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, member be currently enrolled on the Oregon Health Plan (OHP) 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 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

3.6 HRS information can be located on the CHA website at: https://www.cascadehealthalliance.com/for-members/health-related-services/ and within the CHA member handbook.

3.6.1 Providers can access the Flex Fund request form on the Provider Portal at: https://www.cascadehealthalliance.com/for-providers/health-related-services/

3.6.2 Members may request flexible funds through their provider, or the Case Management team as referenced in *Flexible Funds Policy and Procedure PP06008.*The Flex fund request form is available in both English and Spanish. Flex fund request can also be made available in other languages upon request.

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 may be requested and approved by both clinical and non-clinical providers

4.3 CBI like Supporting Health for All through Reinvestment (SHARE Initiatives) are community-level interventions 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 Member Experience & Health Equity 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 HRS may also include multi-sector interventions if the activity meets the criteria defined above in the Policy Statement.

5.2 Provider or the Case Management team 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.

5.3 Routine requests are reviewed and processed within 14 calendar days by the Case Management Department

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

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

5.5 Approval of Flex Funds is noted in the Flex Fund Request Form 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".

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

    5.6.1 Upon approval:

        5.6.1.1 The provider is emailed an Authorization Summary via Essette, when applicable.

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

    5.6.2 Upon denial:

        5.6.2.1 Denial Letter and Auth Summary are autogenerated and sent to provider via fax or provider portal within required timeline, when applicable.

        5.6.2.2 Denial Letter and Auth Summary are autogenerated and sent to member via mail within required timeline.

5.7 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

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

5.9 Members are notified by telephone when an item is ready for pickup or will be delivered; 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.

5.10 Any CHA staff can submit a HRS request using the HRS Check Request form

    5.10.1 All HRS requests are reviewed by the Director of Customer Experience and Health Equity then routed through the CHA chain of command.

    5.10.2 HRS requests can be made by CHA staff members, if the request falls under OHA and Federal guidelines:

        5.10.2.1 Activities that improve health care quality (45 CFR 158.150).

        5.10.2.2 Expenditures related to health information technology and meaningful use requirements to improve health care quality (45 CFR 158.151).

        5.10.2.3 Health-related services are defined by Oregon Administrative Rules (OAR 410-141-3500 and 410-141-3845), the 1115 waiver special terms and conditions, and federal regulations.

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 CHA members who receive Flex Fund will receive a follow up call within 6 months of the intervention to receive feedback on the effect of the Flex Fund intervention of the given member's health and/or wellbeing. This feedback will be documented to inform decisions on similar interventions in future.

6.1.2 CHA monitors its community benefit interventions funded through the HRS and SHARE Initiative through receipts; pictures; videos; periodic project reports; site visits etc. This may also entail soliciting feedback from beneficiaries of the specific projects.

6.1.3 CHA's Health Equity Council (beginning with its Member Experience Subcommittee) will review and analyze individual level feedback and data collected for monitoring and tracking from these projects in order to identify spending effectiveness in alignment with CHA's Health Equity Plan and Transformation and Quality Strategy. Projects whose outcomes inform quality improvement will be considered for continued and/or future funding from CHA.

6.1.4 The Community Advisory Council (CAC) will review the findings of the HEC.

6.1.4.1 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.

6.1.4.2 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.

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

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

6.1.7 Evaluation of the HRS and SHARE Initiative Plan and Performance annually also includes review and revision of policies and procedures as necessary by the HEC and the Health Equity Department.

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 Clinical Operations 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 & Health Equity 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 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   *SDOH Health Equity Priorities Spending PP11005*

8.7   *Health Equity PP14001*

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

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

8.10   Health-Related Services Community Benefit Initiatives, March 2020

8.11   HRS CCP Policy Requirements and Evaluation Criteria, December 2020

8.12   Health-Related Services Roadmap

8.13   Health Insurance Portability and Accountability Act (HIPAA)

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

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

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