Advantage Dental
From DentaQuest

Policy Name: Flexible Services	**Policy Number: PL027-Flexible Services-CARE**
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Responsible Department: Plan Operations	
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Approved By: Clinical and Credentialing Sub-Committee	**Approved Date: 7/17/2019**

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

Definitions:

Flexible Services – Health-related non-covered services under Medicaid intended to improve care delivery and enrollee health that are cost-effective services offered to an individual enrollee to supplement covered benefits.

References: 42 CFR 438.100; OAR 410-141-3150

Background:

To ensure Flexible Services are administered in a fair and equitable manner and compliant with CMS requirements and Oregon Health Authority (OHA) and Coordinated Care Organization (CCO) guidance, the DCO has outlined guidelines that are intended to support managing Flexible Services consistently, while providing flexibility to meet individual enrollee needs.

Flexible Services are unable to be reported in the conventional manner using CDT, CPT or HCPCS codes and are likely to effectively treat or prevent the physical, mental or dental health condition. Flexible Services might involve classes, programs, special clothing or footwear, or equipment or appliances.

Flexible Services are funded from the global budgets of each CCO. *There are no additional funds allocated to Flexible Services by the state or CCOs.* Since they are allocated from OHP state funds they are subject to all applicable rules and regulations for Medicaid expenditures. Flexible Services may only be provided to Oregon Health Plan (OHP) enrollees and must be accounted for in reports that the DCO will submit to the CCO and then in turn the CCO will submit to OHA. Flexible Services are reported quarterly as heath related services, which is a component of medical (enrollee service) and will be included when determining the medical loss ratio.

POLICY:

The DCO supports Flexible Services funds to be used for the benefit of members to promote health, prevent decompensation, divert from higher levels of care, assist in environmental stability and increase independence from formalized services.

1. Requirements for Administering Flexible Services:

    A. Items and services purchased must not be otherwise Medicaid reimbursable;
    B. Funds are used when no other funding source is available to cover the cost of the service or item purchased (e.g. AMHI, ENCC);
    C. There are documented processes in place for authorizing funds, coordinating services and providing oversight;
    D. There is a defined mechanism for a provider to request a Flexible Service at the individual enrollee level;
    E. Staff decision making authority is clearly outlined. All staff who administer Flexible services are provided adequate education and training;
    F. All services and supports provided must be clearly related to achieve a treatment goal and documented in the enrollee's plan of oral health care;
    G. All Flexible Services provided are tracked including number of enrollees served, services provided and associated costs;
    H. Denial of an enrollee Flexible Service request is not an adverse benefit determination and is not subject to appeal or hearing rights; and
    I. Enrollees, their representatives and any provider who participated will be provided with written notification of a refusal of individual flexible services request. This written notification will inform the enrollee and provider of the enrollee's right to file a grievance in response to the outcome. See Enrollee Grievance and Appeals policy.

2. Financial Reporting Related to Flexible Services:

    A. All non-encountered Health Related Flexible Services are reported quarterly through Exhibit L (L6, line 17a and L6.2).

    B. Report L12.1 is intended to be used to track cost of goods and services provided under the member expense line by category since this information is not collected on a claim form. The data elements include: enrollee ID, date of service, health condition to be improved, name of provider or payee for services or goods, category of Flexible Service as outlined below, rationale, how effectiveness of goods or services will be measured. The total amount of L6.2 should directly tie to Report L6, line 17a).

    C. Flexible Services Categories as per OHA:
        1) Training/education for health improvement or management (e.g. class on healthy meal preparation or diabetes self-management curriculum)
        2) Self-help or support group activities (e.g. post-partum depression programs, Weight Watchers groups)
        3) Care coordination, navigation or case management activities in support of an individual enrollee (not covered under State Plan benefits)
        4) Home/living environment items or improvements (non-DME items to improve mobility, access, hygiene or other improvements to address a particular health condition)
        5) Transportation not covered under OHA benefits
        6) Programs to improve the general community health
        7) Housing supports related to social determinants of health (e.g. shelter, utilities, critical repairs)

8) Other

Reviewed and Revised By:

12/14/2012	Jeanne Dysert	Tamara Kessler	Missy Mitchell	
04/10/2015	Jeanne Dysert	Tamara Kessler		
02/23/2016	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Jeff Dover
02/14/2017	Jeanne Dysert	Tamara Kessler	Missy Mitchell	
03/17/2017	QI/UR Committee			
03/12/2018	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Rose Novak
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