

Health-Related Services Brief

November 2022



Executive Summary

Defining health-related services (HRS)

- HRS = flexible services + community benefit initiatives
- Oregon Administrative Rules state HRS are non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being
- Oregon's 1115 waiver states HRS must meet the requirements for activities that improve health care quality ([45 CFR 158.150](#)) or expenditures related to health information technology and meaningful use requirements to improve health care quality ([45 CFR 158.151](#))

Activities that improve health care quality must meet four criteria:

1. Designed to improve health quality;
2. Increase the likelihood of desired health outcomes in ways that can be objectively measured and produce verifiable results and achievements;
3. 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-enrollees; **and**
4. 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

Activities¹ that are excluded from HRS definition:

1. Covered services for an OHP member
2. Administrative activities to support the delivery of covered services
3. Coordinated Care Organization (CCO) contractual requirements, such as ensuring an adequate provider network or required care coordination for covered services
4. Provider workforce or certification training
5. Building new buildings and other capital investment activities

Activities that improve health care quality are designed to:

1. Improve health outcomes and reduce health disparities;
2. Prevent hospital readmissions;
3. Improve patient safety, reduce medical errors, and lower infection and mortality rates; **or**
4. Increase focus on wellness and health promotion activities

Health information technology expenditures that support the activities above also qualify as HRS.

Financial incentives for CCOs to spend on HRS:

CCOs use the global budget to fund HRS and are incentivized to provide HRS through the minimum medical loss ratio (MLR) and performance-based reward (PBR). Expenditures that meet HRS criteria are reflected in the MLR calculation and are included in the PBR calculation as part of the rate-setting process. This maximizes the federal financial participation in HRS allowable under Oregon's Medicaid authority.

¹ This is not an exhaustive list of exclusions. See question 14 in the [HRS FAQ](#) for a more complete list.

Background

In 2012, under a renewal to its 1115 Medicaid demonstration waiver, Oregon began the process of transforming its Medicaid delivery system by establishing coordinated care organizations (CCOs), charging them with integrating and coordinating care and requiring them to meet key quality metrics tied to financial incentives for achieving performance benchmarks. CCOs receive an integrated global payment for each member, which provides CCOs with the flexibility to offer health-related services (HRS) to improve the health of Oregon's Medicaid population. These HRS were known as flexible services, but through the [1115 Medicaid demonstration waiver](#) for 2017–2022, OHA clarified that HRS includes flexible services and community benefit initiatives.

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.

The purpose of this brief is to define HRS, describe the use of HRS among CCOs, and explain how HRS are incorporated into CCO payments. Additional guidance and technical assistance around HRS, including a FAQ to support CCO HRS implementation, can be found on [OHA's HRS website](#).

Definition of health-related services

HRS are non-covered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements, and are further defined by the Oregon Administrative Rules (OARs), the 1115 waiver special terms and conditions (STCs), and the code of federal regulations ([45 CFR 158.150](#) and [45 CFR 158.151](#)). CCOs should refer to the definition and criteria included in this brief and OARs [410-141-3500](#) and [410-141-3845](#).

Definition

The goals of 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. HRS, which are non-covered services under the Oregon Health Plan that are intended to improve care delivery and overall member and community health and well-being, are cost-effective services offered as a supplement to covered services. HRS include:

1. Flexible services, which are cost-effective services offered to an individual member to supplement covered benefits, and
2. Community benefit initiatives, which are community-level interventions that include members, but are not necessarily limited to only members, and are focused on improving population health and health care quality.

To be considered a health-related service, a service must meet the requirements for: a) activities that improve health care quality, as defined in [45 CFR 158.150](#) or b) expenditures related to health information technology and meaningful use requirements to improve health care quality, as defined in [45 CFR 158.151](#).

Criteria of activities that improve health care quality

Activities that improve health care quality must meet all of 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.

OARs [410-141-3500](#) and [410-141-3845](#), [45 CFR 158.150](#) and [45 CFR 158.151](#) provide examples of services that are considered activities that improve health care quality. The following list of examples taken from the CFRs is intended to be illustrative and not exhaustive. Further, it should be noted that any medical service covered under the Oregon Health Plan cannot be categorized as a health-related service.

As defined in [45 CFR 158.150](#), activities that improve health care quality should be primarily designed to meet at least one of the following criteria:

- ✓ Improve health outcomes compared to a baseline and reduce health disparities among specified populations. This category can include costs for associated activities such as:
 - Effective case management, care coordination and chronic disease management, including the use of the medical home model;
 - Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities;
 - Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence-based medicine; and
 - Quality reporting and documentation of care in a non-electronic format.
- ✓ Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge. This category can include costs for associated activities such as:
 - Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) to help ensure appropriate care that will, in all likelihood, avoid readmission to the hospital;
 - Personalized post-discharge counseling by an appropriate health care professional; and
 - Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.
- ✓ Improve patient safety, reduce medical errors, and lower infection and mortality rates. This category can include costs for associated activities such as:
 - The appropriate identification and use of best clinical practices to avoid harm;
 - Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;
 - Activities to lower risk of facility-acquired infections;
 - Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions; and
 - Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.
- ✓ Implement, promote and increase wellness and health activities. This category can include costs for associated activities such as:
 - Wellness assessment;
 - Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
 - Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

- Public health education campaigns that are performed in conjunction with state or local health departments;
 - Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities; and
 - Coaching or education programs and health promotion activities designed to change member behavior (for example, smoking or obesity).
- ✓ Enhance the use of health care data to improve quality, transparency and outcomes, and support meaningful use of health information technology consistent with [45 CFR 158.151](#) (see [45 CFR 158.151](#) for additional examples):
- Incentive payments to health care providers for adopting certified electronic health record technologies and their “meaningful use”;
 - Providing technical assistance to support adoption and meaningful use of certified electronic health record technologies;
 - Advancing the ability of enrollees, providers, issuers or other systems to communicate patient- centered clinical or medical information rapidly, accurately and efficiently; and
 - Providing electronic health records, patient portals and tools to facilitate patient self-management.

Activities that are excluded from health-related services

Although CCOs have the flexibility to identify and provide HRS beyond the list of examples in the aforementioned OARs and CFRs, expenditures and activities that **cannot be included** as an activity that improves health care quality are:

- ✓ Those that are designed primarily to control or contain costs;
- ✓ Those that otherwise meet the definitions for quality improvement activities but were paid for with grant money or other funding separate from revenue received through a CCO’s contract;
- ✓ Those that can be billed or allocated by a provider for care delivery and are, therefore, 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;
- ✓ Costs associated with calculating and administering member incentives; and
- ✓ That portion of prospective utilization that does not meet the definition of activities that improve health quality.

Current CCO use of health-related services

CCOs have the flexibility to identify and provide HRS that meet the needs of their members and their communities. Through discussions with CCOs and stakeholders, and based on CCO expenditure data, OHA has identified several examples of activities that CCOs already are or could be providing as HRS. The examples identified can be categorized as follows:

- ✓ Care coordination, navigation or case management activities not otherwise covered under State Plan benefits, including traditional health workers;
- ✓ Education to members and the community for health improvement or education supports, including those related to

SDOH-E (for example, education for health improvement and management, and supports for early childhood education, language and literacy, high school graduation, and higher education);

- ✓ Food services and supports, including those related to SDOH-E (for example, vouchers, meal delivery, farmers market in a food desert);
- ✓ Housing services and supports, including those related to SDOH-E (for example, temporary housing or shelter, utilities, critical repairs, environmental remediation, including lead);
- ✓ Items for the living environment, not otherwise covered under 1915 Home and Community Based Services Waivers, to support a particular health condition (for example, items to improve mobility, air conditioner, athletic shoes, other specialized clothing);
- ✓ Transportation services and supports, including those related to SDOH-E, not otherwise covered under the State Plan (for example, transportation for groceries or non-medical appointments related to individual social needs; community-level transportation improvements such as bike lanes and walking paths);
- ✓ Trauma-informed services and supports across sectors, including those related to SDOH-E (for example, implementing trauma-informed care across sectors, adverse childhood experiences training in schools);
- ✓ Other non-covered health care system services and improvements (for example, supports for community oral health services, electronic health record [EHR] meaningful use);
- ✓ Other non-covered social and community health services and supports (for example, social needs screening and referral, including community resource and referral technology and EHR integration; multi-sector interventions to improve population health; interventions to address other SDOH-E, including employment and built environment improvements); and
- ✓ Other non-covered medical services; (for example, medical services which would otherwise be on above-the-line medical services).

Incorporating health-related services into CCO payments

Health-related services and the CCO medical loss ratio

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](#)).

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.

Health-related services and CCO rates

HRS are reflected in the 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 efficiently and effectively reduce costs and improve care over time by using HRS.

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.

Resources

- OHA's HRS webpage: <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx>
- OHA's HRS FAQ: <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-FAQ.pdf>
- 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/section-158.150>
- 45 CFR 158.151: <https://www.ecfr.gov/current/title-45/section-158.151>

Contact

For comments and questions, please email the OHA HRS team at health.relatedservices@oha.oregon.gov.

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