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POLICY STATEMENT

In addition to Covered Services, AllCare Coordinated Care Organization (CCO) shall provide and cover the cost of Health-Related Services (HRS)in accordance with criteria set forth in Oregon Administrative Rule (OAR)410-141-3845, OAR 141-410-3500, and 45Code of Federal Regulations (CFR)§ 158.150(including those services identified in 45 CFR § 158.151).

45 C.F.R. § 158.150; 45 C.F.R. § 158.151; 410-141-3845; 42 CFR 438.402-408; OAR 410-141-3835 through3915; OAR410-120-1280

PURPOSE

Per OAR 410-141-3500, Flexible Services (FS) are 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. The purpose of this policy and its associated procedures is to establish how AllCare CCO:

(A) Encourages transparency and provider and member engagement, reflects streamlined administrative processes that do not create unnecessary barriers, and provide for accountability for health-related spending;
(B) Describes how health-related spending decisions are made; and

(C) Ensures no limits are placed on the range of permissible health-related services by any means other than by enforcing the limits defined in OAR 410-141-3845.

DEFINITIONS

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

"Flexible Services" and **"FS"** both mean 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" and **"HRS"** both mean 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

POLICY

PROCEDURES

A. AllCare CCO offers multiple avenues for requests for HRS spending for both members and the community
    1. Guidelines for HRS group program spending is outlined in CCO HRS 001
    2. This policy defines the criteria for HRS flexible spending services for CCO members
        a. Members and members' representatives can request HRS flexible services in their preferred language.
            i. Telephonically through Customer Care and/or Care Coordination
            ii. In person at any AllCare location
            iii. By fax or mail

a. AllCare provides a form on their website which may be used to request flexible services
b. The form is not required to process a request

iv. Through their medical, behavioral health, dental, or community agency provider

b. Providers (behavioral health, dental, or community or social services agency) can request HRS flexible services

i. Telephonically through Customer Care and/or Care Coordination
ii. By fax or mail n

a. AllCare provides a form on their website which may be used to request flexible services
b. The form is not required to process a request

iii. Through the AllCare CCO Provider Portal

a. The portal request for HRS flexible services includes the process for requesting funds for the service

i. The portal form is not a requirement for submission

b. Requests for HRS CBI services will be redirected to the CBI team

3. AllCare CCO promotes HRS flexible spending services

a. On our public website
b. In our member handbooks
c. As a promotional postcards distributed

i. To provider offices via our Provider Relations Team
ii. At community events via our Member Health and Wellness Team and Health Equity Team

d. In 2024, all materials will be available in Spanish as well as English

B. All HRS flexible service requests **must meet ALL of (B)(2)(a) and at least one component of (B)(2)(b)**; 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:
        i. Improve health quality;
        ii. Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements;
        iii. Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for then non-members; and
        iv. 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:
        i. Improve health outcomes compared to a baseline and reduce health disparities among specified populations;
        ii. Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;
        iii. Improve patient safety, reduce medical errors, and lower infection and mortality rates;
        iv. Implement, promote, and increase wellness and health activities;
        v. Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.

C. HRS flexible services AllCare CCO members must meet all of the following:
1. Services provided should be cost efficient
    a. If applicable, the least expensive service should be utilized
2. Requested services should be part of a treatment or care plan for the member
    a. Services should supplement covered benefits within the treatment plan and clinical record
3. The service must not be a covered service
    a. Most billable services with an associated code (e.g. CPT, HCPCS, or NDC) are not covered under flex
    b. Services not covered or excluded under the OHP benefit may be covered under HRS

        c. Services that may be covered under the OHP benefit must be reviewed as such before considered for HRS
    4. The service must not be covered by another agency, community partner or other source
        a. Care Coordination staff must work with other Medicaid and DHS agencies to facilitate service requests are provided by the appropriate provider, agency, or payer
        b. Oregon Medicaid is the payer of last resort
        c. When services are covered by community partners, Care Coordination should work with the partner, member and requesting provider to ensure the service can be accessed and there are improved health outcomes for the member
    5. The member must not be able to procure or purchase the service by their own means, or through familial or friend support
    6. Members must have current eligibility for CCO to receive service
    7. The request must be current or prospective
        a. AllCare CCO does not provide reimbursement for retroactive services
    8. The requested service should not be on-going whenever possible
        a. Services should closed ended when possible
        b. For example, AllCare CCO may pay for rent to cover one or more months but could not pay for ongoing rent
    9. The service must have a vendor
        a. AllCare CCO does not provide money directly to individuals or private parties
            i. For example, the member requests funds to help with moving expenses:
                a. The CCO could directly pay a moving company
                b. The CCO could not provide payment to the member to employ a third party for moving expenses

D. HRS flexible services 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 covered under Medicaid that were denied under the medical review 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 allowed under Medicaid coverage
    6. Part of a capitated medical, dental, behavioral health service program
    7. Eligible for appeal or hearing rights
    8. Billed or partially billable to the member

E. The request process for AllCare CCO flexible services is as follows
    1. Flexible services can be requested by the member, a family member, the member's provider, another agency, a community partner, or by internal AllCare staff

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2. All requests for HRS services are considered and reviewed
3. Requests may be made:
    a. Through the AllCare Health Provider Portal
    b. By fax or mail
    c. By telephone
    d. In person
4. The requestor should provide a treatment plan to support the request, although this is not required
    a. The member or member representative requestor will work with a Care coordinator to create a treatment plan, if one does not currently exist
    b. External treatment or care plans may consist of chart or case notes, or letter of medical need;
    c. Internal treatment plans should include Essette case notes
5. Requests are decided as expeditiously as possible but no later than 7 business days after receipt of the request
    a. AllCare CCO does not delegate decisions for flexible services to sub-contractor plans or entities.
    b. Decision making must be made by an appropriate staff member
    c. Requests can be approved, refused or withdrawn
        i. All flexible services requests that meet (B) & (C) of this policy will be approved
        ii. The initiating party, the member or the plan may withdraw the request
        iii. If the HRS flexible request is a Medicaid covered service, the request will be withdrawn by the plan and redirected to review under the process for covered services
    d. If the service is approved, the member and the requestor (if different) are informed inwriting
        i. AllCare staff may order and supervise the delivery of the service to the member or requesting provider
        ii. The requesting provider or agency may order and supervise the delivery of the service
    e. If the member is refused a service:
        i. The member will be sent a written letter of refusal with instructions on their right to file a grievance
        ii. The ordering provider will also be provided a copy of the letter
        iii. Grievances received by AllCare CCO regarding refused HRS spending must follow the procedures specified in 42 CFR438.402-408 and OAR 410-141-3835 through 3915
            a. See Quality department Appeals and Grievances Handbook for more information

F. Requests must be tied to an authorization number from EZCap

1. All requests will be accessible in EZCap
    a. Corresponding supporting documentation assigned the authorization number and tied to the member ID is stored in our document management system FileBound
2. Request history including plan review and decision rationale is available as an interface from EZCap to our Provider Portal
3. Requests are tracked by the identifying number and submitted to finance
4. Requests are reviewed monthly by the Utilization Management and Population Health staff
    a. Automated Business Objects Report:
        i. Daily EZ-CapHRS Requests-8111v1
            a. Used to ensure letters are sent out timely.
            b. Delivered twice daily to HRS team.
    b. SmartSheets are utilized for compliance:
        i. HRS Compliance Report
            a. We utilize this to ensure timely processing is completed and accurate information is being entered for Exhibit L.
    c. Tableau
        i. Monitoring is completed via Tableau Production Reports.
            a. Utilized to see the volume by user of requests coming in. This will help us identify the demand and staffing needs.
5. Annual flexible spending is presented to the Consumer Advisor Council (CAC) and Quality Improvement Committee
    a. For review of trends
    b. For input on potential group flexible spending programs or CBI opportunities
    c. For input on potential quality improvement plans

OVERSIGHT & MONITORING

All HRS spending is reported to the AllCare Health Finance Department provide oversight of all health-related service funds including the amount of the service, the individual member, member ID, a description of the service.

REPORTING

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

SUPPORTING POLICIES

CCO-QUAL-321 - Grievance Policy and Procedure

CCO-COMP-101 - HRS – Community Benefit Initiatives