TITLE: HEALTH-RELATED SERVICES

PURPOSE:
To describe the requirements for review, administration, and reporting of Health-Related Services (HRS) to ensure:

1) Plan Partners, Providers, Members, and their advocates understand how to request and authorize services and items to meet Members' social and health-related needs.
2) Authorized HRS are consistent with OHA goals to promote the efficient use of resources and address Member's social determinants of health to improve health outcomes, alleviate health disparities, improve overall community well-being.
3) Encourages transparency and Provider and Member engagement through streamlined processes to not create unnecessary barriers and provide accountability.

DEFINITIONS:
Community-Benefit Initiatives: Community-level interventions that include, but are not limited to, Members and are focused on improving population health and health care quality.

Covered Services: Medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable Oregon Administrative Rules and the Prioritized List of Health Services above the funding line set by the Oregon Legislature. Covered Services include services that are (a) ancillary services; (b) diagnostic services necessary to determine the existence, nature, or extent of the Member's disease, disorder, disability or condition; (c) necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K; and (d) necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Project.

Extreme Weather Event: An event, such as extreme heat, smoke from wildfires, or power outages, that may adversely impact a Member's health.

Flexible Services: Cost-effective services or items offered to an individual Member to supplement Covered Services. These services may effectively treat or prevent physical, oral, or behavioral health conditions, improve health outcomes, and prevent or delay health deterioration. Flexible Services are consistent with the Member's treatment plan as developed by the Member's care team and documented in the Member's treatment plan and medical record as specified in OAR 410-141-3845.

Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.

Health Plan Services Contract (CCO Contract): Contract entered into between Health Share of Oregon and the Oregon Health Authority pertaining to the administration of the Oregon Health Plan Medicaid program.

Health-Related Services (HRS): Cost-effective services or items offered to Members to supplement Covered Services. These non-state plan, non-Covered Services are provided instead of or as an adjunct

to benefits and are intended to improve care delivery and overall Member and community health and well-being. Health-Related Services must meet the requirement for activities that improve health care quality, as defined in 45 CFR 158.150 and OAR 410-141-3845. Health-Related Services include Flexible Services and Community-Benefit Initiatives.

Member: An Oregon Health Plan client enrolled with Health Share of Oregon.

Plan Partner: An entity that: 1) holds a fully capitated contract with Health Share of Oregon to provide services as defined in the Health Plan Services Contract for Coordinated Care Organizations between the Oregon Health Authority and Health Share; 2) assumes the financial risk of providing health services to Members; and 3) is compensated on a prepaid capitated basis.

Provider: An individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering Provider, or that bills, obligates and receives reimbursement on behalf of a rendering Provider, also termed a billing Provider.

POLICY:

I. HRS are provided as a supplement to Covered Services.

II. HRS must meet the following criteria:
   A. Be designed to improve health quality;
   B. Increase the likelihood of desired health outcomes in a manner that can be objectively measured and produce verifiable results and achievements;
   C. Be directed toward individuals or segments of Health Share's Member population, or provide health improvements to the population beyond those enrolled without additional costs for the non-Members; and
   D. Be based on evidence-based medicine; and/or widely accepted best clinical practice; and/or criteria issued by accreditation bodies, recognized professional medical associations, government associations, or other national health care quality organizations.

III. HRS must be primarily designed to meet at least one of the following criteria:
   A. Improve health outcomes compared to a baseline and reduce health disparities among specified populations.
   B. Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge.
   C. Improve patient safety, reduce medical errors and lower infection and mortality rates.
   D. Implement, promote, and increase wellness and health activities.
   E. Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.

IV. All requests for HRS shall be evaluated pursuant to this policy. Health Share or Plan Partner shall not exclude certain Members or limit the range of permissible HRS that can be requested as long

as the provided services satisfy the requirements of OAR 410-141-3845.

V. Health Share shall submit its financial reporting for HRS on an Exhibit L Financial Reporting form as directed by the CCO Contract.

VI. All of Health Share's Plan Partners are subject to this policy and the requirements described in OAR 410-141-3845.

VII. Health Share shall submit its HRS policy to the Oregon Health Authority (Oregon Health Authority) for approval on an annual basis, within 20 business days of any material change, or within 5 business days of OHA request.

PROCEDURES:

I. Flexible Services:

A. Health Share ensures Members have access to HRS.

1. Health Share provides HRS through a network of five health Plan Partners who each provide HRS to the Members assigned to their plan. Each Plan Partner follows the same process for HRS, as outlined in this policy, to ensure consistency in Member experience within the Health Share system of care.
2. Each Member receives a Health Share ID Card that lists the Member's health Plan Partner as well as their Primary Care Provider.
3. To request HRS, Members can call Health Share's Customer Service, reach out to the Care Coordination team at their assigned Plan Partner, or contact the Primary Care Provider listed on their Member ID Card. The Member has the right to receive this information in their primary language, and translation of written materials or interpretation services will be provided as needed.
4. Health Share posts on its website in multiple languages and describes in its Member Handbook, which is also produced in multiple languages:
   a. Information about HRS.
   b. Instructions for how Members and Providers can contact a Member's Primary Care Provider, care coordination teams, or Health Share Customer Service to request Flexible Services.
   c. Phone numbers for care coordination teams and Health Share Customer Service.
   d. Information about how to access free language assistance.
5. Health Share educates Community-Based Organizations about HRS and how to assist Members to access them.

B. Health Share delegates to Plan Partners the responsibility to:

1. Notify Members, Providers, and care coordinators about HRS, including the process to request them. Notification may happen via community forums, provider trainings, Provider manuals, or individual outreach. Any Provider may request Flexible Services on behalf of a Member by working with the Member's care team. This includes clinical Providers such as Care Coordinators, Primary Care Providers, Discharge Planners, Social Workers, or others working directly to meet the health-related social needs of Members. Non-clinical Providers may include Navigators, Community Health Workers,

or others.
2. Educate Providers and Community-Based Organizations about HRS requests, documentation, and monitoring protocols; and
3. Determine lines of authority for approving Flexible Services, including clinical oversight.
4. Identify vendors or Providers of health-related items or services to be delivered to Health Share Members.
5. Review requests, authorize, and provide Flexible Services to Members including but not limited to:
   a. Care Coordination;
   b. Education supports;
   c. Food services and supports;
   d. Housing services and supports;
   e. Items for the living environment;
   f. Transportation services and supports.
6. Inform requesters of the outcome of their requests.
7. Approve requests and ensure services received are tracked.
8. Track Member requests over time.

C. Flexible Services provided to individual Members shall be consistent with the Member's treatment plan as developed by the Member's care team, which may include individuals supporting the Member in non-clinical settings. The care team and Plan Partner will work directly with the Member and, as appropriate, the family of the Member to determine what, if any, Flexible Services will be effective as alternative or adjunct to the Member's care.

D. All Providers, Members themselves, or the Member's care team may request the use of Flexible Services for a Member by making a request (via written request form, online form, or other agreed-upon method) to the care coordination team at the Member's assigned physical, behavioral, or dental health plan. Members can request Flexible Services by asking their Provider or health plan care coordination team or by contacting Customer Service. The Plan Partner's care coordination team may also initiate a request for Flexible Services. Plan Partners shall coordinate requests and administration of Flexible Services consistently across physical, behavioral, and oral health care coordination teams, as needed, to ensure Member needs are met. Plan Partners may also allocate funds to be used on Flexible Services directly to Providers, including appropriate oversight of those funds to ensure Provider provides them to Members in a manner consistent with this policy.

E. Once a request for Flexible Services is made, the Plan Partner shall authorize an appropriate reviewer to review the request, in a separate process from the standard prior authorization process for Covered Services, with the following criteria in mind:
   1. The items and services requested clearly relate to achievement of a treatment goal.
   2. If the request is made by a behavioral health or dental health plan care coordination team or by a Provider primarily working with a Member to address their behavioral health or dental health needs, that request shall be reviewed for approval or denial by

the receiving entity and shared with the Member's physical health Plan Partner as appropriate to ensure coordination within the Health Share system of care.

3. When possible, the Member is consulted about:
   a. The availability of the item/service;
   b. That there is no direct cost to the Member for the attainment and receipt of that service; and
   c. Any requirements for the Member to participate in obtaining or utilizing the item/service.
4. No other funding source is reasonably available to cover the cost of the service or item requested and Provider or care coordinator has explored and exhausted all other options for potential payment of the requested items or services, including community resources or services provided by external community partners.
5. Based on a review of the criteria listed above, the reviewer shall determine if the request can be approved at that time or if it does not meet the criteria for approval.
6. Requests above a defined dollar amount may require the review of an additional reviewer for final determination. The additional reviewer may be a Supervisor, Medical Director, or other individual with decision-making authority within the Plan Partner's organization.
7. If the request is missing information, the reviewer shall work with the requestor to obtain that information.
8. The outcome of all requests, whether approved or denied, will be communicated in writing to the Member and/or the Member's representative and Provider within 20 business days.

F. If a Flexible Service request is approved, Plan Partner shall:
   1. Ensure that no administrative burden is imposed on the Member by coordinating the acquisition of the approved item or service and delivering it to the Member.
   2. Capture relevant information regarding the approved Flexible Service in Excel or another similar electronic spreadsheet to facilitate data alignment and reporting via the Exhibit L Health-Related Services financial report. This data will enable Member requests to be tracked over time.

G. Flexible Service decisions are subject to the Grievance provisions of OAR 410-141-3875 through 410-141-3915. If a Flexible Service request is not approved, Plan Partner shall:
   1. Notify the Member and/or the Member's representative and Provider in writing, within 20 business days, of the decision to not approve an individual Flexible Services request, including notice of the Member's right to initiate the Grievance process related to the non-approval. Such notice shall be copied to any representative of the Member and any Provider who made or participated in the request on the Member's behalf;
   2. Acknowledge that Members do not have appeal or hearing rights with regard to non-approval of a Flexible Service request;
   3. Establish and follow a written procedure to acknowledge the receipt, disposition, and documentation of each Grievance from a Member regarding a Flexible Service request.

H. All Plan Partner staff who review and or administer HRS requests shall be provided adequate education and training on the purposes and use of HRS as well as required reporting

requirements.

I. Plan Partner shall be responsible if a Flexible Service or item is not delivered and to provide the Member with contact information for who can resolve issues related to the approved service or item.

II. Community-Benefit Initiatives

A. Community Benefit Initiatives (CBI) are HRS provided on a community-based level. They are intended to improve population health and health care quality through providing resources that address social determinants of health and promote health equity. CBI are not Flexible Services and are not required to be documented in a treatment plan or clinical record. Health Share does not authorize individual Providers or individual Plan Partners' care coordination teams to request CBI or accept any unsolicited requests for CBI.

B. Health Share has two Committees that participate in HRS CBI spending decisions at the CCO level: the Community Advisory Council (CAC) and the Community Impact Committee (CIC). Health Share's Board of Directors approves all CBI spending decisions for the organization. The CIC works closely with the entire CAC, which includes Tribal Council representatives, on CBI recommendations to the Board of Directors for final approval. The CIC consists of representatives from the CAC and from each of Health Share's Plan Partners. The CAC and CIC collaborate to ensure alignment between HRS CBI spending and CHP priority areas. The CAC participates in these CBI spending decisions through the following roles:
   1. A CAC representative serves on the CIC to ensure that CAC input is incorporated into CBI spending recommendations;
   2. Two CAC Members serve on the Board of Directors, which makes all HRS CBI spending decisions.

C. Plan Partners may choose to capture spending on community-based interventions as CBI. If they do so:
   3. They shall engage with Health Share's CAC, which includes Tribal Council representatives, in these recommendations;
   4. They shall share a summary of these interventions with Health Share's CIC;
   5. They shall include all required information necessary to fill out the Exhibit L financial reports in their reporting to Health Share, including how the spending aligns with the priorities identified in Health Share's CHP, and with any HRS CBI spending priorities identified by Oregon Health Authority.

III. Extreme Weather Event Outreach and Supports

A. In the event of an Extreme Weather Event, staff across the Health Share collaborative will work together to ensure a CCO-wide response to effectively support Member needs during the event.

B. Plan Partners will outreach to Members at highest risk for adverse health impacts.
   1. At minimum, plans must develop and utilize a methodology to outreach to Members at highest risk based on clinical condition, social risk factors, and/or environmental

considerations during an Extreme Weather Event. Plan Partners may choose to use Health Share's Climate dashboard to determine population for outreach.

2. Outreach may be done by the Plan Partner or delegated to Providers who agree to contact their assigned Members.
3. Plan Partners will ensure Member-facing staff and Providers are using aligned messaging and are informed of the availability of climate-related services and/or supports and the process for requesting such services and/or supports.
4. Plan Partners will ensure that outreach to Members includes inquiry around the following and that linkage to other services and/or supports are made when appropriate.
    a. Other health needs (e.g., pharmacy, DME, food, utilities, NEMT).
    b. Confirmation of the individual's safety plan, including Member access to power source/electricity (if required for requested item).
    c. Discussion of installation process for requested services and/or supports and confirmation that the Member's home environment will support the requested item and/or whether additional services and/or supports may be needed.
5. Outreach that results in a Member request for climate-related services and/or supports will generally follow current procedures for provision of Health-Related Services. Climate-related services and/or supports can be requested outside of Extreme Weather Events.
    a. Members who have received climate support in previous years are not excluded from current or future climate support services. Individual assessment and review of request will be conducted in compliance with current HRS policy.
    b. Should the Oregon Health Authority (OHA) require any automatic approvals for specific climate-related services and/or supports, Plan Partners must adhere to OHA rules.
    c. Plan Partners may require that Members or their delegate must be present at the time of delivery and installation of the requested services and/or support.

C. Plan Partners shall document and report the following information to Health Share via their quarterly financial reporting, at minimum. At times, Health Share may request this information from Plan Partners outside of the typical reporting schedule to satisfy urgent requests for recent data.
    1. Mode of outreach to Members (e.g. mail, direct phone call, text message, other).
    2. Number and percentage of individual Members reached through outreach through each mode of outreach.
    3. Number of Members not included in outreach who were denied a climate-related service and/or support.
    4. Number of each of the following items that were distributed:
        a. Air Conditioners
        b. Air Purifiers (includes Air filters)
        c. Generators

IV. Reporting and Analysis of Health-Related Services

A. Health Share shall include expenses related to HRS in its quarterly financial reporting to Oregon Health Authority, consistent with the CCO Contract, in compliance with 42 CFR 438.8 Medical Loss Ratio (MLR) and in response to all required fields in an Exhibit L Financial Reporting form. Plan Partners shall include expenses related to HRS in their financial reporting to Health Share, consistent with the requirements described above. To ensure data quality and consistency, Health Share and Plan Partners shall use a standard Health-Related Services nomenclature to report:
   1. Expenditure/Health-Related Service investment name;
   2. Description of services provided;
   3. Health-Related Service category;
   4. Rationale for the investment.

B. Plan Partners shall document, track, and monitor their organization's Flexible Services spending.

C. Plan Partners shall report data monthly to Health Share on their Members who have received Flexible Services. That data will be submitted via an agreed upon template to Health Share

D. Health Share shall use the information described in III.B and III.C above to analyze, as reasonably possible, the effectiveness HRS on reduction of medical costs and/or improvement in care and opportunities for optimizing utilization of HRS, with a specific focus on promoting health equity. Plan Partners may also analyze their own HRS spending and utilization, but that is not required.

E. Analysis shall occur at least annually and include review of:
   1. Qualitative and fiscal reports specific to each Plan Partner that determine number of Members served, Member populations served, types of services requested, cost of services requested, the rationale for the provision of the Flexible Service, measurable outcomes, length of investment, and projected return on the investment.
   2. Cumulative and de-identified data for all Plan Partners to identify trends in types of Flexible Services requested; utilization; outcomes and associations between those services and diagnostic codes associated with unique Member populations over time. That information shall be reported to Health Share's Health-Related Services Strategy Workgroup and shared with Health Share's quality team. If a Plan Partner does conduct an analysis of their own HRS spending and utilization, they are encouraged to share their conclusions with the Health-Related Services Strategy Workgroup as well.

V. Oversight and Monitoring of HRS

A. Health Share ensures that Plan Partners provide HRS services consistent with OAR 410-141-3845 and the Procedures documented in this Policy through:
   1. Review of Plan Partner's HRS policies and procedures on an annual basis;
   2. Formal review of compliance with all delegated functions, obligations and other responsibilities, performance deficiencies, and areas for improvement on an annual basis. If deficiencies are found in Plan Partner performance for any delegated function, whether identified by Health Share or the Oregon Health Authority, Health Share will

require the Plan Partner to respond and remedy those deficiencies within the timeframes determined by the Oregon Health Authority.

B. Oversight of HRS occurs throughout Health Share's governance structure, as evidenced by:
   1. The HRS Strategy Workgroup, which reviews reports regarding HRS expenditures, and submits its formal analysis and recommendations regarding HRS utilization and spending to the Operational Excellence Member Advisory Committee and Quality Health Outcomes Committee on at least an annual basis;
   2. The Governance and Operational Excellence Committee, which reviews the Strategic Investment Fund (SIF) policy on an annual basis.

REFERENCES:
ORS 413.042
OAR 410-141-3500
OAR 410-141-3845: Health-Related Services
Health Plan Services Contract
Exhibit L Financial Reporting Form
Health Share Policy: CORP-02 Delegated Functions and Oversight
Health Share Policy: CORP-07 Strategic Investment Fund

Signed by:
Beth Spinning
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Beth Spinning, COO

10/7/2024
Date

Department: Integration	**Author:** Tanya Nason, Program Specialist
Effective Date(s): October 2014	**Review Frequency:** Annually
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☒ *Required by Health Plan Services Contract*

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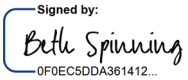
Beth Spinning spinningb@healthshareoregon.org COO Health Share of Oregon Security Level: Email, Account Authentication (None)	Signed by:  0F0EC5DDA361412... Signature Adoption: Pre-selected Style Using IP Address: 76.115.97.11	Sent: 10/2/2024 | 08:51 AM Resent: 10/7/2024 | 08:26 AM Viewed: 10/7/2024 | 09:24 AM Signed: 10/7/2024 | 09:24 AM

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Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

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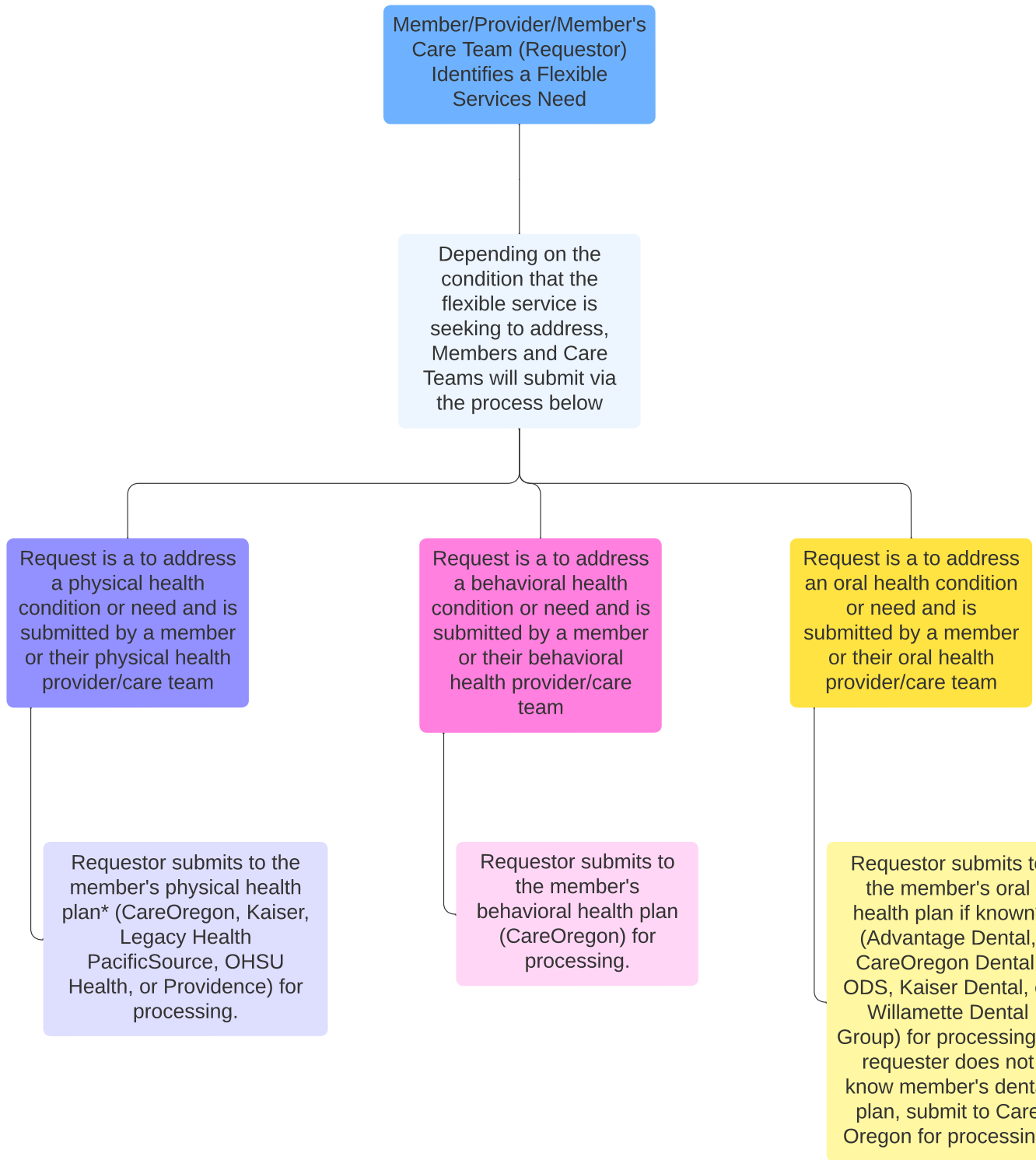
Envelope Sent	Hashed/Encrypted	10/2/2024 | 08:51 AM
Certified Delivered	Security Checked	10/7/2024 | 09:24 AM
Signing Complete	Security Checked	10/7/2024 | 09:24 AM
Completed	Security Checked	10/7/2024 | 09:24 AM

Payment Events	Status	Timestamps



- The member's health plan information is on their Member ID card or by contacting Health Share Customer Service for assistance..

Title: Health-Related Services: Global Policy		Version: 7	Ref #: 827
Owner: Keshia Bigler (Director, Social Health)			
Approved by ELT/CEO: 10/02/2023	Effective Date: 01/21/2021	Next Review: 10/02/2024	
Applies to *(check all that apply)*: ☐ *Medicare* ☒ *Medicaid* ☐ *Housecall Providers* ☒ *CareOregon Corporate*			

Scope

- All staff supporting members who express immediate social needs where no community resources exist
- Lines of Business: Medicaid – Columbia Pacific CCO, Jackson Care Connect, Metro – Health Share of Oregon CCO
- In-house Benefit: Physical Health, Behavioral Health, Dental, NEMT
- Subcontractors

Purpose

To ensure Health-Related Services (HRS) are administered in a fair and equitable manner and compliant with CMS requirements and Oregon Health Authority (OHA) guidance, CareOregon has outlined guidelines that are intended to support managing Health-Related Services within any CareOregon subcontractor.

These guidelines apply both to Health-Related Services, which are flexible services provided to individual members, and community benefit initiatives, which are health-related services provided on a community-based level. Community Benefit Initiatives (CBI) are initiated by the CCO and shall promote alignment with its then-current Community Health Improvement Plan (CHIP).

These guidelines describe the requirements for review and administration of Health-Related Flexible Services to Members and to ensure all CareOregon subcontractors providing health-related services are following state and federal requirements related to such services.

Definitions

Care Coordinators	a team-based position that coordinates care through state benefits and community resources. This position takes into consideration the global health of an individual given their physical, social, mental, and dental health needs and coordinates timely access and continuity of care to promote positive health outcomes
CareOregon Subcontractor	an entity that has entered into a contract with CareOregon or an affiliated CCO for the administration of the Oregon Health Plan Medicaid program.

Clinical Health-Related Services Review	review process for requested items and/or services within the Flexible Services guidelines that require an in-depth clinical review on behalf of an individual CareOregon member.
Clinical Operations Department	CareOregon department responsible for receiving and processing requests for Prior Authorizations, Inpatient Services, Durable Medical Equipment, Appeals and Grievances, and Quality oversight. Includes administrative and clinical management processes worked by appropriately experienced and credentialed staff.
Community Advisory Council	Advisory group of individuals facilitated by CCO service area per county that engages with members and partners who serve them. CACs provide important feedback and advisement on local health issues, decision-making opportunities, and assisting community health needs assessments and regional health improvement plans.
Community Benefit Initiative/ Health Related Services	means non-mandated state plan, non-covered services under Oregon's Medicaid State Plan, also referred to as "other non-medical services." Be directed toward segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members
Contract Manager	CareOregon, Columbia Pacific CCO, and/or Jackson Care Connect designated staff that is responsible for contract management and administration made with any third-party external agency. Contract managers, as related to this policy, is limited to clearly defined agreement terms and obligations for eligible Health-Related Services.
Covered Services	Medically appropriate health services described in ORS Chapter 414 and applicable administrative rules that the Legislature funds, based on the Prioritized List of Health Services
Discretionary Health-Related Spending	Process of a CareOregon staff member and/or authorized subcontractors to purchase items and/or services within Flexible Services guidelines that do not require a clinical review, on behalf of an individual CareOregon member.
Flexible Services/Health Related Services	Cost-effective services (or items) offered to an individual CCO member to supplement covered benefits
Health-Related Services	means non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-3845. Health-related services include flexible services and community benefit initiatives.
HRSF Support Staff	A team within CareOregon's Clinical Operations Department trained in the daily processing of HRSF requests, including but not limited to reviewing member eligibility, assessing and/or gathering documentation, processing per internal guidelines, and coordinating payment of HRSF items/services.

Grievance	A member's expression of dissatisfaction to CareOregon or a provider about any matter other than an Action
Member	An Oregon Health Plan client assigned to CareOregon, enrolled in an affiliated coordinated care organization, dental care organizations, and/or behavioral health entity.
Metro	A team of staff across various CareOregon departments that focus on healthcare and social services for CareOregon members enrolled with Health Share of Oregon CCO, as well as Health Share members enrolled with other plan partners for behavioral health and dental health.
Care Team	Multidisciplinary group of health and social care professionals who work together and directly to deliver local accessible health and social services to CareOregon members via Physical, Behavioral, and/or Dental Health networks. This definition includes Traditional Health Workers.
Provider	An individual, facility, institution, corporate entity, or other organizations that supplies health or health-related services or items, also termed a rendering provider, or bills, obligates and receives reimbursement on behalf of a rendering provider, also termed a billing provider.
Strategic Business Partnerships Department	CareOregon department overseeing policy changes and governance of health-related services. This department provides subject-matter expertise to other CareOregon departments on provision of flexible services and community benefit initiative requests, and is responsible for monitoring HRS policy changes to incorporate into organizational policy and procedure as needed.
QNXT	Web-based information services platform accessed through Internet Explorer that allows access to portals for Call Tracking, Utilization Management, and Member, Provider and Claims Portals for CareOregon members
Tribal Liaison	CCO staff that acts as a liaison to federally recognized tribal entities and shared populations by acting as a subject matter expert on tribal health systems and interactions with CCO. Collaborates with tribal entities or their delegate representatives on activities such as but not limited to improving access and health equity of tribal populations.

A. Subsection: Policy

CareOregon supports HRS funding to be used for the benefit of current Medicaid members to promote health, prevent decompensation, divert from higher levels of care, assist in environmental stability, and increase independence from formalized services

I. HRS are defined as described in OAR 410-141-3500 and 410-141-3845
   a. CCOs have the flexibility to identify and provide HRS beyond the list of examples in 45 CFR §§ 158.150, 158.151, as long as the HRS satisfy the requirements of this rule;

i. As allowed under 42 CFR 438.6(e), CCOs may offer additional services that are separate from HRS and delivered at the complete discretion of the CCO;

b. HRS may be used to pay for non-covered health care services including physical health, mental health, behavioral health, oral health, and tribal-based services.

II. To qualify as an HRS, an item and/or service must meet the following requirements, consistent with 45 C.F.R. 158.150:

a. Services and items must also be designed to:

i. Improve health quality;

ii. Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements;

iii. Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those without additional costs for the non-members;

iv. Evidence-based medicine;

v. Widely accepted best clinical practice; and

vi. Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations."

III. HRS shall be primarily designed to meet at least one of the following goals:

i. Improve health outcomes compared to a baseline and reduce health disparities among specified populations;

ii. Prevent avoidable hospital readmission through a comprehensive program for hospital discharge;

iii. Improve patient safety, reduce medical errors, and lower infection and mortality rates;

iv. Implement, promote, and increase wellness and health activities;

v. Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities both above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.

IV. The following types of expenditures and activities that are excluded from HRS:

a. Those that are designed primarily to control or contain costs;

b. Those that otherwise meet the definitions for quality improvement activities but that were paid for with grant money or other funding separate from revenue received through a CCO's contract;

c. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are

designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 codes sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 1320d-2, as amended;

d. That portion of the activities of health care professional hotlines that do not meet the definition of activities that improve health quality;
e. All retrospective and concurrent utilization review;
f. Fraud prevention activities;
g. The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
h. Provider credentialing;
i. Costs associated with calculating and administering individual member incentives; and
j. That portion of prospective utilization that does not meet the definition of activities that improve health quality.

V. Health-Related Flexible Services encourages transparency and accessibility of how to access and the process to obtain qualifying items/services eligible
   a. This includes but not limited to materials or information contained within the following
      i. CCO member handbooks
      ii. CCO online websites and webpages
      iii. CCO sponsored social media accounts
      iv. Standalone paper and electronic informational materials available for online access, printing and mailings, and/or paper copies to be made available in community and clinic settings
   b. Materials shall meet OHA standards for member materials which include requirements for translation and accessible formats

VI. Health-Related Flexible Services provided to individual members shall be consistent with the Member's treatment plan as developed by the Member's care team.
   a. Procedures for health-related services shall be designed in a manner that does not place undue burden on providers or members in submission of requesting eligible items and/or services
      i. This is inclusive of offering alternative options to submit request forms in hard copy, electronic, fax and/or secure email

VII. Health-Related Services Community Benefit Initiatives (CBI) provided to clinical and non-clinical providers and/or community based-organizations designed to be community-level interventions that include, but not limited to, members and are focused on improving population health and health care quality and/or

addressing social needs or gaps in the ability to address social determinants of health for a community or population.

a. Community Benefit Initiatives administered by CCOs shall designate a role for the community advisory council in directing, tracking, and reviewing community benefit initiatives, as provided in OAR 410-141-3845
b. CCOs shall also include, at the tribes and/or local Indian health care providers discretion, provide input into CBIs decisions. This may be through CCO Tribal Liaison roles and/or other tribal representation through CCO Community Advisory Council avenues.

VIII. All requests for HRS shall be evaluated pursuant to this policy and CareOregon entity shall not limit the range of possible HRS that can be requested other than by enforcing the limits defined in the OAR citations and this policy

a. Jackson Care Connect CCO, Columbia Pacific CCO, and Health Share of Oregon CCO delegate the functional oversight of a centralized access point for qualified Flexible Services to individual members and requesting care teams to CareOregon
    i. CareOregon Member Services department is designated with ensuring members are informed how they may request a Flexible Service in any manner (for example, online, completing a form, verbal, or written requests on paper) to ensure the process is accessible directly to members
    ii. CareOregon Clinical Operations department is designated the responsibility of daily operations supporting Flexible Services centralized access point and meeting policy criteria defined in Subsections B-C
    iii. CareOregon Population Health Partnerships (PHP) department is designated responsibility as subject matter experts on policy changes, updates and guidance for all applicable Health-Related Service pilot projects, programs, contracts, and/or projects
        1. As related to the NEMT benefit management, PHP will collaborate with Strategic Business Partnerships department and CCO to outline qualifying flexible services that may be offered via the NEMT benefit
    iv. If the request is made by a behavioral health or dental health plan care coordination team or by a Provider primarily working with a Health Share member to address their behavioral health or dental health needs, that request shall be addressed by the receiving entity and shared with the Member's physical health Plan Partner as appropriate to ensure coordination within the Health Share system of care

b. CareOregon Population Health Partnerships department has a responsibility to develop additional policies and/or procedures for all of the following:
    i. condition-based flexible services offered to members, if they may circumvent typical Health-Related Services procedures as a "preapproval" strategy.
        1. Design of these strategies outline a "preapproval" method used to identify highest risk populations that can be subject of outreach and expedited support.
        2. Approval standards for individuals or populations who may not be included in defined highest risk populations still qualify and utilize the Flexible Services centralized access point and meet policy criteria defined in Subsections B-C
    ii. Referrals from CareOregon Member Services department from members that may request a qualified Flexible Service in their preferred manner.
    iii. All relevant Health-Related Services policy, procedure and reporting obligations required by the OHA of CCOs are transferred to the designated CareOregon or CCO Contract Managers
    iv. This transference of responsibilities pertains to contract agreements with health care providers, traditional health worker entities, and/or community-based organizations that include qualified Health-Related Services
    v. If CareOregon or its CCOs delegate HRS administration to a third party, this Health-Related Services policy and procedure shall be shared with those subcontractors. Any delegation will clearly define the role of CareOregon, the CCO, and the role of the subcontractor as a delegate.

IX. CareOregon or subcontractor shall provide to Members a written outcome regarding the refusal of the Health-Related Flexible Service requests and will copy any representative of the Member and any Provider who made or participated in requests on the Member's behalf. The written outcome must inform the Member and any Provider of the Member's right to file a Grievance in response to the outcome

X. The outcome of an HRS request does not constitute an "Adverse Benefit Determination" as defined by OAR 410-141-3845 or 410-141-3875

XI. HRS outcomes are subject to the Grievance provisions of OAR 410-141-3875 and 410-141-3880, in which written outcomes shall inform the member and any provider of the member's right to file a grievance in response to the outcome

XII. Except as provided in section (VIII-X), members have no appeal or hearing rights in regard to an HRS outcome

XIII. CareOregon shall submit their financial reporting for HRS with the appropriate CareOregon CCO as directed through the contracting agreement with the Oregon Health Authority

B. Subsection: Health-Related Services Flexible Service Requests

I. Requesting Health-Related Flexible Services
   a. CareOregon or subcontractor network Providers (clinical and non-clinical), treatment providers, and care teams may submit requests for the use of HRS(via written request form or other agreed method) to the identified team at the Member's assigned health plan. CareOregon enrolled Medicaid members may also submit requests on their own behalf.
      i. Procedural directions are defined in the corresponding Health-Related Services Global Procedure
      ii. CareOregon offers bulk purchase funding for health-related services. Bulk purchase funds are intended to ensure that needed supplies are immediately available for community based agencies, health care provider staff, and/or clinical teams to distribute to members as a means to effectively serve their member populations.
         1. Bulk purchased items are purchased by the health care provider and/or agency approved to do and reimbursed for eligible items. Or, bulk items are purchased on behalf of the health care provider and/or agency and coordinated delivery of items to the requested location(s).
      iii. Care Coordination staff participating in direct member services, including telephonic support, can access Health-Related Flexible Service funds. This department will work with community partners, providers, primary care teams, and case managers to determine eligibility for health-related service funding requests and make appropriate recommendations to submit requests and complete request documentation that meet Subsection E of this policy.
      iv. Members can request Health-Related Flexible Services funds directly by completing the request form found online or by calling Customer Service. Care Coordination staff will work directly with members who request assistance completing forms and will perform outreach to members as needed to obtain information missing from member submitted requests.

II. Dissemination of Approved Health-Related Flexible Services for Members
   a. Reference Health-Related Services Global Procedure describing activities to ensure there are transparent and communication of alternative procedures to ensure successful receipt of approved items.

C. Subsection: Clinical Review Criteria for Health-Related Flexible Services:

I. Review of Health-Related Flexible Services requests for Members
   a. Once a request for HRS is made, it shall be first reviewed as a completed form, in a separate process from standard prior authorization process for Covered Services, by an appropriate team of reviewer(s) with the following criteria in mind:
      i. The member is eligible, determined whether they are or have active coverage as primary or secondary CareOregon Medicaid health plans
      ii. No other funding source is reasonably available to cover the cost of the service or item requested and primary care team has explored and exhausted all other options for potential payment of the requested items or services
   b. If a request does not pass first review, reviewers will respond to the requesting party indicating the requested item/service is incomplete and/or the member is not eligible for health-related services.

II. Items and/or service request thresholds, that meet the above stated policy and completeness criteria, shall be reviewed clinically or approved without clinical review shall include, but not limited to:
   a. Approved items/services without clinical review
      i. Non-housing related items $750 or under
      ii. Housing & Home Improvement related items
         1. Clean and sober housing for first two months
         2. Application fees
         3. First month's rent for Adult Foster Home and/or Residential Treatment Home, while being supported in applying for Social Security Income benefits
         4. Recuperative Care Program (RCP) bridge requests (beds are unavailable at the time of hospital discharge and approved authorization for RCP program admission)
      iii. Temporary approved related to declared state of emergencies (tied to public health agency and state moratoriums and guidance) as extraordinary circumstance exceptions
         1. Temporary housing requests that meet all of the below criteria:
            a. Individual members flagged as high risk for physical and/or behavioral health conditions that have been identified to be higher risk susceptibility to related declared state of emergency

b. Individual members cited as experiencing homelessness/houselessness

2. Transportation to essential services, not considered medical services, rendered through unique vendors and/or the Non-Emergent Medical Transportation Provider network.

b. Items/services requiring clinical review shall include, but not limited to:
   i. Non-housing related items $751 or above
   ii. All other requests for housing, home improvement items, out-of-area non-medical transportation, care coordination, and other items/services intended to improve care delivery and overall member and community health and well-being.

D. Subsection: Community Advisory Council Designated Role in Community Benefit Initiative spending decisions

I. CareOregon and its CCOs work with the priorities identified in the respective CHIPs to support community health improvements. Funding for these efforts are considered CBI when they meet the following definition as described in Section VI, as provided in OAR 410-141-3845.

II. CBI Funding decisions are made with the following criteria in mind:
   a. Alignment with current CHIP priorities
   b. Alignment with CCO or CO strategic priorities as defined by respective Board of Directors
   c. The Board of Directors may designate CBI funds for CAC authority. The CAC is to be the final decision authority on these funds. Decisions must include participation by the tribal representative or delegate.

E. Subsection: Monitoring of Health-Related Services Expenditures

I. CareOregon and its CCOs work across departments and lines of business to track, monitor and document health-related services expenditures as needed to submit financial reports to OHA and for potential future investment and/or CCO clinical strategies
   a. Refer to documentation of Flexible Service expenditures in the Health-Related Services Procedure
   b. Strategic Business Partnerships will partner across CareOregon CCOs and departments to support cost and utilization reports related to Flexible Service expenditures
   c. CareOregon CCOs will partner across CareOregon departments to support reporting approved through CAC and/or other CBI approved funding

II. CareOregon shall use the information described in Subsection E(I) above to analyze, as reasonably possible, the effectiveness of health-related services to improve healthcare quality and health outcomes

i. This analysis will be used to inform quality improvement efforts to better support targeted usage of HRS funds based on CCO and population needs

Ownership/Responsibilities

Responsible	Population Health Partnerships
Accountable	Chief Medical Officer and CCO Executive Leadership

Compliance Enforcement

Chief Medical Officer is responsible, in partnership with CCO Executive Leadership, to provide oversight and adherence of this policy

Regulations

OAR 410-141-3845 -
https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265554

Related

Bulk Purchasing Policy
Housing Sub-policy
Health Share of Oregon OPS 09 Health Related Services Policy
Health-Related Services Procedures

Title: Health-Related Services: Housing Sub-policy		Version: 3	Ref #: 741
Owner: Keshia Bigler (Director, Social Health)			
Approved by ELT/CEO: 08/25/2023	Effective Date: 04/10/2020	Next Review: 08/25/2025	
Applies to *(check all that apply)*: ☐ *Medicare* ☒ *Medicaid* ☐ *Housecall Providers* ☒ *CareOregon Corporate*			

Scope

All staff supporting members who express immediate social needs where no community resources exist

- Lines of Business: Medicaid – Columbia Pacific CCO, Jackson Care Connect, Health Share of Oregon
- In-house Benefit: Physical Health, Behavioral Health, Dental, NEMT
- Subcontractors and network providers

Purpose

To ensure Health-Related Services (HRS) are administered in a fair and equitable manner and compliant with CMS requirements and Oregon Health Authority (OHA) guidance, CareOregon has outlined guidelines that are intended to support managing Health-Related Services within any CareOregon subcontractor.

To ensure Health-Related Services (HRS) are administered in a fair and equitable manner and compliant with CMS requirements and Oregon Health Authority (OHA) guidance, CareOregon has outlined guidelines that are intended to support managing Health-Related Services within any CareOregon subcontractor.

For general guidelines applied across all Health-Related Service types, criteria, and general policy guidance, refer to global policy.

The following policy offers additional and specific guidelines to describe the requirements for qualified housing-related supports under Health-Related Services.

Housing-related services and supports are groups of specific interventions that must follow and comply with federal and state regulations, temporary lodging policies, and meet the individual's immediate social need.

This sub-policy is intended to clarify guidance on housing-related services that fall under the umbrella policy of HRS globally.

DEFINITIONS:

Action: OAR 410-141-0000	In the case of a Prepaid Health Plan or CCO: • The denial or limited authorization of a requested covered service, including the type or level of service. • The reduction, suspension or termination of a previously

	authorized service. • The denial in whole or in part of payment for a service. • The failure to provide services in a timely manner, as defined by Medical Assistance Program (MAP). The failure of a Prepaid Health Plan to act within the time frames as provided by 42 CFR 438.408(b). ("For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 30 days from the day the MCO or Prepaid Health Plan receives the grievance.")
Care Coordinators	a team-based position that coordinates care through state benefits and community resources. This position takes into consideration the global health of an individual given their physical, social, mental, and dental health needs and coordinates timely access and continuity of care to promote positive health outcomes
CareOregon Subcontractor	an entity that has entered into a contract with CareOregon or an affiliated CCO for the administration of the Oregon Health Plan Medicaid program.
Clinical Health-Related Services Review	review process for requested items and/or services within the Flexible Services guidelines that require an in-depth clinical review on behalf of an individual CareOregon member.
Community Benefit Initiative/ Health Related Services	means non-mandated state plan, non-covered health related services, also referred to as "other non-medical services." Be directed toward segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members
Covered Services	Medically appropriate health services described in ORS Chapter 414 and applicable administrative rules that the Legislature funds, based on the Prioritized List of Health Services
Discretionary Spending	Process of a CareOregon staff member and/or authorized subcontractors to purchase items and/or services within Flexible Services guidelines that do not require a clinical review, on behalf of an individual CareOregon member.
Grievance	A member's expression of dissatisfaction to CareOregon or a provider about any matter other than an Action
Health-Related Services	means non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-

	3845. Health-related services include flexible services and community benefit initiatives.
Homeless	Defined as living in housing that is below the minimum standard or lacks secure tenure.
Hotel:	an establishment providing temporary accommodations, meals, and other services for travelers or tourists
Houseless/ Houselessness	a condition of being without a house or home, the absence of safe and secure shelter
Housing-related supports	Services that aim to develop or sustain an individual's capacity and self-sufficiency to live independently or supportive in accommodations
Liability Waiver Form	form used to verify the identity and receipt of information on policy adherence and liability coverage. Responsible parties acknowledge and agree to follow temporary lodging policies.
Member	An Oregon Health Plan client assigned to CareOregon, enrolled in an affiliated coordinated care organization, dental care organizations, and/or behavioral health entity.
Motel	roadside hotel designed primarily for motorists, typically having rooms arranged in a low building with parking directly outside.
Primary Care Team	multidisciplinary group of health and social care professionals who work together and directly to deliver local accessible health and social services to CareOregon members via Physical, Behavioral, and/or Dental Health networks
Provider	An individual, facility, institution, corporate entity, or other organizations that supplies health services or items, also termed a rendering provider, or bills, obligates and receives reimbursement on behalf of a rendering provider, also termed a billing provider
QNXT	Web-based information services platform accessed through Internet Explorer that allows access to portals for Call Tracking, Utilization Management, and Member, Provider and Claims Portals for CareOregon members

POLICY

I. CareOregon supports HRS funding to be used for the benefit of current Medicaid members to promote health, prevent decompensation, divert from higher levels of care, assist in environmental stability, and increase independence from formalized services

II. HRS are defined as described in OAR 410-141-3500 and 410-141-3845

III. HRS may be used to pay for non-covered health care services including physical health, mental health, behavioral health, oral health, and tribal-based services that do not have billable and/or encounterable codes

IV. To qualify as a housing-related supports, an item and/or service must meet the requirements consistent with the Health-Related Services Flex global policy and federal regulations, 45 C.F.R. 158.150 and designed to achieve the following interventions:
    a. Crisis interventions are usually time-limited case management supports used in cases during which an individual's housing status is at risk, related to domestic violence, safety and their immediate health outcomes and acute conditions, that connect individuals and families to informal and formal community supports;
    b. Stabilization interventions are usually time-limited, and services are most intensive at the point when families and individuals exit homelessness and move into permanent housing, with the intention of improving their housing-related and self-sufficiency skills;
    c. Transitional supports are temporary accommodations and interventions that are intended to bridge the gap from homelessness to permanent housing by offering structure, supervision, support, life skills, and in some cases education and training

V. Housing-Related supports shall be primarily designed to meet at least one of the following goals:
    a. Improve health outcomes compared to a baseline and reduce health disparities among specified populations;
    b. Prevent avoidable hospital readmission through a comprehensive program for hospital discharge;
    c. Improve patient safety, reduce medical errors, and lower infection and mortality rates;
    d. Implement, promote, and increase wellness and health activities;
    e. Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities both above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.

VI. Housing-Related support requests provided to individual members shall be consistent with the Member's treatment plan as developed by the Member's primary care team. The primary care team, CareOregon provider, and/or community-based organization housing supportive program will work directly with the Member and, as appropriate the family of the member to determine what, if any, HRS will be effective as an alternative or adjunct to the Member's care.

Subsection A: Housing-related Support Request Criteria:

I. Items and/or service request thresholds, that meet the above stated policy and completeness criteria, shall be reviewed clinically or approved without clinical review shall include, but not limited to:
   a. Approved items/services without clinical review
      i. Housing Case Management (HCM) program, an internal Population Health Partnerships (PHP) program, has an allowance of $1000 per member per calendar year without clinical review to support pre-tenancy, tenancy sustaining, and medical legal partnership activities that support obtaining permanent housing-related supports. Individual and additional costs above $1000 will be sent for clinical review. Member must be referred and enrolled into HCM under their respective policies and procedures to qualify.
      ii. Housing & Home Improvement related items
         1. Clean and sober housing for first two months
         2. Application fees
         3. First month's rent for Adult Foster Home, Secure Residential Treatment Facilities and/or Residential Treatment Home, while being supported in applying for Social Security Income or entitlement program benefits
         4. Recuperative Care Program (RCP) bridge requests (beds are unavailable at the time of hospital discharge and approved authorization for RCP program admission)
         5. Furnishings through Community Warehouse, when requested by the Housing Case Management team
      iii. Temporary lodging approvals related to public health emergencies and other declared disasters as extraordinary circumstance exceptions
         1. Temporary housing requests that meet all of the below criteria:
            a. Individual members flagged as high risk for physical and/or behavioral health conditions that have been identified to be vulnerable to the emergency or disaster
            b. Individual members cited as experiencing homelessness or houselessness
            c. Individual members represented to live in congregate settings as applicable to the emergency or disaster

d. Requester has cited risk of negative health outcomes exacerbated by public health emergency or disaster in request form

2. Transportation to essential services, not considered medical services, rendered through unique vendors and/or the Non-Emergent Medical Transportation Provider network.

b. Items/services requiring clinical review shall include, but not limited to:
   i. HCM member requests that exceed the allowance of $1000
   ii. All other requests for housing, home improvement items, out-of-area non-medical transportation, care coordination, and other items/services intended to improve care delivery and overall member and community health and well-being.

Subsection B: Housing-related items that may qualify under HRS:

I. Long term housing supports; requests may require a housing support and crisis plan to be submitted prior to a review for approval/denial of any item in the list below
   a. Utilities fees and bills
      i. Natural Gas
      ii. Electricity
      iii. Water & Sewage
      iv. Internet or Voice services
   b. Pre-tenancy services
      i. Application fees
      ii. Identity document replacements
      iii. Move-in fees (security deposits, first month's rent, transportation needs, other lease/rental costs)
      iv. Cleaning-fees
   c. Tenancy-sustaining services
      i. Rental assistance for short term or one-time requests
      ii. Supportive items and/or services needed while developing a housing support and crisis plan
   d. Medical-legal partnership
      i. Support for individuals to resolve housing-related legal issues

II. Short term and/or temporary housing supports
   a. Hotels, motels, and/or shelters
   b. Members and requestors will be sent a liability waiver form upon receipt of a temporary housing request at a hotel or motel
   c. Member and requestors will be required to return the signed liability waiver form upon approval and coordination steps prior to checking in at a hotel or motel

Subsection C: Housing-related items that do not qualify as HRS:

I. Requests not associated with a crisis intervention, stabilization, and/or transition for a patient/member
    a. Ongoing temporary housing supports for hotels, motels and/or shelters for more than 6 cumulative weeks per calendar year
    b. Ongoing rental assistance for more than 6 cumulative months per calendar year
    c.

II. Requests not associated with a direct health benefit

III. Capital investments in brick-and-mortar-housing
    a. Direct funding development of new housing units

Subsection D: Temporary Housing Accommodations Limitation of Liability, Liability Waiver Form

I. After receiving a request for temporary housing accommodations, CareOregon will inform the requesting provider to communicate to the member, of the member's responsibility and liability for following local laws and the institution's policies if request is approved. CareOregon informs requesting provider an approval is for funding the room and board costs only and that their responsibility is to ensure the policy is explained to the member. The responsibility of verbal communication is held between the requesting provider and the member.

II. The policy statement shall outline: If the member violates a shelter, hotel or motel's policies through prohibited behaviors, negligence, or illegal acts and consequently are billed for damages or requested to leave the premises, CareOregon will not cover payment those costs and may discontinue the service (no replacement at a different location).

III. In accordance to the policies related to written outcome letters, once temporary housing accommodations have been approved, an adjunct statement written in accordance to readability standards, shall be sent to the member and requester informing of this liability and responsibility.

IV. Prior to checking in and completing registration, member will sign a Liability Waiver Form or requesting provider will attest to a verbal conversation and member's subsequent acknowledgement and agreement.

Ownership/Responsibilities

Strategic	Responsible for monitoring policy changes and updating guidance

Partnerships	and related departments
Clinical Operations	Responsible for executing this policy per daily operations
Chief Medical Officer	Accountable

Compliance Enforcement

Chief Medical Officer, in partnership with CCO Executive Leadership, are responsible for oversight and adherence to this policy.

Regulations

OAR 410-141-3845 - https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265554

Related

Health-Related Services Global Policy

OHSU Health IDS LLC		**Policy & Procedure**			
Company:	OHSU Health IDS LLC	**Committee Name:**		Clinical Value and Transformation	
Subject:	OHSU Health IDS Health-Related Services				
P&P Original Effective Date:	1/1/2020	**P&P Origination Date:**	1/1/2020	**P&P Published Date:**	1/1/2020
P&P Revision Effective Date:	10/27/2024	**P&P Revision Published Date:**		04/24/2024	
Reference Number:	CICP-105	**Next Review Date:**		04/2025	
Product (check all boxes applicable to this policy) ☒ Medical ☐ Pharmacy ☒ Behavioral Health					

I. Policy Statement and Purpose

OHSU Health IDS through the Care Integration and Coordination Program (CICP) oversees the Health-Related Services (HRS) and Health-Related Social Needs (HRSN) Programs. Health-related, non-State Plan services are intended to improve care delivery, Member health, and lower costs. Health-Related Services are sometimes called "Flexible Services."

The OHSU Health IDS Health-Related Services policy is consistent with Health Share of Oregon Health-Related Services Policy and Oregon Administrative Rules. This policy is focused on Health-Related Services. Health-Related Social Needs (HRSN) is addressed in a separate policy document - CICP-110.

II. Definitions

A. Community-Benefit Initiatives: Community-level interventions that include, but are not limited to, programs that are intended to develop a health community for Members that advocate and create health equity, and are focused on improving population health and health care quality through providing resources that combat social determinants of health. These types of interventions are not considered Flexible Services and may not be documented in a treatment plan or a clinical record.

B. Covered Services: Medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable Oregon Administrative Rules and the Prioritized List of Health Services above the funding line set by the Oregon Legislature. Covered Services include services that are (a) ancillary services; (b) diagnostic Services necessary to determine the existence, nature, or extent of the Member's disease, disorder, disability or condition; (c) necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K; and (d) necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Project.

C. Health-Related Services (HRS): Cost-effective services or items offered to Members to supplement Covered Services. These non-State Plan, non-Covered Services are provided instead of or as an adjunct to benefits and are intended to improve care delivery and overall Member and community health and well-being. Health-Related Services lack traditional billing or encounter codes, are not

encounterable, and cannot be reported for utilization purposes. Health-Related Services must meet the requirement for activities that improve health care quality, as defined in 45 CFR 158.150 and OAR 410-141-3845. Health-Related Services include Flexible Services and may include Community-Benefit Initiatives.

1. Only Services that are not billable (Covered or Non-covered) with medical, behavioral or oral health coding under the Oregon Health Plan (OHP) are eligible for reimbursement.
2. Health-Related Services are provided as a supplement to Covered Services.
3. Health-Related Services are intended to meet immediate social needs, stabilize crisis situations and support a sustainable plan for ongoing needs
4. Health-Related Services can only be used as the payor of last resort when other funding is not available.
5. Health-Related Services may be capped at a set funding amount, per item and/or annually per member or item requested. These details are included in the HRS Processing Guidelines.

D. Flexible Services: Cost-effective services or items offered to an individual Member to supplement Covered Services. These services may effectively treat or prevent physical, dental, or behavioral health conditions, improve health outcomes, and prevent or delay health deterioration.
   1. Flexible Services are consistent with the Member's treatment plan as developed by the Member's care team and documented in the Member's treatment plan and medical record (Care Profile) as specified in OAR 410-141-3845.
   2. Only Services that are not billable (Covered or Non-Covered) with medical, behavioral or dental health coding under the Oregon Health Plan (OHP) are eligible for reimbursement.

E. Member: An Oregon Health Plan (OHP) client enrolled with OHSU Health IDS through the Health Share of Oregon CCO contract.

III. Procedure

A. Health-Related Services are primarily designed to meet at least one of the following criteria:
   1. Improve health outcomes compared to a baseline and reduce health disparities among specified populations;
   2. Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;
   3. Improve patient safety, reduce medical errors and lower infection and mortality rates;
   4. Implement, promote, and increase wellness and health activities;
   5. Support expenditures related to health information technology and meaningful use requirements necessary to accomplish activities above that set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.

B. Key Elements for Health-Related Services are:
   1. In-lieu of traditional benefits, health-related, non-State Plan services are intended to improve care delivery, Member health and lower overall healthcare costs.
   2. Cost-effective alternatives to traditional services but cannot take the place of the covered service if the Member wants a medically necessary covered service.
   3. Based on evidence-based medicine; and/or widely accepted best clinical practice; and/or criteria issued by accreditation bodies, recognized professional medical associations, government association, or other national health care quality organizations.

4. A key lever for health system transformation, and include:
    a. Consistent with the Member treatment plan as developed by the Member's primary care team and documented in the electronic medical record (Care Profile);
    b. Likely to be cost-effective alternatives to covered benefits and likely to generate savings (return on the investment);
    c. Likely to improve health care outcomes compared to a baseline; reduce health disparities among specified populations; and prevent or delay health deterioration.

C. Health-Related services are considered in the context of the Member's overall integrated care planning and management by the primary care team, including the Member's behavioral and dental health.

D. Health-Related Services categories are consistent with the categories associated with those included in the Oregon Health Authority required reporting.

E. Health-Related Services policies and operational guidelines shall encourage transparency, provider and Member engagement, reflect streamlined administrative processes that do not create unnecessary barriers, and provide accountability.

F. Health-Related Services include but are not limited to – items listed here are for example only and may be approved if consistent and appropriate with the Member treatment plan, there is an identified clinical need, and there is an associated sustainability plan. These may include:
    1. Training and education for health improvement or management (e.g., classes on healthy meal preparation, diabetes self-management, etc.)
    2. Self-help support group activities (e.g., post-partum depression programs, Weight Watchers groups, etc.)
    3. Care coordination, navigation, or case management activities not covered under State Plan benefits (e.g., high utilizer intervention programs)
    4. Technology for communication/telehealth appointments
    5. Home/living environment items and/or improvements; non-DME items to improve mobility, access, hygiene, or other improvements to address a particular health condition (e.g., air conditioner, athletic shoes, or other special clothing, etc.). Items such as air conditioners or heaters requested will first be considered for HRSN benefit, prior to being considered for HRS funding, as noted in CICP-110.
    6. Transportation not covered under the State Plan benefits (e.g., transportation other than to a medical appointment)
    7. Programs to improve the general community health (e.g., farmer's markets, Farm to Family services, Meals on Wheels, etc.)
    8. Housing and related costs (e.g., clinically necessary bridge motel stays, short-term rental assistance related to a clinical need with an identified sustainability plan, shelters, utilities, critical repairs)
    9. Assistance with food or social services (e.g., supplemental food, referral to job training or social services, etc.).

G. Entities providing Health-Related Services are selected based on the overall needs of the Members; are established organizations within the local community; and have agreed to accept third-party payment for services rendered.
    1. Health-Related Service providers new to the community go through an interview process

with OHSU Health IDS or have been identified for engagement as a participating entity within the Connect Oregon (Unite Us) platform for service access and/or with Health Share of Oregon.

H. Participating providers are notified of the availability to request Health-Related Services for OHSU Health IDS Members through the OHSU Health IDS Provider Manual and the OHSU IDS website.

I. Participating providers and/or members of the primary care team may submit a request for Health-Related Services
    1. The Health-Related Services request form is available on the OHSU Health IDS website
    2. Members of the primary care team include, but are not limited to:
        a. Primary Care Provider
        b. Specialist Provider
        c. Care Manager – RN or Social Worker
        d. Inpatient Care Team members
        e. Agency Case Worker (e.g., Aging and Persons with Disabilities Case Worker)
        f. Other OHSU Health IDS delegated entities or persons (e.g., members of the Care Integration and Coordination Program staff).

J. Members may contact the OHSU Health IDS Customer Services department to request a Health-Related Services request is submitted on the Member's behalf. If the Member is receiving care coordination and/or care management services, the Member may also request the care coordinator/care manager submit a request.

K. All Health-Related Services requests are routed to the Care Integration and Coordination Program (CICP) HRS Coordinating Committee for review.
    1. Requests are reviewed by the CICP HRS Coordinating Committee and/or a delegated sub-committee of the HRS Coordinating Committee for consideration.
    2. If the Member has a care manager or a Community Outreach Specialist (COS) assigned, the care manager/COS will provide input into the request for consistency with the Member treatment/care plan.

L. Health-Related Services requests will be reviewed to ensure:
    1. Consistency with the Member treatment/care) plan and clearly related to achievement of a treatment goal as documented in the Member's treatment/care plan
    2. Consistency with those services identified as approvable under Health-Related Services, as outlined in the Definition section
    3. Items and services requested are not otherwise reimbursable by the Oregon Health Plan (e.g., meets Flexible Services criteria; are not reimbursable under the State K-Plan)
    4. When possible, the Member is consulted regarding:
        a. Availability of the item/service
        b. That there is no direct cost to the Member for the attainment and receipt of the service
        c. Any requirements for the Member to participate in obtaining or utilizing the item/service
        d. No other funding source is reasonably available to cover the cost of the service or item requested and provider/requester has explored and exhausted all other options for potential payment of the requested item or service, including community resources or services provided by external community partners (e.g., not reimbursable under the State K-Plan).

M. Health-Related Services/Flexible Services Request processing:
    1. Review request for a service that extends beyond the Member's benefit plan or for a service or supply that is not covered under the Member's covered benefits or other available sources
    2. Confirm Member eligibility as an active Member with OHSU Health IDS
    3. If the Member has not had a Basic Intake/Health Risk Assessment completed within the last calendar year prior to a HRS submission, this will be facilitated before the HRS request is considered
        a. If a request is for Recuperative Care Program (RCP),Novel Interventions in Children's Healthcare (NICH) or Leading emerging Adults in Understanding and Navigating Challenges in Healthcare (LAUNCH) services – a Care Manager will be assigned to also complete a General Assessment/High-Risk Screening
    4. Review information provided with the request to determine consistency with the Member's treatment plan and that the Member has a sustainability plan
    5. Determine if there is compelling documentation that the authorization of requested services would be cost effective and would improve the medical, dental or behavioral health status or treatment outcome of the Member
    6. Requests under a Chief Medical Officer (CMO) Standing Order may be processed without additional review
    7. Requests where it is uncertain that there is a sufficient return on the investment or whether the request is of benefit to the treatment plan will be referred to the Chief Medical Officer or their designee, for additional review and a determination
    8. Vendors identified to provide Health-Related Services must be willing to accept payment from a third-party
    9. If the Health-Related Services request is approved this decision is documented in the EPIC EMR (Member Care Profile) and a letter or Epic message will be sent to the requestor as to the determination
        a. This determination states what service or supply is being approved and includes the level of funding allowed
    10. Coordinate the acquisition of the approved item or service with the Member
    11. Ensure there is a follow-up with the Member regarding the Member's use of an item or service, and the effect the item or service has had on the Member's treatment plan
    12. If the Health-Related Services request is not approved this decision will be documented in the EPIC EMR (Member Care Profile); and a letter, Epic message or MyChart message will be sent to the requestor and the Member as to the determination within twenty (20) days of the decision including notice of the Member's right to initiate the Grievance process related to the non-approval.

N. There are no appeals or hearing rights for non-approval of Health-Related Services. Members may file a grievance by contacting the OHSU Health IDS Customer Service department.

O. Extreme Weather Events Outreach and Supports

1. In the event of an extreme weather event, Health Share will notify OHSU Health IDS of the need to outreach to Members at highest risk based on clinical condition, social risk factors, and/or environmental considerations during an extreme weather event.

2. Member Outreach will include inquiry as to the following:

a. Other health needs in addition to climate-related needs (e.g., pharmacy, DME, food, utilities and Non-emergency Medical Transport (NEMT)

b. Confirmation of the Member's safety plan, including Member access to power source/electricity (if required for the HRS item requested).

c. Discussion of installation needs for the requester service and/or supports and confirmation that the Member's home environment will support the requested item and/or whether additional services and/or supports may be needed

3. Outreach that results in a Member request for climate-related services and/or support will follow the standard process for review and determination for other Health-Related Services.

a. Members who have received climate support in previous years are not excluded from current or future climate support services. However, limitations in the frequency of when devices can be obtained may apply. Individual assessment and review of the request will be conducted in compliance with current HRS policy and guidelines.

b. OHSU Health IDS may require that the Member or their delegate be present at the time of delivery and/or installation of the requested service or support.

4. Devices that qualify under Health-Related Social Needs (HRSN) benefit will first be considered under the HRSN benefit before being considered for Health-Related Services as noted in CICP-110.

5. OHSU Health IDS shall document, and report as requested the following information to Health Share via the quarterly financial reporting. Health Share may request this information from OHSU Health IDS outside of the standard reporting schedule to satisfy urgent requests for recent data.

a. Mode of outreach to Members (e.g., mail, direct phone call, text message, other)

b. Number and percentage of individual Members reached through the climate outreach, reported for each mode of outreach utilized

c. Number of Members who were approved for a climate related service and/or support

d. Number of Members not included in outreach who were not approved a climate-related service and/or support

e. Number of each type of service and support provided (e.g., air conditioners, etc.)

P. Health-Related Services requests will be tracked for reporting purposes that includes information for reporting aggregate services and individual Member requests.
   1. Health-related Services expenditures are monitored and analyzed to identify how spending correlates to the effectiveness of the use of the Health-Related Service.
   2. Analysis of Health-Related Services will be completed annually to determine if changes in Health-Related Services policies should be revised.

Q. Exhibit L Reporting to Health Share will occur at least quarterly as instructed by Health Share.
   1. Reconciliation of Health-Related Service invoices and submission of Exhibit L on behalf of OHSU Health IDS will be managed by the Finance Program
   2. Exhibit L will report the following information:
      a. Expenditure/Health-Related Service investment name;
      b. Description of services provided;
      c. Health-Related Service category; and
      d. Rationale for the investment

R. Community Benefit Initiatives: HRS spending on Community Benefit Initiatives shall promote alignment with the priorities identified in the Health Share of Oregon Community Health Improvement Plan, and with any HRS community benefit initiative spending priorities identified by Oregon Health Authority. OHSU Health limits Community Benefit Initiatives to those related to Education and Research. OHSU Health IDS may consider HRS spending on Community Benefit Initiatives if in alignment with Program goals. The process for consideration is through a grant request approach under the OHSU Health IDS Quality Program. Funding for Community Benefit Initiatives are reviewed by the Board, which includes representatives from within the Community.

S. Program Monitoring
   CICP Leadership is responsible for establishing and conducting routine monitoring of the management of Health-related Services.

IV. Related Policies & Procedures, Forms and References

OAR 410-141-3845
CCO Contract – Exhibit K, Section 9.d-e

V. Revision Activity

New P&P/Change/Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
New Policy	OHSU IDS Clinical Value and Transformation	1/1/2020	1/1/2020
Revision to align with OHSU-IDS	OHSU Health Clinical Value and Transformation	3/17/2021	3/17/2021
Board Oversight-Consent Agenda	OHSU Health IDS Board of Directors	4/27/2021	3/17/2021
Revisions for required OHA contract language insertion and new section III P for Community Benefit Initiatives	OHSU Health IDS Clinical Value and Transformation Committee	10/27/2021	10/27/2021
Board Oversight Consent Agenda	OHSU Health IDS Board of Directors	12/9/2021	10/27/2021
Updates made to align with OARs and CCO contract requirements. Section I clarification this policy is for HRN and not HRSN. Section II, added HRS definition. SEction III, added clarification when the request is HRS vs. HRSN, how	OHSU Health IDS Clinical Value and Transformation Committe	04/24/2024	04/24/2024

HRS requests are received, timeframes for member communication, added procedures for extreme weather events outreach and supports Minor grammar updates for consistency made.			
Board Oversight-Consent Agenda	OHSU Health IDS Board of Directors	07/30/2024	04/24/2024

Policy and Procedure	
SUBJECT: **Oregon Health Plan Health Related Services**	DEPARTMENT: **CM – Care Management**
EFFECTIVE DATE: **01/01/2024**	ORIGINAL EFFECTIVE DATE: 01/2016 DATE(S) REVIEWED/REVISED: **03/17, 08/17, 05/18, 05/19, 11/19, 01/20, 12/20, 06/21, 12/21, 04/22, 10/22, 10/23, 07/24**
APPROVED BY:  **Greg Dietzman, VP Healthcare Operations, Transformation, & Advocacy Services**	NUMBER: **OHP CM 20** PAGE: **1 of 5**

SCOPE:
Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:
☒ Physical Health Care Management
☐ Behavioral Health Care Management where the Company is the Managed Care provider.

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange ☐ Oregon Off Exchange ☐ Washington Off Exchange	☐ Oregon On Exchange (SHOP) ☐ Oregon Off Exchange (SHOP)	☐ Oregon ☐ Washington	☐ ASO ☐ PBM	☐ Medicare	☒ Medicaid
☐ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:
The Company provides funds to be used for non-covered items and services including physical health, mental health, behavioral health, and oral health; here in after referred to as Health Related Services (HRS). The goal of HRS funds is to support members' treatment plan and care plan goals improving care delivery and overall member health and wellbeing while reducing avoidable utilization as a result of health disparities. HRS include flexible services, which are cost-effective services offered as an adjunct to covered benefits, and community benefit initiatives, which are community-level interventions focused on improving population health and health care quality. HRS funding aligns with and supports a member's treatment plan as developed by the member's care team and documented in the member's medical record as specified in OAR 410-141-3845.

The Company will provide HRS to its Oregon Health Plan (OHP) members following Oregon Health Authority (OHA) guidance. The Company will fund HRS from the global budget and

will ensure that allocations conform to all applicable rules and regulations for Medicaid expenditures.

The Company will submit their financial reporting for HRS expenditures as directed through the CCO contract.

The Company promotes transparency of HRS by posting information on examples of what the funds can be used for, and how to request the funds. Accessibility to HRS funds is achieved by informing practitioners about the availability of HRS funds. Members can also call customer service, reach out to their Care Team, or contact their primary care provider (PCP). The Company website notes how to access free language assistance and interpreter services. The company educates Community-Based Organizations about HRS and how to assist members to access them. The Company's Care Management and Customer Service teams are provided with HRS process training.

PROCEDURE:

I. Guidelines for Administering HRS:
   a. Items and services purchased must not be otherwise Medicaid reimbursable.
   b. HRS funds are used when no other funding source is available to cover the cost of the service or items purchased. HRS funds are the payer of last resort.
   c. All services provided must be clearly related to achieve a treatment goal in alignment with the member's care plan and documented as such in the Care Plan.
   d. All services provided must:
      i. Be designed to improve health quality.
      ii. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and produce verifiable results and achievements.
      iii. Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non- members.
      iv. Be grounded in evidence-based medicine, widely accepted best clinical-practice, or criteria issued by accreditation bodies, recognized professional medical associations, government agencies or other national health care quality organizations.
      v. Be designed to achieve at least one of the following goals: improve health outcomes, prevent avoidable hospital admissions, improve patient safety, implement, promote, and increase wellness and health activities, and support expenditures related to health information technology.

II. Requesting Funds for HRS:

a. Funding requests for HRS are processed through the Company's Care Management Department.
b. Members can request HRS by calling customer service, reaching out to their Care Team, or contacting their PCP.
c. Any participating primary care clinic, specialty practitioner, or care team member must request the use of HRS funding through Company Care Management via phone, email, or online form. A care team member requesting or providing HRS can be both clinical and non-clinical.
d. Prior to requesting HRS funding, the requestor must verify there is no reimbursed clinical services associated with the request, and that the requested service is not otherwise being provided by Health Share of Oregon Behavioral or Dental Health carrier or any other community resource.
    i. Requests for HRS related to oral or behavioral care are coordinated with the assigned Behavioral or Dental carrier.
e. If the request can be reimbursed as a clinical service, the requestor should submit the request through the existing prior authorization process.
f. The company has a $1500 per member per calendar year maximum.
g. Unless otherwise restricted by purchasing card (P-Card) protocol, each transaction may be limited to not exceed and be reviewed by:
    i. Up to $500 approved by HRS Team Lead(s)
    ii. $501-$1500 approved by Clinical Program Manager, Manager or Director
    iii. Single requests >$1500 or requests above the $1500 maximum per calendar year must be reviewed by Company Director or Medical Director for funding exception consideration.
        1. P-Card use is approved by the Company's Care Management Manager or Director. P-Card training is mandatory for all holding a card in their name and purchases are monitored monthly.
        2. After requesting, confirmation of delivery or payment can be obtained from Project Access Now.

III. Documentation Requirements
a. The Company must document all HRS provided, including member(s) served, services provided and associated costs.
b. Care Management provides HRS funding with Company P-Card(s), 3rd party to provide HRS directly to members, or through Project Access Now.
c. Care Management caregivers document all HRS requests, whether approved or not, in the medical management platform. A decision is rendered and documented within five business days of when a request is considered a complete request. Requests received that

do not meet the required documentation are considered incomplete requests and do not apply to the decision timeframe. Notification to the requester outlining deficient elements or required documentation is sent with instructions to resubmit, restarting the decision timeframe.

d. Care Management caregivers provide notification of the request outcome, written at a 6.9 grade level or below, to the requesting practitioner and member (or member representative) within three business days of when a request is considered a complete request. The notification will include the member's right to file a grievance and the process by which they may do so.
e. Oversight of HRS spending is performed by Care Management to ensure funds are used to purchase items align with this policy, including tracking funds spent on each member for repeat requestors.

IV. Financial Reporting Requirements
   a. All HRS provided directly by the Company are reported to Health Share of Oregon quarterly through Exhibit L (L6, line 17, L6.21 and L6.22)
   b. Purchases made using a P-Card must be attributed to the Company Health Related Services account, to ensure proper reporting of funds.
   c. Report L6.21 is intended to be used to track the costs of goods and services provided under the member expense line by category (this information is not collected on a claim form). The required data elements include category of items or services as outlined below, number of members receiving HRS, and cost of services. The total amount of L6.21 should directly tie to Report L6, line 17.
   d. Report L6.21 and L6.22 are typically due each quarter on the 15th day of the month after the close of the quarter. It is intended to be used to provide details of HRS. The required data elements include expenditure/HRS investment name, HRS category, amount incurred, description of rationale for the HRS investment, and length of investment.
   e. The Company uses the information above to analyze the effectiveness, as possible, of HRS on reduction of medical costs and opportunities for optimizing the use of HRS.
   f. L6.21 categories for HRS:
      i. Care coordination, navigation, or case management activities not otherwise covered under State Plan benefits, including Traditional Health Workers.
      ii. Education for health improvement or education supports, including those related to Social Determinants of Health and Equity (SDOH-E).
      iii. Food services and supports, including those related to SDOH-E.
      iv. Housing services and supports, including those related to SDOH-E.
      v. Items for the living environment, not otherwise covered under 1915 Home and Community Based Services, to support a particular health condition.

vi. Transportation services and supports, including those related to SDOH-E, not otherwise covered under the State Plan.
vii. Trauma informed services and supports across sectors, including those related to SDOH-E.
viii. Other non-covered clinical services and improvements.
ix. Other non-covered social and community health services and supports.

REFERENCES:

1. Health Share of Oregon/Providence Health Assurance Contract Health Share of Oregon/Oregon Health Authority Contract
2. Oregon Health Plan Health Related Funds Request Form
3. Oregon Administrative Rules 410-120-0000, 410-141-3500, 410-141-3845
4. 45 CFR 158.150
5. 45 CFR 158.1

Health Related Services

LOB(s):	State(s):
☐ *Commercial* ☐ *Medicare*	☐ *Idaho* ☐ *Montana* ☐ *Oregon* ☐ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon* ☐ *Washington*

Medicaid Policy

Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Guideline only applies to PacificSource Community Solutions in Oregon. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Guidelines do not constitute medical advice nor guarantee coverage.

Background

The following policy and procedures apply to all PacificSource Community Solutions (PCS) CCOs (Central Oregon, Columbia Gorge, Marion-Polk, and Lane) and the Integrated Delivery System in the Portland-Metro region under Health Share of Oregon.

PCS provides Health Related Services (HRS) to members, which are non-covered services under Oregon's Medicaid Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-3845. HRS includes Flexible Services (FS) and Community Benefit Initiatives (CBI). HRS are intended to improve health delivery and member health and to lower costs. HRS are likely to be cost-effective alternatives to covered benefits and are likely to generate savings. FS are cost-effective services offered as a supplement to covered benefits; they are consistent with a member's treatment plan as developed by the member's care team and documented in the member's medical record. CBI are community level interventions that include members, but are not necessarily limited to only members, and are focused on improving population health and health care quality. Health Information Technology (HIT) is a sub-category of CBI. HRS lack traditional billing or encounter codes, are not encounterable, and cannot be reported for utilization purposes. HRS may be used to pay for non-covered services, including physical health, behavioral health, oral health, and tribal-based services on a limited and case-by-case basis, in accordance with OAR 410-141-3845. Any community health related services provider is eligible to request and provide HRS to PCS members following the procedures outlined below.

To qualify as an HRS services, the service must meet the following requirements, consistent with 45 CFR §158.150:

- The services must be designed to improve health quality, increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce

verifiable results and achievements, be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members;

- Be based on any of the following: evidence-based medicine, widely accepted best clinical practice, or criteria used by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

The services must be primarily designed to achieve at least one of the following goals:

- Improve health outcomes compared to a baseline and reduce health disparities among specified populations;
- Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge~~;~~
- Improve patient safety, reduce medical errors, and lower infection and mortality rates~~;~~
- Implement, promote, and increase wellness and health activities;
- Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR 158. 151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.

1. Engagement

a. Requests for FS may come from a variety of sources (e.g., a primary care team member, a PCS member, HRS team member, an internal Member Support Specialist or Nurse Case Manager) by e-mail, fax, mail, and referral through Connect Oregon. PCS has a standard form that can be used to submit requests. The request form offers providers, PCS members, and community partners the option to have the form sent in another language and/or larger font. PCS ensures that the form is accessible to the Community Advisory Council (CAC) and Clinical Advisory Panel (CAP)/Provider Engagement Panel (PEP), which serves as a liaison between PCS and its provider community. PCS also ensures that providers are updated and informed about the accessibility of the form and this Policy during routine provider workshops and provider newsletters. The request form in English and Spanish can also be found on the PCS's webpage or members, providers, and community partners can request by phone or e-mail that the request form be e-mailed or mailed to them directly. Translation services are also available. PCS members and primary care teams will be engaged in all requests during both the intake process and in fulfillment. PCS will use the same process of engagement with members and primary care teams, regardless of the source of the request (e.g., from a PCS member, primary care team member, or other health related services provider). PCS personnel work closely with the primary care team (using direct outreach or secure messaging, as applicable) to evaluate requests pursuant to the criteria set forth below. In addition, PCS distributes information to the primary care team as discussed below under "Data Collection and Tracking Reporting Plan" and "Fulfillment."

b. CBI funds are included in PCS' global budget on an annual basis and apportioned for both CAC and Tribe decision making. Each CCO region has an annual CBI budget approved by both the Regional Health Council Board of Directors, which are the CCOs' governing boards, and PacificSource Board of Directors. The CAC decides the allocations for seventy-five (75%) of the CBI funds. This allocation and subsequent CBI decision making is delegated to each

Regional Health Council which holds its own regional policy that is approved by its Board of Directors. Twenty-five percent (25%) of each CCO's CBI budget are earmarked for Tribal decision making, pooled, and then equally distributed to the seven federally recognized Tribes in PCS' four CCO service areas who opt in for participation. PCS' Tribal Liaison will assist the Tribes with decision making, distribution of funds, and CCO CBI reporting. The Regional Health Council or Tribal Liaison, via the Tribe, may decide to deploy a Request for Proposals. The process adopted by the regional Health Councils is transparent, rooted in public meetings, and accessible to all community-based organizations submitting proposals which meet all CBI requirements. The regional Health Councils provide technical assistance to requestors, as needed. Each regional Health Council operates under its Board of Directors approved policies. CAC's and Tribes will evaluate CBI requests to determine feasibility, population impact, and evidence supporting the initiative, as well as alignment with the Community Health Improvement Plan and/or Regional Health Improvement Plan. Communication regarding the evaluation of the CBI requests will be distributed to the CAC or Tribe. The CAC and Tribes will advise PCS on what initiatives should be funded, and at what amount, although their recommendation will not be binding. PCS or the Regional Health Council will ask Tribal or CAC members that represent community-based organizations to identify potential conflicts of interest and to recuse themselves from decisions that may favor their own organizations. If required by the OHA, CBI spending will also be aligned with a designated statewide priority area. By November of each contract year, the Regional Health Councils will determine its annual CBI allocation plans, with approval by the CAC and Regional Health Council Board of Directors. By November of each contract year, the Tribes will determine its annual CBI allocation plans, with approval by the PCS Tribal Liaison. PCS will collaborate with Health Councils and Tribes to administer CBI funds, per each entity's annual allocation plan, and ensure all CBI funds spent are accurately recorded per Exhibit L reporting requirements. All CBI funds will be spent by December 31st of each contract year. PCS will annually conduct an analysis of how CBI spending correlates to the effectiveness and efficiency of the program and determine any potential impact reflected in this policy.

c. HIT investments will be determined internally but in collaboration and coordination with Health Councils and other community partners.

d. When necessary, a Medicaid actuary will be consulted to determine which type of benefit a Request is and advise on reporting considerations.

2. Providers

A primary care team member or other provider outside of the primary care team may request and coordinate FS. Any community health related services provider is eligible to request and provide Health Related Services to PCS members.

3. Members

Members may request FS using the form on our member website or by calling PacificSource. If the member initiates a request, PCS will follow-up with the submitter to obtain medical necessity information to process the request. If legible, PCS will accept handwritten requests from their members.

4. Capture Services

Requests for HRS will be collected in the Review Queue. All FS requests will be captured within the PCS member's clinical record in the internal medical management system (which is available across all PCS CCO and visible inter-departmentally).

5. Decision Making

The Procedures set forth below provide for efficient decision-making processes that are separate from PCS's prior authorization protocols.

a. The HRS team has the authority to cancel FS requests for various reasons, including, but not limited to:

- **i.** Forms that are incomplete
- **ii.** Item or service has a traditional billing code that is covered through the Medicaid plan
- **iii.** Request was previously denied with no new information
- **iv.** Items not consistent with OHAs definition of Flexible Services
- **v.** Membership based services
- **vi.** Is not a PCS member
- **vii.** After three attempts were made to obtain information within a reasonable timeframe without response.

6. Community Resources

PCS shall provide a generalized report to the CAC, and other Health Council bodies as needed, on disbursements made pursuant to this Policy. The CAC has at least quarterly meetings open to members of the public. Community partners may engage in this and other forums to learn about the disbursements made pursuant to this Policy, as well as provide public comment pursuant to applicable agendas. PCS and community stakeholders will review reports as consideration of community resources and in coordination with community partners. Because member-level detail may not be shared during the CAC meetings, PCS personnel will examine member-level detail to determine whether any opportunities exist to better consider community resources or coordinate with community partners.

7. Data Collection and Tracking Reporting Plan

All FS decisions will be transmitted to the PCS member. Requesting providers will be expected to include the FS information into the PCS member's external clinical record. PCS will regularly track and report all requests and decisions in the internal medical management system.

8. State Plan Service

A member's request to have an approved state plan service rather than a Health-Related Service will be honored when medically necessary.

9. Range of HRS; Consideration

This Policy does not limit the range on types of requests for HRS (individually, the "Request," and collectively, the "Requests") that will be considered. PCS will consider any Request received for HRS.

10. Written Outcome

PCS will provide to members a written outcome regarding refusal of requests for FS. The written outcome will be copied to any representative of the member and any provider who made or participated in the request on the member's behalf. Written outcomes offer providers, PCS members, and community partners the option to have the letter sent in another language and/or larger font. Cancelled requests do not require written documentation of outcome.

11. Grievance

The written outcome will inform the member and any provider of the member's right to file a grievance in response to the outcome. Outcomes are subject to the grievance provisions of OAR 410-141-3835 through 410-141-3915 and Exhibit I of the CCO contract. A HRS outcome is not an "adverse benefit determination" within the meaning of OAR 410-141-3875.

12. Appeals

Members have no appeal or hearing rights for a refusal of a request for HRS.

Procedure

1. Operations

PCS will follow these procedures in operationalizing the Policy:

a. Cost Center. PCS has created an HRS line item within the Health Services Budget. PCS has created a cost center code for each individual CCO for tracking disbursements from these accounts. During its annual budget setting process or on an intermittent basis, PCS shall use its discretion to determine how much money to allocate to HRS during any budget year.

b. PCS Personnel; Committee:

i. Each HRS team member may expend up to $2500 per member per month to grant Requests. Any expenditures requiring a check must be approved in OnBase pursuant to PCS's Disbursement Level Policy and Procedures.

ii. .

iii. In the event a HRS team member receives a request or generates a need for FS funds that exceeds $2,500, that team member shall bring the request to the HRS Committee (See below). The Committee shall have up to 60 days to make a decision about a Request unless there are provider delays and pending documentation.

iv. A HRS Committee is convened as needed to oversee the program and to review requests for Flex Services requests. This committee is comprised of HRS Leadership, the Medicaid Medical Director, the Directors and Community Health Coordinators of Central Oregon, Columbia Gorge, Lane, Marion-Polk, and Portland Legacy Health Share CCOs/IDS, the Director of Case Management, Managers of Case Management of the five CCO/IDS regions, and at least one HRS team member with primary responsibility for the HRS program.

2. Intake

PCS will review HRS requests transmitted to healthrelatedservices@pacificsource.com, faxed to 541-322-6435 or Connect Oregon referral. If a member requires verbal submission, PCS staff will assist the member.

3. Review Criteria

PCS may fund a Request that fulfills the following criteria:

a. Definition. The Request meets the definition of HRS set forth above. Specifically, the Request is intended to improve health delivery, member health, and lower costs, HRS may be used to pay for non-covered services, including physical health, behavioral health, oral health, and tribal-based services on a limited and case-by-case basis, in accordance with OAR 410-141-3845.

b. Efficient and Cost Effective. The Request will efficiently and effectively reduce costs and improve care. PCS reserves the right to determine the cost effectiveness of items/services requested.

c. Treatment Plan. For FS requests, the Request is consistent with the member's treatment plan, as developed by the member's care team and agreed to by PCS.

d. Effective Alternative. For FS requests, the Request is effective as an alternative in the member's care. PCS will work with the member and, as appropriate, the family of the member in determining whether the Request is effective as an alternative.

e. Documentation. For FS Requests, the Request may be documented in the internal medical management system and Exhibit L for financial reporting purposes.

f. Evidence-Based- The request is consistent with evidence-based medicine practices and produces objective results in increasing desired health outcomes.

g. Last resort- PCS Flexible Services is the payer of last resort.

4. Fulfillment

In the event that PCS elects to fulfill a FS Request, PCS will follow these steps:

a. Disbursement. PCS may disburse funds to the member's care team to fulfill the Request, or PCS may fulfill the Request itself. Depending on the Request, PCS may work directly with a community partner to coordinate other community resources in conjunction with the Request. In no case will PCS disburse funds or reimburse the member directly.

b. Documentation. PCS must document how the FS disbursement is consistent with the member's treatment plan(s). In addition, the HRS team member must document the FS disbursement in the internal medical management system

c. Accountability. PCS is accountable to ensure that funds disbursed to fulfill the approved Requestor purchase the Flexible Service item/service designated in the Request. In the event that PCS elects to fulfill a CBI, PCS will disburse funds in a block amount and will require quarterly reporting from the entity with the following information:

i. Number of individuals serviced

ii. Funds expended

d. Monitoring. The HRS Committee will convene an annual review in January to discuss the HRS procedures and processes, along with the effectiveness and impact of the previous

year's requests. The committee will review each PCS region spending, identify the greatest need from data in OnBase, and determine if specific items and/or services meet the specific HRS guidelines with the evidence-based case studies the HRS team member provided upon initial decision making. Additional follow up with members may be done upon committee request. In addition to monitoring for compliance, the committee will also measure effectiveness and inform quality improvement efforts. Should areas for improvement be identified, the committee will determine next steps to evaluating the area of concern utilizing techniques such as root cause analysis and PDSA cycles. Additionally, for CBI specific investments, the Regional Health Councils and Tribes will review quantitative and qualitative outcome data from programs that have received funding to measure effectiveness and inform quality improvement efforts.

5. **Validation**

After fulfilling a FS Request, PCS will validate that no cost-sharing is required, and no administrative burden is placed on the member. PCS ensures that Medicaid is the payer of last resort.

Appendix

Policy Number:

Effective: 1/1/2016 **Next review:** 11/1/2024

Policy type: Government

Author(s): Leslie Neugebauer, Jamie Cosci, Debbie Montez, Polly Watt-Geier

Depts.: Health Services; Administration

Applicable regulation(s): CCO Contract Deliverable

Government OPs: 2/2024

Approved by OHA: 10/31/2023

Modification History

Date	Modified By	Reviewed By	Modifications
9/6/2024	T. Wilder D. Montez		Updated HRS guideline language for second bullet on page two to align with December 2023 OHA HRS Guidance FAQ.
1/25/2024	D. Montez P. Watt-Geier	PNP Committee Miriam McDonell, MD Amy Strachan, MD	Updated language throughout policy to align with OHA Deliverable requirements. OHA approved policy changes on 10/31/2023. Approved as part of consent agenda.
4/20/2023	P. Watt-Geier	PNP Committee Miriam McDonell, MD Jeffrey Davis, MD	OHA approved the policy on 11/07/2022. Updated Appendix. Approved as part of consent agenda.
9/22/2022	P. Watt-Geier	PNP Committee Justin Montoya, MD Bhavesh Rajani, MD	Approved as part of consent agenda.
9/07/2022	D. Montez P. Watt-Geier	PNP Subcommittee Justin Montoya, MD Jeffrey Davis, MD	Updated policy LOB header. No content changes. Updated appendix: next review date and Government OPs. Resubmitted to OHA for approval on 9/1/2022. Approved for consent agenda.
4/28/2022	P. Watt-Geier	PnP Committee Miriam McDonell, MD Justin Montoya, MD	OHA approved the policy on 1/19/2022. Placed approved policy into approved template format.
12/29/2021	L. Neugebauer K. Arteaga	J. Sayers S. Gascon	Updated to satisfy revised OHA evaluation requirements.
12/09/2021	P. Watt-Geier	David Stenstrom, MD Alison Little, MD	No changes on annual review. Waiting for OHA approval. Policy will be updated once PCS receives OHA approval of updates.
10/22/2021; 10/29/2021	L. Neugebauer K. Arteaga	J. Sayers S. Gascon	Updated to satisfy revised OHA evaluation requirements.
3/11/2021	K. Pittman	Justin Montoya, MD	Approved as written
2/17/2021	Katie Arteaga, Leslie Neugebauer	David Pringle Scott Gascon Jessica Sayers	Updated policy to satisfy OHA requirements as a result of their policy evaluation.
12/7/2020	Katie Arteaga	Alison Little Jaime Cosci Jana Halligan Leslie Neugebauer Jessica Sayers	Added that Non-covered items with a billable code may be considered on a limited and case by case basis; Added additional cancellation reason for Member Support Specialist - is not a PCS member; Removed Nurse Case Manager from PCS personnel; Committee under Operations; Updated Health Related Services Committee attendees and the 5 CCO/IDS regions; Added fax number; Deleted #7 in its entirety; Edited CBI process; Added HIT elements and process.
10/07/2019	Alison Little, MD	Jessica Sayers	Modified to add clarifying language.
4/09/2019	L. LaFerriere Alison Little, MD	Alison Little, MD	Added to #4 Decision Making: The Member Support Specialist has the authority to reject requests for various reasons, including but not limited to: forms that are incomplete, no PCP approval service has a traditional billing code, request was previously rejected by medical director

3/05/2018	Alison Little, MD	Leslie Neugebauer Lindsey Hopper Devona Tafalla	Major edits to capture revised OHA policy and renaming of program. Process split to separate FS and Community Benefit Initiatives. Renamed.
3/20/2017	Leslie Neugebauer	Alison Little, MD Patricia Gardner Jane Hannabach Lindsey Hopper	Made minor edits in Track Changes.
2/05/2016	Lindsey Hopper Leslie Neugebauer	Jill Alessi; Jane Hannabach; Alison Little	New P&P