Health-Related Services Frequently Asked Questions

August 2018

CCOs receive a global payment for each member, which provides CCOs with the flexibility to offer health-related services (HRS) to improve the health of Oregon’s Medicaid population. Further, under Oregon’s approved 1115 Medicaid demonstration waiver for 2017-2022, OHA continued its commitment to promote CCOs’ use of HRS to achieve the triple aim of better health, better quality and lower costs for all Oregonians.

Below are responses to frequently asked questions (FAQ) about health-related services. This FAQ will be updated as additional questions are addressed.

**Note:** All resources referenced below are listed at the end of this document and posted to the Transformation Center website: [http://www.oregon.gov/oha/HPA/CSI-TC/Pages/Health-Related-Services.aspx](http://www.oregon.gov/oha/HPA/CSI-TC/Pages/Health-Related-Services.aspx). This document expands upon the Health-Related Services Brief, which defines health-related services, describes examples of health-related services used among CCOs, and explains how OHA incorporates health-related services into CCO payments. Additional questions can be emailed to Health.RelatedServices@dhsoha.state.or.us.

1. **What are the criteria for being considered health-related services (HRS)?**

2. **Under OAR 410-141-3150(5)(c), there is an exclusion from health-related services (HRS) for services “that may be billed or allocated by a provider for care delivery and that are, therefore, reimbursed as clinical services.” If a service (such as health education or exercise or nutrition classes) is provided in such a way that it cannot be billed using standard medical billing (for example, 837, CMS-1500, UB-02) or is not provided by a licensed provider, can it be an HRS?**

3. **How do health-related services (HRS) intersect with the Prioritized List? Can something be covered as an HRS that was denied (for example, because it is below the funding line, is cosmetic or experimental; doesn’t follow a Health Evidence Review Commission (HERC) guideline; or is not medically necessary/appropriate)?**

4. **Can community-based activities such as supporting a farmers market in a “food desert” be supported with health-related services (HRS)?**

5. **Can CCOs rely on published studies to support the use of health-related services (HRS), or will CCOs be expected to provide organization- and population-specific data?**

6. **What is an example of a CCO’s process to determine whether a service can be a health-related service (HRS) and demonstrate evidence-based criteria?**
1. **What are the criteria for being considered health-related services (HRS)?**

CCOs should refer to the criteria defined under Oregon Administrative Rules (OARs) [410-141-3000](https://www.oregon.gov/cedar/Regulations/OSB/Pages/default.aspx) and [410-141-3150](https://www.oregon.gov/cedar/Regulations/OSB/Pages/default.aspx) and Code of Federal Regulations (CFRs) [45 CFR 158.150](https://www.codexfed.gov/cfr/2019/cfr_45.html#158.150) and [45 CFR 158.151](https://www.codexfed.gov/cfr/2019/cfr_45.html#158.151).

Specifically, to be considered an HRS, a service must meet the following criteria:

- Be designed to improve health quality;
- Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and produce verifiable results and achievements;
- Be directed toward either individuals or segments of enrollee populations, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and

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7. **Are there exclusions to the activities that can be counted as a health-related service (HRS)?**

8. **Will spending on health-related services (HRS) be considered in rate development?**

9. **What housing-related services can be covered using dollars that will be considered in rate development?**

10. **Can health-related services (HRS) be used to address social determinants of health and health equity?**

11. **What are CCO reporting requirements for health-related services (HRS) investments?**

12. **What are some categories of health-related services (HRS) commonly used by CCOs?**

13. **Must the member’s primary care provider or clinician approve a flexible service? Is it a requirement to have consistency between the health-related service (HRS) and the member’s treatment plan?**

14. **Will medical loss ratio reporting (MLR) be modified given the language in the health-related services (HRS) brief around MLR calculation?**

15. **How are health-related services (HRS) considered within the medical loss ratio (MLR) calculation compared to rate development?**

16. **Can CCOs expect any limiting factors and/or credibility adjustments due to CCO size in the consideration of health-related services (HRS) in their rates?**

17. **What is a CCO’s responsibility to a member when health-related services (HRS) are requested?**

18. **Can CCOs use health-related services (HRS) for advertising, corporate sponsorships, or other activities that are not listed in the OAR 410-141-3150?**

19. **Can capital investments in new buildings for providing medical or imaging services to be considered health-related services (HRS)?**
• 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.

In addition, the HRS must meet at least one of the following criteria:
• 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 laid out in 45 CFR 158.151, which promote clinic community linkage and/or referral processes or support other activities as defined in 45 CFR 158.150.

2. Under OAR 410-141-3150(5)(c), there is an exclusion from health-related services (HRS) for services “that may be billed or allocated by a provider for care delivery and that are, therefore, reimbursed as clinical services.” If a service (such as health education or exercise or nutrition classes) is provided in such a way that it cannot be billed using standard medical billing (for example, 837, CMS-1500, UB-02) or is not provided by a licensed provider, can it be an HRS?

Yes. If the service meets the other criteria under OAR 410-141-3150, it can be an HRS, even if a similar service might be a covered service if billed using standard medical billing by a licensed provider enrolled with OHP. In general, services billed by licensed, enrolled providers using HIPAA-compliant claims are medical services (whether covered or not), instead of being counted as HRS. Examples (also see Table 1):

1. A CCO gives Dr. Sanchez a stack of yoga punch cards (purchased with HRS money) for members who come in with high-risk back pain. Dr. Sanchez gives one to Sue, a CCO member, who has back pain. She uses it to attend a group exercise class that would meet the definition of S9451 (HCPCS billing code). However, since the yoga studio doesn’t operate under clinical supervision, has no National Provider Identification (NPI), doesn’t provide or deal with diagnosis codes, per se, and is not enrolled as a Medicaid provider, the yoga class cannot be a covered (encounterable) medical service. This can be an HRS.

2. A CCO contracts with an unlicensed yoga instructor to offer a yoga class in a local community center. The instructor is not supervised by a clinician and the class is free to anyone, but CCO members have priority (meeting the requirement in OAR 410-141-3150(1)(c) that there’s no extra cost to offer to non-CCO members) and there is a 20-person limit per class. It’s not a covered service because there’s no way for the instructor to bill it. There is no NPI, no diagnosis, and the instructor doesn’t create medical claims even though there would be a procedure code. This can be an HRS.

3. A CCO contracts with a clinic, which is a Patient-Centered Primary Care Home. One of the clinic’s employees offers a yoga class for patients on Tuesday mornings, and the employee
(who may not be licensed) is supervised by medical professionals. Dr. Sanchez refers Mike, a CCO member, to this class for his back pain and he attends. The clinic bills HCPCS billing code S9451 for a diagnosis of back pain and the CCO covers it at the negotiated rate. **This is a covered service and cannot be an HRS.**

4. Same scenario as #3 above, but the class is offered for an uncomplicated ankle sprain (an unfunded condition). Regardless of whether the CCO pays this claim, the CCO must report this in encounter data as a medical service since it is provided as a medical service and billed by a licensed provider. **This cannot be an HRS.**

5. A primary care clinic provides case management services to CCO members and bills them using HCPCS code T2022. Regardless of whether the CCO pays or denies this claim, it should be reported as a medical expense. **This cannot be an HRS.**

<table>
<thead>
<tr>
<th>Medical Services</th>
<th>Health-Related Services</th>
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<tbody>
<tr>
<td>Are:</td>
<td>Are:</td>
</tr>
<tr>
<td>• Billed to CCO by a licensed, enrolled Medicaid provider (may be rendered by non-licensed staff under supervision)</td>
<td>• Services meeting requirements of Oregon Administrative Rules (OARs) <a href="https://www.oregon.gov/Rulefinder/SearchResults.cfm?Language=en&amp;searchText=410-141-300">410-141-3000</a> and <a href="https://www.oregon.gov/Rulefinder/SearchResults.cfm?Language=en&amp;searchText=410-141-3150">410-141-3150</a> and Code of Federal Regulations (CFRs) <a href="https://www.federalregister.gov/a/2020-20710">45 CFR 158.150</a> and <a href="https://www.federalregister.gov/a/2020-20710">45 CFR 158.151</a></td>
</tr>
<tr>
<td>• Billed to CCO using standard medical billing codes (ICD-10, CPT, HCPCS)</td>
<td>• Reported by CCO to OHA on Exhibit L of the financial reports</td>
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<tr>
<td>• Reported by CCO to OHA as encounter data (837)</td>
<td>• Considered for non-benefit load in capitation rate setting</td>
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<tr>
<td>• Considered for benefit load in capitation rate setting</td>
<td></td>
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<tr>
<td>May be:</td>
<td>May be:</td>
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<tr>
<td>• Paid by CCO as covered benefit</td>
<td>• Purchased directly by CCO at retail or through contracts</td>
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<tr>
<td>• Paid by CCO as exception</td>
<td>• Similar to some services that are Medical Services</td>
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<tr>
<td>• Denied by CCO</td>
<td>• Provided directly by CCO staff</td>
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<td></td>
<td>• Provided by unlicensed providers not under supervision</td>
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<tr>
<td>May NOT be:</td>
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<tr>
<td>• Services that were billed to the CCO by a licensed, enrolled Medicaid provider</td>
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<tr>
<td>• Services which require a medical license or prescription according to law</td>
<td></td>
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<tr>
<td>• Covered through medical review exception process</td>
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</table>
3. **How do health-related services (HRS) intersect with the Prioritized List? Can something be covered as an HRS that was denied (for example, because it is below the funding line, is cosmetic or experimental; doesn’t follow a Health Evidence Review Commission [HERC] guideline; or is not medically necessary/appropriate)?**

Services denied due to Prioritized List placement or not being included in the benefit package cannot be considered an HRS because they could be covered under a medical exception process. These services would be considered a medical, oral or behavioral health service and could not be considered an HRS. In general, services billed by licensed, enrolled providers using HIPAA-compliant claims are medical services.

4. **Can community-based activities such as supporting a farmers market in a “food desert” be supported with health-related services (HRS)?**

As approved under the [2017-2022 1115 waiver](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CMS-1115-Waiver), HRS includes a category of community benefit initiatives, which are community-level interventions that may include members and non-members, and are focused on improving population health and/or health care quality. To be considered an HRS, a service must meet the following criteria (Code of Federal Regulations [CFRs] [45 CFR 158.150](https://www.federalregister.gov/code-of-federal-regulations-search) and [45 CFR 158.151](https://www.federalregister.gov/code-of-federal-regulations-search)):

- Be designed to improve health quality;
- Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and produce verifiable results and achievements;
- Be directed toward either individuals or segments of enrollee populations, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and
- 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.

In addition, the HRS must meet at least one of the following criteria:

- 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 laid out in [45 CFR 158.151](https://www.federalregister.gov/code-of-federal-regulations-search), which promote clinic community linkage and/or referral processes or support other activities as defined in [45 CFR 158.150](https://www.federalregister.gov/code-of-federal-regulations-search).

5. **Can CCOs rely on published studies to support the use of health-related services (HRS), or will CCOs be expected to provide organization- and population-specific data?**

CCOs won’t be expected to provide organization- and population-specific data to support the use of an HRS. As referenced in the [HRS brief](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CMS-1115-Waiver), CCOs may use existing evidence-based best practices,
research or guidelines issued by government agencies, medical associations or national health care quality organizations to identify HRS that improve health outcomes, alleviate health disparities, and improve overall community well-being. In addition to other resources a CCO or OHA may identify, OHA has identified the following resources as acceptable sources for published studies or evidence to support an HRS:

- Social Interventions Research and Evaluation Network
- Community Preventive Services Task Force Findings
- Healthy People 2020
- Centers for Disease Control and Prevention: Social Determinants of Health
- Centers for Disease Control Community Health Improvement Navigator
- Centers for Disease Control and Prevention Health Impact in 5 Years
- Leveraging the Social Determinants of Health: What Works? (Massachusetts Foundation)
- University of California, San Francisco Social Interventions Research & Evaluation Network
- HERC multisector intervention reviews – OHA’s Health Evidence Review Commission has created a body of evidence-based reviews for multisector interventions that are intended to aid CCOs in population health improvement and are not considered covered medical services. CCOs could use the evidence compiled by the HERC to support offering an HRS to individual members or the community.

All resources can be found at [www.transformationcenter.org](http://www.transformationcenter.org).

6. **What is an example of a CCO’s process to determine whether a service can be a health-related service (HRS) and demonstrate evidence-based criteria?**

Example: A CCO is interested in offering assistance to an individual or community experiencing food insecurity. The CCO may use the existing evidence base to support its HRS decision-making process, referencing the health impacts of nutritional assistance programs. Nutritional assistance meets the four main criteria for an HRS: is designed to improve health quality (see table below); has been shown to improve desired health outcomes in ways that can be measured; can be directed toward an individual or segment of enrollee population; and has an evidence base that suggests it both improves health outcomes and reduces health care costs for high-risk women, infants and children, and older adults with functional and cognitive impairments. It can be argued that the activity of nutritional assistance is primarily designed to meet the following criteria: 1) improve health outcomes compared to a baseline and reduce health disparities among specified populations and 2) implement, promote and increase wellness and health activities. The sample studies in Table 2 offer an evidence base to support a CCO in offering nutritional assistance as an HRS.

**Table 2**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Target Group – Place</th>
<th>Author, Year</th>
<th>Summarized Outcomes</th>
</tr>
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<tbody>
<tr>
<td>Women, Infants, and Children (WIC) and Canada Prenatal</td>
<td>Low-income women and children – selected cities and states (U.S.) and</td>
<td>Foster, Jiang &amp; Gibson-Davis, 2010; Khanani et al., 2010; Hoynes, Page &amp; Stevens, 2009; Lazariu-Bauer et al.,</td>
<td>Better health outcomes; $176 million per year in net savings in U.S.</td>
</tr>
</tbody>
</table>
### Nutrition Program (CPNP)
- **Nationwide (Canada)**
- **2004; El-Bastawissi et al., 2007; GAO, 1992; Muhajarine et al., 2012**

### Healthy Start
- **Low-income women and children – selected cities and states**
- **Kothari et al., 2014**
- Better health outcomes among some groups

### Food assistance programs
- **Older adults – nationwide**
- **Kim & Frongillo, 2007**
- Better health outcomes; no cost analysis reported

### Resident Opportunities for Self-Sufficiency (ROSS)
- **Older adults and people with disabilities – Seattle**
- **Siu, 2009**
- Better health outcomes; no cost analysis reported

### Home-delivered meals
- **Older adults – nationwide**
- **Thomas & Mor, 2013a; Thomas & Mor, 2013b; Thomas & Dosa, 2015**
- Better health outcomes; a 1% increase in meals delivered to homes of older adults was associated with reduction of $109 million in Medicaid costs; a $25 annual increase in home-delivered meals per older adult was associated with a 1% decline in nursing home admissions

### 7. Are there exclusions to the activities that can be counted as a health-related service (HRS)?
Yes. CCOs have the flexibility to identify and provide HRS beyond the list of examples in the Oregon Administrative Rules (OARs) 410-141-3000 and 410-141-3150 and Code of Federal Regulations (CFRs) 45 CFR 158.150 and 45 CFR 158.151. However, expenditures and activities that cannot be included as an activity that improves health care quality are:

- Those that are designed primarily to control or contain costs;
- Those that otherwise meet the definitions for quality improvement activities but were paid for with grant money or other funding separate from revenue received through a CCO’s contract;
- Those that can be billed or allocated by a provider for care delivery and are, therefore, reimbursed as clinical services;
- 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 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended;
- That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
- All retrospective and concurrent utilization review;
• Fraud-prevention activities;
• 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;
• Provider credentialing; and
• Costs associated with calculating and administering member incentives. If a class/program is offered in a cohort format that includes both CCO members and non-members, then the CCO must exclude the portion of expenses for the class/program that are attributable to the non-CCO members.

8. **Will spending on health-related services (HRS) be considered in rate development?**
   Currently, OHA reviews and considers CCO expenditures as a part of CCO rate development, and HRS expenditures are included in that review. OHA payments to CCOs are limited by an annual sustainable rate of growth and any CCO expenditures, including HRS, are subject to potential policy adjustment if CCOs’ cost growth exceeds the annual targets, and/or budget limitations exist in the coming year.

9. **What housing-related services can be covered using dollars that will be considered in rate development?**
   OHA and the Medicaid Advisory Committee are producing a guide to using health-related services (HRS) on housing activities, which will include a variety of examples. This guide will be available in fall 2018.

10. **Can health-related services (HRS) be used to address social determinants of health and health equity?**
    Yes. The goals of HRS are to promote the efficient use of resources and address members’ social determinants of health and health equity to improve health outcomes, alleviate health disparities, and improve overall community well-being.

11. **What are CCO reporting requirements for health-related services (HRS) investments?**
    CCOs are required in their contracts to have written policies and procedures for administering HRS, and to submit those policies to the OHA. CCOs will be expected to report on HRS investments in the Exhibit L of the CCO financial reports, Minimum Medical Loss Ratio Rebate Calculation, and Transformation and Quality Strategy reports. Reporting instructions for HRS investments are outlined in the instructions for these reports. OHA is also considering other reporting requirements to better track and report health outcomes and cost savings to CMS.

12. **What are some categories of health-related services (HRS) commonly used by CCOs?**
    Through discussions with CCOs, the following categories of activities have been identified as meeting the criteria and definition for HRS:
    • Training and education for health improvement or management (for example, classes on healthy meal preparation, diabetes or self-management of chronic conditions);
• Home and living environment items or improvements not otherwise covered by 1915 Home and Community Based Services Waivers (non-durable medical equipment to improve mobility, access, hygiene or other improvements to address a particular health condition; for example, air conditioners, athletic shoes, or other special clothing);
• Transportation not covered under Oregon State Medicaid Plan benefits (for example, transportation other than to a medical appointment);
• Programs to improve community or public health (for example, farmers market in a “food desert,” or workforce development);
• Housing supports related to social determinants of health (for example, temporary housing or shelter, utilities or critical repairs);
• Assistance with food or other social resources (for example, supplemental food, referral to job training or social services); and
• Other non-covered services that fit the definition of HRS in OAR 410-141-3000.

13. **Must the member’s primary care provider or clinician approve a flexible service? Is it a requirement to have consistency between the health-related service (HRS) and the member’s treatment plan?**

The CCO must approve the flexible service, but clinical approval is not required. OAR 410-141-3150 states that a flexible service, which is an HRS offered to an individual member, must be consistent with a member’s treatment plan as developed by the care team and agreed to by the CCO. However, it does not specify that the care team include the primary care provider or clinician. These services shall be documented in the treatment plan and clinical record whenever possible.

14. **Will medical loss ratio reporting (MLR) be modified given the language in the health-related services (HRS) brief around MLR calculation?**

The MLR instructions have been modified and updated to include information about the three-year rolling MLR, as explained in the HRS brief. More information is available on the CCO Contract Forms page: [http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx](http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx)

15. **How are health-related services (HRS) considered within the medical loss ratio (MLR) calculation compared to rate development?**

**HRS example:** Cooking classes for people with diabetes
- **MLR:** Included in the medical component of the MLR as an activity that improves health care quality ([45 CFR 158.150](https://www.gpo.gov/fdsys/freefulltext/2016-25565.htm))
- **Rate setting:** Considered in the non-benefit load of the rate setting

**HRS example:** Assistance for rent after discharge from hospital
- **MLR:** Included in the medical component of the MLR as an activity that improves health care quality ([45 CFR 158.150](https://www.gpo.gov/fdsys/freefulltext/2016-25565.htm))
- **Rate setting:** Considered in the non-benefit load of the rate setting

OHA will consider HRS investments in evaluations of cost-effectiveness because HRS investments could be associated with reductions in spending in other categories.
16. Can CCOs expect any limiting factors and/or credibility adjustments due to CCO size in the consideration of health-related services (HRS) in their rates?
No, OHA does not anticipate a credibility adjustment, but will be looking at reasonableness as it relates to the per-member-per-month equivalent and impact on the total non-benefit load percentage.

17. What is a CCO’s responsibility to a member when health-related services (HRS) are requested?
OAR 410-141-3150 (12) (a) states that CCOs shall provide members with a written notification of a refusal of individual flexible services request and shall copy any representative of the member and any provider who made or participated in the request on the member’s behalf. The written notification shall inform the member and provider of the member’s right to file a grievance in response to the outcome.

18. Can CCOs use health-related services (HRS) for advertising, corporate sponsorships or other activities that are not listed in the OAR 410-141-3150?
No, HRS must meet specific criteria as outlined in Oregon administrative rule.

19. Can capital investments in new buildings for providing medical or imaging services to be considered health-related services (HRS)?
No, spending that is designed primarily to control costs is excluded from HRS.

Resources
- Oregon Administrative Rule 410-141-3000 defines health-related services: https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=244264
- Oregon Administrative Rule 410-141-3150 defines the criteria health-related services must meet: https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=239547
- 45 CFR 158.150 – Activities that improve health care quality: https://www.ecfr.gov/cgi-bin/text-idx?SID=656e988fc35ee492f4fcf2e34067cd1&mc=true&node=se45.1.158_1150&rgn=div8
- 45 CFR 158.151 – Expenditures related to health information technology and meaningful use requirements: https://www.ecfr.gov/cgi-bin/text-idx?SID=656e988fc35ee492f4fcf2e34067cd1&mc=true&node=se45.1.158_1151&rgn=div8