Oregon Health Authority

Health-Related Services Guide for CCOs

Updated March 2020

HRS FREQUENTLY ASKED QUESTIONS

Background

In 2012, under a renewal to its 1115 Medicaid demonstration waiver, Oregon began the process of transforming its Medicaid delivery system by establishing coordinated care organizations (CCOs), charging them with integrating and coordinating care and requiring them to meet key quality metrics tied to financial incentives for achieving performance benchmarks. CCOs receive an integrated 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. These HRS were known as flexible services, but through the 1115 Medicaid demonstration waiver for 2017–2022, OHA expanded HRS to include flexible services and community benefit initiatives.

Definitions

Health-related services (HRS): Non-covered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being.

Flexible services (FS): Cost-effective services delivered to an individual OHP member to supplement covered benefits and improve their health and well-being.

Community benefit initiatives (CBI): Community-level interventions that include — but are not limited to — OHP members and are focused on improving population health and health care quality.

HRS are defined as non-covered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being. One of the purposes of HRS is to give CCOs a specific funding mechanism within their global budgets to address the social determinants of health (SDOH), including the health-related social needs of their members.

For CCOs to use federal Medicaid funds to pay for HRS, they must comply with state and federal criteria. For a full definition of HRS, CCOs should rely primarily on the OHA HRS Brief[i] and Oregon Administrative Rules (OARs) 410-141-3500[ii] and 410-141-3845.[iii] The Code of Federal Regulations (45 CFR 158.150[iv] and 45 CFR 158.151[v]) should be used for supplemental CCO guidance only.

The purpose of this FAQ is to expand upon the OHA HRS Brief, provide examples of what is and what is not HRS, describe how CCOs might implement HRS, and describe how OHA incorporates HRS into CCO payments. Additional guidance and technical assistance can be found on OHA's HRS webpage.[vi]

This FAQ will be updated as additional questions are addressed. Please email questions to Health.RelatedServices@dhsoha.state.or.us.

Contents

Criteria, inclusions and exclusions for HRS activities

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

   CCOs should refer to the criteria defined under Oregon Administrative Rules (OARs) 410-141-3500 and 410-141-3845 and Code of Federal Regulations (CFRs) 45 CFR 158.150 and 45 CFR 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
   - 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

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2. **Under OAR 410-141-3845(2)(c)(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 410-141-3845, 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. Covered services that are billed by licensed, enrolled providers using HIPAA-compliant claims are medical services and are not 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 a yoga instructor that is not a licensed provider 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 410-141-3845(2)(a)(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 weekly yoga class for patients, 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. Same scenario as #3 above, but the class is offered both to CCO members, with and without back pain, and non-members. The cost of attendance for CCO members with back pain would be a covered service. The cost of attendance for CCO members without back pain could be HRS, flexible services. The cost of attendance for non-CCO members could be HRS, community benefit initiative.

Table 1

Medical Services	Health-Related Services
Are:	**Are:**
• Billed to CCO by a licensed, enrolled Medicaid provider (may be rendered by non-licensed staff under supervision) • Billed to CCO using standard medical billing codes (ICD-10, CPT, HCPCS) • Reported by CCO to OHA as encounter data (837) • Considered for benefit load in capitation rate setting (only if they are covered services)	• Services meeting requirements of Oregon Administrative Rules (OARs) 410-141-3500 and 410-141-3845 and Code of Federal Regulations (CFRs) 45 CFR 158.150 and 45 CFR 158.151 • Reported by CCO to OHA on Exhibit L of the financial reports • Considered for non-benefit load in capitation rate setting
May be:	**May be:**
• Paid by CCO as covered benefit • Paid by CCO as exception and reported as a medical loss • Denied by CCO	• Non-covered medical services • Purchased directly by CCO at retail or through contracts • Provided directly by CCO staff • Provided by unlicensed providers not under supervision
	May NOT be:
	• Covered services under OHP or services covered under a medical review exception process • Services paid for with grants or other non-Medicaid funds • Administrative expenses such as continuing education for providers and staff

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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 can be considered HRS if they are not covered under a medical exception process and meet HRS criteria. In general, services billed by licensed, enrolled providers using HIPAA-compliant claims are medical services. However, if the services are not covered benefits under OHP, then they may be considered HRS.

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4. **How are health-related services (HRS) related to value-based payments?**

   A non-covered service could be HRS, or could be part of a value-based payment (VBP) arrangement, depending on how the CCO agrees to pay for the service. If a clinic is contracted to provide services to a member through a capitated VBP arrangement with a link to quality, and chooses to include goods/services not covered under Medicaid as a part of their treatment, those costs are considered part of a VBP, not HRS. If a clinic is not already receiving a capitated VBP for a CCO member, they could request the CCO provide funding for goods/services not covered under Medicaid, and the CCO could claim those costs as HRS. If a clinic has a capitated VBP arrangement, they could request funding for goods/services not covered under Medicaid, and the CCO could claim those costs as HRS, as long as the value of the service is not included in the VBP payment. A CCO must only report value of goods/service either as HRS, or as a VBP, not both.

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

   Yes. The goals of HRS are to promote the efficient use of resources and address members' social determinants of health and equity (SDOH-E) to improve health outcomes, alleviate health disparities, and improve overall community well-being. OHA has additional guidance available to CCOs on using HRS to address SDOH-E that is available on the HRS website.

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6. **What housing-related services can be considered health-related services (HRS)?**

   OHA and the Medicaid Advisory Committee have produced a housing guide to using HRS on housing activities, which includes a variety of examples. This guide is available on the HRS website.

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7. **Can community-based activities such as supporting a farmers market in a food desert or supporting a homeless shelter be supported with health-related services (HRS)?**

   As approved under the 2017–2022 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 and 45 CFR 158.151):

   - 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, which promote clinic community linkage and/or referral processes or support other activities as defined in 45 CFR 158.150

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8. 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:

- Care coordination, navigation or case management activities not otherwise covered under State Plan benefits, including traditional health workers;
- Education provided to members for health improvement or education supports, including those related to social determinants of health and equity (SDOH-E) (for example, education for health improvement and management, and supports for early childhood education, language and literacy, high school graduation, and higher education);
- Food services and supports, including those related to SDOH-E (for example, vouchers, meal delivery, farmers market in a food desert);
- Housing services and supports, including those related to SDOH-E (for example, temporary housing or shelter, utilities, critical repairs, environmental remediation, including lead);
- Items for the living environment, not otherwise covered under 1915 Home and Community Based Services Waivers, to support a particular health condition (for example, items to improve mobility, air conditioner, athletic shoes, other specialized clothing);
- Transportation services and supports, including those related to SDOH-E, not otherwise covered under the State Plan (for example, transportation for groceries or non-medical appointments related to individual social needs; community-level transportation improvements such as bike lanes and walking paths);
- Trauma-informed services and supports across sectors, including those related to SDOH-E (for example, implementing trauma-informed care across sectors, ACEs training in schools);

- Other non-covered clinical services and improvements (for example, supports for community oral health services, EHR meaningful use); and
- Other non-covered social and community health services and supports (for example, social needs screening and referral, including community resource and referral technology and EHR integration, multi-sector interventions to improve population health, and interventions to address other SDOH-E, including employment and built environment improvements).

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9. 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 examples cited in the Oregon Administrative Rules (OARs) 410-141-3500 and 410-141-3845 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.

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10. Can CCOs use health-related services (HRS) for advertising, corporate sponsorships or other activities that are not listed in the OAR 410-141-3845?

No, HRS must meet specific criteria as outlined in Oregon administrative rule.

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

No, capital investments in new facilities designed to provide billable health services are considered administrative expenses. HRS are intended to distinguish between normal administrative costs and certain types of spending that are directly related to a member's health. The cost of creating the physical and administrative structure to bill for covered services is considered an administrative cost, not an HRS.

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Implementing, tracking and reporting HRS

12. 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, 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 HRS:

- Social Determinants of Health (Centers for Disease Control and Prevention): Resources for social determinants of health data, tools for action, programs and policy.
- Community Health Improvement Navigator (Centers for Disease Control and Prevention): Expert-vetted tools and resources for health system, hospital, public health agency and other community organization staff leading community health improvement efforts.
- Health Impact in 5 Years (Centers for Disease Control and Prevention): Highlights non-clinical, community-wide approaches that have evidence reporting 1) positive health impacts, 2) results within five years, and 3) cost effectiveness or cost savings over population lifetime.
- Community Preventive Services Task Force Findings (The Community Guide): What works to promote healthy communities.
- Leveraging the Social Determinants of Health: What Works? (Massachusetts Foundation): The Massachusetts Foundation's report on what works for interventions addressing social determinants of health.
- Social Determinants of Health 101 for Health Care (National Academy of Medicine): What health care needs to know and learn about social determinants of health to achieve the national quality strategy of better care.
- Social Interventions Research & Evaluation Network (University of California, San Francisco): Includes both peer-reviewed and other types of resources, such as webinars and screening tools/toolkits on medical and social care integration.

- Healthy People 2020 (US Department of Health and Human Services): Resources to learn how communities across the country are addressing the social determinants of health.
- Multisector Intervention Reviews (OHA Health Evidence Review Commission): Evidence-based reviews for multisector interventions that are intended to aid CCOs in population health improvement and are not considered covered medical services.

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13. 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

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

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

The CCO must approve the flexible service, but clinical approval is not required. OAR 410-141-3845 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.

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

OAR 410-141-3845(4)(a) states that CCOs shall provide members with a written notification of a refusal of an individual flexible service 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. If an HRS request is denied because other Medicaid or community resources are available for the same service or product, CCOs are encouraged to inform the member or requester of the availability of those resources and coordinate a referral whenever possible.

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16. 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 OHA. CCOs are expected to report on HRS investments in Exhibit L of the CCO financial reports and Minimum Medical Loss Ratio Rebate Calculation. 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.

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HRS considerations in rate development, medical-loss ratio and performance-based reward

17. 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.

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

Per the 2016 Medicaid and Children's Health Insurance Program Managed Care Final Rule, activities that improve health care quality, as defined above, are included in the numerator of the MLR calculation. Not only are HRS included as medical expenditures in the MLR if they meet the requirements under 45 CFR 158.150 or 45 CFR 158.151, but they are also considered in rate development within the non-benefit load of the CCO's rate.

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)
- **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)
- **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.

More information is available on the CCO Contract Forms page.

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19. Can CCOs expect any credibility adjustments based on CCO size in the consideration of health-related services (HRS) in their rates?

No, OHA does not anticipate a credibility adjustment for HRS spending, 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.

20. How are health-related services (HRS) related to performance-based reward?

As a part of CCO 2.0, performance-based reward begins in 2020, and a CCO's HRS spending is a primary driver of their performance-based reward. For more information, see OHA's CCO 2.0 Procurement Rate Methodology for January 1, 2020–December 31, 2020 Capitation Rates.

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References

[i] OHA HRS Brief: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-Health-Related-Services-Brief.pdf

[ii] OAR 410-141-3500: https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265499

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

[iv] 45 CFR 158.150: https://www.ecfr.gov/cgi-bin/text-idx?SID=656e988fc35ee492f4fcfce234067cd1&mc=true&node=se45.1.158_1150&rgn=div8

[v] 45 CFR 158.151: https://www.ecfr.gov/cgi-bin/text-idx?SID=656e988fc35ee492f4fcfce234067cd1&mc=true&node=se45.1.158_1151&rgn=div8

[vi] OHA HRS website: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx