



HRS FREQUENTLY ASKED QUESTIONS (FAQ)

Background

Health-related services (HRS) began in 2013 with the inception of Oregon's Coordinated Care Organizations (CCOs). The history of HRS and how it has evolved is further detailed in the [HRS Brief](#). HRS are defined as non-covered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being. One of the purposes of HRS is to give CCOs a specific funding mechanism within their global budgets to address the social determinants of health (SDOH), including the health-related social needs of their members.

For CCOs to use federal Medicaid funds to pay for HRS, they must comply with state and federal criteria. For a full definition of HRS, CCOs should rely primarily on the [OHA HRS Brief](#) and Oregon Administrative Rules (OARs) [410-141-3500](#) and [410-141-3845](#). The Code of Federal Regulations ([45 CFR 158.150](#) and [45 CFR 158.151](#)) should be used for supplemental CCO guidance only.

This FAQ expands upon the OHA HRS Brief, provides examples of what is and what is not HRS, describes how CCOs might implement HRS, and describes how OHA incorporates HRS into CCO payments. Additional guidance and technical assistance can be found on OHA's [HRS webpage](#).

This FAQ will be updated as additional questions are addressed. Please email questions to health.relatedservices@oha.oregon.gov.

Definitions

Health-related services (HRS): Non-covered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being. The two types of HRS include flexible services and community benefit initiatives, as defined below

Flexible services (FS): Cost-effective services delivered to an individual OHP member to supplement covered benefits and improve their health and well-being.

Community benefit initiatives (CBI): Community-level interventions that include — but are not limited to — OHP members and are focused on improving population health and health care quality.

Contents: Frequently Asked Questions

Changes in the September and December 2023 FAQ releases	3
Criteria, inclusions and exclusions for health-related services (HRS) activities	3
1. What are the criteria for being considered HRS?	3
2. Are there exclusions to the activities that can be counted as HRS?.....	4
3. Can HRS fund services that cannot be billed using standard medical billing?.....	5
4. How does HRS intersect with the Prioritized List and can HRS be used to fund denied services?.....	6
5. Can HRS be used to address SDOH?	6
6. How are HRS related to value-based payments?	6
7. Can HRS CBIs fund both pilot initiatives and long-term initiatives?	7
HRS and other spending mechanisms	7
8. How is HRS spending different from in ILOS spending?	7
9. How is HRS spending different from SHARE initiative spending?.....	7
10. Can HRS continue to include housing and food-related flexible services with the upcoming HRSN covered benefits in the 2022-2027 Medicaid 1115 Demonstration Waiver?	8
11. Can HRS be used to fund staff?.....	8
12. Can HRS be used to cover OTC medications or durable DME?.....	8
13. Can HRS be used to fund paramedic services?	8
14. Can HRS be used to purchase mobile hot spots, internet service, and tablets for social service agencies?.....	8
15. Can HRS be used to fund gaps in eligibility for other social services or Medicaid covered services?	9
16. Can HRS be used to fund housing-related services?.....	9
17. Can HRS support community-based activities, such as a farmers' market or a houseless shelter?.....	9
18. Can CCOs use HRS for advertising, corporate sponsorships or other activities that are not listed in OAR 410-141-3845?	9
19. Can HRS be used to fund capital investments in new buildings for providing medical or imaging services?	9
20. Can HRS be used to support provider workforce training?	9
Member access to HRS	10
21. What is a CCO's responsibility to share HRS information with members and the community?	10
22. Does the member's primary care provider or clinician have to approve a HRS flexible service?	10
23. What is a CCO's responsibility to a member when an HRS request is denied?.....	10
24. Are CCO A members the only CCO members eligible to receive HRS?.....	10
Implementing, tracking and reporting HRS	11
25. Can OHA pre-approve CCO HRS spending?	11
26. Do the CCO's CAC and do Tribes need to participate in the approval of all HRS CBIs?	11
27. What are CCO reporting requirements for HRS investments?	11
28. Can CCOs rely on published studies to support the use of HRS?.....	11
29. Is a positive return-on-investment (ROI) required as a part of any evidence-based criteria?	12
30. How should the CCO report HRS investments paid from quality pool dollars?	12
31. Can CCOs report matching funds provided by a CCO to a community organization or agency as HRS?	12
HRS considerations in rate development, medical-loss ratio and performance-based reward	12
32. How are HRS considered within the medical loss ratio (MLR) calculation compared to rate development?.....	12
33. How are HRS considered in rate development and related to performance-based reward (PBR)?	13
34. Can CCOs expect any credibility adjustments based on CCO size in the consideration of HRS in their rates?	13
Resources	13

Changes in this December 2023 FAQ release

- ✓ This December 2023 version of the HRS FAQ primarily included organizational and formatting updates to improve document navigation and readability.
- ✓ Question 20 was updated to include information about OHA's Health Care Provider Incentive Program as a resource for improving provider network capacity.
- ✓ Question 21 was added to address questions about CCOs' responsibility in sharing HRS information with members and the community.

Changes in the September 2023 FAQ release

- ✓ Question 2 was updated to reflect HRS exclusions referenced in other HRS guidance documents.
- ✓ Question 10 was added and question 16 was updated to address questions about HRS and the upcoming health-related social needs benefits in the 2022–2027 Medicaid 1115 Demonstration Waiver.
- ✓ Questions 13-15 were added to address specific service provider and service eligibility questions including paramedics, internet services, and other social services provided outside of Medicaid.
- ✓ Question 20 was updated to address questions about education and scholarships.
- ✓ Question 24 was added to address questions related to HRS eligibility by CCO member type.
- ✓ Question 25 was added to outline how CCOs can request OHA feedback on HRS spending prior to OHA's annual review of CCO HRS spending.

Criteria, inclusions and exclusions for health-related services (HRS) activities

1. What are the criteria for being considered HRS?

CCOs should refer to the criteria defined under Oregon Administrative Rules (OARs) [410-141-3500](#) and [410-141-3845](#) and Code of Federal Regulations (CFRs) [45 CFR 158.150](#) and [45 CFR 158.151](#). Specifically, to be considered an HRS, a service must meet the following criteria:

- Be designed to improve health quality;
- Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and produce verifiable results and achievements;
- Be directed toward either individuals or segments of enrollee populations, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and
- Be grounded in evidence-based medicine, widely accepted best clinical practice or criteria issued by accreditation bodies, recognized professional medical associations, government agencies or other national health care quality organizations.

In addition, the HRS must meet at least one of the following criteria:

- Improve health outcomes compared to a baseline and reduce health disparities among specified populations
- Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge
- Improve patient safety, reduce medical errors, and lower infection and mortality rates

[Back to top](#)

- Implement, promote and increase wellness and health activities
- Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are laid out in [45 CFR 158.151](#), which promote clinic community linkage and/or referral processes or support other activities as defined in [45 CFR 158.150](#)

2. Are there exclusions to the activities that can be counted as HRS?

Yes. CCOs have the flexibility to identify and provide HRS beyond examples cited in the Oregon Administrative Rules (OARs) [410-141-3500](#) and [410-141-3845](#) and Code of Federal Regulations (CFRs) [45 CFR 158.150](#) and [45 CFR 158.151](#). However, the following expenditures and activities are excluded from HRS because they do not meet the definition of "improving health care quality" in CFR:

- Those that are designed primarily to control or contain costs;
- Those which otherwise meet the definitions for quality improvement activities but were paid for with grant money or other funding separate from premium revenue;
- Those activities that can be billed or allocated by a provider for care delivery (and therefore are reimbursed as clinical services);
- Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended;
- That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
- All retrospective and concurrent utilization review;
- Fraud-prevention activities;
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
- Provider credentialing;
- Marketing expenses;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- That portion of prospective utilization that does not meet the definition of activities that improve health quality.

Additionally, based on prior OHA guidance, the following are also excluded from HRS:

- Administrative activities to support the delivery of covered services
- CCO and clinic staff time on administering HRS (see also question 11 for additional details on staff costs)
- Community partner staff time for activities not associated with HRS services (see also question 11 for additional details on staff costs)
- CCO contractual requirements, such as ensuring an adequate provider network, required care coordination for covered services, or establishing and supporting a CCO community advisory council
- Provider workforce or certification training (see also question 20 for additional details on workforce training)
- Broad assessments or research, as it does not directly or on its own improve member and/or community health or health care quality
- Advocacy work that does not directly improve member and/or community health or quality of health care

[Back to top](#)

- Marketing and promotional materials of CCO services or products that are distributed to the broader community and are not considered member health education materials
- Capital investments in new housing structures or in new structures that will provide OHP covered services

3. Can HRS fund services that cannot be billed using standard medical billing due to the way they're provided such as health education, exercise or nutrition classes or peer-led support groups, or other services provided by an unlicensed provider?

Yes. As long as the service is not eligible to be a covered service for the particular member, and the service meets the other criteria under [OAR 410-141-3845](#), it can be HRS. Covered services are prohibited by federal rule from being HRS. It is also helpful to understand how OHA applies the terms “covered services” and “billable services” to HRS:

Covered services vs. Billable services

In federal rule, [45 CFR 158.150\(c\)\(4\)](#) excludes from HRS “Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services.” OHA interprets this to mean that services which are reimbursed as clinical services because they meet the definition of covered services are not HRS. OHA does not interpret this to exclude “billable” services from HRS. Thus, covered services are not the same as billable services when applied to HRS. Covered services are services described in CCO contracts and in Oregon’s Medicaid State Plan as being part of the benefits that CCOs are required to provide to their members. HRS are a complement to covered services. The term “billable” is often used to describe whether a facility or provider currently has the necessary licensing and Medicaid provider enrollment status to perform Medicaid billing functions. Whether a CCO member is eligible for covered services is not affected by whether a provider can (or wants to) bill Medicaid. See the examples below and Table 1: Medical Services vs. Health-Related services for further explanation.

Examples

- A CCO contracts with a yoga instructor that is not an enrolled Medicaid provider to offer a yoga class in a local community center. The instructor is not supervised by a clinician and the class is free to anyone, but CCO members have priority (meeting the requirement in [OAR 410-141-3845\(2\)\(a\)\(C\)](#) that there’s no extra cost to offer to non-CCO members) and there is a 20-person limit per class. It’s not a covered service because there is no diagnosis (even though there would be a procedure code if the instructor could bill medical claims). **This can be an HRS.**
- A CCO contracts with a clinic, which is a Patient-Centered Primary Care Home. One of the clinic’s employees offers a weekly yoga class for patients, and the employee (who may not be licensed) is supervised by medical professionals. Dr. Sanchez refers Mike, a CCO member, to this class for his back pain and he attends. The clinic bills HCPCS billing code S9451 for a diagnosis of back pain and the CCO covers it at the negotiated rate. **This is a covered service and cannot be an HRS.**
- Same scenario as #1 above, but the class is offered both to CCO members, with and without back pain, and non-members. The cost of attendance for CCO members with back pain would be a covered service. **The cost of attendance for CCO members without back pain could be HRS, flexible services. The cost of attendance for non-CCO members could be HRS, community benefit initiative.**

Table 1: Medical Services vs. Health-Related Services

Medical Services	Health-Related Services
Are:	Are:
<ul style="list-style-type: none"> Billed to CCO by a licensed, enrolled Medicaid provider (may be rendered by non-licensed staff under supervision) Billed to CCO using standard medical billing codes (ICD-10, CPT, HCPCS) Reported by CCO to OHA as encounter data (837) Considered for benefit load in capitation rate setting (only if they are covered services) 	<ul style="list-style-type: none"> Services or goods not covered by Medicaid Services meeting requirements of OARs 410-141-3500 and 410-141-3845 and CFRs 45 CFR 158.150 and 45 CFR 158.151 Reported by CCO to OHA on Exhibit L of the financial reports Considered for non-benefit load in capitation rate setting
May be:	May be:
<ul style="list-style-type: none"> Paid by CCO as covered benefit Paid by CCO as HRS, if it is not a covered benefit for that particular member Paid by CCO under an exceptions process and reported as a medical loss Denied by CCO 	<ul style="list-style-type: none"> Purchased directly by CCO at retail or through contracts Provided directly by CCO staff Provided by unlicensed providers not under supervision
	May NOT be:
	<ul style="list-style-type: none"> Covered services under OHP or services covered under a medical review exception process Services or goods available through other programs based on Medicaid being the payer of last resort Services paid for with non-CCO grants or other non-Medicaid funds Administrative expenses such as continuing education for providers and staff

4. How does HRS intersect with the Prioritized List and can HRS be used to fund denied services?

Some services may be denied because they are below the funding line, don't meet criteria of a Health Evidence Review Commission (HERC) guideline, or are considered cosmetic, experimental, or not medically necessary/appropriate. Those types of services can be considered HRS if they are not covered under a medical exception process and meet other HRS criteria. In general, services billed by licensed, enrolled providers using HIPAA-compliant claims are medical services. However, if the services are not covered benefits under OHP, then they may be considered HRS if they meet all other HRS criteria. See also Question 3 above for additional details on "billable services" versus "covered services".

5. Can HRS be used to address social determinants of health (SDOH)?

Yes. The goals of HRS are to promote the efficient use of resources and address members' SDOH to improve health outcomes, alleviate health disparities, and improve overall community well-being. OHA has additional guidance for CCOs on using HRS to address SDOH-E on the [HRS webpage](#).

6. How are HRS related to value-based payments?

A non-covered service could be HRS or could be part of a value-based payment (VBP) arrangement, depending on how the CCO agrees to pay for the service. If a clinic is contracted to provide services to a member through a capitated VBP arrangement with a link to quality, and chooses to include goods/services not covered under Medicaid as a part of their

[Back to top](#)

treatment, those costs are considered part of a VBP, not HRS. If a clinic is not already receiving a capitated VBP for a CCO member, they could request the CCO provide funding for goods/services not covered under Medicaid, and the CCO could report those costs as HRS. If a clinic has a capitated VBP arrangement, they could request funding for goods/services not covered under Medicaid, and the CCO could report those costs as HRS, as long as the value of the service is not included in the VBP payment. A CCO must report the value of goods/service as either an HRS or VBP, but not as both.

7. Can HRS community benefit initiatives (CBIs) fund both pilot initiatives and long-term initiatives?

Yes. CCOs have the flexibility to identify and provide HRS CBIs that are pilot initiatives or long-term initiatives, as long as the service meets all other HRS criteria.

Health-related services (HRS) and other spending mechanisms

8. How is HRS spending different from in lieu of services (ILOS) spending?

HRS are non-covered services that are offered as a complement to covered benefits under Oregon's Medicaid State Plan. ILOS are determined by OHA to be a medically appropriate and cost-effective substitute for a covered benefit under Oregon's Medicaid State Plan. Similar to HRS, CCO spending on ILOS is optional. Receiving ILOS as a substitute for a covered benefit is also optional for CCO members.

Guidance on ILOS is available on the [ILOS webpage](#), which includes an [HRS and ILOS comparison document](#). Additional ILOS details are available in the [CCO contract](#), [Oregon's 1115 Medicaid Demonstration Waiver](#) and [42 CFR 438.3\(e\)\(2\)](#).

9. How is HRS spending different from the Supporting Health for All through REinvestment (SHARE) spending?

HRS gives CCOs a specific funding mechanism within their global budgets that they can voluntarily use to address SDOH-E, including the health-related social needs of their members. SHARE requires a portion of CCOs' profits be reinvested in their communities and improve member and community health by requiring reinvestments go toward upstream factors that impact health (for example, housing, food and transportation). That is, while CCOs may use dollars from their global budgets to fund HRS, CCOs must spend some of their net income or reserves on SHARE Initiatives.

While SHARE Initiative dollars may fund many of the same types of SDOH-E activities and initiatives as HRS, SHARE Initiative spending does not qualify as HRS for the purposes of reporting or capitation rate setting, and HRS expenditures may not be counted as part of the CCO's SHARE designation.

For more information on SHARE spending, see the [SHARE webpage](#), which includes an [HRS and SHARE comparison document](#).

10. Can HRS continue to include housing and food-related flexible services with the upcoming health-related social needs (HRSN) covered benefits in the [2022-2027 Medicaid 1115 Demonstration Waiver](#)?

HRS can continue to include housing, food and other flexible services to meet members' health-related social needs in 2023 and subsequent years. Only those services that become covered HRSN benefits for defined eligible members within a transition population will no longer be eligible for HRS. For example, if a CCO provided short-term rental assistance to a member as an HRS flexible service in 2023, it will only be excluded as HRS beginning in 2024 if that specific service is a covered HRSN benefit and that member is an eligible member within a life transition population.

Health-related services (HRS) use cases

Questions 11–20 below address eligibility questions about frequent HRS use cases. For additional guidance, see common categories and examples of HRS spending in the list of [examples of past-approved HRS expenditures](#).

11. Can HRS be used to fund staff?

No, HRS does not cover CCO or clinic staff costs. For non-CCO and non-clinic staff, the salary or hiring costs for staff are also generally excluded from HRS because they are the cost of administering HRS and not the services themselves. CCOs are encouraged to report costs in terms of the services provided and not in terms of staffing costs (including staff benefits, bonuses, etc.).

12. Can HRS be used to cover over-the-counter (OTC) medications or durable medical equipment (DME)?

HRS funds can be used to cover OTC medications if they are not otherwise covered by the CCO and meet HRS criteria, regardless of whether the condition is funded or unfunded. HRS can be used for DME when the item is not covered through [OAR 410-122-0080\(20\)](#), which requires medical appropriateness for the member. However, there are no absolute exclusions to DME, and there is an exceptions process in OAR 410-122-0080(20) that can be utilized instead of HRS.

13. Can HRS be used to fund paramedic services?

Only the services provided that are not covered services or part of required care coordination could be funded by HRS. For example, assessing housing safety, transportation that does not qualify as non-emergent medical transportation, or navigation for non-covered services like housing or food may meet HRS requirements. Reporting in Exhibit L should clearly describe the services being provided and who is receiving the services to help assess whether the services meet HRS criteria, or whether they are covered services. Additionally, funding paramedic staff would not be HRS. Generally, staff are not considered HRS (see Question 11).

14. Can HRS be used to purchase mobile hot spots, internet service and tablets for social service agencies?

Yes. HRS funds could be used to purchase mobile hot spots, internet service and tablets for social service agencies as long as 1) the agencies' services align with HRS criteria and are not covered services, and 2) the technology is

necessary for those services to be provided. However, providing this technology to a clinic that provides covered services would not be HRS. In this case, the required technology would be considered an administrative expense.

15. Can HRS be used to fund gaps in eligibility for other social services or Medicaid covered services?

Yes. If a member is applying to receive goods or services as a benefit under OHP, such as medical infant or child formula or oral nutrition supplements, HRS can be used to cover the cost of the formula or supplements prior to receiving a formal program decision. Likewise, if a member is applying for eligibility for social services outside of the CCO system, HRS can be used for the period prior to the member becoming eligible for the regular receipt of that service.

For example, if CCO members are leaving a hospital care setting and will be newly eligible for Long Term Services and Supports provided by DHS, or housing assistance through Oregon Housing and Community Services, HRS can be used to meet the members' needs until an eligibility determination is made.

16. Can HRS be used to fund housing-related services?

HRS can be used for short-term housing services and supports that meet HRS criteria and that are not otherwise covered by Medicaid. OHA and the Medicaid Advisory Committee have produced a guide to using HRS on housing activities, which includes a variety of examples. This [guide](#) is available on the [HRS webpage](#).

17. Can HRS support community-based activities, such as a farmers market in a food desert or a houseless shelter?

Yes. As approved under the 2017–2022 and [2022–2027 Oregon Health Plan 1115 Demonstration Waivers](#), one type of HRS, community benefit initiatives, are community-level interventions that may include members and non-members and are focused on improving population health and/or health care quality. Supporting food access in a food desert or a houseless shelter can be HRS as long as the funded activities meet the HRS criteria in question 1.

18. Can CCOs use HRS for advertising, corporate sponsorships or other activities that are not listed in [OAR 410-141-3845](#)?

No. HRS must meet specific criteria as outlined in Oregon administrative rule.

19. Can HRS be used to fund capital investments in new buildings for providing medical or imaging services?

No, capital investments in new facilities designed to provide billable health services are considered administrative expenses. HRS are intended to distinguish between normal administrative costs and certain types of spending that are directly related to a member's health. The cost of creating the physical and administrative structure to bill for covered services is considered an administrative cost, not an HRS.

20. Can HRS be used to support provider workforce training?

No. Previous HRS guidance has indicated that provider workforce training is excluded from HRS because it is an administrative expense. This exclusion applies to all aspects of provider workforce training, including provider network development, recruitment, education, training, materials, incentives, benefits and bonuses of any kind for any providers

[Back to top](#)

(or individuals the CCO intends to become providers through these expenditures) performing any Medicaid covered services. However, funding educational scholarships for students as part of an equity strategy may qualify as HRS as long as the scholarship does not result in qualification or certification of a provider who will be contracted or subcontracted with the CCO to provide covered services.

While not HRS, there are other OHA supports to increase provider network capacity. OHA Health Care Provider Incentive Program offers various incentives, such as loan repayment, loan forgiveness and insurance subsidies to both students and providers who commit to serving patients in underserved areas of the state. More information is available on the OHA [Health Care Provider Incentive Program](#) webpage and the OHSU [Office of Rural Health's Provider Incentive Programs](#) webpage. Please contact the OHA Health Care Provider Incentive Program team (providerincentives@odhsoha.oregon.gov) with any questions.

Member access to health-related services (HRS)

21. What is a CCO's responsibility to share HRS information with members and the community?

CCOs are required to have HRS policies and procedures in place that meet OHA requirements in [OAR 410-141-3845](#) and CCO contract, and are subject to annual review by OHA. The CCO HRS policy must encourage transparency, support provider and member engagement, and reflect processes that do not create undue burden for members, member advocates or providers in requesting HRS. This includes providing information about HRS in alternate languages and formats. In addition to the HRS policy requirement, CCOs must also provide information about HRS and how to request HRS in CCO member handbooks.

22. Does the member's primary care provider or clinician need to approve a HRS flexible service?

The CCO must approve the flexible service, but clinical approval is not required by OHA. [OAR 410-141-3845](#) states that a flexible service, which is an HRS offered to an individual member, must be consistent with a member's treatment plan as developed by the care team and agreed to by the CCO. However, it does not specify that the care team include the primary care provider or clinician. These services shall be documented in the treatment plan and clinical record whenever possible, but this is not required.

23. What is a CCO's responsibility to a member when an HRS request is denied?

CCOs are required, based on [OAR 410-141-3845\(4\)\(a\)](#), to provide members with a written notification of a refusal of an individual flexible service request. The CCO must also provide a copy of the notification to any representative of the member and any provider who made or participated in the request on the member's behalf. The written notification must inform the member and provider of the member's right to file a grievance in response to the outcome. If an HRS request is denied because other Medicaid or community resources are available for the same service or product, CCOs are encouraged to inform the member or requester of the availability of those resources and coordinate a referral whenever possible.

24. Are CCO A members the only CCO members eligible to receive HRS, or are any CCO member types eligible?

Any decision to fund HRS is at the discretion of the CCO that administers the contract with OHA and that receives a global budget to manage the care of its member population. Additionally, OHA has not restricted CCOs from providing HRS based on CCO member type.

[Back to top](#)

Implementing, tracking and reporting health-related services (HRS)

25. Can OHA pre-approve CCO HRS spending?

While OHA cannot provide official pre-approval for CCO HRS spending, OHA can provide feedback on whether spending aligns with HRS criteria and OHA published guidance on HRS. If spending does not align, OHA can also provide feedback as to why it does not align. Official approval can only happen through OHA review of CCO HRS data submitted in the annual Exhibit L financial template. If what is submitted in Exhibit L does not align with how HRS spending was described to OHA in obtaining prior feedback, OHA must use the Exhibit L data, not prior descriptions of spending, to determine if the spending counts as HRS.

To request feedback prior to OHA review of HRS data submitted in the annual Exhibit L financial template, the CCO should reach out to the HRS team. This can be done by attending quarterly HRS office hours, which are posted to the HRS webpage, emailing the HRS team at health.relatedservices@oha.oregon.gov, and utilizing the optional HRS data submission in the Quarter 2 Exhibit L financial template.

26. Do the CCO's community advisory council (CAC) and Tribes need to participate in the approval of all community benefit initiatives (CBIs)?

Although CCOs are required by contract to develop a role for their CACs and Tribes in CBI expenditure decisions, that role is not required to ensure CACs and Tribes will participate in CBI decisions for each and every investment. The CCO needs to follow its own HRS policies in determining who needs to be part of each of their CBI decisions.

27. What are CCO reporting requirements for HRS investments?

CCOs are required in their contracts to have written policies and procedures for administering HRS, and to submit those policies to OHA.

CCOs are also expected to report on HRS investments annually in Exhibit L of the CCO financial reports and Minimum Medical Loss Ratio Rebate Calculation. Reporting instructions for HRS investments are outlined in the instructions for these reports.

CCOs are expected to report in Exhibit L the number of members receiving each flexible service. Should the CCO have a precise number of members receiving a community benefit initiative, the CCO is encouraged to report that number as well. Note that if the sum of HRS items and services given to a member in a calendar year exceeds \$200, the member's ID must be reported for each of the items and services received.

28. Can CCOs rely on published studies to support the use of HRS, or will CCOs be expected to provide organization- and population-specific data?

CCOs won't be expected to provide organization- and population-specific data to support the use of an HRS. As referenced in the [HRS Brief](#), CCOs may use existing evidence-based best practices, research or guidelines issued by government agencies, medical associations or national health care quality organizations to identify HRS that improve health outcomes, alleviate health disparities and improve overall community well-being. In addition to other resources a CCO or OHA may identify, OHA has provided a list of potential sources for published studies or evidence to support HRS on the [OHA HRS webpage](#).

29. Is a positive return-on-investment (ROI) required as a part of any evidence-based criteria?

No. CCOs are not required to report ROI data or evidence for HRS expenditures, and the ROI reporting field was removed from the Exhibit L template. However, CCOs may choose to use ROI data or evidence to evaluate HRS spending. OHA has identified the following resources to support CCOs in calculating ROI.

- [Commonwealth Fund ROI Calculator](#): This calculator is designed to help health systems and their community-based organization partners plan sustainable financial arrangements to fund the delivery of social services to high-need, high-cost patients. To help users of this ROI calculator, the Commonwealth Fund has provided a summary assessment of available evidence of health care impact for interventions related to addressing health-related social needs for high-need adults.
- [Center for Health Care Strategies ROI Forecasting Calculator](#): This web-based tool is designed to help Medicaid state agencies, health plans and other stakeholders assess and demonstrate the cost-savings potential of efforts to improve quality.

30. How should the CCO report HRS investments paid from quality pool dollars?

CCOs are responsible to fill out the Exhibit L in a fashion that results in no duplication across report tabs. The HRS expenditures could be reported in the HRS L6.21 OHP tab instead of the Quality Pool L17.1 tab, but it cannot be reported in both tabs. This may result in the appearance that the quality pool dollars have not been 100% distributed, but this can be explained in the narrative field for the quality pool in the L17 tab. For example, if 5% of the quality pool dollars were expended as HRS, the CCO could note that 3% of quality pool dollars were expended as HRS community benefit initiatives and 2% as HRS flexible services.

Additional questions or concerns related to the Exhibit L template should be directed to the actuarial service mailbox (actuarial.services@odhsoha.oregon.gov).

31. Can CCOs report matching funds provided by a CCO to a community organization or agency as HRS?

CCOs can count matching funds or braided funds provided to a community agency as HRS if the goods or services provided through the CCO funds meets the HRS criteria. Ultimately, only CCO funds from its global budget can be reported as HRS. Funds from other sources, such as foundations or government grants, cannot be reported as HRS.

Health-related services (HRS) considerations in rate development, medical-loss ratio and performance-based reward

32. How are HRS considered within the medical loss ratio (MLR) calculation compared to rate development?

A medical loss ratio (MLR) is the proportion of premium revenues spent on clinical services and quality improvement. CCOs are required to meet the state's MLR standard of 85 percent. According to the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (CMS-2390-F) that was finalized April 25, 2016, HRS are reflected in calculating the MLR if they meet the requirements under federal rules ([45 CFR 158.150](#) and [45 CFR 158.151](#)).

[Back to top](#)

Specifically, if expenditures for HRS meet the definitions laid out above, these expenditures are reflected in the MLR calculation. CCOs' use of HRS helps them meet the state's MLR standard. To determine if HRS expenditures meet HRS definitions, OHA annually reviews CCO reported HRS expenditures. Expenditures that do not meet HRS definitions are excluded from the MLR calculation.

33. How are HRS considered in rate development and related to performance-based reward (PBR)?

HRS are reflected in the medical loss ratio (MLR) if they meet the requirements under [45 CFR 158.150](#) or [45 CFR 158.151](#). They are also considered in development of the non-benefit load of the CCO's rate. The non-benefit load is an additional rate added on top of medical expenses; this may include administrative expenses, underwriting margin, performance-based rewards, and managed care organization tax. CCOs are expected to use HRS to efficiently and effectively reduce costs and improve care over time.

As CCOs provide HRS that are more cost-effective than State Plan services, the per-capita growth rate for capitation rates should gradually decrease over the waiver period. As reflected in the 2017 1115 Medicaid demonstration waiver, and continued under the 2022 1115 waiver, OHA has implemented a performance-based reward (PBR) initiative in rate setting for the 2020–2024 CCO contract cycle. The PBR is calculated as a part of the rate-setting process and is intended to counteract decreases in capitation rates, also known as premium slide, which might otherwise discourage HRS spending. The PBR initiative rewards CCOs with a higher underwriting margin when costs are held lower, quality is maintained, and CCOs invest in qualified HRS spending. Expenditures that do not meet HRS definitions are excluded from PBR.

34. Can CCOs expect any credibility adjustments based on CCO size in the consideration of HRS in their rates?

No, OHA does not anticipate a credibility adjustment for HRS spending but will be looking at reasonableness as it relates to the per-member-per-month equivalent and impact on the total non-benefit load percentage.

Resources

- OHA's HRS webpage: <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx>
- OHA's SHARE webpage: <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx>
- OHA's ILOS webpage: <https://www.oregon.gov/oha/HSD/OHP/Pages/ILOS.aspx>
- OHA's 1115 Medicaid waiver webpage: <https://www.oregon.gov/oha/hsd/medicaid-policy/pages/waiver-renewal.aspx>
- OAR 410-141-3500: <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265499>
- OAR 410-141-3845: <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265554>
- 45 CFR 158.150: <https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-158/subpart-A/section-158.150>
- 45 CFR 158.151: <https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-158/subpart-A/section-158.151>

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