PLAN OPERATIONS	Advantage Dental From DentaQuest			
	Policy and Procedure			
	Policy Name:	**Health-Related Services**	Policy ID:	**PLANCG-27**
	Approved By:	Quality Assurance and Performance Improvement Committee	Last Revision Date:	12/09/2020
	States:	Oregon	Last Review Date:	1/20/2021
	Application:	Medicaid	Effective Date:	1/21/2021

PURPOSE

To set forth Dental Care Organization's (DCO's) policy on health-related services, when they are applicable and the process for obtaining health-related services.

POLICY

The goals of health-related services are to promote the efficient use of resources and address enrollee's 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. Health-related services may be provided as flexible services or as community benefit initiatives, as those terms are defined below;
B. The DCO has the flexibility to identify and provide health-related services;
C. As allowed, the DCO may offer additional services that are separate from health-related services and delivered at the complete discretion of the DCO;
D. Health-related services may be used to pay for non-covered oral health care services;

To qualify for a health-related service, a service must meet the following requirements:

A. The services must be designed to:
    1. Improve health equity;
    2. Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements;
    3. Be directed toward either individuals or segments of enrollees, or provide health improvements to the population beyond those enrolled without additional costs for the non-enrollees; and
    4. 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 dental associations, government agencies, or other national oral health care quality organizations.
B. The service must be primarily designed to achieve at least one of the following goals:
    1. Improve oral health outcomes compared to a baseline and reduce health disparities among specified populations;
    2. Improve patient safety, reduce dental errors, and lower infection and mortality rates;
    3. Implement, promote, and increase wellness and health activities

4. Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities that promote clinic community linkage and referral process.

C. The following types of expenditures and activities are not considered health-related services:
    1. Those that are designed primarily to control or contain costs;
    2. 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 DCO's contract with a Coordinated Care Organization (CCO) or the Oregon Health Authority (OHA)
    3. Those activities that may be billed or allocated by a provider for care delivery and that are, therefore, reimbursed as clinical services;
    4. 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;
    5. That portion of the activities of oral health care professional hotlines that do not meet the definition of activities that improve health quality;
    6. All retrospective and concurrent utilization review;
    7. Fraud prevention activities;
    8. 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;
    9. Provider credentialing;
    10. Costs associated with calculating and administering individual member incentives; and
    11. That portion of prospective utilization that does not meet the definition of activities that improve health quality.

The DCO's health-related services spending on community benefit initiatives shall promote alignment with the priorities identified in the applicable CCO's community health improvement plan, and with any health-related services community benefit initiative spending priorities identified by the OHA.

The DCO's health-related spending decisions will be coordinated with the contracted CCO and/or OHA, as applicable.

Flexible services (as defined below) shall be consistent with the enrollee's treatment plan as developed by the enrollee's care team and agreed to by the DCO. The care team and the DCO shall work with the enrollee and, as appropriate, the family of the enrollee in determining the health-related services needed to supplement the enrollee's oral health care. These services shall be documented in the enrollee's treatment plan and clinical record

A. The DCO shall provide enrollees with a written notification of a refusal of individual flexible services request and shall copy any representative of the enrollee and any provider who made or participated in the request on the enrollee's behalf. The written notification shall inform the enrollee and provider of the enrollee's right to file a grievance in response to the outcome;
B. The DCO's refusal to permit an individual flexible service request is not an "adverse benefit determination."

DCOs shall submit their financial reporting for health-related services as directed through its CCO and/or OHA contract, as applicable.

REFERENCES
45 CFR 158.150; OAR 410-141-3845; OAR 410-141-3500

DEFINITIONS

"**Health-Related Services"** means non-covered services intended to improve care delivery and overall member and community health and well being, as defined in OAR 410-141-3845. Health-Related Services include Flexible Services and Community Benefit Initiatives.

"Flexible Services" means cost-effective services offered to an individual enrollee as an adjunct to covered benefits.

"**Community Benefit Initiatives**" means community-level interventions that include, but are not necessarily limited to, enrollees and are focused on improving population health care quality.

"Adverse Benefit Determination" means the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the State. The failure to act within applicable timeframes regarding the standard resolution of grievances and appeals. For a resident of a rural area with only one DCO, the denial of an enrollee's request to exercise his or her right to obtain services outside of the network. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Revision History

Date:	Description
12/14/2012	Approval and adoption.
04/10/2015	Updates based on annual review.
02/23/2016	Updates based on annual review.
02/14/2017	Updates based on annual review.
03/12/2018	Updates based on annual review.
04/24/2019	Updates based on annual review.
12/05/2019	Conversion to revised policy and procedure format and naming convention.
12/09/2020	Updates based on annual review.