Health-Related Services Summary

2020 CCO Health-Related Services Spending

November 2021

Oregon Health Authority

Contents

Acknowledgments

This publication was prepared by the Oregon Health Authority's cross division health-related services team.

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Executive Summary

Purpose of this Spending Summary

This spending summary provides an overview and trends of CCO health-related services (HRS) spending, with a goal of increased transparency. The document also may support increased HRS spending by providing guidance to CCOs for optimizing their 2021 HRS reporting to the Oregon Health Authority (OHA). This summary does not reflect all CCO spending on social determinants of health, such as CCO spending through the Supporting Health for All through Reinvestment Initiative.

Defining HRS

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. CCOs may use HRS as a funding mechanism within their global budgets to address the social determinants of health (SDOH) and the health-related social needs of their members. This flexibility to focus beyond direct medical care improves CCOs' impact on member and community health.

> HRS spending more than doubled from 2019 to 2020 with $34,153,552 spent in 2020.

CCO HRS Reporting

CCOs are not required to utilize HRS, but all CCOs do spend a small proportion of their global budget on HRS. CCOs are required to submit annual HRS spending reports to OHA. OHA reviews the reports to ensure all spending meets HRS criteria. HRS spending that was accepted for 2020 was included in the CCOs' performance-based reward calculations for setting 2022 capitation rates.

Highlights

Accepted CCO spending on HRS more than doubled from 2019 to 2020, totaling $16,163,747 and $34,153,552, respectively. The increase was not solely due to increased Medicaid eligibility during the pandemic, as the per member per month (PMPM) spending also almost doubled from $1.51 PMPM in 2019 to $2.93 PMPM in 2020. Individual CCO HRS spending ranged from $0.48 PMPM to $15.51 PMPM.

> Top three areas of 2020 CCO HRS spending were HIT ($7,756,901), COVID-19 ($7,578,071), and Housing ($4,944,757).

In 2020, OHA promoted HRS as the primary funding method to address social determinants of health. Reporting shows that 49% ($16,845,416) of CCO spending on HRS went to SDOH partners.

HRS spending on health information technology (HIT), housing, prevention, education, family resources, substance misuse and addiction, and food access accounted for 71% of all HRS spending. Another 23% of CCOs' HRS spending was used to address community and member needs exacerbated by COVID-19, as well as emergency needs related to wildfire relief.

CCOs noted that they changed how they used HRS funds to address health inequities made worse by the pandemic. CCOs provided HRS funding directly to community-based organizations that were already working with and providing support to Black, Indigenous and other Communities of Color.

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 both flexible services and community benefit initiatives.

For CCOs to use federal Medicaid funds for HRS, they must comply with state and federal criteria. For a full definition of HRS, CCOs should rely primarily on the OHA HRS Brief and Oregon Administrative Rules (OARs 410-141-3500 and 410-141-3845). The Code of Federal Regulations (45 CFR 158.150 and 45 CFR 158.151) should be used for supplemental CCO guidance only. Additional guidance and technical assistance can be found on OHA's HRS webpage.

Financial incentives for CCOs to spend a portion of their global budgets on HRS include a contractual requirement to maintain a minimum medical loss ratio and reflection of confirmed 2020 HRS spending in the performance-based reward (PBR) component of CCOs' 2022 capitation rates. More details are available in OHA's HRS Brief.

WHAT ARE HEALTH-RELATED SERVICES?

Health-related services (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. The two types of HRS include flexible services and community benefit initiatives as defined below.

Flexible services are defined as cost-effective services offered to an individual CCO member to supplement covered benefits.

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

This spending summary provides an overview and trends of CCO HRS spending, and may serve as guidance to support increased CCO HRS spending. The document also provides transparency in CCO HRS spending and allows CCOs an opportunity to optimize their 2021 HRS reporting prior to submission to OHA.

This spending summary provides an overview and trends of CCO HRS spending, with a goal of increased transparency. The document also may support increased HRS spending by providing guidance to CCOs for optimizing their 2021 HRS reporting to OHA. The way that CCOs report their 2021 HRS spending may affect the PBR component of their 2023 capitation rates.

OHA Review of CCO HRS Spending

Spending Assessment

All CCOs are required by contract to submit annual reports of their spending on health-related services (HRS) to the Oregon Health Authority (OHA). The annual financial reporting template, Exhibit L, includes dollars spent and detailed descriptions of HRS spending (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). The annual Exhibit L financial report with the HRS spending details is due to OHA by April 30 of the year following the spending.

Upon receipt of the annual Exhibit L financial report, the HRS team reviews the spending details in the tab L6.21 to ensure the spending meets HRS criteria. For spending that does not initially meet HRS criteria, the CCO has the opportunity to provide additional information to better demonstrate how the spending meets criteria. OHA uses that additional information to make a final determination that spending does or does not meet HRS criteria. Allowing CCOs to submit additional information before OHA's final determination began with 2019 HRS spending, which means prior year spending data is not as comparable.

The financial reporting details for HRS that are accepted do not reflect all CCO spending on social determinants of health. Other CCO funding mechanisms for social determinants of health and equity includes the Supporting Health for All through Reinvestment (SHARE) Initiative. More information about CCO spending through SHARE is available on the OHA SHARE webpage. CCOs may also opt to use other funding to support SDOH initiatives and have expressed investing more broadly in SDOH than HRS and SHARE spending reported to OHA.

Spending Analysis

Spending that meets HRS criteria is analyzed to track total HRS spending, types of HRS spending, percent of total budget spent on HRS, and per member per month HRS spending by year.

Additionally, OHA's HRS technical assistance consultant, the Oregon Rural Practice-Based Research Network, qualitatively codes all HRS spending. This provides more consistent and detailed spending categories than the reporting categories included in Exhibit L. In 2020, many CCOs shifted a portion of HRS spending to focus on pandemic and wildfire response and relief. To account for this, the 2020 qualitative code set was adapted to include COVID-19 and wildfire related codes.

HRS Spending Highlights

Spending Acceptance Rates

The percentage of spending accepted as meeting HRS criteria increased from 62% in 2019 to 87% in 2020. This improvement is likely due to three key changes. First, OHA provided feedback to CCOs on 2019 HRS spending details and allowed CCOs to submit additional information. This gave CCOs the opportunity to learn from prior reporting missteps. Second, OHA significantly increased HRS guidance and technical assistance opportunities to help CCOs better understand what meets HRS criteria. Lastly, with the implementation of PBR, reported HRS spending that was not accepted as meeting HRS criteria was disregarded in CCOs' PBR calculations, which provided an additional incentive for improved reporting.

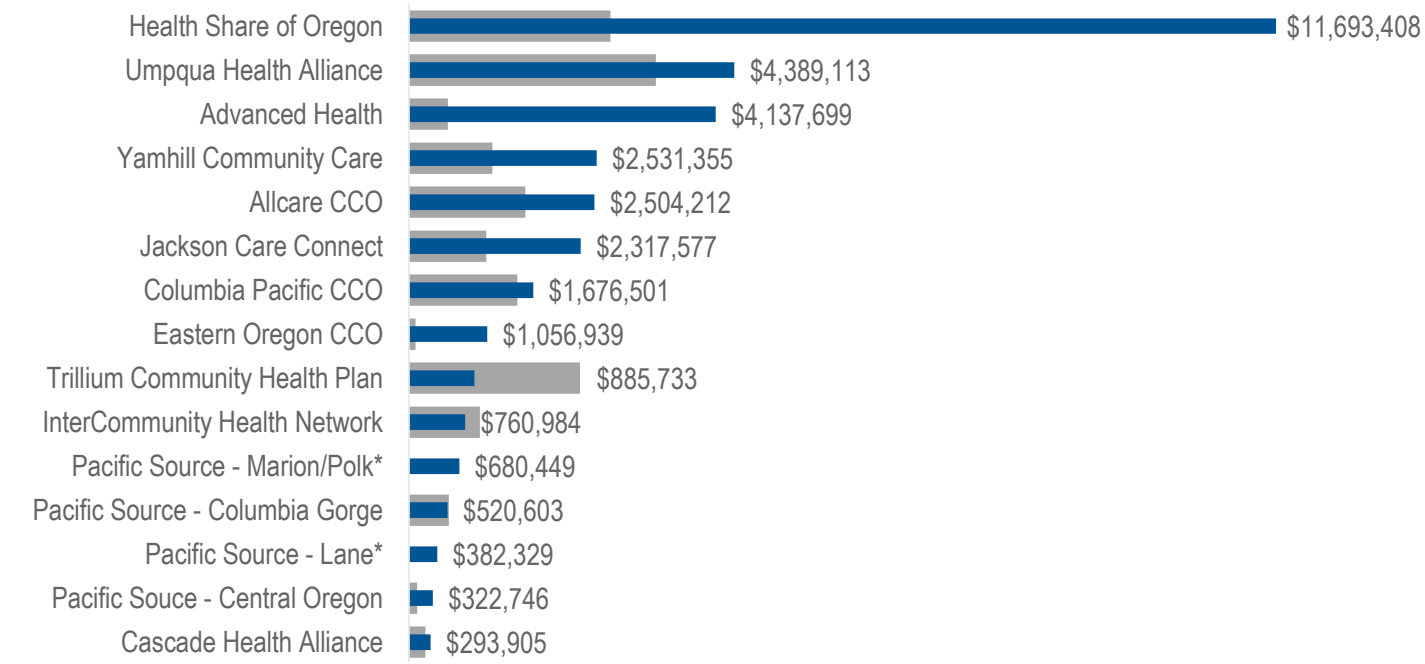
Throughout the remainder of this document, all analysis will focus only on the 87% of 2020's CCO HRS spending that was accepted as meeting HRS criteria.

Total Spending

Total CCO HRS spending more than doubled from 2019 to 2020 with an increase from $16,163,747 to $34,153,552. However, HRS spending still only accounts for 0.70% of total CCO spending (an increase from 0.36% in 2019). Across CCOs, total spending ranged from $293,905 to $11,696,408 and percent of total CCO spending ranged from 0.11% to 3.39%. See Figures 1 and 2 below for total HRS dollars spent by CCO and percent of total spending by CCO, respectively.

Figure 1: Total HRS spending by CCO and year

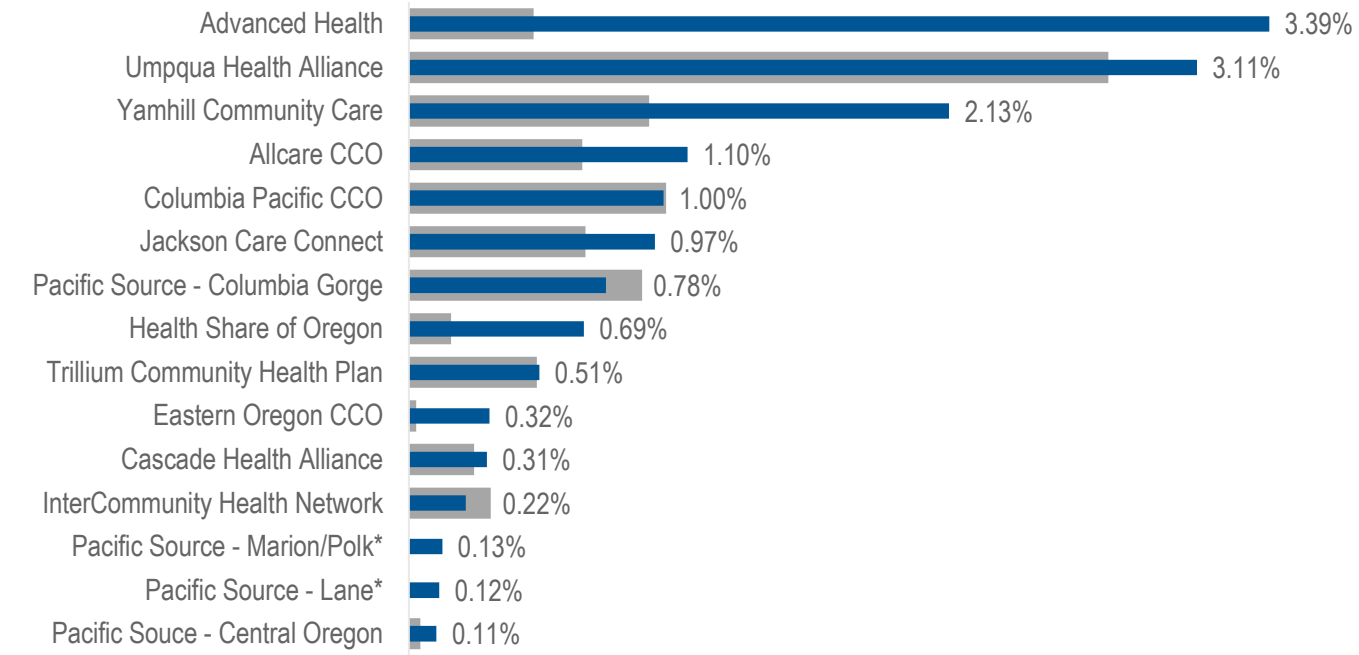
HRS spending increased for all but three CCOs that reported HRS spending in 2019 and 2020.



* New CCO in 2020 with no 2019 HRS spending.

Figure 2: Total HRS spending as a percent of total spending by CCO and year

Percent of total spending spent on HRS increased for all but three CCOs that reported HRS spending in 2019 and 2020.



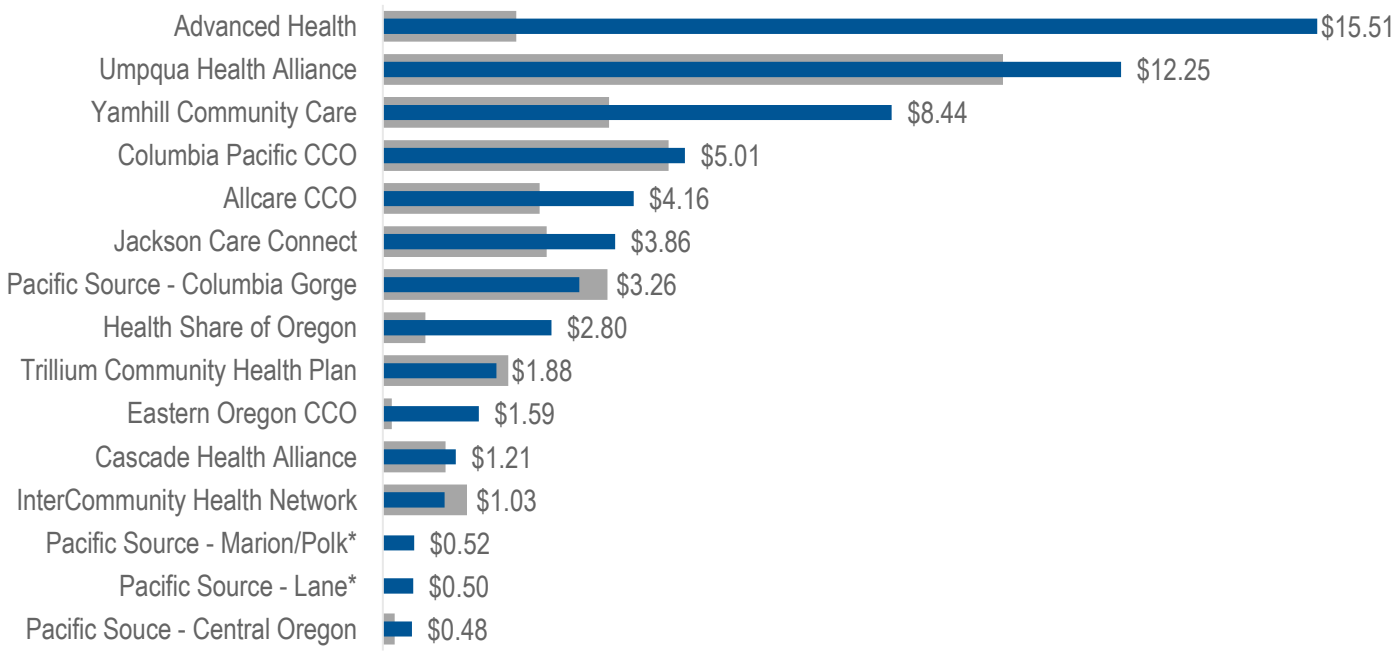
* New CCO in 2020 with no 2019 HRS spending.

Average spending across all CCOs per member per month (PMPM) came close to doubling from 2019 to 2020 with an increase from $1.51 PMPM to $2.93 PMPM. This demonstrates that CCO HRS spending did not increase solely due to increases in CCO membership, as more individuals became

eligible for Medicaid during the pandemic. While Oregon Health Plan enrollment increased by 24% from January 2020 to December 2020, PMPM HRS spending almost doubled. See Figure 3 below for PMPM by CCO.

Figure 3: HRS per member per month (PMPM) spending by CCO and year

PMPM HRS spending increased for all but three CCOs that reported HRS spending in 2019 and 2020.



* New CCO in 2020 with no 2019 HRS spending.

Spending Types

Across HRS spending, 62% was provided to the broader community through community benefit initiatives (CBI). This is a slight increase from 2019, when CBI accounted for 58% of total HRS spending. Meanwhile, flexible services (FS) spending on individual members slightly decreased from 18% of total HRS spending in 2019 to 15% of total HRS spending in 2020. Health Information Technology (HIT) HRS spending is allowed under the definition of CBI spending, but it is reported separately from CBI in Exhibit L. HIT spending remained almost unchanged, from 23% of total HRS spending in 2019 to 22% of total HRS spending in 2020.

In terms of HRS dollars spent, the amounts doubled or close to doubled from 2019 to 2020 for all three types of HRS (see Table 1 and Figure 4 below).

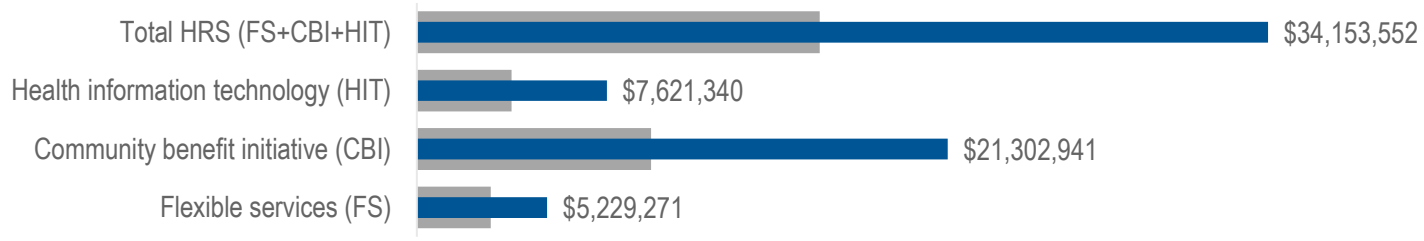
Table 1: Total dollars spent by year across service types

HRS service type	2018	2019	2020
Flexible services	$2,380,536	$2,964,730	$5,229,271
Community benefit initiative	$7,492,380	$9,401,773	$21,302,941
Health information technology	n/a[1]	$3,797,244	$7,621,340

[1] HIT is a subset of community benefit initiative (CBI) and HIT was not reported separately from CBI until 2019.

Figure 4: Total HRS spending by type and year

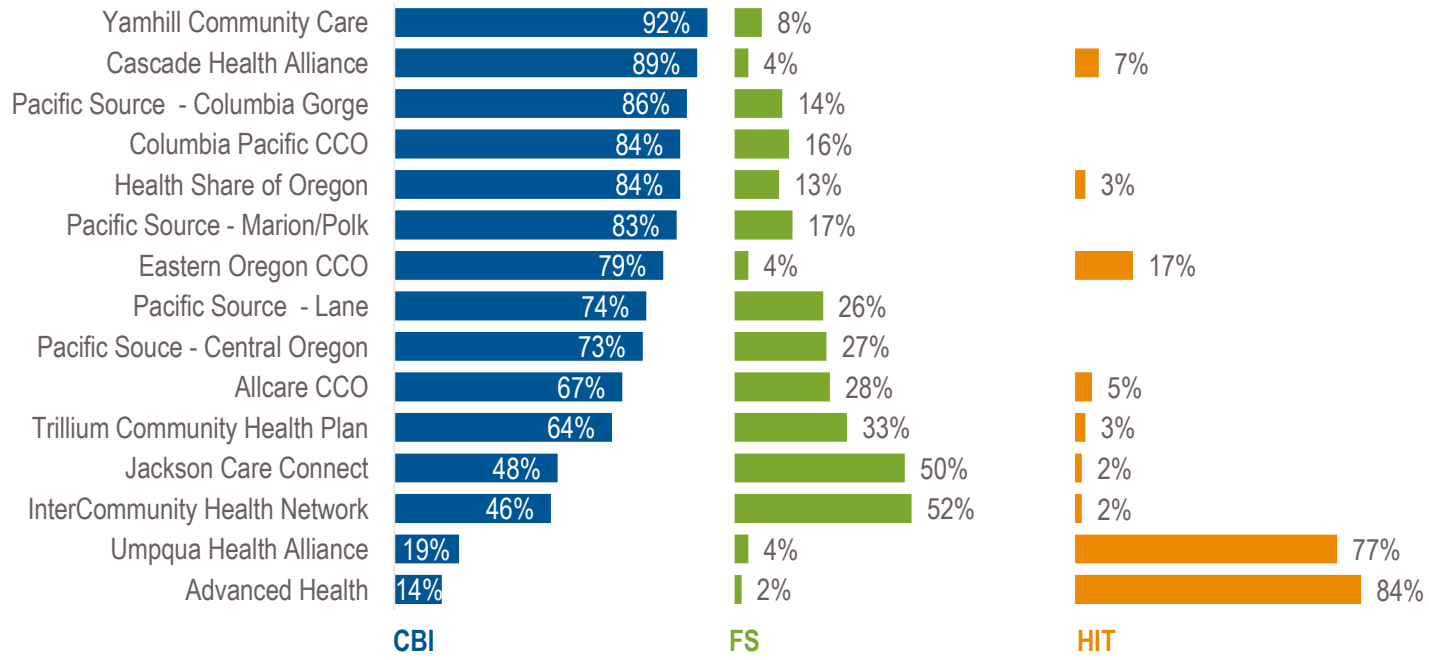
All spending types doubled or close to doubled from 2019 to 2020.



Across CCOs, the distribution of spending types varied in terms of FS, CBI and HIT, but most CCOs spent the majority of HRS dollars on CBIs. See Figure 5 below for details.

Figure 5: 2020 HRS spending type distribution by CCO

Most CCOs spent the majority of HRS on community benefit initiatives



Spending Recipients

In 2020, HRS became the primary funding method for CCOs to address the social determinants of health (SDOH). With that emphasis, CCO HRS spending reporting requirements changed to include the entity receiving HRS funds. The entities tracked include social determinant of health partners, public health entities, and clinical providers.

Across HRS spending in 2020, 65% of HRS spending ($22,162,029) was received by those three entity types with 49% of HRS spending ($16,845,416) going to social determinant of health partners (see Table 2 below for details). However, some expenditures were attributed to more than one entity.

Table 2: 2020 HRS funding recipients

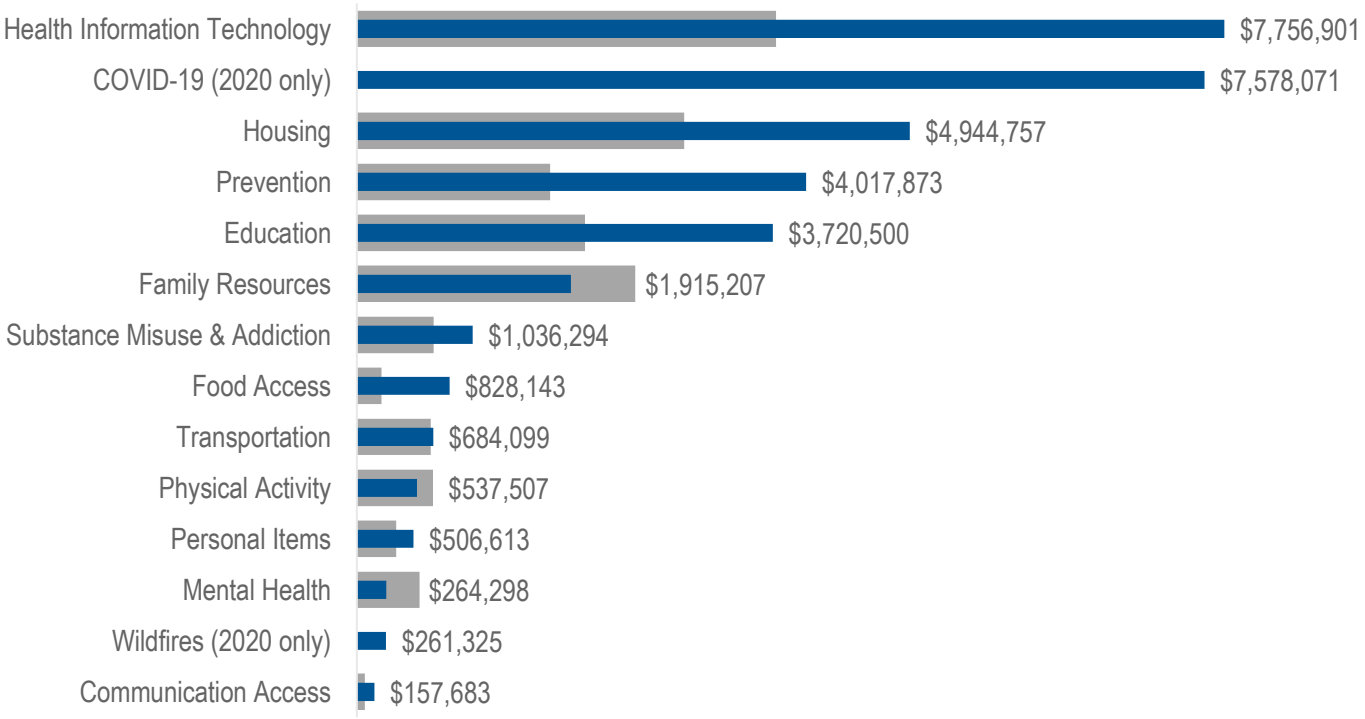
Funding Recipient	Funding Amount	Percent of all HRS Spending
Social determinant of health partner	$16,845,416	49%
Public health entity	$718,070	2%
Clinical provider	$4,598,543	13%

Spending in Key Areas

The top four areas of HRS spending, excluding COVID-19 related spending, all increased from 2019 to 2020. This includes health information technology (HIT), housing, prevention (does not include covered preventive services), and education. Several key areas of spending more than doubled from 2019 to 2020, including food access, prevention, communication access and HIT. Food access alone increased by over 270%. See Figure 6 below for spending details.

Figure 6: HRS spending by category in 2019 and **2020**

Top three spending categories for 2020 include HIT, COVID-19 and Housing



Two spending areas of interest for OHA include housing and food access. Within housing-related spending, the majority of funds ($4,837,237) went towards temporary housing, homelessness, affordable housing, rental assistance, and utilities. Within food access-related spending, the majority ($534,809) went to groceries and pantry items, which was over a 500% increase from 2019. See Figures 7 and 8 below for food access and housing spending details. It is also important to note that the increases in spending on housing and food access is an undercount. Both COVID-19 and wildfire-related spending included spending on housing and food, however each occurrence could only be counted once, and they were attributed to the two emergency related categories.

Figure 7: HRS spending on food in 2019 and **2020**

Grocery and pantry items assistance leads HRS food access spending

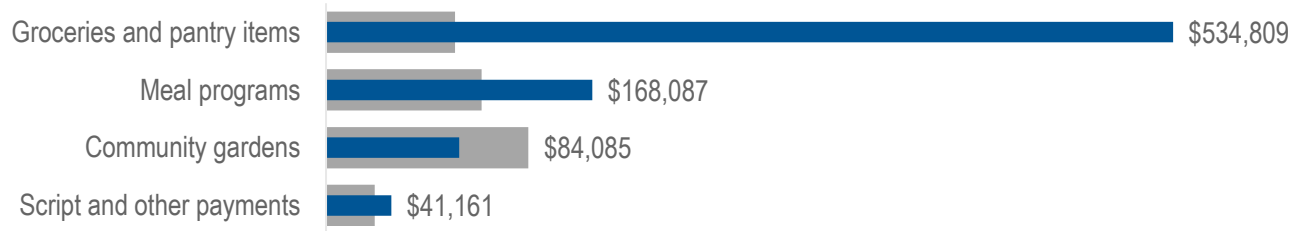
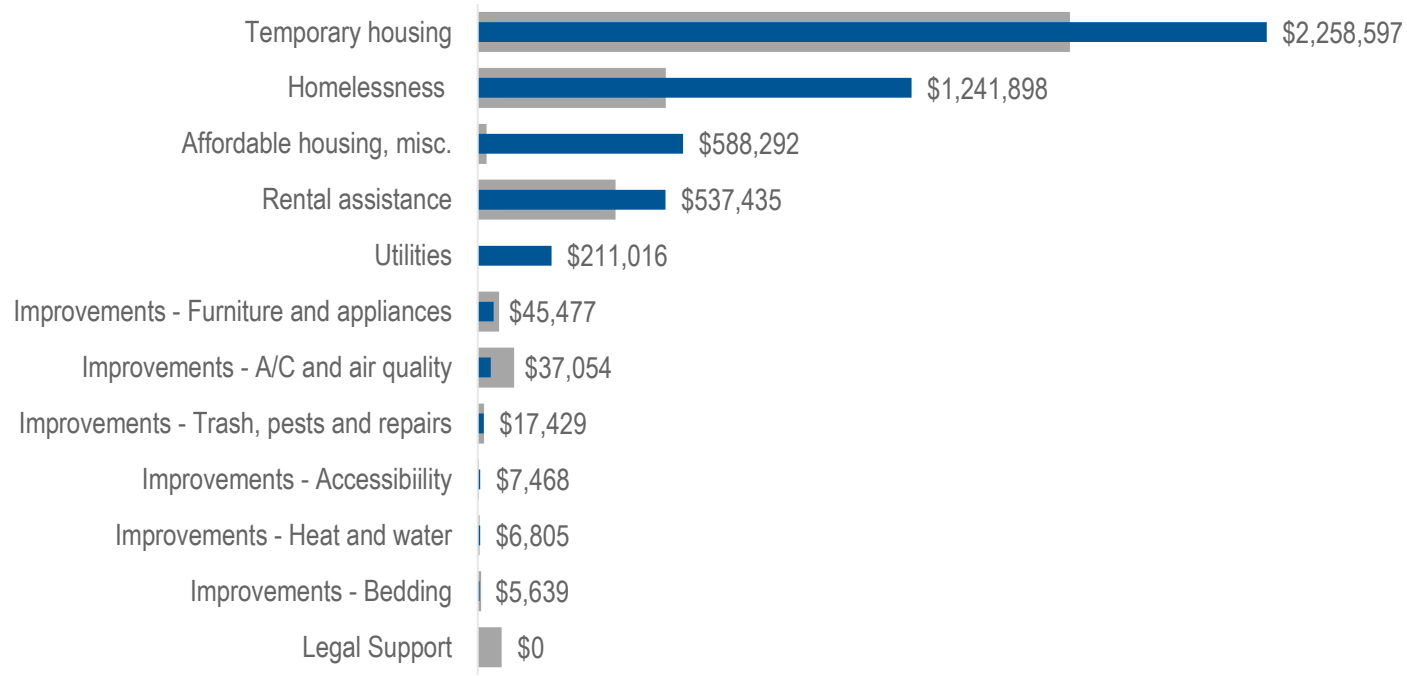


Figure 8: HRS spending on housing in 2019 and **2020**

Temporary housing assistance leads HRS housing spending



Spending on COVID-19 and Wildfire Response

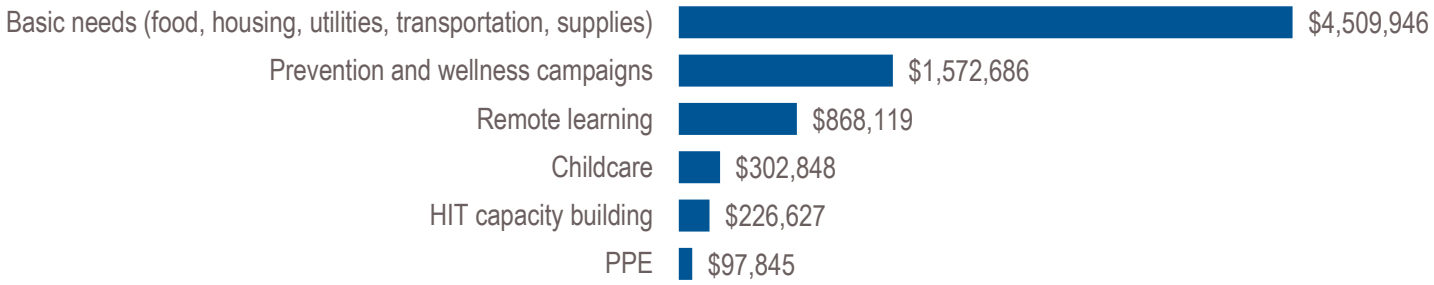
As the COVID-19 pandemic unfolded, CCOs began to utilize HRS spending to address COVID-19-related needs across their communities. In 2020, CCO HRS spending included over $7.5 million for COVID-19-related services to address the pandemic and OHA expects spending to continue in 2021.

Specifically, CCOs spent HRS to support basic needs, remote learning and childcare needs, and community PPE needs that emerged, as well as COVID-19 prevention and wellness campaigns. The majority of COVID-19 HRS spending covered basic needs, such as food, housing, utilities, transportation, and supplies. See Figure 9 below for COVID-19-related spending details.

Although not reported in the required HRS spending details, during HRS technical assistance opportunities CCOs noted that they changed how they used HRS funds to address health inequities made worse by the pandemic. CCOs provided HRS funding directly to community-based organizations that were already working with and providing support to Black, Indigenous and other Communities of Color. OHA continues to provide technical assistance and support peer sharing across CCOs to support such strategic investing.

Figure 9: HRS spending on COVID-19 related services in 2020

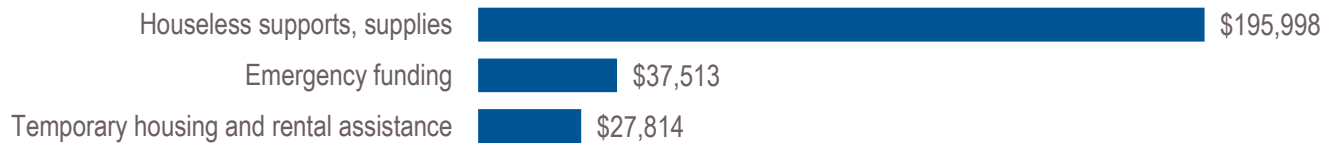
The majority of assistance related to COVID-19 was to provide basic needs to the community



In addition to COVID-19 related needs, some Oregon communities also experienced unprecedented needs related to summer wildfires. In the regions affected, CCOs used $261,325 of HRS funds to support temporary housing and rental assistance, emergency funding, and houseless supports and supplies. See Figure 10 below for wildfire related spending details.

Figure 10: HRS spending on wildfire related services in 2020

Funds were spent on housing support and supplies for wildfire relief



Next Steps for CCO HRS Reporting

In 2022, OHA will follow the same process and timeline to assess and provide feedback to CCOs on their 2021 HRS spending reports:

- April 30, 2022: CCOs submit Exhibit L report with annual HRS level detail covering 2021 spending.
- May – June 2022: OHA assesses 2021 CCO HRS spending to confirm whether they meet all HRS criteria.
- May 16 – June 30, 2022: On a rolling basis, each CCO receives their initial assessment and request for more information. The CCO then has two weeks to submit revised HRS spending details for OHA reconsideration.
- No later than July 15, 2022: OHA finalizes 2021 HRS spending assessment decisions and releases them to CCOs and OHA's Office of Actuarial and Financial Analytics (OAFA). Based on assessment of 2021 HRS spending, the final OHA spending determinations will inform OHA OAFA's PBR calculations.

CCOs' use of HRS continues to evolve as CCOs explore new ways to meet the needs of their members. The findings 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.

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