Populations

- Adults and youth discharged from an Institution for Mental Disease in past 365 days
- Adults and youth released from incarceration in past 365 days
- Youth currently involved or previously with the Oregon child welfare system
- Individuals transitioning to Dual Status within the next 90 days, or who transitioned in the past 270 days
- Individuals who are houseless or at risk of homelessness according to the HUD
- Young Adults with Special Health Care Needs (YSHCN) (starting in 2025)





# HRSN Climate-Related Supports



Climate (Launching March 2024) - Devices include:

**Air conditioners** for heat risks



**Air filtration devices** to protect against wildfire smoke



**Mini fridges** for temperature-controlled medications



**Portable heaters** for winter



**Portable power supplies** for home medical equipment



# HRSN Outreach & Engagement Services



## Outreach & Engagement (Launching March 2024)

These supports include outreach and linkages to other Medicaid or non-Medicaid benefits, especially for individuals within eligible HRSN populations.

Current Benefit: the activities performed for the purpose of identifying OHP enrolled individuals for HRSN Climate-Related Services

- Contacting and engaging Members.
- Checking enrollment of the Member to refer appropriately (Open Card or CCO).
- Sending the HRSN Request Form or information to the Open Card entity or CCO.
- Providing eligible members with info and support to connect them to resources.

# Upcoming HRSN Services



**Housing (11/2024):** Eligible members could be connected to rental and utilities assistance, tenancy support, and one-time moving costs. The supports focus on members at risk of homelessness, according to the HUD definition, who need support staying in their current or already identified housing. Additionally, OHA is focusing on people who need support maintaining their current housing or moving into already identified housing on November 1, 2024.



**Nutrition (01/2025):** These supports include services such as prescriptions for fruits and vegetables, pantry-stocking, nutrition education, or paying for medically tailored meals.

# Health Related Services (HRS) vs. Health Related Social Need (HRSN) Services

## HRS

- Available to CCO Members; Members can request services from CCO
- Services available since 2012
- Services not covered under OHP
- Paid for by Coordinated Care Organizations (CCOs)
- Examples: Cell phones, preschool programs, grocery store gift cards, temporary hotel, wheelchair ramp, etc.

## HRSN

- Available to both CCO and Open Card Members; Members must meet HRSN eligibility criteria
- Services starting 2024
- Services covered under the OHP
- Paid for with the state OHP budget
- Examples: Housing, nutrition, climate-related support, and outreach & engagement

**Intended to improve care delivery and overall member and community health and well-being**

# HRSN Service Provider



**HRSN service providers** are individuals or organizations that will provide HRSN services in a way that is culturally and linguistically appropriate, responsive and trauma-informed

- All contracted HRSN providers must meet certain provider qualifications
- Once an HRSN provider is enrolled, they can bill for services

# HRSN Provider Minimum Qualifications



## All HRSN services providers must:

- Be accessible to Members
- Have the ability to effectively serve eligible Members, including at least one of OHA's Priority Populations
- Employ staff who are qualified to perform responsibilities of service delivery
- Have the ability to provide culturally and linguistically responsive and trauma-informed service delivery
- Demonstrate a history of responsible financial practices

**Please Note:** CCOs and the Open Card will be required to ensure that HRSN service providers meet and maintain compliance with these minimum qualification requirements.

# HRSN Provider Minimum Qualifications, cont.



## All HRSN services providers must:

- Meet readiness standards and be able to comply with requirements related to:
  - Information privacy and security
  - Appropriate business licensing or accreditation
  - Ability to receive referrals and report on service delivery status
  - Ability to invoice for services
- Comply with all reporting, oversight, and business registration requirements
- Enroll as Medicaid provider in MMIS, OHA's electronic system that processes Medicaid claims.

**Please Note:** CCOs and the Open Card will be required to ensure that HRSN service providers meet and maintain compliance with these minimum qualification requirements.

# HRSN Service Provider Overview



## DO

- Need to submit enrollment forms to Oregon Health Authority to become a HRSN provider for Open Card Members.
- Need to work with the specific Coordinated Care Organization to be recognized as a service provider so invoice for services can be submitted for CCO Members.
- Work with Acentra (authorization) and AYIN Health Solutions (billing) once enrolled as a service provider for Open Card Members so invoice for services can be authorized and submitted.



## PLEASE NOTE

- Even if already enrolled as Medicaid provider, there will need to be a new enrollment application for HRSN Provider Specialty.



# 1115 Waiver Communications

## ▪ Current resources:

- [1115 Waiver Webpage](#)
- [Bi-weekly newsletter](#)
- [Video: HRSN Partner Work Sessions](#)

## ▪ Upcoming resources:

- [1115 Waiver Climate Benefit Webpage](#)
  - [Climate-Related Supports two-pager](#)
  - [Climate-Related Supports FAQ](#)
- HRSN Service Provider Web Page
  - Outreach & Engagement Services two-pager
  - HRSN Service Provider Qualification two-pager
  - Member and Provider Journey documents, detailing steps within the HRSN Service Delivery process, tips, and resources



*Materials will be translated in OHA's expanded list of languages.*

# Provider Overview and Enrollment

Todd Howard and Brenda Blobaum-Aldan  
Oregon Health Authority



# Enrollment

For step-by-step instructions for using the MMIS Provider Enrollment, reference the MMIS Provider Web Portal Provider Enrollment Guide.

<https://www.oregon.gov/oha/HSD/OHP/Tools/Provider-Enrollment-Guide.pdf>

To access the MMIS Provider Enrollment application, utilize the link below.

<https://www.or-medicaid.gov/>

Complete and save the enrollment forms to your computer or desktop.



# Required forms for organizations enrolling as HRSN providers

OHA [3972](#)

[Save form](#) [Print form](#) [Clear form](#)

HEALTH SYSTEMS DIVISION  
Provider Enrollment Unit



## Oregon Medicaid Provider Enrollment / Update / Revalidation

Oregon Medical Assistance Program  
(Oregon Health Plan)

### What is this request for? (choose one)

- New or re-enrollment (check box if request is for a new provider or inactive provider)
- Provider update (check box if request is for an active provider submitting updated information)
- Revalidation (check box only if request is for a provider who received notice to revalidate or has been instructed to complete by Provider Enrollment)

### Definitions and enrollment information

- Payable Individual  
Payable Individual – Individual provider who is enrolling to bill Oregon Medicaid directly (not through an organization) for services using their individual National Provider Identifier (NPI). This includes Sole Proprietors who intend to use their Social Security Number (SSN) or their Federal Employer Identification Number (FEIN) and associated name for payment / tax purposes.
- Organization  
Organization – Groups, clinics, LLC, non-profit, etc., who is enrolling to bill Oregon Medicaid for services rendered by individual providers using the organizations National Provider Identifier (NPI).

### Business type – check all that apply (organizations only)

- Is the Provider owned or operated by a State, county, city or other local governmental agency or instrumentality?  Yes  No
- Corporation
  - Government-owned
  - Limited Liability Corporation (LLC)
  - Limited Liability Partnership (LLP)
  - Limited Partnership
  - Not-for-profit
  - Partnership
  - Professional Corporation
  - Other: (enter below)

OHA [3974](#)

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Provider Enrollment Unit



[Print](#) [Save](#)

Oregon Medicaid  
(Oregon Health Plan)

[Reset](#)

## Provider Disclosure Statement of Ownership and Control, Business Transactions and Criminal Convictions

All pages of this form must be returned even if pages are blank. This form supersedes any previous form received for this enrolled / enrolling provider.

### Please check the box that explains the reason for disclosure:

- New Enrollment
- Change in ownership
- Removal of owner or managing employee see page 12
- Re-enrollment
- Change in managing employee
- Removal of director or officer if organized as a corporation see page 12
- Revalidation

### Organization Information (disclosing entity)

|   |  |      |
|---|--|------|
| Organization legal name:                      |  |      |
| Doing Business As (DBA) name (if applicable): | Federal Employer Identification Number (EIN) (## - #######): |      |
| National Provider Identifier (NPI):           | Existing Medicaid Provider ID (MCD) (if known):              |      |
| Business address (not mailing)                |  |      |
| Street:                                       |  |      |
| City:   | State:   | Zip: |

### Business type (check one)

- Corporation
- Government-owned
- Limited Liability Corporation (LLC)
- Limited Liability Partnership (LLP)
- Limited Partnership
- Not-for-profit
- Partnership
- Professional Corporation
- Tribally owned
- Other: (enter below)

Is the disclosing entity organized as a corporation?  Yes  No  
If yes, complete Section II, Question 2 and 3 are also required.

OHA [3975](#)

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Provider Enrollment Unit



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Oregon Medicaid  
(Oregon Health Plan)

[Reset](#)

## Provider Enrollment Agreement

The Oregon Health Authority (OHA) administers Oregon's medical assistance program for individuals eligible for Medicaid, the Children's Health Insurance Program (CHIP), and other federally funded medical programs, called the Oregon Health Plan (OHP). To comply with Federal law 42 CFR 455 Subpart E, OHA is required to enroll eligible providers into the Oregon Medicaid Program, pursuant to Oregon Administrative Rule 943-120 and 410-120, as a condition of delivering health services to OHP members.

All providers including non-payable (non-billing), payable (billing), individuals and organizations must fill out and sign this Agreement and all other required documents to receive an OHP provider number from OHA. An OHP provider number must be issued before a claim or encounter for delivered health services or goods is sent to OHA for payment.

The type of providers enrolled by OHA are defined in OAR 410-120-1260 and include billing agents, managed care entities (MCEs) and other providers who order, refer or prescribe services or goods.

Provider name: \_\_\_\_\_ National Provider Identifier (NPI): \_\_\_\_\_

### Scope of Agreement

This Provider Enrollment Agreement sets forth the rights, responsibilities, terms and conditions governing provider participation in the Oregon Medicaid program. Per OAR 410-120-1260(17), the provision of health care services or items to OHP clients is a voluntary action on the part of the provider. Providers are not required to serve all Division clients seeking service.

To be eligible for enrollment, a provider must:

- A. Complete and submit an Enrollment Application
- B. Agree to and sign this Provider Enrollment Agreement (Agreement)
- C. Complete, sign and submit a Medicaid Provider Disclosure Statement (organizations and billing providers only)

# Tip for completing the required OHP 3974 for organizations enrolling as HRSN providers

★ It is a **federal** requirement to list out the Date(s) of Birth and Social Security Number(s) of the individual(s) who own 5% or more of the organization and are managing employees. **Please do not skip this step.** Reference the definitions on page 7 of the [3974](#) form for more information.

**Section II, Question 4: Controlling Interest**  
 Complete this question if there are any other individuals or organizations with a Controlling Interest in the disclosing entity. Refer to glossary for definition.

List the name, address, date of birth (DOB) and Social Security Number (SSN) for each person who has a Controlling Interest in the disclosing entity. List the name, Tax Identification Number (TIN), primary business address, every business location and PO Box Address of each organization, corporation, entity having a Controlling Interest.


Note: If there are 1 – 7 individuals/organizations with Controlling Interest, fill out the chart below. If there are 8 or more individuals/organizations with Controlling Interest, attach a list with the required fields labeled, "Section 2, Question 4".  
 Check this box if you attached a list.

| Name of Individual or Organization | Complete Address                     | DOB (Individual)<br>SSN (Individual)<br>TIN (entity) | Title<br>(as applicable) |
|------------------------------------|--------------------------------------|--|--------------------------|
|                                    | Street:<br>City:<br>State:      Zip: | DOB:<br>SSN/TIN:                                     |                          |
|                                    | Street:<br>City:<br>State:      Zip: | DOB:<br>SSN/TIN:                                     |                          |
|                                    | Street:<br>City:<br>State:      Zip: | DOB:<br>SSN/TIN:                                     |                          |
|                                    | Street:<br>City:<br>State:      Zip: | DOB:<br>SSN/TIN:                                     |                          |
|                                    | Street:<br>City:<br>State:      Zip: | DOB:<br>SSN/TIN:                                     |                          |
|                                    | Street:<br>City:<br>State:      Zip: | DOB:<br>SSN/TIN:                                     |                          |
|                                    | Street:<br>City:<br>State:      Zip: | DOB:<br>SSN/TIN:                                     |                          |

# Required forms for **individuals** enrolling as HRSN providers

HEALTH SYSTEMS DIVISION  
Provider Enrollment Unit

OHA **3113**



[Print](#) [Save](#) [Reset](#)

**Oregon Medicaid**  
(Oregon Health Plan)

**Non-Billing Providers**  
Employed by an organization

This form is used to enroll/re-enroll a provider, update information for an actively enrolled provider, and revalidate an actively enrolled provider.

**What is this request for? (choose one)**

New or re-enrollment  
*Requires OHA 3975*

Provider update – actively enrolled  
*OHA 3975 not required*


Revalidation (*check box only if request is for a provider who received notice to revalidate or has been instructed to complete by Provider Enrollment*)  
*Requires OHA 3975*

By submitting an application, you agree to adhere to all program rules related to provider type and specialty indicated. This is in addition to any provider enrollment and/or billing rules outlined in OAR 410-120.

Non-Payable Provider Enrollment Form 200-435509 OHP 3113 (02/2024)  
Page 1 of 4

HEALTH SYSTEMS DIVISION  
Provider Enrollment Unit

OHA **3975**



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**Oregon Medicaid**  
(Oregon Health Plan)

**Provider Enrollment Agreement**

The Oregon Health Authority (OHA) administers Oregon's medical assistance program for individuals eligible for Medicaid, the Children's Health Insurance Program (CHIP), and other federally funded medical programs, called the Oregon Health Plan (OHP). To comply with Federal law 42 CFR 455 Subpart E, OHA is required to enroll eligible providers into the Oregon Medicaid Program, pursuant to Oregon Administrative Rule 943-120 and 410-120, as a condition of delivering health services to OHP members.

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The type of providers enrolled by OHA are defined in OAR 410-120-1260 and include billing agents, managed care entities (MCEs) and other providers who order, refer or prescribe services or goods.

Provider name

National Provider Identifier (NPI)

**Scope of Agreement**

This Provider Enrollment Agreement sets forth the rights, responsibilities, terms and conditions governing provider participation in the Oregon Medicaid program. Per OAR 410-120-1260(17), the provision of health care services or items to OHP clients is a voluntary action on the part of the provider. Providers are not required to serve all Division clients seeking service.

**To be eligible for enrollment, a provider must:**

- A. Complete and submit an Enrollment Application
- B. Agree to and sign this Provider Enrollment Agreement (Agreement)
- C. Complete, sign and submit a Medicaid Provider Disclosure Statement (organizations and billing providers only)

Provider Enrollment Agreement 200-246151 OHA 3975 (01/2024)  
Page 1 of 10



# Provider Type, Specialty and Taxonomy Code

- **What is a provider type?**
  - This is the value that indicates the type of health care provider. This includes individuals, facilities, and vendors.
- **What is a provider specialty?**
  - This is the value that indicates the specific area that the provider specializes in.
- **What is a taxonomy code?**
  - This is a unique 10-character code that designates the providers type and specialty.

# HRSN Provider Type and Codes

All Medicaid enrolled providers have a provider type and specialty. You will use the HRSN provider type, specialty and taxonomy when completing the enrollment application.

## HRSN Provider Type: **68**

- Climate Specialty Code: **680**
  - Taxonomy Code: 171WH0202X - Home Modifications
- Outreach and Engagement Specialty Code: **681**
  - Taxonomy Code: 172V00000X - Community Health Worker
- Housing Specialty Code: **682**
  - Taxonomy Code: 177F00000X - Lodging Provider
- Nutrition Specialty Code: **683**
  - Taxonomy Code: 332U00000X - Supplier/Home Delivered Meals
  - Taxonomy Code: 335G00000X - Medical Foods Supplier



# Helpful Enrollment Tips

- Under Step 4 in the web application, **you do not need to provide the National Provider Identifier (NPI) under Base Information.**

The screenshot shows a web application form titled "Base Information". The form is divided into two main columns. The left column contains fields for "Application Type\*", "Application NPI" (highlighted with a red box), "License", "License State", "License Type", "License Certification", "License Certification End", "UPIN", "Ownership" (set to "No"), "Birthdate\*", and "SSN\*". The right column contains fields for "Name Type\*" (with radio buttons for "Business Name" and "Personal Name"), "Name\*", "Address 1\*", "Address 2", "City\*", "State\*", "Zip\*", "Phone\*", "Contact", and "Gender" (set to "N/A"). At the bottom of the form are "previous" and "next" buttons. The top right corner of the form indicates "Page 3 of 10".

- HRSN applications are being expedited. Once application is submitted, email Provider Enrollment at [Provider.Enrollment@odhsoha.oregon.gov](mailto:Provider.Enrollment@odhsoha.oregon.gov), putting "HRSN" in the subject line.

# Enrollment Next Steps

- Once enrolled, you will be emailed a Medicaid Welcome letter containing your Medicaid provider number with helpful links and information.
- You will be mailed a PIN letter, which will give you instructions on how to set up your provider web portal access so you can check OHP Member eligibility. This is not a requirement.
- If you cannot apply on the web page, you can fax your application to Provider Enrollment to (503)378-3074, utilizing the instructions on the EDMS Coversheet.

# Provider Assistance

- For enrollment questions, call OHA's Provider Enrollment Team at 800-336-6016, option 6, or email [Provider.Enrollment@odhsoha.oregon.gov](mailto:Provider.Enrollment@odhsoha.oregon.gov).
- For assistance with provider web portal setup and password assistance, you can call Provider Services at 800-336-6016, option 5 or email [DMAP.ProviderServices@odhsoha.oregon.gov](mailto:DMAP.ProviderServices@odhsoha.oregon.gov).
- The email for Provider Services MMIS Password unlock/resets request for access is [TEAM.Provider-access@odhsoha.oregon.gov](mailto:TEAM.Provider-access@odhsoha.oregon.gov)



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# HRSN Provider Introduction

**Acentra**  
HEALTH

# Acentra Health Overview

- ❖ Acentra Health (formerly Kepro) has served the OHP Open Card members in Oregon for over 13 years in partnership with OHA.
- ❖ Our work centers around risk assessment and in providing equity-centered, culturally and linguistically appropriate care coordination services.

## Care Coordination Services

2011 - Current

- Member Outreach
- Provider Referrals
- Service Referrals
- Nurse Advice Line
- Language Translation
- Warm Handoffs
- SDOH Assessments
- Lead Coordinating Entity Assessment

## Case Management Services

2011 - Current

- Clinical Care Coordination
- Clinical Management
- Intensive Case Management
- Individualized Service Plans
- Coordination of Benefits

## Health Related Social Needs

Phase-in starts 3/1/2024

- Climate Device Outreach, Referral Intake, and Service Coordination
- November 2024: Housing Supports Service Coordination
- January 2025: Nutrition Supports Service Coordination



# HRSN Process Summarization

*The goal of HRSN is to connect members with appropriate resources for climate-control devices, nutritional resources with education, and safe housing.*



## Acentra Receives Referral

- Member
- Connector Agent
- Provider
- Family
- Other

## Eligibility and Assessment

- Open Card Member
- At Risk Groups
- At Risk Diagnoses

## Coordinate Needed Services

- Appropriate Resources for
- Climate Related Devices
    - Safe Housing
  - Nutritional Resources

## Invoicing Submitted to Ayin

Payment for Services will be submitted by each individual HRSN service provider to Ayin for payment processing.





# Acentra Health Provider and Program Process Overview

Acentra Health will support OHA, HRSN Providers and Ayin end to end to ensure a closed loop process.



## Recruitment

Acentra will be recruiting providers and organizations for HRSN services in partnership with CCOs and OHA.



## Enrollment

Acentra will support enrollment for the HRSN program with enrollment links and forms posted on our website.



## Resources

Acentra will connect providers to OHA and Ayin processes necessary to serve members in all aspects of the HRSN program.



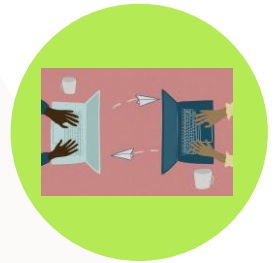
## Referrals

Acentra will be coordinating referral submissions to initiate service coordination and provider invoicing to Ayin for O & E.



## Coordination

Acentra will outreach to HRSN program service providers and members for service coordination of eligible devices or services.



## Provider Portal

Acentra has a web-based provider portal designed to streamline service requests, bi-directional communication and coordination.

# HRSN Eligibility Form

### Member Information

| <i>Required Information</i>            |                         |
|--|-------------------------|
| Full Legal Name                        | [first] [middle] [last] |
| Medicaid ID                            |                         |
| Date of Birth                          |                         |
| <i>Additional optional Information</i> |                         |
| Preferred name                         |                         |
| Pronouns                               |                         |
| Language and accessibility needs       |                         |
| Preferred Contact Information          |                         |



### Member Attestation and Authorization

- Check each box to confirm that the Member has:
- Attested if they are receiving the same or a substantially similar service as the identified HRSN Services need from a local, state, or federally funded program.
  - Agreed to receive authorized HRSN Services.
  - Agreed to be contacted for essential communications related to delivery of HRSN Services or member rights and responsibilities.
  - Attested that they can safely use the climate device in their primary place of residence, as applicable.
  - Member has requested to not use information technology methods of personal data sharing, such as Community Information Exchange





# HRSN Provider Referral Form (Partial Example)

**Health-Related Social Needs (HRSN) Request Form**

**CLIMATE-RELATED SERVICES**

OHP may be able to help you get a heater, air conditioner, air filter, mini-refrigerator, and power supply to manage certain medical conditions during extreme weather.

**AGREEMENT for SERVICE REQUEST**

I am requesting help from my health plan to see if I qualify for a heating, cooling, or air purification equipment to help me during times of extreme weather.

- Yes
- No

My health plan can contact me to get more information about this request.

- Yes
- No

| OHP MEMBERSHIP       |   |
|----------------------|---|
| I have OHP/Medicaid  | Yes / No / Unsure   |
| My OHP/Medicaid Card | Name<br><div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;">Picture of OHP card</div> |
| My Medicaid ID #     |   |

IF "No" to have OHP, get help applying for OHP:  
<https://healthcare.oregon.gov/Pages/find-help.aspx>

| Member Information  |  |
|---|--|
| My Name on OHP/Medicaid Card  |  |
| Preferred Name  |  |
| Accessibility Needs (preferred spoken language, sign language, braille, large font)               |  |
| Pronouns  |  |
| Date of Birth MM/DD/YYYY  |  |
| The best way to contact me is:  |  |
| <input type="checkbox"/> Phone<br><input type="checkbox"/> Text<br><input type="checkbox"/> Email |  |



# HRSN Eligibility Form – 2 (Partial Example)



**HRSN Transition Populations criteria**

The HRSN Covered Population to which the Member belongs:

- Discharged from an Institution of Mental Diseases (IMD) within the past 365 days.
- Released from a state or federal prison, local correctional facility, juvenile detention facility, Oregon Youth Authority closed custody correction, tribal correctional facility, or immigration detention facility within the past 365 days.
- Current or past involvement in Oregon’s Child Welfare system through being in foster/substitute care; the recipient of adoption or guardianship assistance or family preservation services; or the subject of an open child welfare case in any court.
- Transitioning to dual Medicaid/Medicare status: eligible for HRSN Services during the 90 days (3 months) preceding the date Medicare coverage is to take effect and the 270 days (9 months) after it takes effect.
- Meets 24 CFR § 91.5 definition of homeless or at risk of homelessness, as used by the U.S. Department of Housing and Urban Development (HUD)

**Climate Service Needs and Climate Device Clinical Risk Factor Criteria**

Please fill out the following table with the specific clinical device needs, authorization determination, and corresponding qualifying clinical criteria. Include the date of climate device authorization or reason for denial as applicable.

| Climate Devices | Qualifying Clinical Criteria by Device<br>(current medical condition, active in past 12mo) |
|-----------------|--|
|-----------------|--|

|  |  |
|--|--|
| <p style="text-align: center;"><b>Air Conditioner</b></p> <p><input type="checkbox"/> <b>Authorized</b></p> <p><b>Date of service authorization:</b></p> | <p><input type="checkbox"/> <b>Pregnant and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN services protocol</b></p> <p><input type="checkbox"/> <b>Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN services protocol</b></p> <p><input type="checkbox"/> <b>Adult 65 years and older and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN services protocol</b></p> |
|--|--|



# Contact Information

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HRSN RESOURCES CAN BE FOUND  
ONLINE @ [OHPCC.ORG](http://OHPCC.ORG)

---

ACENTRA HRSN PHONE:  
888-834-4304

---

ACENTRA HRSN FAX:  
833-551-2607

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ACENTRA HRSN WEBSITE:  
[ORHRSN@ACENTRA.COM](mailto:ORHRSN@ACENTRA.COM)

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[HOME](#) [MEMBER](#) [PROVIDER](#) [FEEDBACK & SURVEYS](#) [CONTACT US](#)



## Oregon's Health Related Social Needs Program

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Acentra's ORHRSN (Oregon Health Related Social Needs) program is offered at no-cost to Oregon Health Plan qualified, Open Card Medicaid members who are not enrolled with a Coordinated Care Organization. We support you through care coordination services related to Health-related social needs. HRSN refers to the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They include things such as housing instability, housing quality, food insecurity, employment, personal safety, lack of transportation and affordable utilities, and more.



Providers



Members



Connectors and Navigators





**Questions?**

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# Ayin | Health Solutions

# Open Card Reimbursement Request Process

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HRSN Climate Related Services and Outreach & Engagement

# Reimbursement Submission

## Landing Page

Beginning March 1st, HRSN providers delivering services to Open Card members can visit [ayin.com/hrsn](https://ayin.com/hrsn) to begin the reimbursement request process.

From this page providers can:

- Access reminders about the submission process
- Obtain the current reimbursement form
- Submit the completed reimbursement form online



# Reimbursement Submission

## Landing Page

Beginning March 1st, HRSN providers delivering services to Open Card members can visit [ayin.com/hrsn](https://ayin.com/hrsn) to begin the reimbursement request process.

### From this page providers can:

- **Access reminders about the submission process**
- Obtain the current reimbursement form
- Submit the completed reimbursement form online

## Health Related Social Needs Reimbursement

### Before you get started

- All entities requesting reimbursement must be enrolled as an HRSN Provider with the Oregon Health Authority prior to performing services. Submissions without a valid Medicaid Provider ID will be rejected.
- Outreach & Engagement services do not require prior authorization. However, OHP Open Card eligibility must be validated prior to submission.
- All other services must be authorized in advance. Submissions without a valid authorization number will be rejected

If you need help enrolling as a HRSN Provider, verifying OHP Open Card eligibility or obtaining service authorization - please contact (888) 834-4304 for more information.



# Reimbursement Submission

## Landing Page

Beginning March 1st, HRSN providers delivering services to Open Card members can visit [ayin.com/hrsn](https://ayin.com/hrsn) to begin the reimbursement request process.

### From this page providers can:

- Access reminders about the submission process
- **Obtain the current reimbursement form**
- Submit the completed reimbursement form online

## Submitting a Reimbursement Request

1. Download the Reimbursement Request Form:

[Download Form](#)

2. Review the instructions and complete the form. Please complete electronically and avoid hand written forms.
3. Submit the form either:

### Electronically

Submit the PDF form using our electronic submission workflow

[Submit Electronically](#)

OR

### Mail the completed form to:

OHA Climate-Related Supports  
PO Box 12809  
1050 25<sup>th</sup> St SE  
Salem OR 97309

# Reimbursement Submission Request Form

The reimbursement request form will be available as a fillable PDF. This form requires HRSN providers to submit three types of information:

- Member Information
- Provider Information
- Service Information

## Open Card Health Related Social Needs Climate-Related Supports Reimbursement Request Form

| Member Information                                   |                         |
|--|-------------------------|
| Name: (Last) _____ (First) _____ (Middle Init) _____ | Medicaid ID: _____      |
| Date of Birth: ____/____/____                        |                         |
| Service/Delivery Address: _____                      |                         |
| City: _____  | State: _____ Zip: _____ |
| Provider Information (Must Match OHA Registration)   |                         |
| Provider Name: _____                                 | Medicaid ID: _____      |
| Phone: _____   | Email: _____            |
| Provider Pay To Address: _____                       |                         |
| City: _____  | State: _____ Zip: _____ |

| Service  | Quantity                  | Authorization Number | Delivery Date (MM/DD/YY) | Charges (\$0.00) | Model Number |
|--|---------------------------|----------------------|--------------------------|------------------|--------------|
| <input type="checkbox"/> Air Conditioner             |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Air Filtration Device       |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Air Filter Replacement      |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Portable Power Supply       |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Heater                      |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Mini Refrigerator           |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Climate Device Installation |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Outreach & Engagement       | ____min*                  | <b>Not Required</b>  | / /                      | .                |              |
|  | *Round to nearest 15 mins |                      | <b>Amount Due</b>        | .                |              |

For more information or to submit online visit [www.ayin.com/hrsn](http://www.ayin.com/hrsn)  
 Contact Ayin Health Solutions, Open Card Provider Reimbursement at (971) 428-2516 for assistance with this reimbursement form

# Reimbursement Submission

## Request Form

The reimbursement request form will be available as a fillable PDF. **This form requires HRSN providers to submit three types of information:**

- **Member Information**
- Provider Information
- Service Information

| Member Information        |                |         |       |               |       |              |       |
|---------------------------|----------------|---------|-------|---------------|-------|--------------|-------|
| Name: (Last)              | _____          | (First) | _____ | (Middle Init) | _____ | Medicaid ID: | _____ |
| Date of Birth:            | ____/____/____ |         |       |               |       |              |       |
| Service/Delivery Address: | _____          |         |       |               |       |              |       |
| City:                     | _____          | State:  | _____ | Zip:          | _____ |              |       |

# Reimbursement Submission

## Request Form

The reimbursement request form will be available as a fillable PDF. **This form requires HRSN providers to**

**submit three types of information:**

- Member Information
- **Provider Information**
- Service Information

| Provider Information (Must Match OHA Registration) |                    |            |
|--|--------------------|------------|
| Provider Name: _____                               | Medicaid ID: _____ |            |
| Phone: _____                                       | Email: _____       |            |
| Provider Pay To Address: _____                     |                    |            |
| City: _____  | State: _____       | Zip: _____ |

# Reimbursement Submission

## Request Form

The reimbursement request form will be available as a fillable PDF. **This form requires HRSN providers to**

**submit three types of information:**

- Member Information
- Provider Information
- **Service Information**

| Service  | Quantity                  | Authorization Number | Delivery Date (MM/DD/YY) | Charges (\$0.00) | Model Number |
|--|---------------------------|----------------------|--------------------------|------------------|--------------|
| <input type="checkbox"/> Air Conditioner             |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Air Filtration Device       |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Air Filter Replacement      |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Portable Power Supply       |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Heater                      |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Mini Refrigerator           |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Climate Device Installation |                           |                      | / /                      | .                |              |
| <input type="checkbox"/> Outreach & Engagement       | _____min*                 | <b>Not Required</b>  | / /                      | .                |              |
|  | *Round to nearest 15 mins |                      | <b>Amount Due</b>        | .                |              |

# Reimbursement Submission

## Landing Page

Beginning March 1st, HRSN providers delivering services to Open Card members can visit [ayin.com/hrsn](https://ayin.com/hrsn) to begin the reimbursement request process.

### From this page providers can:

- Access reminders about the submission process
- Obtain the current reimbursement form
- **Submit the completed reimbursement form online or view mailing address**

## Submitting a Reimbursement Request

1. Download the Reimbursement Request Form:

[Download Form](#)

2. Review the instructions and complete the form. Please complete electronically and avoid hand written forms.

3. Submit the form either:

### Electronically

Submit the PDF form using our electronic submission workflow

[Submit Electronically](#)

OR

### Mail the completed form to:

OHA Climate-Related Supports  
PO Box 12809  
1050 25<sup>th</sup> St SE  
Salem OR 97309

# Reimbursement Submission

## Online Submission Page

Online submission is enabled through the PH TECH Help Center (now AYIN Health Solutions). To submit online, enter the following information:

- Email Address
- Your Name
- Phone Number
- Member Medicaid ID
- Attach Your Completed PDF

Note: Please submit one reimbursement form at a time and do not submit any other form or format of invoice.

## Submit a request

If this is your first time submitting a request, you will be required to verify your email address to ensure your request is received. After submission, please check your email, including the spam/junk folder, for our verification message.

HRSN Invoice Submission

Your email address

Name

Please provide your full name

Phone Number

Please provide your phone number.

Member Medicaid ID

**Please attach only one Reimbursement Request Form per submission. You can download form from [here](#).**

Add file or drop files here

Submit

# Reimbursement Submission

## Online Submission Page

### Important Note:

The first time you submit a request, you will receive an email asking you to verify that your email is valid. It is important that you complete this verification to ensure we receive your request.

We will also use this tool to notify you if there is an issue with your electronic submission.

## Submit a request

If this is your first time submitting a request, you will be required to verify your email address to ensure your request is received. After submission, please check your email, including the spam/junk folder, for our verification message.

HRSN Invoice Submission

Your email address

Name

Please provide your full name

Phone Number

Please provide your phone number.

Member Medicaid ID

**Please attach only one Reimbursement Request Form per submission. You can download form from [here](#).**

Add file or drop files here

Submit



# Reimbursement Submission

## Paper Submission

If needed, provider's will be able to submit completed PDF forms via mail.

- OHA Climate-Related Supports  
PO Box 12809  
1050 25th St SE  
Salem, OR 97309
- Paper submissions will be notified of any issues processing your request by mail.

## Submitting a Reimbursement Request

1. Download the Reimbursement Request Form:

[Download Form](#)

2. Review the instructions and complete the form. Please complete electronically and avoid hand written forms.

3. Submit the form either:

### Electronically

Submit the PDF form using our electronic submission workflow

[Submit Electronically](#)

**OR**

### Mail the completed form to:

OHA Climate-Related Supports  
PO Box 12809  
1050 25<sup>th</sup> St SE  
Salem OR 97309

# Reimbursement Submission

## Additional Notes

### General Process

- Before requesting reimbursement, all providers must be enrolled with the Oregon Health Authority as an HRSN provider.
- Outreach & Engagement Services must verify the member's Open Card eligibility with Acentra prior to submission.
- All other climate services require prior authorization.

### Reimbursement & Payment

- Always visit [ayin.com/hrsn](https://ayin.com/hrsn) to download the most recent form. Required data elements may change over time.
- Incomplete forms and requests without confirmed eligibility / authorization will be returned for correction and resubmission.
- Payments will be made directly from OHA.
- Please allow 2-4 weeks after a complete/accurate submission to receive payment.
- We are here to help. Ayin and Acentra's phone numbers will be posted on our website and PDF form for easy access.

# Thank you for your time!

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Visit [ayin.com/hrsn](https://ayin.com/hrsn) beginning March 1st.

# Provider Payments and Forms

Mary Durrant  
Oregon Health Authority



# How to receive payment for HRSN Services

- For reimbursement of HRSN Services with electronic payment, an Electronic Funds Transfer (EFT) Form will need to be completed.
- If an Electronic Funds Transfer (EFT) Form is not completed, payments will be sent to the provider address on enrollment application.



Read instructions prior to completing.

**Section A – Provider’s information**

|                              |                |                                  |                       |
|------------------------------|----------------|----------------------------------|-----------------------|
| Provider name:               |                | Provider number (if applicable): |                       |
| <b>Provider address</b>      |                |                                  |                       |
| Street:                      | City:          | State/province:                  | ZIP code/postal code: |
| Telephone number: (Required) | Email address: |                                  |                       |

**Section B – Provider identifier’s information**

|   |
|---|
| Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): |
| National Provider Identifier (NPI):   |

**Section C – Financial institution information**

|   |  |                 |                       |
|---|--|-----------------|-----------------------|
| Financial institution name:                           |  |                 |                       |
| <b>Financial institution address</b>                  |  |                 |                       |
| Street:   | City:  | State/province: | ZIP code/postal code: |
| Financial institution routing number:                 | <b>Type of account at financial institution</b><br><input type="checkbox"/> Checking* OR <input type="checkbox"/> Savings <input type="checkbox"/> Personal* OR <input type="checkbox"/> Business*<br>*Copy of preprinted voided check or bank verification letter required. |                 |                       |
| Provider’s account number with financial institution: | Account number linkage to provider identifier (Medical ID number):   |                 |                       |



**Section D – Submission information**

|  |
|--|
| Reason for submission:   |
| <input type="checkbox"/> New enrollment (Start) <input type="checkbox"/> Change enrollment <input type="checkbox"/> Cancel enrollment (STOP) |

**Important! Please read and sign before submitting.**

This form is used to authorize direct deposit to a checking or savings account. For all Department of Human Service (DHS) and Oregon Health Authority (OHA) programs and payment systems.

- **International transaction certification** – I certify that the entire amount of my direct deposit is NOT ultimately deposited into a financial institution outside the United States.
- **Recovery of funds deposited in error** – In the event an erroneous deposit occurs creating an overpayment, DHS/OHA will reserve the right to debit your account accordingly.

I certify that I have read and understand the information contained in this form. I acknowledge that the origination of transactions to the authorized account must comply with provisions of Oregon and US law. I certify that I am authorized to enter into this agreement as the account holder.

**Authorized signature:**

|  |                  |
|--|------------------|
| Written signature of person submitting enrollment: | Submission date: |
| Printed name of person submitting enrollment:      |                  |

|                        |   |                 |          |
|------------------------|---|-----------------|----------|
| <b>Office use only</b> | <input type="checkbox"/> OR-Kids <input type="checkbox"/> MMIS <input type="checkbox"/> SFMA <input type="checkbox"/> CBC/CEP | Date processed: | Initial: |
|                        | Original documentation on file with DHS.  |                 |          |
|                        | Agency signature:   | Date:           |          |

# Electronic Funds Transfer (EFT) Enrollment Form

# When EFT Enrollment Form is complete

1. Attach a copy of a voided preprinted check or official bank verification letter of the account name, routing number and account number. **This information is required for all new accounts. (Deposit clips not accepted.)**
  - **Note:** Checks must be personalized or imprinted with the business name and address. Handwritten, blank checks will not be accepted.

2. Return by secure email to: [DHSOHA.ProvDirDep@dhsoha.state.or.us](mailto:DHSOHA.ProvDirDep@dhsoha.state.or.us)

- Or return by fax to: 503-945-6860
- Or return by mail to:

Department of Human Services/Oregon Health Authority  
Office of Financial Services/Attn: EFT Coordinator  
500 Salem St. NE, E-97  
Salem, OR 97301-1080

3. Retain a copy for your records.

4. For questions, contact:

DHS/OHA EFT Coordinator at 503-945-6872 or 503-945-5710.

# HRSN Process Overview



Enroll with OHA to  
become a HRSN Provider



Contact Acentra for  
authorization of services



Send invoices to AYIN  
Health Solutions



# Resources

- For Provider enrollment assistance, please contact Provider Enrollment at 800-336-6016, option 6, or email [Provider.Enrollment@odhsoha.oregon.gov](mailto:Provider.Enrollment@odhsoha.oregon.gov)
- For provider web portal setup and password assistance, please contact Provider Services at 800-336-6016, option 5 or email [TEAM.Provider-access@odhsoha.oregon.gov](mailto:TEAM.Provider-access@odhsoha.oregon.gov).
- For Electronic Funds Transfer (EFT) form assistance, please contact ODHS/OHA EFT Coordinator at 503-945-6872 or 503-945-5710.
- For authorization assistance, please contact Acentra at (888) 834-4304.
- For invoicing assistance, please contact AYIN Health Solutions at (971) 428-2516.



# How to contact the different CCOs

| CCO Name                                     | CCO Phone Number |
|--|------------------|
| Advanced Health                              | (541)269-7400    |
| AllCare CCO                                  | (888)460-0185    |
| Cascade Health Alliance                      | (541)883-2947    |
| Columbia Pacific CCO                         | (503)488-2822    |
| Eastern Oregon CCO                           | (503)765-3521    |
| Health Share of Oregon                       | (503)416-8090    |
| InterCommunity Health Network CCO            | (541)768-5207    |
| Jackson Care Connect                         | (855)722-8208    |
| PacificSource Community Solutions            | (800)431-4135    |
| Trillium Community Health Plans - Southwest  | (541)485-2155    |
| Trillium Community Health Plans - Tri-County | (877)600-5472    |
| Umpqua Health Alliance                       | (541)229-4842    |
| Yamhill Community Care                       | (855)722-8205    |

More information here:

<https://www.oregon.gov/oha/hsd/ohp/pages/coordinated-care-organizations.aspx>

# Questions?



# Upcoming Sessions

## ★ 4th Tuesday of each month

Ongoing technical assistance and training

### March/April topic preview:

- Using the Provider Portal (e.g., checking Member eligibility in MMIS)
- How to use the HRSN Request Form
- Information Sharing Authorization Form
- Other topics?



**Thank you for your collaboration  
and ongoing partnership!**

