FLEXIBLE FUNDS POLICY AND PROCEDURE

In this document, CCC is referenced in place of CCC and CHA.

CONTENTS

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Terms not defined in the DEFINITIONS section of this document may be found in our Glossary.

1 PURPOSE

1.1 This policy and procedure establish guidelines for expenditures defined as ‘flexible services” flex funds, support the well-being of members, and how these services can be applied for flexible services. Flex funds include supplies, equipment, or services paid for out of CHA’s Flex Fund program.

2 SCOPE

2.1 This policy defines resources available to members to support necessary care. The requested items or services are considered in the context of the member’s overall integrated care planning and management by the care team, including the member’s CHA case manager and medical, behavioral, and oral health providers. These requests are initiated by clinical or non-clinical providers.

3 POLICY STATEMENT

3.1 Flexible Funds are used to support member treatment plans to assist in promoting member safety, health, and wellness. To be eligible, the Oregon Health Plan (OHP) member must have medical coverage through Cascade Health Alliance (CHA) and be currently enrolled when a request is reviewed. Exception is made during pregnancy and for neonates if enrollment is in process. Individuals reviewing the application are responsible for verifying member eligibility status with Medicaid Management Information System (MMIS) and/or Essette Services requested must be consistent with the member’s treatment plan as developed by the member’s medical, behavioral and oral health providers or case management team. These may be clinical or non-clinical providers.

3.1.1 Treatment plans are developed in collaboration with the member, in the member’s preferred language and responsive to the member’s cultural needs.

3.2 Flex Fund coverage of services or equipment may be applied for by any participant of the member’s care team. Members desiring an item through Flex Funds should communicate with their provider or CHA Case Manager to have request submitted for review.

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3.2.1 Flex Fund request forms may be received through mail, fax or through the Provider Portal located on CHA's website. Members can find more information about flex funds and HRS on CHA's website https://www.cascadehealthalliance.com/for-members/health-related-services/

3.2.2 Documentation must be included with the request describing the need for the goods or services, how the services requested will promote Member's health, safety, or treatment goals. Documentation must be current within the last 6 months of request.

3.3 Services, supplies, and equipment needs may be identified through coordinated intervention planning with community agencies/partners but may not duplicate services that are provided through any other community agency.

3.4 Flex Funds are designated to meet the unique needs of an individual member. If the flex fund expense is not addressing a unique need, it is not an appropriate use of flex funds.

3.5 Flex Funds are used after other known sources of funding have been exhausted.

3.6 The purpose of the Flex Fund covered item or service must not be solely for diversional or recreational activities or items.

3.7 Flex Funds are limited to eligible members; members must be eligible on the date of the request review per MMIS.

3.8 Flex Fund expenditures will be documented with receipts and a brief statement of the therapeutic purpose of the expense.

3.9 Payments for Flex Fund services/goods are made directly to the vendor by CHA.

3.10 Flex Funds must be time limited per the member's care/treatment plan and cost-efficient.

3.11 Flex Funds disbursements are reported and categorized per Oregon Health Authority (OHA) criteria.

4 PROCEDURE

Process

4.1 The requesting individual must submit a completed *Flex Fund Request Form PP06008.01* to the Case Management (CM) Department. Forms are accepted by fax, mail, or the Provider Portal.

1.1 Requests are reviewed and processed within 14 calendar days by managers in the CM Department.

1.1.1 Requests that have a special circumstance my require additional review from the Member Experience & Health Equity Department.

1.2 Requests exceeding $500.00 in one calendar year will be sent to the Director of Clinical Operations and/or Director of Member Experience and Health Equity for second level review before approval.

4.2 Approval of Flex Funds is noted in the request and in member's Essette PM chart. If member is open to Case Management, the CM is notified, and approval is noted in CM chart notes under category heading "Flexible Funds".

4.3 Denial of Flex Fund request may be sent to the Director of Clinical Operations and/or Director of Member Experience and Health Equity for second level review. The CM Department will notify the provider and member of the decision.

4.3.1 Upon approval:

4.3.1.1 The provider is emailed an Authorization Summary via Essette.

4.3.1.2 Then a Case Assist will follow up with the member via phone to verify shipping address.

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4.3.2 Upon denial:

4.3.2.1 Denial Letter and Auth Summary are autogenerated and sent to provider via email.

4.3.2.2 Denial Letter and Auth Summary are autogenerated and sent to member via mail.

4.3.2.3 A member has the right to file a grievance in case of a denial for Flex Funds. A written notice of denial will be sent to the member with their right to file a grievance.

4.4 Denial of Flex Funds is noted in the request and in member's Essette PM chart. If member is open to Case Management, the CM is notified, and denial is noted in CM chart notes under category heading "Flexible Funds".

4.5 No appeal or reconsideration rights are allowed under the Flex Fund policy.

4.6 Most items can be ordered online and shipped directly to the Member after verification of shipping address. If member cannot be reached after at least 3 attempts with at least one in writing in a 30-day period, the Flex Fund request will be cancelled, and item not ordered.

4.7 When items are available through the CHA office, members are notified by telephone when an item is ready for pickup; items are available for 30 calendar days after notification. If items are not picked up during that time, items may be returned, and the request cancelled.

4.8 CHA staff will work with member's PCP/clinic to obtain current, viable contact information as needed.

Tracking

4.9 Flex Fund requests are processed in the standard Utilization Management platform and are searchable and reportable.

4.10 A Flex Fund log is maintained, per contract year, to track the cost of goods and/or services provided. A separate line/row for each payment of service is made. Each log must include, at a minimum:

4.10.1 Member ID

4.10.2 Date of service

4.10.3 Health condition to be improved.

4.10.4 Name of provider or payee for the service or goods

4.10.5 The applicable Flexible Service category (new categories cannot be added):

4.10.5.1 Health improvement

4.10.5.2 Medical supplies

4.10.5.3 Home safety needs

4.10.5.4 Food and oral supplements

4.10.6 The applicable Rationale for the Flexible Service

4.10.7 How the effectiveness of the goods and/or services are measured and demonstrated

4.10.8 Cost

5 RESPONSIBILITIES

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Compliance, Monitoring and Review

5.1 The Flex Fund log is compiled and stored in the Case Management shared folder on the secure network.

5.2 The Executive Approval Committee will review this policy for compliance with OHA contract and guidelines at least once a year, or as applicable.

Reporting

5.3 Flexible Funds are recorded within Exhibit L and submitted to the state as specified by OHA. The amount reported is the total expenditure for all flexible services provided to members during the reporting period.

5.3.1 Exhibit L Financial Reporting Template can be found at https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx

Records Management

5.4 Team Members must maintain all records relevant to administering this policy and procedure in our record management system.

6 DEFINITIONS

Terms and Definitions

6.1 **Flexible Services:** Health-related, non-State Plan services intended to improve health outcomes, care delivery, prevent and/or delay health deterioration and lower cost. Flexible Services are considered in the context of the member's overall integrated care planning and management by the primary care team, including the member's behavioral and oral health. Flexible Services are often unable to be reported in the conventional manner using Current Procedural Terminology (CPT) or Healthcare Common Procedural Coding System (HCPCS) codes and can effectively treat the physical or mental healthcare condition documented in the Member's health or clinical record Services must be consistent with member's treatment plan as developed by the primary care team and documented in the clinical record. Services must be cost effective alternatives to cover benefits and likely to generate a savings. Flexible Services may include, but are not limited to:

6.1.1 Purchased good and/or services necessary to meet the identified needs to member/family as part of the treatment plan.

6.1.2 Non-prescription nutritional items of services (e.g., training in healthy food preparation)

6.1.3 Educational services, both group and individual

6.2 **Flex Funds**: The program which processes, pays for, and dispenses requested Flexible Services.

7 RELATED LEGISLATION AND DOCUMENTS

7.1 OHA: Coordinated Care Organizations (CCO)

7.2 OHA Exhibit L Financial Reporting Template

8 FEEDBACK

8.1 Team Members may provide feedback about this document by emailing policyfeedback@cascadecomp.com.

9 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	Executive Approval Committee
Committee Review Dates	10/09/2018, 10/17/2019
Approval Dates	10/23/2019

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10 APPENDICES

10.1 APPENDIX 1: *Flex Fund Request Form PP06008.01*

10.2 APPENDIX 2: *Flex Fund Dispense Form PP06008.03*

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