410-141-3845 Health-Related Services

(1) The goals of health-related services (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. Health-related services are provided as a supplement to covered health care services.

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

(b) 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.

(c) 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.

(2) To qualify as an HRS within the meaning of this rule, a service must meet the following requirements, consistent with 42 C.F.R. § 158.150:
(a) The service must be designed to:

(A) Improve health quality;

(B) Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements;

(C) Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and

(D) Be based on any of the following:

(i) Evidence-based medicine; or

(ii) Widely accepted best clinical practice; or

(iii) Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

(b) The service must be primarily designed to achieve at least one of the following goals:

(A) Improve health outcomes compared to a baseline and reduce health disparities among specified populations;

(B) Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;

(C) Improve patient safety, reduce medical errors, and lower infection and mortality rates;

(D) Implement, promote, and increase wellness and health activities;

(E) Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.

(c) The following types of expenditures and activities are not considered HRS:

(A) Those that are designed primarily to control or contain costs;

(B) Those that otherwise meet the definitions for quality improvement activities but that were paid for with grant money or other funding separate from revenue received through a CCO's contract;

(C) Those activities that may be billed or allocated by a provider for care delivery and that are, therefore, reimbursed as clinical services;

(D) 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 codes sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 1320d-2, as amended;

(E) That portion of the activities of health care professional hotlines that do not meet the definition of activities that improve health quality;

(F) All retrospective and concurrent utilization review;

(G) Fraud prevention activities;

(H) 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;

(I) Provider credentialing;

(J) Costs associated with calculating and administering individual member incentives; and

(K) That portion of prospective utilization that does not meet the definition of activities that improve health quality.

(3) CCOs shall implement policies and procedures (P&Ps) for HRS. These P&Ps shall be submitted to the Authority for approval.

(a) HRS P&Ps shall encourage transparency and provider and member engagement, reflect streamlined administrative processes that do not create unnecessary barriers, and provide for accountability.

(b) A CCO's HRS spending on community benefit initiatives shall align with the priorities identified in the CCO's community health improvement plan. CCOs will align HRS community benefit initiatives spending with any HRS CBI spending priorities identified by the Authority.

(c) The P&P shall describe how HRS spending decisions are made, including the role of the CAC and tribes in spending decisions.
(d) MCEs shall not limit the range of permissible health-related services by any means other than by enforcing the limits defined in this rule.

(4) Flexible services are cost-effective services offered to an individual member to supplement covered benefits. Flexible services shall be consistent with the member's treatment plan as developed by the member's care team and agreed to by the CCO. The care team and the CCO shall work with the member and, as appropriate, the family of the member in determining the HRS needed to supplement the member's care. These services shall be documented in the member's treatment plan and clinical record.

(a) A CCO's refusal to permit an individual flexible service request is not an "adverse benefit determination" within the meaning of OAR 410-141-3875. CCOs shall have written procedures to acknowledge the receipt, disposition, and documentation of each grievance from members, which shall be modelled on the procedures specified in 42 CFR 438.402-408 and OAR 410-141-3835 through 3915. CCOs shall provide members with a written notification of a refusal of individual flexible services request and shall copy any representative of the member and any provider who made or participated in the request on the member's behalf;

(b) The written notification shall inform the member and provider of the member's right to file a grievance in response to the outcome.

(5) Community benefit initiatives are community-level interventions that include, but are not necessarily limited to, members and are focused on improving population health and health care quality.

(a) CCOs shall designate a role for the community advisory council in directing, tracking, and reviewing community benefit initiatives, as provided in OAR 410-141-AAAA [new SDOH-HE rule].

(b) Community benefit initiatives that are initiated by the CCO shall, for documentation purposes, be included in the CCOs' Transformation and Quality Strategy mid-year update and annual reports. Community benefit initiatives may not be documented in a treatment plan or clinical record.

(6) CCOs shall submit their financial reporting for health-related services as directed through the CCO contract and in compliance with 42 CFR 438.8 Medical Loss Ratio (MLR).

(7) Except as provided in section (4), members have no appeal or hearing rights in regard to a refusal of a request for HRS.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042

410-141-3735 Social Determinants of Health and Equity; Health Equity

(1) This rule defines and establishes requirements for the social determinants of health and equity (SDOH-E) spending programs, role of the Community Advisory Councils in supporting SDOH-E, and for developing health equity infrastructure within a Coordinated Care Organization (CCO). The rule provides structure and guidance to CCOs to support long-term, community-specific investment and partnership in SDOH-E.

(2) The following definitions apply for purposes of this rule:

(a) "Adjusted Net Income" is the pre-tax net income reported by a CCO for a calendar year (or a partial year, if relevant) pursuant to OAR [SB 1041 financial reporting rules under SAP], modified by the following items at the discretion of the Authority:

(A) Excessive administrative expenses, including management bonuses

(B) Improper allocation of expenses across lines of businesses

(C) Non-operating revenues and expenses

(D) Adjustments to base data made as part of the capitation rate development

(E) Other expenses not supported by legitimate business purposes

(F) Payments or transfers to subcontractors, parent companies, affiliates, or subsidiaries

(b) "Health Disparities" are the structural health differences that adversely affect groups of people who systematically experience greater economic, social, or environmental obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. Health disparities are the metric used to measure progress toward achieving health equity

(c) "Social Determinants of Health and Equity" (SDOH-E).

(A) The social determinants of health refer to the social, economic, 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. Social determinants of health fall into the following domains: Neighborhood and Built Environment, Economic Stability, Education, and Social and Community Health.

(B) The social determinants of equity refer to systemic or structural factors that shape the distribution of the social determinants of health in communities.

(d) "SDOH-E Partner" means a community-based entity that delivers services or programs, or supports policy and systems change, or both to address the social determinants of health and health equity; that the CCO has selected to receive a portion of the CCO's SDOH-E Spending.

(e) "SDOH-E Spending" means spending on services and initiatives designed to address SDOH-E. SDOH-E spending may consist of spending on health-related services, as that term is defined in OAR 410-141-

3845 and OAR 410-141-3500. SDOH-E programs may involve interventions that occur outside a clinical setting, and may pursue mechanisms of change including:

(A) Population health policy change, meaning changes to rules or procedures within a community or organization;

(B) Systems change, meaning changes to infrastructure within a community or organization, and,

(C) Services to address individual's' health-related social needs, meaning an individual's social and economic barriers to health, such as housing instability or food insecurity.

(f) "SDOH-E Spending Program" means a program overseen by the Authority with specific requirements for a CCO's SDOHE Spending as set forth in the contract. SDOH-E spending programs include, but may not be limited to:

(A) Supporting Health for All through Reinvestment Initiative (SHARE Initiative)

(B) Boosting Up Investment in Long-term Development for SDOH-HE Fund (BUILD Fund)

(3) The following general requirements apply to any SDOH-E spending program:

(a)CCOs shall select SDOH-E spending priorities based on:

(A) The CCO's most recent Community Health Improvement Plan (CHP) that is a shared plan with the Collaborative Partners, as defined in 410-141-3730, including local public health authorities and local hospitals. If the CCO has not yet developed a shared CHP, the CCO shall align its priorities with those identified in CHPs developed by other stakeholders in the service area, such as local public health authorities, hospitals, and other CCOs.

(B) Any SDOH-E priority areas identified by the Authority.

(b) A portion of SDOH-E Spending Program expenditures must go directly to SDOH-E Partner(s) for the delivery of services or programs, policy, or systems change, or any of these, to address the social determinants of health and equity as agreed by the CCO. CCOs shall enter into a contract with each SDOH-E Partner that defines the services to be provided and the CCO's data collection methods as provided in the contract between the Authority and the CCO. These contracts shall be submitted to the Authority for.

(c) CCOs shall report completed and anticipated SDOH-E expenditures using the format specified by the Authority. These reports will be posted publicly.

(4) The following requirements are specific to the SHARE Initiative:
(a) For each calendar year starting on or after January 1, 2021, CCOs shall dedicate a portion of their previous calendar year's adjusted net income or reserves to SDOH-E spending, pursuant to ORS 414.625(1)(b)(C) (as such statute was amended by 2018 HB 4018) and as set forth in the contract.

(b) The portion of adjusted net income or reserves spent, as referenced above, shall equal or exceed the greater of:

(A) % of adjusted net income for the prior calendar year on a sliding scale based on Contractor's % Risk Based Capital (RBC) as of the end of that year (but prior to the SHARE portion calculation); or

(B) A proportion of the amount sent in dividends or payments or both to shareholders, parents, or other owners in that prior year.

(c) The Authority will provide the specifications for (A) and (B), including the sliding scale, as an initial reference document to CCOs by October 1, 2019, and publish any revisions for subsequent years by October 1st preceding a calendar year affected by such revision.

(d) The value of the %RBC floor, for the purposes of the sliding scale, will be the greater of:

(A) 250% RBC, or

(B) the percentage established in rule development for SB 1041 in relation to dividend payment restrictions.

(e) The Authority's discretion in adjusting net income shall be for the purpose of ensuring that CCOs do not distribute net income to stakeholders through other means than dividends (or similar payments to owners) to avoid SHARE Initiative spending. The Authority's discretion may also extend to relief from SHARE Initiative requirements in the event of net losses outside the CCO's reasonable control that would otherwise place the CCO's capital, surplus or reserves below 200% RBC.

(5) The following requirements are specific to the BUILD Fund:

(a) Dependent on availability of funds under the Medicaid growth cap, and within the Authority's budget at the discretion of its Director, the Authority may require that CCOs spend a fixed portion of their income on SDOH-E, in compliance with all SDOH-E Spending Program rules as set forth in this OAR, in the Contract between the CCO and the Authority, and in related guidance documents.

(6) Community Advisory Councils (CAC).

(a) CCOs shall designate a role for the CAC in directing, tracking, and reviewing spending on SDOH-E, including the SDOH-E Spending Programs, and health-related services community benefit initiatives, as defined in OAR 410-141-3845. Interested CAC members—for example, a member whose employer is up for consideration as an SDOH-E partner—shall recuse themselves from the decision-making process.

(b)CCOs shall submit reports to the Authority no less than annually that describes the CAC's role in making decisions on these issues, as well as the CCO's efforts to align the CAC's composition with the CCO membership's demographic composition and CHP priorities. These reports will be posted publicly with appropriate redactions.

(8) Health Equity Infrastructure.

(a) CCOs shall develop and implement a "Health Equity Plan" to address health disparities that exist among the CCOs' members and, more generally, the communities within the CCOs' service areas. The health equity plan shall include the following:

(A) Narrative of the health equity plan development process, including description of meaningful community engagement.

(B) Health equity focus areas, including strategies, goals, objectives, activities and metrics.

(C) A plan for ensuring that the CCO's staff and provider network are trained on cultural responsiveness, implicit bias, and anti-discrimination laws, in accordance with the Authority's standards.

(b) The health equity plan shall be submitted to the Authority for review and approval.

(c) CCOs shall designate a single point of accountability for health equity with budgetary decision-making authority and health equity expertise.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3730 Community Health Assessment and Community Health Improvement Plans (Revised 7/30/19)

(1) CCOs shall comply with the requirements in ORS 414.627 and 414.629, as well as any requirements specified in the contract regarding the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHP). To the extent a CCO shares all or part of a Service Area, the CCO must develop a shared CHA and CHP with all of the following organizations and entities: local public health authorities, hospitals, other CCOs, and, if a federally recognized tribe has already developed or will develop their own CHA or CHP, CCOs must invite the tribe to participate in the shared CHA and CHP. These entities will be refered to as the Collaborative CHA/CHP Partners. This collaboration shall be documented in the CHA and CHP documents, inclusive of CHP progress reports.

(2) In developing and maintaining a CHA, CCOs shall, with the Collaborative CHA/CHP Partners, meaningfully and systematically engage representatives of local and tribal governments, community partners and stakeholders, and critical populations to assess the Community health needs of Contractor's Service Area. The following must be engaged in the CHA process, without limitation:

(a) County and city government representatives;

(b) Federally recognized tribes (if not already collaborating on a shared CHA);

(c) SDOH-HE partners, as defined in OAR 410-141-3735;

(d) Local public health authorities;

(e) Local mental health authorities and community mental health programs;

(f) Hospitals;

(g) Physical, behavioral, and oral health care providers;

(h) Indian Health Care Providers;

(i) Traditional Health Workers;

(j) School nurses, school mental health providers, and other individuals representing child and adolescent health services;

(k) Culturally specific organizations, including Regional Health Equity Coalitions;

(l) Representatives from populations who are experiencing health and health care disparities;

(3) The CHA must include or identify and analyze, at a minimum, all of the following:

(a) The demographics of all of the Communities with Contractor's Service Area, including race, ethnicity, languages spoken, disabilities, age, gender, and sexual orientation;

(b) The health status and issues of all the Communities within Contractor's Service Area;

(c) The health disparities among all of the Communities within Contractor's Service Area;

(d) Findings on health indicators, including the leading causes of chronic disease, injury and death within Contractor's Service Area;

(e) Findings on social determinants of health indicators across the four key domains (economic stability, education, neighborhood and built environment, social and community health);

(f) Assets and resources that can be utilized to improve the health of the all of the Communities served within Contractor's Service Area with an emphasis on determining the current status of:

(A) Access to primary prevention resources;

(B) Disproportionate, unmet, health-related needs;

(C) Description of assets wthin the Community that can be built on to improve the Community's health;

(D) Systems of seamless continuum of care; and

(E) Systems or programs of collaborative governance of community benefit.

(g) Identify programs that promote the health and treatment of children and adolescents within Contractor's Service Area, including any treatment prevention and Early Intervention programs, and analyze the sufficiency and effectiveness of any such programs;

(h) Identify areas for improvement; and

(i) Document the persons, organizations, and entities with whom Contractor collaborated and process for collaboration in creating the CHA as such persons, organizations, and entities are identified in Section (2) of this rule.

(4) The CCOs' CACs shall oversee, with the Collaborative CHA/CHP Partners, the development of the shared CHA.

(5) CCOs and their CACs must develop meaningful baseline data on health disparities identified through the CHA process. CCOs and their CACs may collaborate with the Authority in developing this data, which includes health disparities defined by race, ethnicity, language, health literacy, age, disability, gender identity, sexual orientation, behavioral health status, geography, living setting or other factors. This data will be used to identify and priortize health disparities in the development of their CHPs.

(6) CCOs shall develop, review, and update its CHA at least every five years (or more often, if so requested by the Authority).

(7) Using the findings documented in their CHAs, including any health disparities data and other reliable data, CCOs shall draft a CHP, which shall serve as a strategic plan for developing a population health and health care system plan to serve the Communities within the CCOs Service Areas. Any Collaborative CHA/CHP Partners from the shared CHA, must collaborate in the development of a shared CHP or shared CHP priorities and strategies. The CCOs' CACs are responsible for adopting CHPs.

(8) In developing a CHP, CCOs shall, with the Collaborative CHA/CHP Partners, meaningfully and systematically engage representatives of local and tribal governments, community partners and stakeholders, and critical populations. The following must be engaged in the CHP process, without limitation:

(a) County and city government representatives;

(b) Federally recognized tribes (if not already collaborating on a shared CHA);

(c) SDOH-HE partners, as defined in OAR 410-141-3735;

(d) Local public health authority;

(e) Hospitals

(f) Local mental health authorities and community mental health programs;

(g) Phsyical, behavioral, and oral health care providers;

(h) Indian Health Care Providers;

(i) Traditional Health Workers;

(m) School nurses, school mental health providers, and other individuals representing child and adolescent health services;

(j) Culturally specific organizations, including Regional Health Equity Coalitions;

(k) Representatives from populations who are experiencing health and health care disparities.

(9) A CHP adopted by a CAC shall describe the health priority goals and strategies that will govern the activities and services the CCO will implement in order to address the population health needs and resources of the Community.

(a) CHP health priority goals are intended to improve the Community's health, and may include, without limitation, issues related to:

(A) Closing the gap on disproportionate, unmet, health-related needs;

(B) Creating access to primary prevention;

(C) Building a system of seamless continuum of care;

(D) Building on current Community resources and improving Community capacity to improve health or address SDOH/HE, or both; and

(E) Engaging the Community in the implementation of the CHP.

(b) The CHP strategies should be based on research and may include, without limitation:

(A) Developing a Health Policy that supports the CHP goals and objectives;

(B) Implementing community health or SDOH/HE interventions, or both, to support the CHP goals and objectives, with emphasis on evidence-based interventions as available;

(C) Developing public and private resources and capacities;

(D) Designing and building a system of Integrated service delivery;

(E) Developing and implementing best practices of culturally and linguistically appropriate care and service delivery.

(c)The CHP shall include metrics or indicators used to monitor progress toward CHP goals and strategies.

(d) The CHP must also include a component for addressing the health of child and youth in the CCO service area. This must be developed with the input of school nurses, school mental health providers, and other individuals representing child and adolescent health services, the Early Learning Council, Early Learning Hubs, the Youth Development council and the school health providers in the region. This component addressing the needs of adolescents and children in a CCO's Service Area and must:

(A) Include findings based on research, including adverse childhood experiences and must identify funding sources and additional funding necessary to address the health needs of children and adolscents in the community and to meet the goals of the plan;

(B) Evaluate the adequacy of existing school-based resources including school-based health centers (SBHC) to meet the specific pediatric and adolescent health care needs in the community; and make recommendations relating to the improvement of, and undertake efforts that will ensure, SBHC networks meet the specific health care needs of children and adolescents in the Community, including the addition or improvement of electronic medial records and billing systems;.

(C) Take into consider whether integration of school-based health centers with the larger health system or system of community clinics would further advance the goals of the plan;

(D) Primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents.

(10) CCOs shall collect and maintain data on race, ethnicity, and primary language for all members on an ongoing basis in accordance with standards established by the Authority, including REAL-D. CCOs shall track and report on any quality measure by these demographic factors. The CCOs shall make this information available by posting on the web.

(11) In addition, CACs shall annually publish a CHP progress report that evaluates and describes progress towards advancing CHP goals and strategies, addressing health disparities, and improving health equity. Progress reports will be submitted in the manner and form proscribed by OHA.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685