HEALTH-RELATED SERVICES 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 the Glossary.

1 PURPOSE

1.1 Establishes Cascade Health Alliances (CHA's) Health-Related Services (HRS) policy in order to ensure that services not covered by the Oregon Health Plan (OHP) yet will improve care delivery, overall member health and well-being, as well as the quality of healthcare provided are available to members.

1.2 Ensures the efficient use of CHA resources.

1.3 Allows for assistance in addressing the Social Determinants of Health and Health Equity (SDOH-HE) impacting members in order to improve member health outcomes, alleviate health disparities, and improve the overall well-being of our community.

2 SCOPE

2.1 This policy applies to all staff, members and provider partners.

2.2 This policy includes the provision of Flexible Funds and Community Benefit Initiatives (CBI).

3 POLICY STATEMENT

3.1 HRS are services that improve health care quality as defined by the following four criteria:

3.1.1 Activities that are specifically designed to improve health quality

3.1.2 Activities that increase the likelihood of desired health outcomes in ways that can be objectively measured and demonstrate verifiable results

3.1.3 Activities are directed toward individuals or segments of member populations, or provide health improvements to the community without cost to non-CHA members

3.1.4 Activities that are evidence-based, widely accepted best clinical practice, or practices recognized by accreditation bodies, recognized professional medical organizations, government agencies, or other national health care quality organizations

3.2 Activities designed to improve health care quality must meet at least one of the following criteria:

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

3.2.2 Prevent avoidable hospital readmissions

3.2.3 Improve patient safety, reduce medical errors, and lower infection and mortality rates

3.2.4 Implement, promote and increase wellness and health activities that can address Social Determinants of Health (SDOH)

3.2.5 Support expenditures related to health information technology and meaningful use requirements

3.3 Flexible Services may be used to support member treatment plans to assist in improving overall member health and wellness. To be eligible, the Oregon Health Plan (OHP) member must have at least one year of continuous enrollment with medical coverage through Cascade Health Alliance (CHA) and be currently enrolled when a request is made. 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 primary care team.

3.3.1 Treatment plans are developed in the member's preferred language and responsive to the member's cultural needs.
3.3.2 Documentation must be included in the clinical record describing how the services requested are appropriate and needed to achieve the treatment goals. Documentation must be current within the last 6 months of request.
3.3.3 Services may include coordinated intervention planning with community agencies/partners but may not duplicate services that are provided through any other community agency.
3.3.4 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.
3.3.5 Flexible Funds are only to be used after all other sources of funding have been exhausted.
3.3.6 Flex funds may not be used purely for diversional or recreational activities or items.
3.3.7 Flex funds are limited to eligible members; members must be eligible on the date of the request per MMIS.
3.3.8 Flex services expenditures must be documented with receipts and a brief statement of the therapeutic purpose of the expense.
3.3.9 Payments for flex fund services/goods are made directly to the vendor by CHA.
3.3.10 Flex funds must be time limited per the member's care/treatment plan and cost-efficient.
3.3.11 Flex funds are limited to $250.00 per member per calendar year.
3.3.12 Flex service funds are reported and categorized per Oregon Health Authority (OHA) criteria.

3.4 Health-related services are provided as a supplement to covered health care services:

3.4.1 HRS may be provided as flexible services or as community benefit initiatives, as those terms are defined below.

3.4.2 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

3.4.3 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.

3.5 HRS may include but are not limited to the following:

3.5.1 Training and education; for example, classes on healthy meal preparation, diabetes and self-management programs

3.5.2 Care coordination, navigation, or case management activities not otherwise covered by OHP; for example, high utilizer prevention programs

3.5.3 Home and living environment items or improvements not otherwise covered by 1915 Home and Community Based Services authorities; for example, Durable Medical Equipment (DME) items to improve mobility, access, or hygiene; for example, air conditioners, athletic shoes or other special clothing

3.5.4 Transportation not otherwise covered under OHP

3.5.5 Assistance with food or other social resources; for example, sponsoring a Farmer's Market in a "food desert" or workforce development programs

3.5.6 Housing supports related to SDOH; for example, temporary housing or shelter, utilities, or critical repairs

3.5.7 Assistance with food or other social resources; for example, supplemental food, referrals to job training or social services

4 PROCEDURE

4.1 HRS may not pose an administrative burden to the individual member or member of the community, nor will individual members or members of the community at large be required to share the cost of these services.

4.2 Flexible Funds are cost effective services designed to supplement covered benefits.

4.2.1 Flexible Funds are administered by the Case Management (CM) Department in accordance with the *Flexible Funds Policy and Procedure PP06008*.

4.2.1.1 Flexible Funds must be for an individual member and in alignment with the member's treatment plan.

4.2.1.2 Flexible Funds bay be requested and approved by both clinical and non-clinical providers

4.3 CBI are community-level interventions, which include details on Supporting Health for All through REinvestiment (SHARE Initiatives), that focus on addressing barriers in SDOH for members and improving the health of the entire community.

4.3.1 CBI are administered by the Government Relations Department through the *SDOH Health Equity Priorities Spending PP11005*.

4.3.1.1 CBI are defined in Section four (4) of *SDOH Health Equity Priorities Spending PP11005* under the Community Fund Programs.

4.3.2 CBI must be in alignment with the Community Health Improvement Plan (CHIP) and SDOH-HE priority areas established by the Community Advisory Council (CAC).

4.3.3 The *SDOH Health Equity Priorities Spending PP11005* defines the CAC's role and the Tribal role in CBI funding decisions.

4.3.4 CBI must have defined measures of success and a timeline for reporting progress and outcomes of the project.

4.3.5 CBI engagement strategies are defined in the *SDOH Health Equity Priorities Spending PP11005* and the Cascade Health Alliance Community Engagement Plan.

4.3.5.1 This includes CHA's engagement with SDOH-HE service providers.

4.4 HRS may also include multi-sector interventions if the activity meets the criteria defined above in the Policy Statement.

4.4.1 Multi-sector interventions are determined by Executive Leadership

4.4.2 Multi-sector interventions must have defined measures of success and a timeline for reporting progress and outcomes of each proposed intervention.

4.4.3 Interventions and/or projects are targeted to prioritized populations based on performance metrics which clearly identify a need in the community or within the prioritized population and are designed to address disparities among the prioritized population(s).

5 PROCESS

5.1.1 Provider must submit a completed *Flex Fund Request Form PP06008.01* to the Case Management (CM) Department. Forms are accepted by fax or mail.
5.1.2 Routine requests are reviewed and processed within 14 calendar days by the CM Department.
5.1.3 Denial of Flex Fund request requires the review of a Case Manager and may be sent to the Chief Medical Officer (CMO) for second level review. The CM Department must notify the provider and member of the decision.
5.1.4 No appeal or reconsideration rights are allowed under the Flex Fund policy.
5.1.5 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 are returned to stock and another request for the same item will not be accepted unless six months have passed from the previous request.

6 RESPONSIBILITIES

Compliance, Monitoring and Review

6.1 The Director of Customer Experience and Health Equity is responsible for the overall administration of the HRS Plan and its supporting policies and procedures and ensures its compliance with CHA's Policies and Procedures as well as CHA's contract with the Oregon Health Authority (OHA), including:

6.1.1 Reviewing progress reports and outcomes of projects funded through the CAC (Community Benefit Initiatives).

6.1.1.1 Grantees identified as not meeting the stated objectives of the project consistently through two quarters' review will be contacted and offered technical assistance and/or placed on a Corrective Action Plan to enable them to meet the project's stated objectives.

6.1.1.2 Grantees who do not meet the project's stated objectives at the conclusion of the funding year will not be considered for future funding until they can demonstrate the necessary infrastructure and resources to do so.

6.1.2 Analyzing performance data to identify prioritized populations whereby multi sector interventions may have an impact on the health outcomes of our community.

6.1.3 Making recommendations to Executive Leadership for funding consideration based on community performance metrics.

6.1.4 Evaluation of the HRS Plan and Performance annually, including review and revision of policies and procedures as necessary.

6.2 The Chief Financial Officer (CFO) is responsible for the aggregation and submission of financial reporting as in Exhibit L of the OHA contract.

6.3 The Chief Operations Officer(COO) or designee is responsible for oversight of the Community Advisory Council and Community Projects Advisory Committee, including:

6.3.1 Review of all submitted project proposals

6.3.2 Monitoring progress of all funded projects

6.3.3 Reporting progress of all funded projects to the CAC and the Operations Council

6.4 The Director of CM is responsible for oversight and management of Flexible Funds, including:

6.4.1 Ensuring accurate documentation and reporting of all funds expended

6.4.2 Timely communication with providers, members and/or caregivers regarding funding requests

6.4.3 Ensuring family and member engagement and participation in the development of treatment plans

6.4.3.1 Treatment plans will be developed in the member's preferred language and responsive to the member's cultural needs

6.5 Executive Leadership is responsible for reviewing funding recommendations as presented by community stakeholders and partners and/or the Member Services Department based on analysis of data indicating a community need.

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

Reporting

6.7 The Director of Customer Experience and Health Equity will submit all HRS policies and procedures to OHA on October 1 of every year, or sooner as requested by OHA.

6.8 The CFO will submit Exhibit L to the OHA as required by CHA's contract with OHA.

Records Management

6.9 The COO or designee maintains all records pertaining to CBI, including but not limited to:

6.9.1 Requests for Grant Proposals

6.9.2 CPAC deliberations regarding the determination of the granting of funds.

6.9.3 Progress reports submitted by grantees, including outcome data related to the project.

6.9.4 Minutes of the meetings of the CAC.

6.10 The Director of CM maintains all records pertaining to Flexible Funds, including but not limited to:

6.10.1 All funding requests

6.10.2 All funds dispersed, including the documentation of the item for which funds were dispersed

6.10.3 Member treatment plans demonstrating the necessity of the items for which Flexible Funds were used.

6.11 The Provider Network Manager maintains all contracts executed with community partners, including SDOH partners.

7 DEFINITIONS

Terms and Definitions

7.1 **Health Equity:** Reaching the highest possible level of health for all people. Health inequities result from health, economic, and social policies that have disadvantaged communities.

7.2 **Health Related Social Needs:** An individual's social and economic barriers to health, i.e. housing instability or food insecurity.

7.3 **Social Determinants of Equity**: Systemic or structural factors that shape the unfair distribution of the social determinants of health in communities. These structural factors are evident in social norms, policies and political systems, both historical and current.

7.4 **Social Determinants of Health (SDOH)**: the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities.

8 RELATED LEGISLATION AND DOCUMENTS

8.1 45 CFR 158.150

8.2 CHA Request for Grant Proposals

8.3 Community Projects Advisory Committee (CPAC) Charter

8.4 Exhibit A for RFGP 2019

8.5 *Flexible Funds Policy and Procedure PP06008*

8.6 Health-Related Services Guidance Document, Oregon Health Authority Health Policy and Analytics Division Office of Health Policy, March 2020

8.7 Using Health-Related Services to Address Housing Needs: A Guide for Oregon CCOs; Oregon Health Authority, December 2020

8.8 Health-Related Services Community Benefit Initiatives, March 2020

8.9 HRS CCP Policy Requirements and Evaluation Criteria, December 2020

8.10 Health-Related Services Roadmap

8.11 Health Insurance Portability and Accountability Act (HIPAA)

8.12 Oregon Administrative Rule (OAR) 410-141-3000; 410-141-3150; 410-141-3180, 410-141-3500, 410-141-3845

8.13 Oregon Health Authority (OHA): Coordinated Care Organizations (CCO)

8.14 *SDOH Health Equity Priorities Spending PP11005*

9 FEEDBACK

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

10 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	Executive Approval Committee

Approval and Review	Details
Committee Review Dates	10/17/2019
Approval Dates	10/18/2019