Health Related Services

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

Medicaid Policy

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, 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 PCS 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. 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 Oregon Health Authority (OHA), CBI spending will also be aligned with a designated statewide priority area. By November of each contract year, the Health Councils will determine its annual CBI allocation plans, with approval by the CAC and 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 HRS provider is eligible to request and provide HRS to PCS members.

3. Members

Members may request FS using the form on our member website or by calling our HRS team. If the member initiates a request, PCS will follow-up with the servicing provider 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 Member Support Specialist 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 FS
    v. Membership based services
    vi. Is not a PCS member

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 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 Member Support Specialist may expend up to $500 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. In the event a Member Support Specialist receives a request or generates a need for FS funds that exceeds $500, but is not greater than $1,500, that individual shall bring the request along with an evidence-based case study to the FS Team Lead for approval or denial. The Team Lead's decision is not subject to review or appeal.

iii. In the event a Member Support Specialist receives a request or generates a need for FS funds between $1,500 and $2,500, that individual shall bring the request to the Case Management Manager.

iv. In the event a Member Support Specialist receives a request or generates a need for FS funds that exceeds $2,500, that individual 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.

v. A HRS Committee is convened as needed to oversee the program and to review requests for FS requests. This committee is comprised of 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 Member Support Specialist 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, a member of the Care Management team 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-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 Effective. The Request will efficiently and effectively reduce costs and improve care.

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.

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 to the member.

b. Documentation. PCS must document how the FS disbursement is consistent with the member's treatment plan(s). In addition, the Member Support Specialist or Nurse Case Manager must document the FS disbursement in the internal medical management system or transmit such documentation to the member's primary care provider as well as the requesting provider (e.g., behavioral health, dentist, etc.) for inclusion in the member's health record.

c. Accountability. PCS is accountable to ensure that funds disbursed to fulfill the Request, purchase the FS 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 Member Support Specialists 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:** 10/1/2023

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: 4/2023

Approved by OHA: 11/07/2022

Modification History

Date	Modified By	Reviewed By	Modifications
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