AllCare Health
Health Related Services
Policies and Procedures

Health Related Services (HRS) Group Programs

Policy number: AllCare CCO HRS 001	Revision number: 1	Revision date: 1/30/2020
Line of Business: AllCare CCO	**Approved by:** CMO	**Approval date:** 1/30/2020

Table of Contents

Overview 1
Purpose 2
Policy 2
Definitions 2
Desk Procedure 2
Programs 5
The Babe Store 5
Health and Wellness Prescription Programs 5
Gym Wear Program 8
Scale Program 9
HRS rides provided by NEMT vendor 11
Additional attendants for NEMT rides 13
Rogue Retreat 15
Oversight and Monitoring 16
Reporting 16
References 16
Revision History 18

Overview

AllCare CCO receives a global payment for each member, which provides the flexibility to offer health-related services (HRS) to improve the health of our CCO population and community. HRS use should strive to achieve the triple aim of better health, better quality and lower costs for all Oregonians.

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Purpose

To define the parameters including reporting requirements for HRS group spending for AllCare CCO.

Policy

Definitions

"Community Benefit Initiatives" (CBI) means community-level interventions focused on improving population health and health care quality. CBI programs are not exclusive to members.

"Flexible Services" means those services that are cost-effective services offered as an adjunct to covered benefits for an individual member or group of members. Flexible services are exclusive to members of the CCO

"Global budget or payment" means the total amount of payment as established by the Oregon Health Authority (OHA) to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services

"Grievance System" means the overall system that includes: (a) Grievances to a managed care entity (MCE) on matters other than adverse benefit determinations; (b) Appeals to an MCE on adverse benefit determinations; and (c) Contested case hearings through the OHA on adverse benefit determinations and other matters for which the member is given the right to a hearing by rule or statute

"Health-Related Services" means non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-3845. Health-related services include flexible services and community benefit initiatives.

Desk Procedure

- (A) AllCare CCO offers multiple avenues for HRS spending for both members and the community
  - (1) This policy defines the criteria for our HRS flexible spending for group programs
    - (a) Guidelines for HRS individual flexible spending and CBI programs are outlines in HRS XXX
  - (2) HRS flexible spending for group programs is referred to as HRS group programs
- (B) All HRS group programs must meet all of (E)(2)(a) and at least one component of (E)(2)(b)
- (C) HRS group programs are provided by AllCare CCO for AllCare CCO members
  - (1) Programs must be approved by the AllCare CCO CHIP and CAC
  - (2) Services provided must be cost efficient
  - (3) Members must have current eligibility for CCO to receive service

(4) When applicable, members must meet any inclusion criteria outlined by the program
(5) Programs are administered by the department that hosts the program
    (a) For example: Approval and tracking for the Gym Wear Program is completed by Health and Wellness staff
(6) Enrollment in group program needs to be tracked in EZCap or Essette
    (a) Charting may or may not be required dependent upon the program
(7) Tracking required for each program with the following required elements:
    (a) Member full name
    (b) Member ID
    (c) Date of approved service
    (d) Expiration or completion date (if applicable)
    (e) Program name
    (f) Service
(8) Tracking should be provided to HRS staff on a monthly basis
(9) If the member is refused a service:
    (a) The member should be sent a written letter of refusal with instructions on their right to file a grievance
    (b) The ordering provider should also be provided a copy of the letter
    (c) Grievances received by AllCare CCO regarding refused HRS spending must follow the procedures specified in 42 CFR 438.402-408 and OAR 410-141-3835 through 3915
        1. See Quality department Appeals and Grievances Handbook for more information

(D) AllCare CCO HRS group programs **cannot** be:
(1) Used for non-CCO enrollees
    (a) Members must be eligible on the plan at the time of the service
    (b) Attendants on flex rides do not have to be on the plan, but the member they are accompanying must be currently enrolled
(2) Services which require a medical license or prescription according to law
(3) Services that were denied under the medical review exception process
(4) Billable as a CCO medical, dental, behavioral health service or services billed to the CCO by a licensed, enrolled Medicaid provider
(5) Have a CPT or other billable service code even if the service is excluded from Medicaid coverage
(6) Part of a capitated medical, dental, behavioral health service program
(7) Eligible for appeal or hearing rights

(E) HRS programs must meet criteria provided by CMS and the OHA as outlined in OAR 410-435-3845:

(1) The goals of health-related services (HRS) are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. Health-related services are provided as a supplement to covered health care services:

(a) HRS may be provided as flexible services or as community benefit initiatives, as those terms are defined below;

(b) CCOs have the flexibility to identify and provide health-related services beyond the list of examples in 45 CFR §§ 158.150, 158.151, as long as the HRS satisfy the requirements of this rule;

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

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

(2) To qualify as an HRS within the meaning of this rule, a service must meet the following requirements, consistent with 45 C.F.R. § 158.150:

(a) The service must be designed to:

1. Improve health quality;
2. Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements;
3. 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; and
4. Be based on any of the following:
    a. Evidence-based medicine; or
    b. Widely accepted best clinical practice; or
    c. Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

(b) The service must be primarily designed to achieve at least one of the following goals:

1. Improve health outcomes compared to a baseline and reduce health disparities among specified populations;
2. Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;
3. Improve patient safety, reduce medical errors, and lower infection and mortality rates;
4. Implement, promote, and increase wellness and health activities;
5. Support expenditures related to health information technology and meaningful use requirements necessary to accomplish 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.

Programs

The Babe Store

Program Definition: The Babe Store is an incentive based wellness and engagement program for members of AllCare and their families who are either pregnant or have recently delivered. It also serves as a resource and referral source for participants. Members are given vouchers for completing various wellness and scheduled visits with their provider. These vouchers can be redeemed at the AllCare Babe store for maternal child health and wellness items such as disposable diapers and cleaning wipes.

AllCare operates four Babe stores. These stores not only serve as a place to redeem vouchers but also offers the AllCare Case Managers an opportunity to interact, educate, and offer additional referrals and resources to members.

Administrator: Care Coordination (CC)
Program Inclusion Requirements:

- Must be a CCO member
- Member must meet eligibility requirements for Babe Store program services

OAR and CFR requirements:
The Babe Store program meets the following requirements, consistent with 45 C.F.R. § 158.150:

- The service 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; and
- Be based on any of the following:
  - Evidence-based medicine; or
  - Widely accepted best clinical practice; or
  - Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

The Babe Store achieves the following goals, consistent with OAR 410-141-3845:

- Improve health outcomes compared to a baseline and reduce health disparities among specified populations;
- Implement, promote, and increase wellness and health activities;

Documentation requirements: (please see CC policy for more information)

Care Coordination team members will document the following:

- Member's name and ID
- Date of Babe Store visit
- Provider or voucher source
- Number of vouchers used
- Items purchased

Tracking requirements: (please see CC policy for more information)

Monthly, the designated staff (Care Coordination) will reconcile and send the inventory expenditures to AllCare Health's Finance Department.

Inventory of the Babe Store is tracked as the amount spent and compared to the annual budget for the store. The budget is reviewed monthly with the Care Coordination Maternal Child Health team.

Reviewed reconciled reports are provided to Finance by the 15th of the following month.

Process for Refusing Services:

Requests for members for services that do not meet the Babe Store program criteria outlined in the policy will be refused the service. A refusal letter will be sent to the member and the ordering provider. The member will be informed of their grievance rights.

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Health and Wellness Prescription Programs

Program Definition: AllCare CCO sponsored Wellness programs that assist members in achieving their weight-loss or pain management goals.

Administrator: Health and Wellness (H & W)

Program Inclusion Requirements:

- Must be a CCO member
- Member must meet eligibility requirements for AllCare CCO script program services

OAR and CFR requirements:

The H & W script program meets the following requirements, consistent with 45 C.F.R. § 158.150:

- The service 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; and
    - Be based on any of the following:
        - Evidence-based medicine; or
        - Widely accepted best clinical practice; or
        - Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

The Health & Wellness prescription program achieves the following goals, consistent with OAR 410-141-3845:

- Improve health outcomes compared to a baseline and reduce health disparities among specified populations;
- Implement, promote, and increase wellness and health activities;

Documentation requirements: (please see H&W policy for more information)

Health and Wellness team members will document the following:

- Member's name and ID
- Date of approved service
- Expiration or completion date (if applicable)
- Upload a copy of program script to members case in Essette

- Program type, Chronic Pain or weight management
- Members success in program, met or not met
- Members attendance
- Members height and weight

Tracking requirements: (please see H&W policy for more information)
Monthly, the designated staff (Health & Wellness) will reconcile and send the debit expenditures to AllCare Health's Finance Department.
Reviewed reconciled reports are provided to Finance by the 15th of the following month.
Process for Refusing Services: Members who were previously approved for the Health & Wellness prescription program may be refused if the member:

- Missed 3 or more scheduled appointments with YMCA staff
- Has been violent, abusive, non-compliant or otherwise threatening to YMCA staff and/or other members in the facility
- Currently seeing a physical therapist or other rehab provider for the referred medical concern

Requests for members for this program that do not meet the H & W script program criteria outlined in the policy will be refused the service. A refusal letter will be sent to the member and the ordering provider. The member will be informed of their grievance rights.

Gym Wear Program

Program Definition: Program to provide gym or swim wear to members using the gym

Administrator: Health and Wellness
Program Inclusion Requirements:

- Must be a CCO member
- Member must meet eligibility requirements for AllCare CCO gym or script program services
- Member must be enrolled in an AllCare gym program or script program
- Item must be appropriate footwear, swimwear, or clothing for gym or pool use
- Item must be $50 or less for shoes and $30 or less for swimwear or gym clothes
- Member cannot request the same item more than once per plan year

OAR and CFR requirements:

The gym wear program meets the following requirements, consistent with 45 C.F.R. § 158.150:

- The service 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; and
    - Be based on any of the following:
        - Evidence-based medicine; or
        - Widely accepted best clinical practice; or
        - Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

The gym wear program achieves the following goals, consistent with OAR 410-141-3845:

- Improve health outcomes compared to a baseline and reduce health disparities among specified populations;
- Implement, promote, and increase wellness and health activities;

Documentation requirements: (please see H&W policy for more information)

Health and Wellness team members will document the following:

- Member's name and ID
- Gym Wear Program
- Type of item: swimsuit, gym shoes, etc.
- Gym or script program
- Date of request

Tracking requirements: (please see H&W policy for more information)

Monthly, the designated staff (Health & Wellness) will reconcile and send the debit expenditures to AllCare Health's Finance Department.

Reviewed reconciled reports are provided to Finance by the 15th of the following month.

Process for Refusing Services:

Requests for items that do not meet the gym wear program criteria outlined in this policy will be redirected for a review under the individual flexible service request process.

Scale Program

AllCare Health
Health Related Services
Policies and Procedures

Health Related Services (HRS) Group Programs

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Program Definition: Program to provide scales to members in an AllCare CCO sponsored weight loss program

Administrator: Health and Wellness
Program Inclusion Requirements:

- Must be a CCO member
- Member must meet eligibility requirements AllCare CCO weight loss or script program
- Item must be a scale
- Item must be $30 or less
- Member cannot request the same item more than once while on plan

OAR and CFR requirements:
The scale program meets the following requirements, consistent with 45 C.F.R. § 158.150:

- The service 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; and
  - Be based on any of the following:
    - Evidence-based medicine; or
    - Widely accepted best clinical practice; or
    - Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

The scale program achieves the following goals, consistent with OAR 410-141-3845:

- Improve health outcomes compared to a baseline and reduce health disparities among specified populations;
- Implement, promote, and increase wellness and health activities;

Documentation requirements: (please see H&W policy for more information)
Health and Wellness team members will document the following:

- Member's name and ID
- Scale Program
- Weight loss or script program
- Date of request

Tracking requirements: (please see H&W policy XXX for more information)
Monthly, the designated staff (Health & Wellness) will reconcile and send the debit expenditures to AllCare Health's Finance Department.
Reviewed reconciled reports are provided to Finance by the 15th of the following month.
Process for Refusing Services:
Requests for items that do not meet the scale program criteria outlined in this policy will be redirected for a review under the individual flexible service request process.

HRS rides provided by NEMT vendor

Program Definition: Transportation provided by the NEMT vendor for CCO members for trips not covered under the Medicaid medical/behavioral/dental health benefit that the CCO does not require an individual flexible spending review for approval of ride

Administrator: UM NEMT
Program Inclusion Requirements:
- Must be a CCO member
- Member must meet eligibility requirements NEMT services
- The ride must fall into one of the following categories:
  - grocery trips
  - health and wellness education classes (e.g. Nutrition, prenatal)
  - support groups such as AA
  - gym trips
  - social services (e.g. UCAN, Social Security office)
- The ride cannot be eligible for an NEMT ride
- The ride must be cost efficient
  - For example: a grocery trip should be for local stores
  - Members should use the least expensive mode of transportation when appropriate
    - Bus or public transportation
    - Group rides

The program meets the following OAR and CFR requirements:
HRS Group Rides meet the following requirements, consistent with 45 C.F.R. § 158.150:
- The service 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; and
- Be based on any of the following:
  - Evidence-based medicine; or
  - Widely accepted best clinical practice; or
  - Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

HRS Group rides achieve the following goals, consistent with OAR 410-141-3845:

- Improve health outcomes compared to a baseline and reduce health disparities among specified populations;
- Implement, promote, and increase wellness and health activities;

Documentation requirements

Members are approved for an HRS group ride by the NEMT liaison. The NEMT liaison enters the following information in the EZCap Customer Service Module as an incident:

- Member's name and ID
- HRS Program Ride
- Type of HRS ride: grocery, pharmacy, class, support group, social services, or gym
- Destination name and (when applicable) address of ride
- Date of ride(s)

Tracking requirements

The NEMT Liaison will receive monthly reports from IT cataloging HRS rides entered in EZCap and reconciled with reports From Ready Ride.

Reviewed reconciled reports are provided to Finance by the 15th of the following month.

Process for Refusing Services

Members approved for HRS rides may be refused if the member:

- Threatens or performs acts of violence on themselves or others while on an HRS ride
- Has been denied NEMT previously due violent disturbances
- Cannot be provided in a cost-efficient method
- Repeatedly no-shows for scheduled HRS rides

Requests for rides that do not meet the HRS ride program criteria outlined in this policy will be redirected for a review under the individual flexible service request process.

Additional attendants for NEMT rides

Program Definition: Transportation to allow either both parents or guardian to attend children's medical appointments or to allow minors to accompany parents or guardians to plan covered appointments. Rides are provided by the NEMT vendor for either:

- A second parent or guardian attendant for CCO members under 18; OR
- Transportation for additional children with a CCO member or parent/guardian attendant to attend appointments if child care is not available

Administrator: UM NEMT

Program Inclusion Requirements:

- The appointment must be covered under the medical/behavioral/dental health benefit for a CCO member
- CCO member must meet eligibility requirements for NEMT services
  - One parent attendant is allowed to attend appointments with minor children covered under NEMT
- A second adult attendant may attend medical/behavioral/dental health appointments when
  - The appointment is for a CCO member under 18 years old
  - The second attendant is a parent or guardian of the CCO member
- Children may accompany a CCO member or guardian attendant to attend medical /behavioral/dental health appointments if child care is not available
  - Accompanying children must be a minor

The program meets the following OAR and CFR requirements:

Additional attendants for NEMT rides meets the following requirements, consistent with 45 C.F.R. § 158.150:

- The service 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; and
- Be based on any of the following:
  - Evidence-based medicine; or
  - Widely accepted best clinical practice; or
  - Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

Additional attendants for NEMT rides achieve the following goals, consistent with OAR 410-141-3845:

- Improve health outcomes compared to a baseline and reduce health disparities among specified populations;
- Implement, promote, and increase wellness and health activities;

Documentation requirements

Requests are approved for an additional attendant by the NEMT liaison. The NEMT liaison enters the following information in the EZCap Customer Service Module as an incident:

- Member's name, age, and ID
- Attendant name, age and relationship to member
- HRS NEMT Additional Attendant
- Destination name and (when applicable) address of ride
- Date of ride(s)

Tracking requirements

The NEMT Liaison will verify appointments that are to specialists or out of the area prior to the ride.

The NEMT Liaison will receive monthly reports from IT cataloging NEMT additional attendant entered in EZCap and reconciled with reports from Ready Ride.

Reviewed reconciled reports are provided to Finance by the 15th of the following month.

Process for Refusing Services

Additional attendants approved for NEMT rides may be refused if the member or attendant:

- Threatens or performs acts of violence on themselves or others while on a ride
- Has been denied NEMT previously due violent disturbances
- Cannot be provided in a cost-efficient method
  - For example, request is for four children but there is not a vehicle with room for the number requested

- Repeatedly no-shows for scheduled rides

Requests for rides that do not meet the additional attendant program criteria outlined in this policy will be redirected for a review under the individual flexible service request process.

Rogue Retreat

Program Definition: Private housing program that provides housing and shelter to homeless members. The program has multiple levels of entry and works through its case management program to help their clients learn self-sufficiency with both short- and long-term goals. AllCare CCO supports our member participation in the program by contracting with Rogue Retreat to provide case management services for our members enrolled in Rogue Retreat's programs.
Administrator: SDoH-E, HRS
Program Inclusion Requirements:

- The member must be an AllCare CCO member
- The member must meet Rogue Retreat inclusion criteria

The program meets the following OAR and CFR requirements:
Support for our members in Rogue Retreat meets the following requirements, consistent with 45 C.F.R. § 158.150:

- The service 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; and
  - Be based on any of the following:
    - Evidence-based medicine; or
    - Widely accepted best clinical practice; or
    - Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

Support for our members in Rogue Retreat achieves at the following goals, consistent with OAR 410-141-3845:

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

- Implement, promote, and increase wellness and health activities;
- Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;
- Improve patient safety, reduce medical errors, and lower infection and mortality rates

Documentation requirements

Rogue Retreat enrollment and disenrollment are approved by Rogue Retreat. Rogue Retreat provides the plan on an invoice with enrollment details to AllCare CCO:

- Member's name and ID
- Rogue Retreat residence or program
- Date of program enrollment and disenrollment

Tracking requirements

AllCare CCO staff will verify members are enrolled in CCO during period invoiced by Rogue Retreat.

Reports will provided from IT listing members who meet eligibility.

Reviewed reconciled reports are provided to Finance by the 15th of the following month.

Process for Refusing Services

AllCare CCO does not refuse entry or services to members eligible for Rogue Retreat. Rogue Retreat has the right to discontinue services to AllCare members based upon their program rules. AllCare CCO pays a PMPM case management rate for housed members but AllCare CCO does not provide funding for any fees the member incurs as a condition of enrollment in a Rogue Retreat program.

Oversight and Monitoring

All programs must be tracked in EZCap, Essette or a spreadsheet. Review of member use of programs should occur monthly by the administrating department's staff. Reconciled reports with ineligible members removed should be provided to Finance by the 15th of the following month.

Reporting

All data is reported to finance and to OHA on the exhibit L

References

45 C.F.R. § 158.150; 45 C.F.R. § 158.151; 410-141-3845; 42 CFR 438.402-408; OAR 410-141-3835 through 3915

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