

Health-Related Services



HEALTH POLICY AND ANALYTICS DIVISION
Office of Health Policy

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Executive summary

Defining health-related services (HRS)

1. HRS = flexible services + community benefit initiatives
2. Oregon Administrative Rules state HRS are non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member health and well-being
3. 1115 Waiver STCs state HRS must meet the requirements for activities that improve health care quality (45 CFR 158.150) or expenditures related to Health Information Technology and meaningful use requirements to improve health care quality (45 CFR 158.151)

Activities that improve health care quality must meet four criteria:

- Designed to improve health quality;
- Increase the likelihood of desired health outcomes in ways that can be objectively measured and produce verifiable results and achievements;
- 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-enrollees; and
- 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

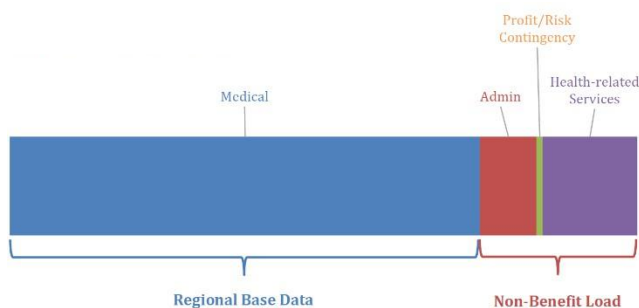
What qualifies as an activity that improves health care quality?

Activities should:

1. Improve health outcomes and reduce health disparities
2. Prevent hospital readmissions
3. Improve patient safety, reduce medical errors, and lower infection and mortality rates
4. Increase focus on wellness and health promotion activities

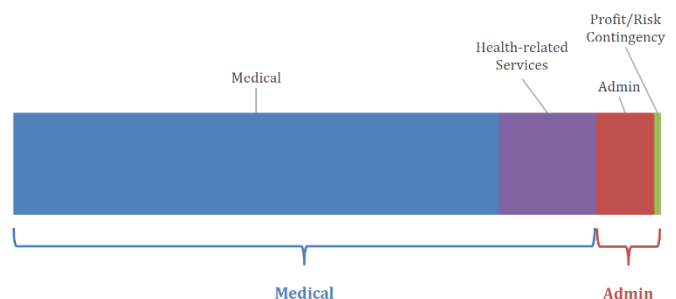
Health information technology expenditures that support the activities above also qualify as HRS

Rate Development



HRS will be considered for rate development within non-benefit load adjustment*

MLR Calculation



HRS will be included as medical expenditures in the Medical Loss Ratio (MLR) helping the coordinated care organization (CCO) meet the state's MLR standard*

*Rate development, as it pertains to non-benefit load and MLR, is explained further in this brief.

Background

In 2012, under a renewal to its 1115 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 to improve the health of Oregon's Medicaid population. Further, under the recently approved 1115 Medicaid demonstration waiver for 2017-2022, OHA has continued its commitment to promote CCOs' use of health-related services.

The purpose of this brief is to define health-related services, describe the use of health-related services among CCOs, and explain how health-related services are incorporated into CCO payments. The brief will be followed up with a frequently asked questions (FAQ) document to further assist CCOs' implementation of health-related services.

Definition of health-related services

Health-related services are defined by the Oregon Administrative Rules (OARs), the 1115 waiver special terms and conditions (STCs), and federal regulations (45 CFR 158.150 and 45 CFR 158.151).

CCOs should rely primarily on the definition and criteria included in this brief and OARs 410-141-3000 and 410-141-3150.¹ The federal regulations, which were developed for qualified health plans in the Marketplace, should be used for supplemental guidance only.

Defining health-related services

Health-related services are non-covered services that are offered as a supplement to covered benefits under Oregon's Medicaid State Plan to improve care delivery and overall member and community health and well-being. Health-related services include flexible services and community benefit initiatives. Flexible services are cost-effective services offered to an individual member to supplement covered benefits. Community benefit initiatives are community-level interventions that include, but are not limited to members, and are focused on improving population health and health care quality.

To be considered a health-related service, a service must meet the requirements for:

- a) Activities that improve health care quality (45 CFR 158.150) or
- b) Expenditures related to health information technology and meaningful use requirements to improve health care quality

¹The Oregon Health Authority and a rules advisory committee have revised OAR 410-141-3000 and 410-141-3150 to reflect the changes included in the 1115 waiver special terms and conditions and 45 CFR 158.150 and 45 CFR 158.151. The revised rules will be effective January 1, 2018.

Definition

The goals of health-related services are to promote the efficient use of resources and address members' social determinants of health² to improve health outcomes, alleviate health disparities, and improve overall community well-being. Health-related services are non-covered services under the Oregon Health Plan that are intended to improve care delivery and overall member and community health and well-being. Health-related services are provided as a supplement to billable office visits, and are cost-effective services offered as an adjunct to covered benefits. Health-related services lack traditional billing or encounter codes, are not encounterable, and cannot be reported for utilization purposes.

Health-related services include:

1. *Flexible services*, which are cost-effective services offered to an individual member to supplement covered benefits, and
2. *Community benefit initiatives*, which 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.

To be considered a health-related service, a service must meet the requirements for: a) activities that improve health care quality, as defined in [45 CFR 158.150](#);³ or b) expenditures related to health information technology and meaningful use requirements to improve health care quality, as defined in [45 CFR 158.151](#).⁴

Criteria of activities that improve health care quality

Activities that improve health care quality must meet all of 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

² The World Health Organization defines social determinants of health as the conditions in which people are born, grow, live, work and age—circumstances that are shaped by the distribution of money, power and resources at global, national and local levels.

³ <https://www.gpo.gov/fdsys/pkg/CFR-2014-title45-vol1/pdf/CFR-2014-title45-vol1-sec158-150.pdf>

⁴ <https://www.gpo.gov/fdsys/pkg/CFR-2013-title45-vol1/pdf/CFR-2013-title45-vol1-sec158-151.pdf>

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- ▶ 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.

OARs 410-141-3000 and 410-141-3150 and 45 CFR 158.150 and 45 CFR 158.151 provide examples of services that are considered activities that improve health care quality. The following list of examples taken from the CFRs is intended to be illustrative and not exhaustive. Further, it should be noted that any medical service covered under the Oregon State Plan cannot be categorized as a health-related service.

As defined in 45 CFR 158.150, activities that improve health care quality should be primarily designed to meet at least one of the following criteria:

- ▶ Improve health outcomes compared to a baseline and reduce health disparities among specified populations. This category can include costs for associated activities such as:
 - Effective case management, care coordination and chronic disease management, including through the use of the medical home model;
 - Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities;
 - Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence-based medicine; and
 - Quality reporting and documentation of care in a non-electronic format.
- ▶ Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge. This category can include costs for associated activities such as:
 - Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) to help ensure appropriate care that will, in all likelihood, avoid readmission to the hospital;
 - Personalized post-discharge counseling by an appropriate health care professional; and
 - Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.
- ▶ Improve patient safety, reduce medical errors, and lower infection and mortality rates. This category can include costs for associated activities such as:
 - The appropriate identification and use of best clinical practices to avoid harm;
 - Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;
 - Activities to lower risk of facility-acquired infections;
 - Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions; and
 - Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.

- ▶ Implement, promote and increase wellness and health activities. This category can include costs for associated activities such as:
 - Wellness assessment;
 - Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
 - Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
 - Public health education campaigns that are performed in conjunction with state or local health departments;
 - Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities; and
 - Coaching or education programs and health promotion activities designed to change member behavior (for example, smoking or obesity).

- ▶ Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are laid out in 45 CFR 158.150. This category can include costs for associated activities such as the following (see 45 CFR 158.151 for additional examples):
 - Incentive payments to health care providers for adopting certified electronic health record technologies and their “meaningful use”;
 - Providing technical assistance to support adoption and meaningful use of certified electronic health record technologies;
 - Advancing the ability of enrollees, providers, issuers or other systems to communicate patient-centered clinical or medical information rapidly, accurately and efficiently; and
 - Providing electronic health records, patient portals and tools to facilitate patient self-management.

Activities that are excluded from health-related services

Although CCOs have the flexibility to identify and provide health-related services beyond the list of examples in the aforementioned OARs and CFRs, 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

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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;
- ▶ Costs associated with calculating and administering member incentives; and
- ▶ That portion of prospective utilization that does not meet the definition of activities that improve health quality.

Current CCO use of health-related services

Through previous discussions with CCOs and stakeholders, OHA identified several examples of activities that could be or were already covered as health-related services by CCOs. CCOs have the flexibility to identify and provide health-related services that meet the needs of their members and their communities. CCOs could continue to offer the list of services below because they meet the criteria as defined under OAR 410-141-3000 and 410-141-3150 and 45 CFR 158.150.

They include:

- ▶ Training and education for health improvement or management (for example, classes on healthy meal preparation, diabetes, or self-management curriculum);
- ▶ Care coordination, navigation or case management activities not otherwise covered under State Plan benefits (for example, high-utilizer intervention program);
- ▶ 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 State Plan benefits (for example, other than transportation 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 health-related services in 410-141-3000.

Future use of health-related services

While neither CCOs nor their members are required to use health-related services, Oregon's recently renewed 1115 Waiver includes provisions that may increase CCOs' use of health-related services. For example, OHA recently updated CCO contract language to require CCOs to use alternative services including health-related services and in lieu of services.⁵

In addition, the waiver supports enhanced use of value-based payment, including development of a plan that describes how the state, CCOs and network providers will achieve a set target of value-based payments by the end of the five-year waiver demonstration period (2017-2022). When CCOs reimburse providers on a fee-for-service basis—which is the payment methodology used for most CCOs' provider reimbursements—there are neither incentives nor available resources for providers to invest in health-related services. Therefore, the state will engage in collaborative efforts with CCOs to develop a plan to increase adoption of value-based payments and support provider use of health-related services.

Incorporating health-related services into CCO payments

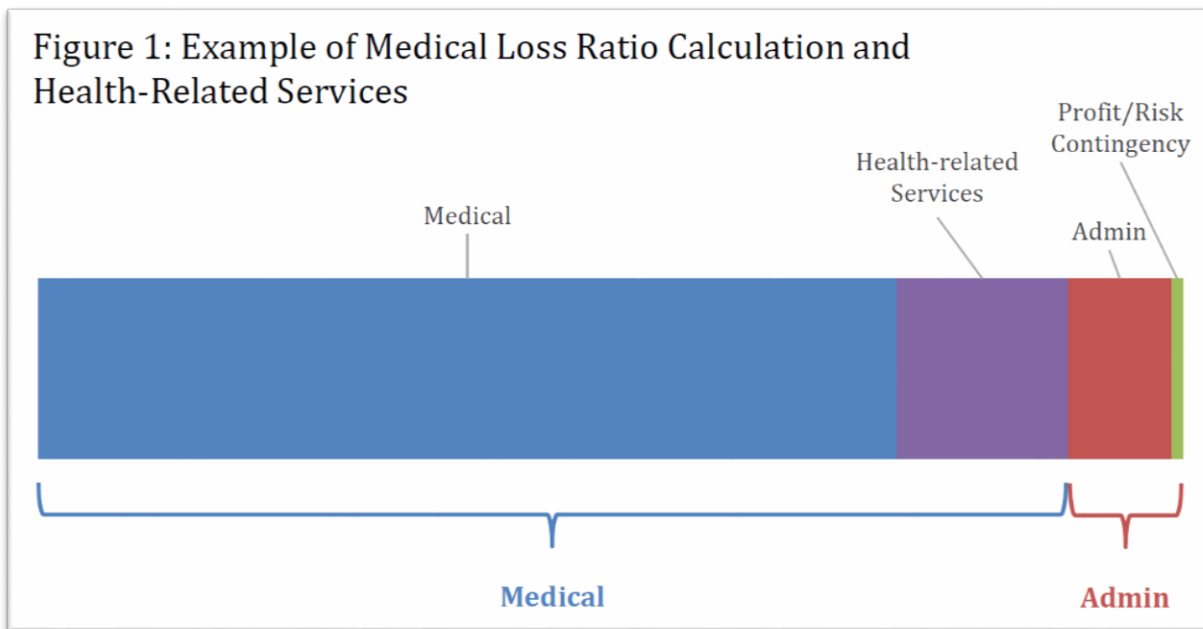
Health-related services and the CCO medical loss ratio

A medical loss ratio (MLR) is the proportion of premium revenues spent on clinical services and quality improvement. According to the Medicaid and Children's Health Insurance Program Managed Care Final Rule (CMS-2390-F) that was finalized April 25, 2016, health-related services are not counted as administrative costs when determining a CCO's MLR; instead, they are included as medical expenditures for the MLR if they meet the requirements under federal rules (45 CFR 158.150 and 45 CFR 158.151).

Specifically, if expenditures for health-related services meet the definitions laid out above for activities that improve health care quality or expenditures related to health information technology and meaningful use requirements, they are included in the numerator of the MLR, meaning CCOs' use of health-related services helps them meet the state's MLR standard of 85 percent.

See Figure 1 below for an example of the split:

⁵ "In lieu of services" is a setting or service that is determined by the state to be a medically appropriate and cost effective substitute for a service or setting covered under the state plan. "In lieu of services" must meet the requirements of 42 CFR 438.3(e)(2).



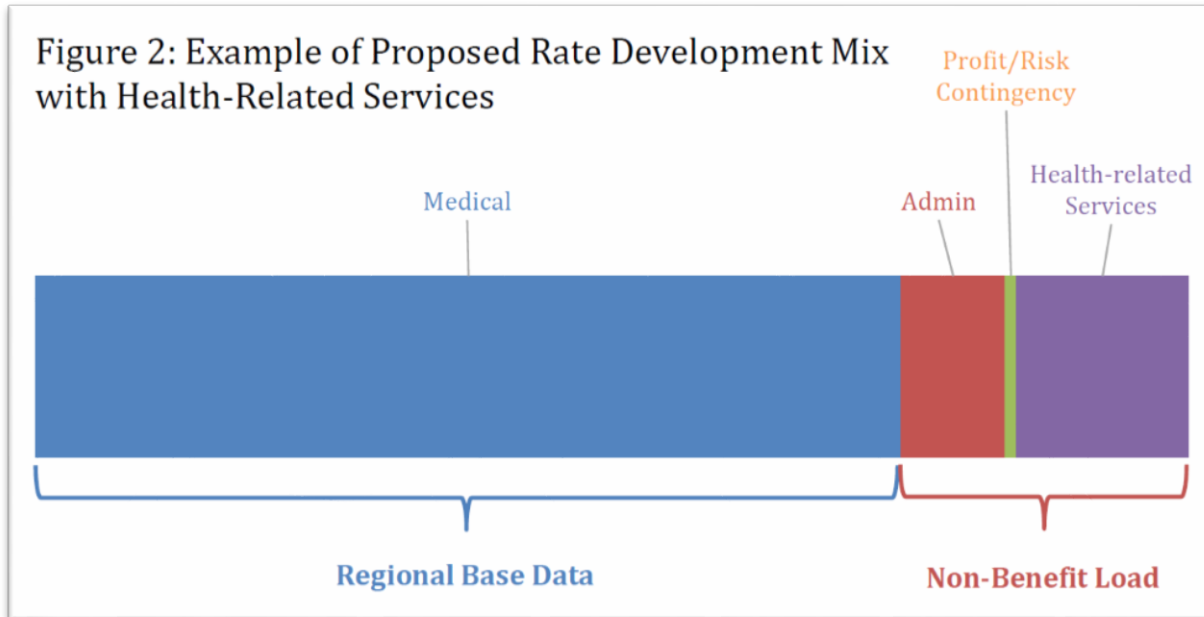
In addition, per Oregon’s updated waiver, OHA’s goal is to implement an MLR standard⁶ that provides the CCO with flexibility to monitor and make adjustments in health-related services spending over a multi-year period to ensure the CCO has time to invest wisely to improve the system and does not go below the MLR standard of 85 percent. In addition, per the Medicaid and CHIP Managed Care final rule (CMS-2390-F), the MLR is now considered in the rate development process.

Health-related services and CCO rates

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 health-related services 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 (see Figure 2). Currently, OHA reviews and considers expenditures as a part of CCO rate development, and HRS expenditures are included in that review. OHA operates under a sustainable rate of growth and any CCO expenditures, including HRS, are subject to potential policy adjustment if growth surpasses the annual targets, and/or budget limitations exist in the coming year. Based on the Medicaid and Children’s Health Insurance Program Managed Care Final Rule, the MLR calculation must be considered and reviewed in actuarially sound capitation rate development (see 42 CFR 438.4, 8). The certifying actuary must take into consideration that the numerator and denominator under the MLR are categorized differently from how they are categorized in rates when performing their review. Figure 1 and Figure 2 describe the differences in how health-related services expenditures are treated in the MLR and rate-setting process. Through the use of health-

⁶ The Oregon Health Authority is currently considering the implementation of a rolling MLR rebate, but specifics will be included in the contracting process.

related services, CCOs are expected to efficiently and effectively reduce costs and improve care over time.



As CCOs provide health-related services that are more cost-effective than State Plan services, the per-capita growth rate for capitation rates should gradually decrease over the waiver period. As reflected in the 1115 Waiver, OHA is exploring mechanisms to account for quality and efficiency outcomes, resulting from increased investments in health-related services, in rate development. Specifically, the state has proposed to develop capitation rates with a profit margin that varies by CCO based on efficiency and quality measurement. Oregon will continue to consider this concept and determine its implementation feasibility.

Contact

Please submit all comments and questions to the Health Related Services Mailbox (Health.RelatedServices@dhsosha.state.or.us).