Health-Related Services Reporting Summary: 2019 CCO Expenditures

Introduction

All CCOs are required by contract to submit annual reports of their expenditures on health-related services (HRS) to the Oregon Health Authority (OHA). The 2019 annual reporting template, Exhibit L, includes dollars spent and detailed descriptions of HRS expenditures (Tab L6.21), and member IDs and HRS services provided to individual members who received more than $200 in Flexible Services for the year (Tab L6.22). In 2020, OHA reviewed the 2019 annual spending data from L6.21 across CCOs to develop this summary, which includes 1) themes on HRS spending, 2) guidance on whether expenditures meet HRS criteria, and 3) guidance on how to submit sufficient details for expenditures to qualify as HRS.

The guidance in this document is intended to give all CCOs an opportunity to optimize their 2020 HRS expenditure reporting prior to submitting the required annual financial reports by April 30, 2021. The way that CCOs report their 2020 HRS spending will affect their Performance-Based Reward, which will be included in 2022 rates (additional detail provided below). It is also important to note that because the 2020 and 2021 CCO capitation rates have already been established, neither the content of the 2019 summary findings below, nor whether CCO 2019 HRS expenditures were confirmed as meeting HRS criteria, will affect the 2020 or 2021 capitation rates.

OHA HRS Guidance

OHA has provided guidance on HRS in the form of an HRS Brief, a Frequently Asked Questions guide, an HRS and Housing guide, a guide for addressing Social Determinants of Health and Equity (SDOH-E) through HRS, a Community Benefit Initiatives guide and a CCO Guidance for Exhibit L Financial Reporting Template communication. Additional HRS guidance continue to be developed by the OHA Transformation Center and OHA HRS team.

HRS are defined in 45 Code of Federal Regulations (CFR) 158.150 and 45 CFR 158.151, and in Oregon Administrative Rules (OAR) 410-141-3845. OHA recommends that CCOs reference these rules when determining if expenditures meet the criteria for health-related services.

HRS reporting categories (column C within Tab L6.21) were updated from 2019 to 2020. These revised categories were incorporated in this report through qualitative coding by OHA staff, thus replacing the CCO-identified categories from the 2019 reporting template. The updated HRS reporting categories are as follows:

- Care coordination, navigation or case management activities not otherwise covered under State Plan benefits, including traditional health workers;
- Education provided to members for health improvement or education supports, including those related to social determinants of health and equity (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, ACEs training in schools);
- Other non-covered clinical services and improvements (for example, supports for community oral health services, EHR meaningful use); and
- 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; and interventions to address other SDOH-E, including employment and built environment improvements).

HRS Expenditure Reporting Guidance and Denied Expenditures

The following information outlines the most common justifications for why some 2019 HRS expenditures were not confirmed as meeting all HRS criteria. Figure 1 (below) further highlights themes for HRS expenditures that were not confirmed.

1. **Expenditures encompassed covered services for Medicaid members or contractual requirements for CCOs, thus not meeting HRS criteria**
    a. These included covered services for Medicaid members, which by HRS definition cannot meet HRS criteria, as well as necessary expenditures to perform CCOs' contractual duties that should be characterized as administrative costs.
    b. Some expenditures were reported that contained description of member care coordination and case management, oral health services for members, and integrated diabetes care, all of which are covered services or administrative costs for CCOs.
    c. Some expenditures were reported to hire a staff person such as an immunization nurse or a nutritionist in a public health clinic. If the staff person provides both covered and non-covered services, costs for the non-covered services should be documented as HRS, but the entire staff salary should not be.
    d. Some expenditures were reported for funding facilities that primarily provide covered services, such as diagnostics. Although there may be a community need and the funding may result in lower-cost services, funding a facility that primarily provides a covered service is considered an administrative expense, and not considered an HRS.
    e. Submissions were also not confirmed when the description of services evidenced both covered and non-covered services for members. In several cases, submissions could have been accepted if CCOs only submitted the non-covered services as a separate expenditure.
2. **Expenditures for trainings and education for network providers and staff**
    a. Trainings and continuing education, including conferences and education events, for CCO staff or network providers is considered an administrative expense and does not qualify as HRS.
    b. The "Training and education for health improvement or management" category is intended to encompass training and education for CCO members, not CCO staff or network providers. These types of trainings for CCO staff or network providers would generally be considered an administrative expense.
    c. Relevant submissions that were not confirmed included equity and inclusion trainings, addiction and substance use disorder conferences, and behavioral health workgroups, all of which focused on network providers as the primary audience, and thus were considered an administrative expense.

3. **Missing required information or data**
    a. When required columns are left blank, OHA is not able to assess if the expenditure meets all HRS criteria.
    b. Flexible service expenditure denials were often missing the "predicted number of members directly receiving" column. Flexible service expenditures are defined as member-level services and must include how many members received the service.
    c. Community benefit initiative denials were sometimes due to the description and rationale describing a member-level service that should have been reported as Flexible Services and included the "predicted number of members" receiving the service.
4. **Insufficient expenditure details to know how the money was spent**
    a. Across all submissions, when the "description of services provided" column has insufficient details, OHA is unable to determine whether expenditures meet HRS criteria.
    b. Some CCOs reported expenditures on categories of services without specifying what services were provided. Reported categories of expenditures such as "Training and education for health improvement or management" or "Assistance with food or other social resources" require additional description of the services provided. Without those description details, OHA is not able to confirm that the expenditure meets all HRS criteria.
    c. Some reported expenditures were a total dollar amount given to a non-profit organization without identifying the services or target population. While some non-profit organizations may improve health care quality for individuals or the community, not all are designed to do so, and they may have a mission and services that are greater in scope. Expenditure reports must include a description of the services provided and the target population for OHA to accurately assess if the expenditure meets all HRS criteria.
    d. Some reported expenditures appeared to be potentially billable services. Without enough details in the description and rationale, OHA is not able to confirm whether these are non-covered services that qualify for HRS.

HRS Expenditure Guidance and Recommendations for Future HRS Reporting

The following reporting practices will help ensure that OHA has enough information to confirm that expenditures met all HRS criteria:

1. Complete all required columns listed in the Exhibit L Financial Reporting Guide from OHA.
2. Provide sufficient level of expenditure detail. For example, a donation to a non-profit includes details on the non-profit's services provided and the target population.
3. Provide sufficient rationale of expenditures. Both examples below include sufficient and clear rationale:

EXAMPLE OF AN EXPENDITURE WITH A CLEAR RATIONALE FOR AN EVIDENCE-BASED PRACTICE

PAX Good Behavior Game is an evidence-based, SAMSHA-endorsed framework for increasing student self-regulation and creating nurturing environments within schools and youth programs. The social emotional and academic returns on this investment have been proven over the past two decades and is resulting in reclaimed instructional time, workforce rejuvenation, and student success measures in cognitive and emotional skills. This expenditure encompassed initial trainings to provide the basic skills needed to implement the PAX framework in schools and other youth serving settings.

EXAMPLE OF AN EXPENDITURE WITH A CLEAR RATIONALE FOR A WIDELY-ACCEPTED PRACTICE

The expenditure provides transportation not covered by Non-Emergent Medical Transportation to improve access to care. Without access to care, health will deteriorate.

4. Include the number of members directly receiving the benefit for all Flexible Services expenditures.
5. Group expenditures to avoid redundancy in line items, but maintain enough description to properly explain the expenditures. For example, the same Flexible Services expenditure provided to multiple members, such as bus tickets, can be aggregated in one expenditure line with the total number of members receiving bus tickets noted.

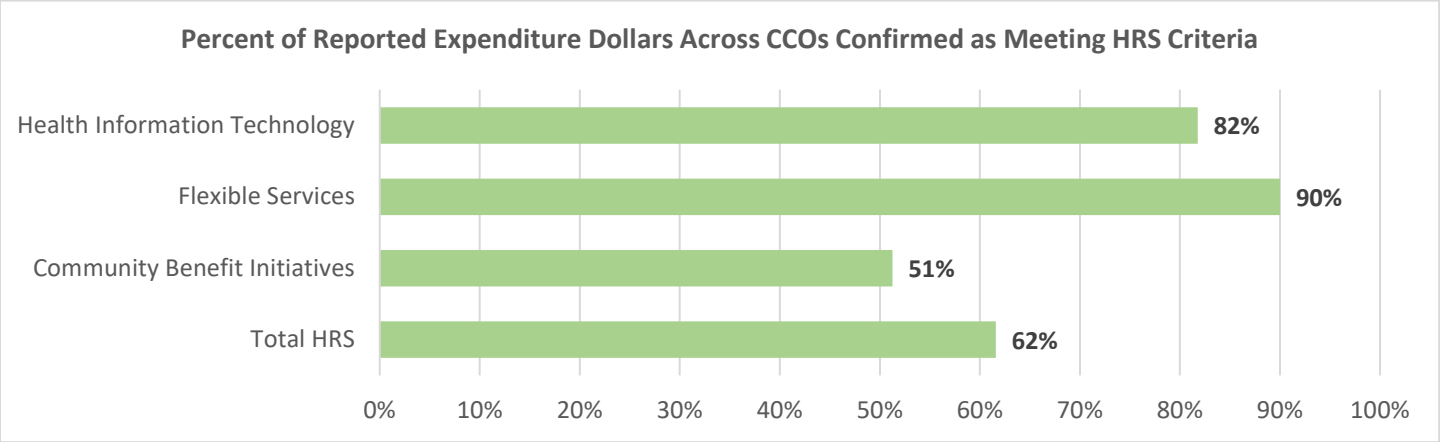
For additional guidance on ensuring proper HRS expenditure reporting, see the Exhibit L Financial Reporting Guide from OHA.

Themes Across CCOs and HRS Expenditures[1]

HRS Expenditure Confirmation Rates

Over 60% of total expenditure dollars submitted as HRS in 2019 (or $16.2 million) were confirmed as meeting HRS criteria, while nearly 90% of distinct expenditure line items (or 724, by count) were confirmed (see Figures 1 and 2 below). This marks an increase from 2018 HRS confirmed expenditure, of which just 48% of total dollars submitted (or $9.8 million) were confirmed as meeting HRS, and less than half of distinct expenditure line items (or 262, by count) were confirmed as meeting HRS criteria. However, HRS expenditure dollars and confirmation rates varied widely across CCOs in 2019 (see Figure 3 below). While the percent of 2019 expenditures confirmed as meeting HRS criteria does not affect CCOs' capitation rates in 2020, Exhibit L expenditures for 2020 that are not confirmed as meeting HRS criteria will influence the Performance-Based Reward (PBR), which will be a component of the 2022 rates. The intended impact of the PBR is to improve the delivery of benefits to CCO members, including more efficient use of medical services, increased delivery of high-value services and increased use of HRS that improves member health.

Figure 1



[1] The analysis for this report includes all 15 CCOs who were contracted through Dec. 31, 2019. This includes PrimaryHealth and Willamette Valley Community Health, two CCOs whose contracts were not renewed in 2020. As neither organization was able to participate in the HRS review process starting in early 2020, the HRS team confirmed the entire $156,549 of HRS expenditures submitted by both CCOs as meeting HRS criteria.

Figure 2

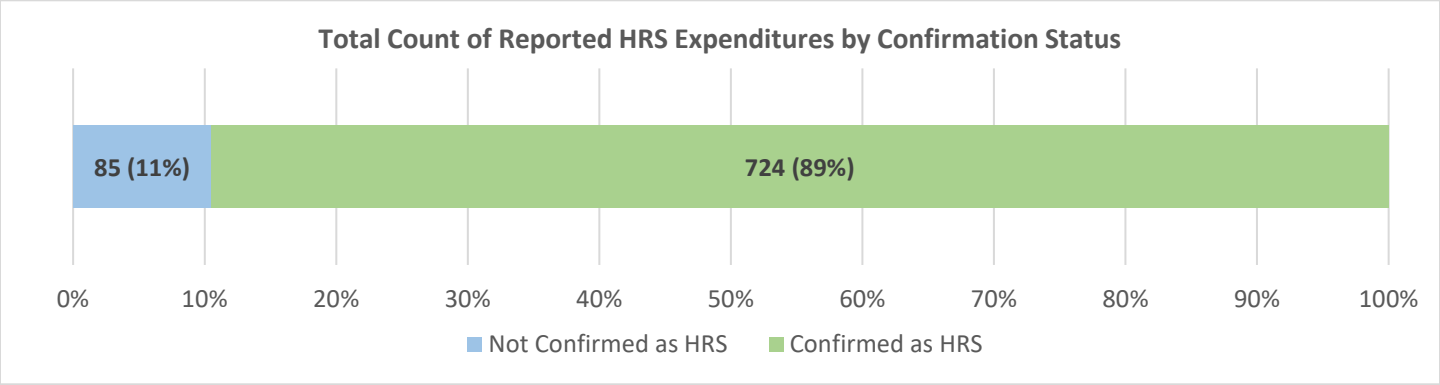
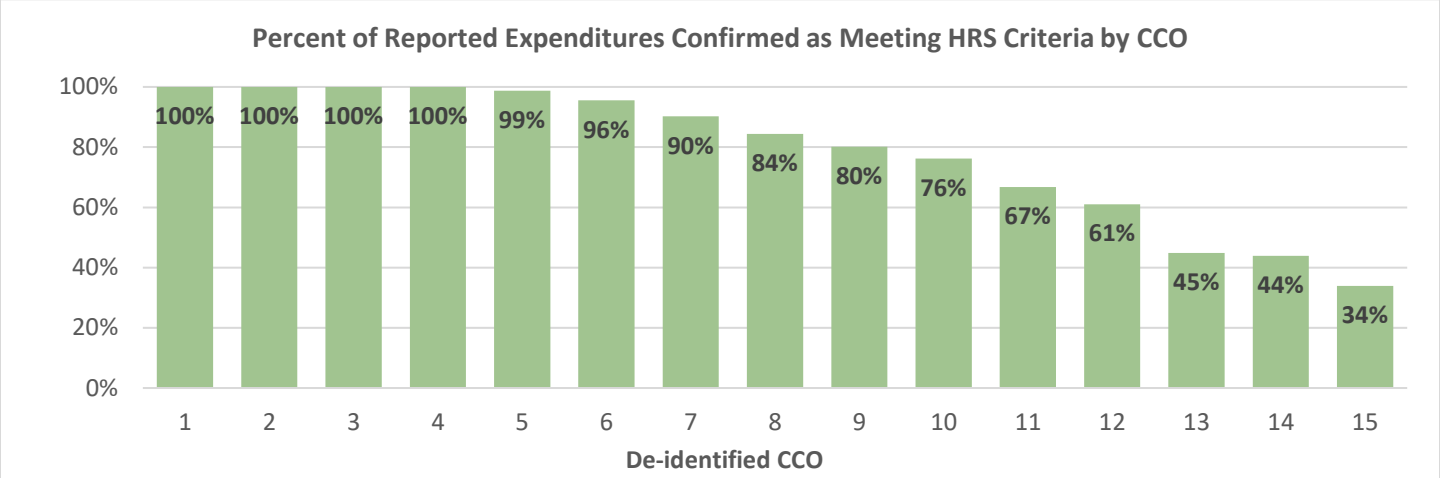


Figure 3



Flexible Services, Community Benefit Initiatives, and Health Information Technology Reported

Among all confirmed HRS expenditure dollars, 58% were determined to be Community Benefit Initiatives (see Figure 4). Flexible Services accounted for 18% of total HRS expenditure dollars, though made up approximately 77% (or 558) of the 723 confirmed HRS distinct expenditure line items (see Figures 4 and 5). Out of all confirmed HRS expenditure line items, only 158 represented Community Benefit Initiatives, though Community Benefit Initiative expenditures had significantly higher average dollar values relative to Flexible Service expenditures (see Figure 6).

Figure 4

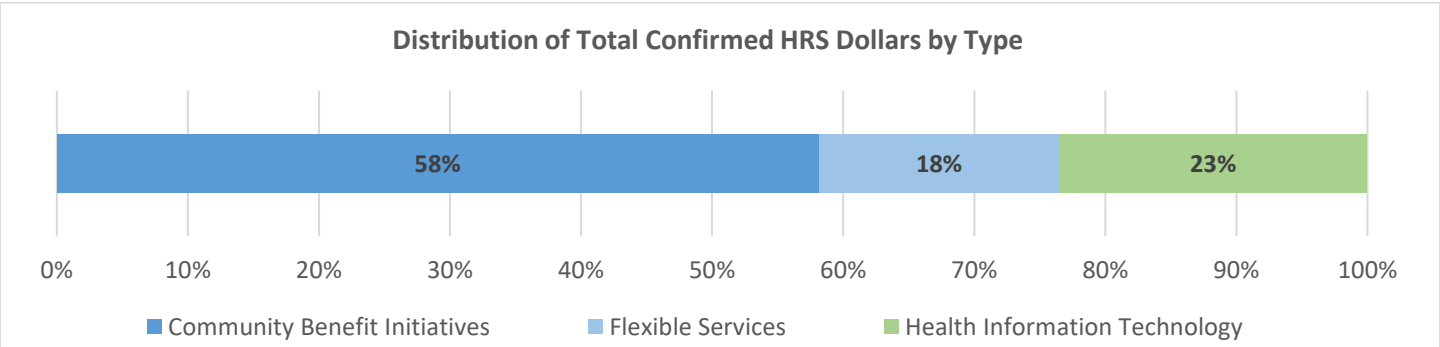
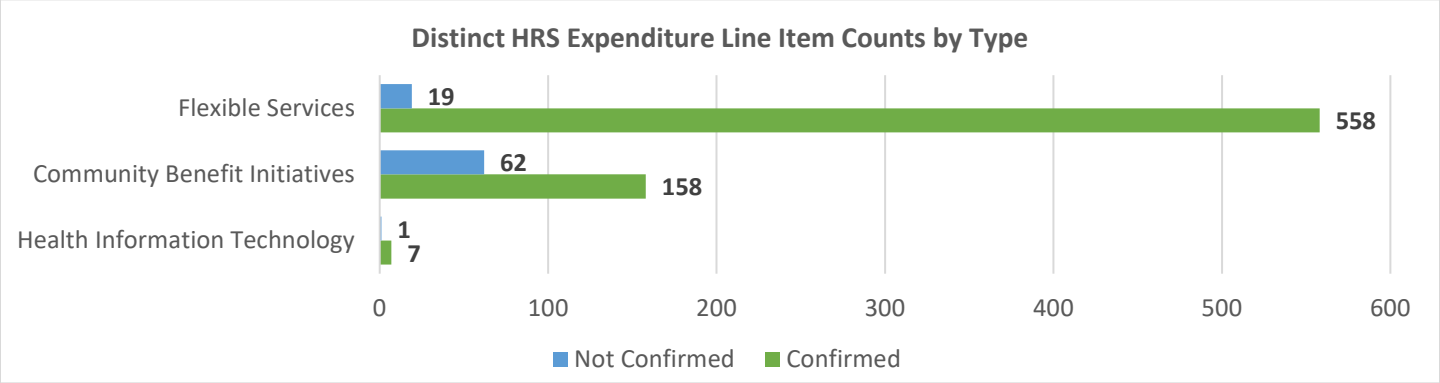


Figure 5



In 2019, CCOs began reporting Health Information Technology (HIT) as a sub-category of Community Benefit Initiatives[2]. HIT accounted for $3.8 million in confirmed HRS expenditures, with 82% of submission dollars confirmed as HRS by OHA (see Figure 1). Despite accounting for just 1% (or 7) of confirmed HRS expenditures, HIT expenditures made up 24% of aggregate confirmed HRS expenditure amounts, averaging $542,463 per expenditure (see Figures 5, 6, and 7). This is expected given HIT expenditures are generally more costly and cover a population instead of individual members. Across CCOs, the distribution of expenditures varied in terms of qualifying as Flexible Services, Community Benefit Initiative, or Health Information Technology (see Figure 8).

Figure 6

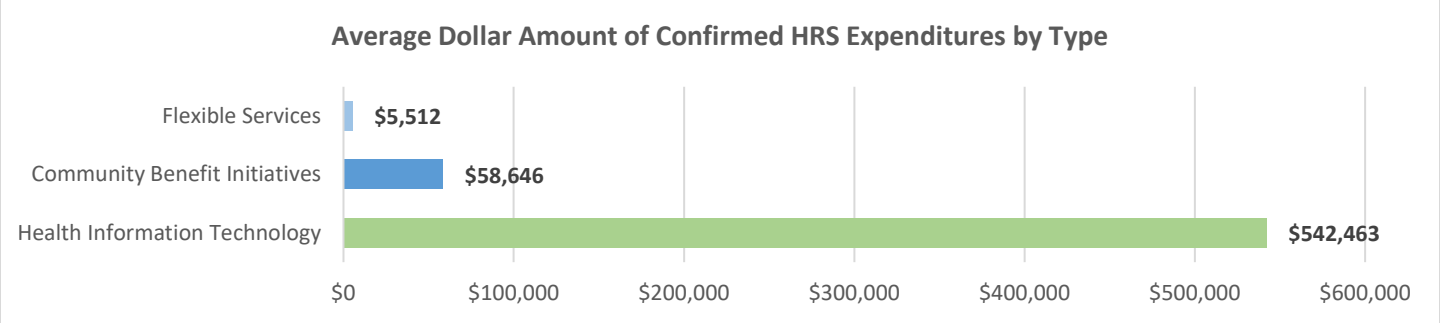
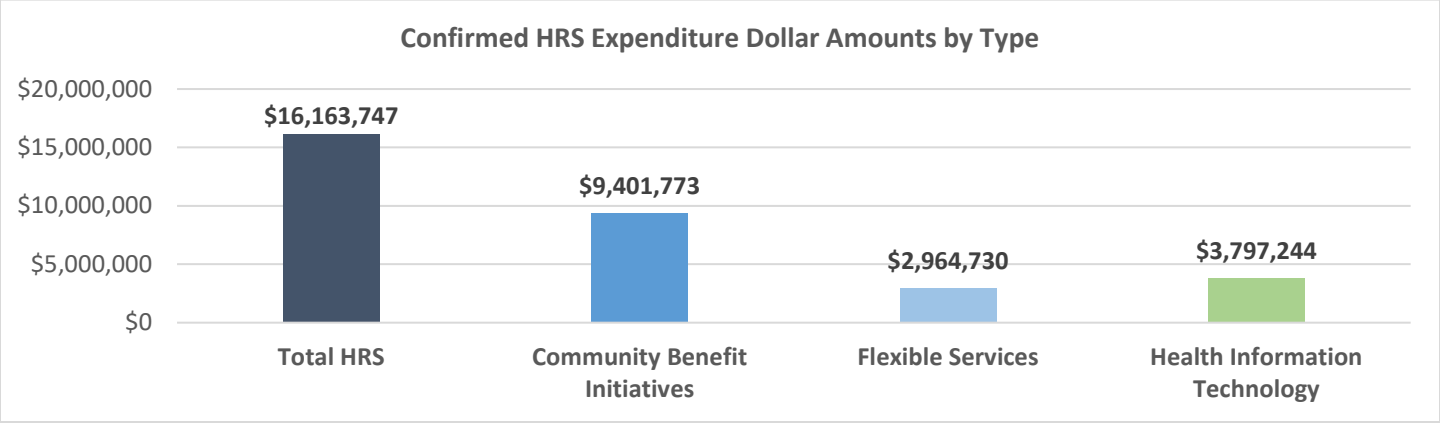
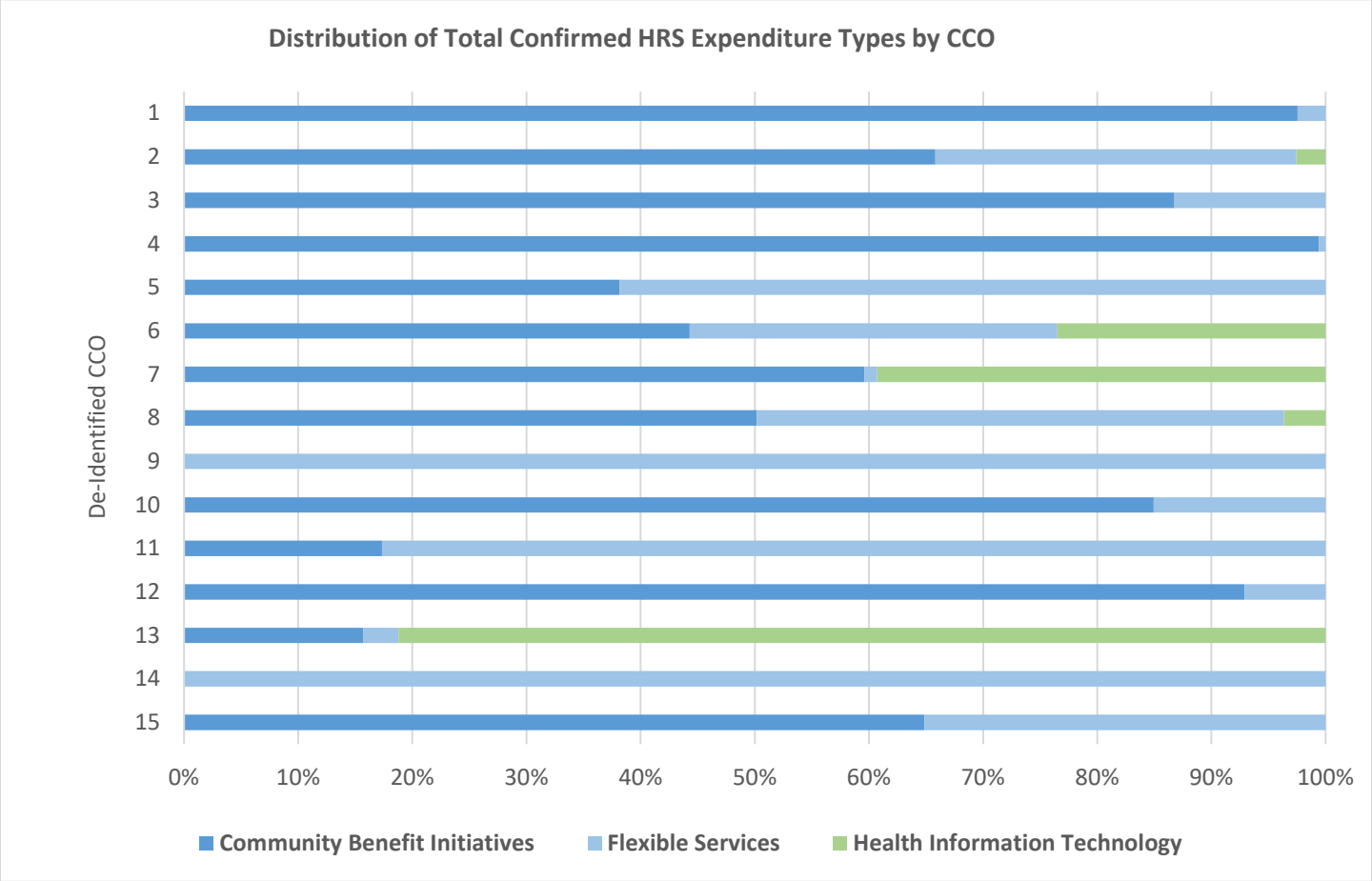


Figure 7



[2] Although Health Information Technology (HIT) is a sub-category of Community Benefit Initiatives (CBI) and not a distinct type of HRS, HIT is analyzed separately from CBI within this report. Analyzing separately provides a clearer picture of CCO HRS spending on HIT while not skewing the total CBI expenditures, given the larger total dollar amount spent on individual HIT expenditures.

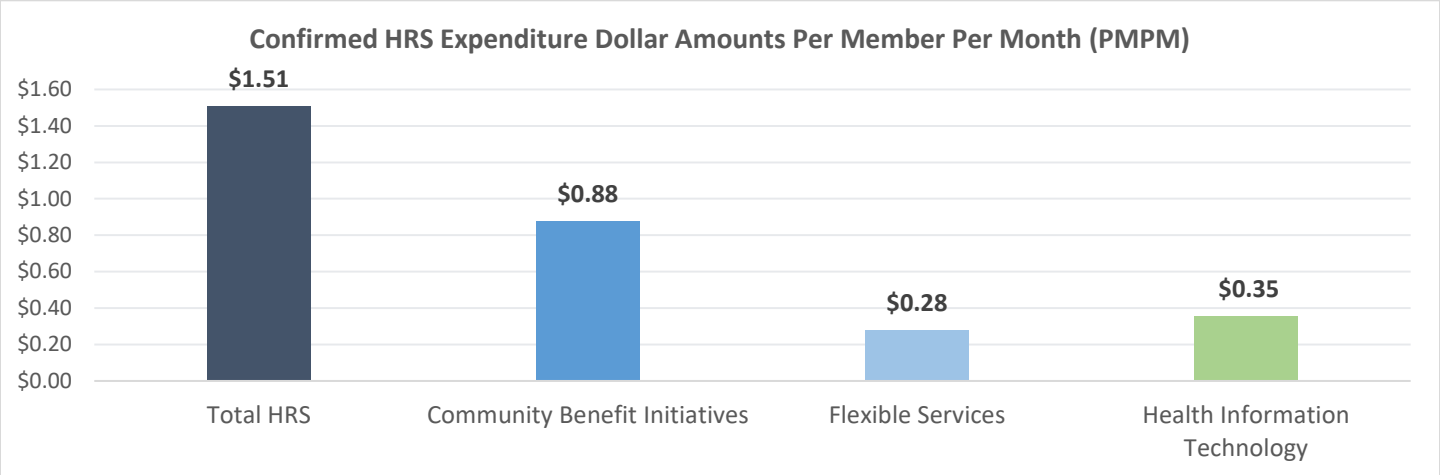
Figure 8



HRS Expenditures Per Member Per Month

Across all CCO HRS spending, confirmed HRS expenditures accounted for $1.51 per member per month (PMPM) (see Figure 9). This marks an increase of over 50% from the average 2018 HRS PMPM across CCOs ($0.95). Community Benefit Initiatives account for the majority of PMPM spending, as displayed in Figure 9 below. This represents just 0.36% of total CCO spending across all CCOs, with a range of 0.01% to 2.76% of individual CCO total spending.

Figure 9

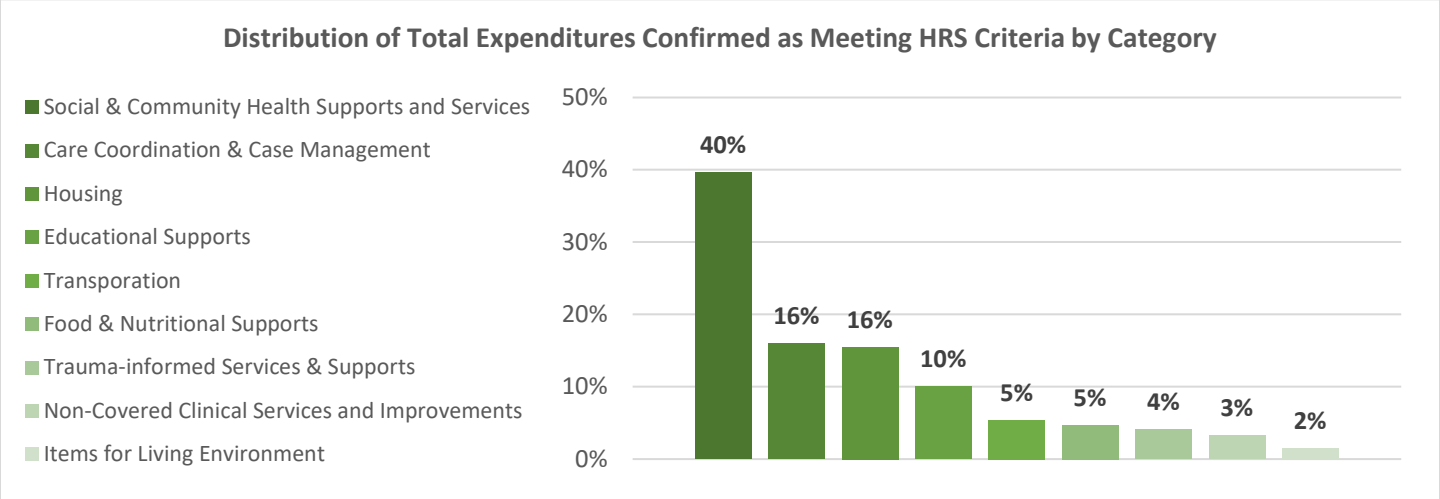


Health-Related Services Reporting Summary: 2019 CCO Expenditures

Categories of HRS Expenditures Reported[3]

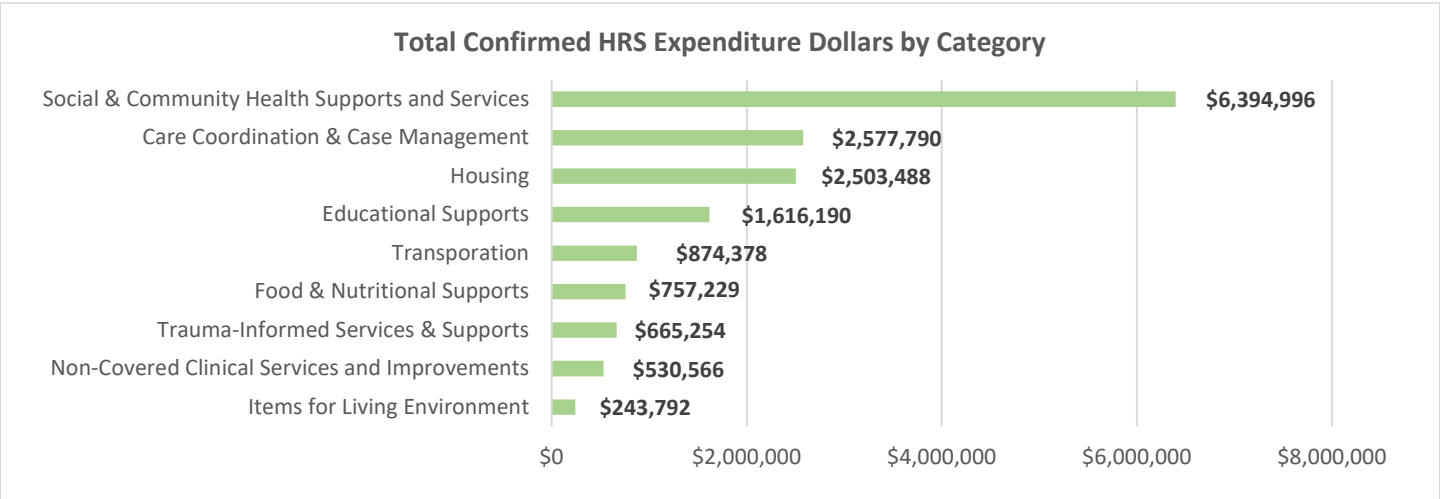
Across CCOs, the three categories accounting for the highest percentage of confirmed expenditures were social and community health supports (40%); housing supports and services (16%); and care coordination, patient navigation, or case management services (16%). The categories with the smallest proportion of confirmed HRS expenditures were clinical services and improvements (3%), and items for living environments (2%). Full details are available in Figure 10.

Figure 10



Despite representing the largest amount of total submitted HRS expenditures, clinical services and improvement expenditures were rarely confirmed as meeting HRS criteria, which resulted in the second smallest confirmed expenditure dollars (see Figure 11). As previously mentioned in this report, expenditures representing staff trainings and education were not confirmed due to not meeting HRS criteria, and these expenditures generally fall within the clinical services and improvements category. Expenditures linked to oral health services, staff incentives, and clinical expansions were also commonly submitted as clinical services and improvements, and were not confirmed due to being required, covered services and administrative expenses.

Figure 11



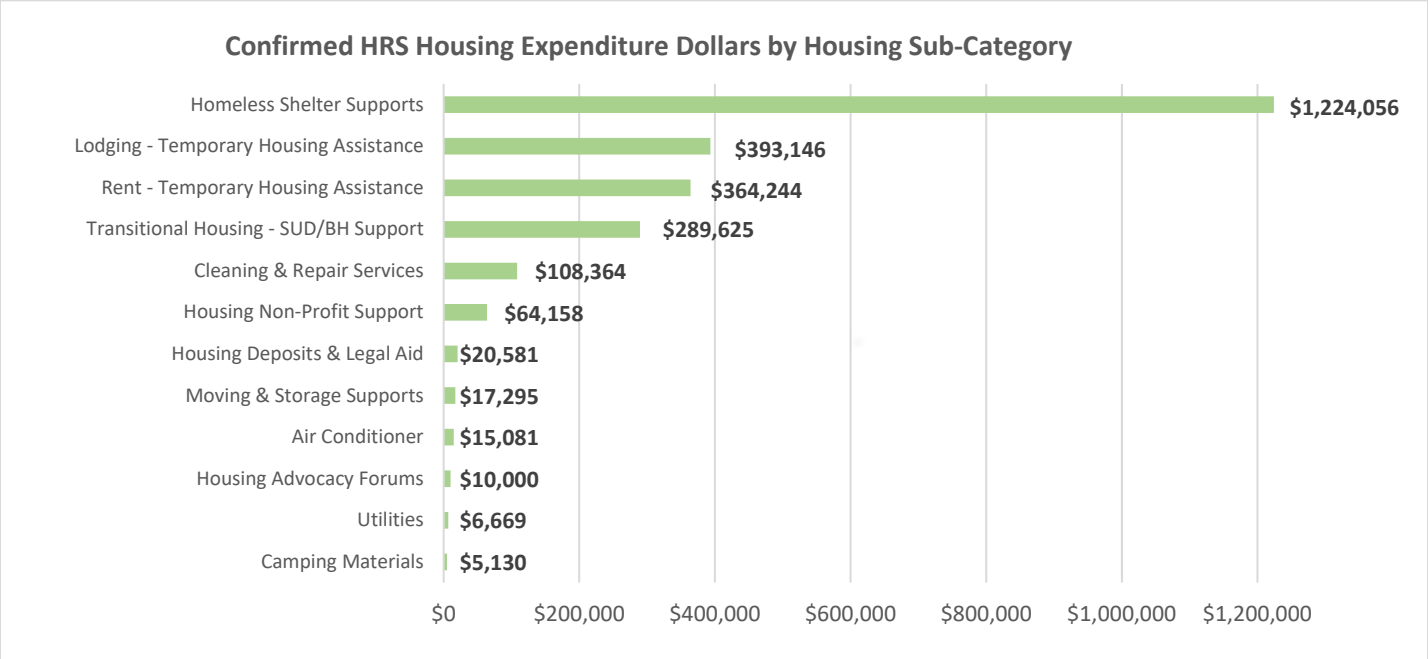
[3] As noted earlier in this report, the HRS categories reported by CCOs in 2019 were modified to match revised 2020 HRS categories. through qualitative coding by OHA Staff.

Health-Related Services Reporting Summary: 2019 CCO Expenditures

HRS Category Highlight: Housing

Expenditures related to housing services and supports have increased from 2018 spending, when housing-related expenditures accounted for approximately 10% of confirmed HRS spending, or just under $1 million in total. In 2019, housing services and supports accounted for 16% of total confirmed expenditures – over $2.5 million in total confirmed value – behind only social/community health supports and care coordination/case management for the highest confirmed HRS category amounts (see Figures 10 and 11). The majority of confirmed housing-related HRS expenditures were made to support transitional housing projects or to fund homeless shelter supports and services (see Figure 12).

Figure 12



For more information on this topic, refer to the HRS and Housing guidance document.

Most Common HRS Expenditures

Across all expenditures, the most frequently submitted and confirmed as meeting HRS criteria included:

- Short-term housing assistance in the form of rental payments or deposits (64 distinct expenditure line items)
- Short-term housing assistance in the form of lodging expenses and hotel fees to prepare for or recover from medical procedures (60 distinct expenditure line items)
- Gym memberships, swim passes, yoga class fees, recreation passes, as well as community fitness programming (41 distinct expenditure line items)
- Food items including groceries, food boxes, and client meals during medical treatment (distinct expenditure line items)
- Clothing items including work attire, shoes, workout clothing, and swimwear (27 distinct expenditure line items)
- Communication supports for members, including cell phones, phone bill payments, charging devices, and iPads (25 distinct expenditure line items)
- Baby support items including strollers, diapers, safe chewable toys, cribs, gates and other items for infant safety and medical needs (22 distinct expenditure line items)

- Furniture and appliances to improve member living environment, including refrigerators, furniture costs and delivery fees for members previously experiencing homelessness, and various other furnishings (21 distinct expenditure line items)
- Bedding and sleeping supports for members, including mattresses, bed frames, heated blankets, pillows and alarm clocks (18 distinct expenditure line items)
- Documentation items and supports including birth certificates, driver licenses, and background check fees (16 distinct expenditure line items)

Individual CCO Expenditure Assessment

CCOs should refer to the HRS final determination spreadsheets provided by OHA in July 2020 along with this guidance for your CCO's expenditure assessment results. Within the file, column Y is OHA's assessment of whether an expenditure was confirmed as meeting HRS criteria and column Z provides feedback to the CCO. In addition, be sure to review the table (columns B-D) below expenditures that notes the percent and total numbers of expenditures confirmed as meeting HRS criteria.

Next Steps for HRS Reporting

The goal of this guidance is to support improved HRS expenditure reporting of investments, which will in turn support a more successful implementation of the PBR. In 2021, OHA will follow the same process and timeline as this year to assess and provide assessment feedback to CCOs on their 2020 HRS expenditure reporting:

- April 30, 2021: CCOs submit Exhibit L report with annual HRS level detail covering 2020 spending.
- May – June 2021: OHA assesses 2020 HRS expenditures to confirm whether they meet all HRS criteria.
- May 15 – June 30, 2021: On a rolling basis, each CCO receives assessment and has two weeks to resubmit HRS expenditure updates for OHA to re-assess.
- No later than July 16, 2021: OHA finalizes 2020 HRS expenditure assessment decisions. Starting in 2021, based on assessment of 2020 HRS expenditures, the final OHA expenditure assessment decisions will inform PBR calculations.

CCOs' use of HRS continues to evolve as CCOs explore new ways to meet the needs of their members. The guidance and feedback in this document will not only support future CCO HRS investments and reporting, but will also strengthen joint efforts by CCOs and OHA to improve member and community health.

Questions?

For additional questions or guidance related to HRS expenditures, please contact the OHA HRS Team (Health.RelatedServices@state.or.us).