Center for Health Systems Effectiveness

Our mission is to provide the analyses, evidence, and economic expertise to build a more sustainable health care system.
Overview

Evaluation aims

Key findings

Recommendations
Evaluation Aims
2017-2022 Waiver goals

Focus on integration of physical, behavioral, and oral health care

Address the social determinants of health (SDOH) and improve health equity

Commit to sustainable rate of growth

Expand the coordinated care model for Medicaid and Medicare dual-eligible members
Interim Report aims

1. Assess progress on integration of physical and oral health.
2. Analyze adoption of Health Related Services (HRS).
3. Assess progress on integration of physical and behavioral health.
4. Examine CCO enrollment and outcomes for dually eligible (Medicare/Medicaid) beneficiaries.
Study methods

Claims analysis (2011-2019) of oral and behavioral health integration outcome measures

Claims analysis (2013-2018) of outcomes for dually eligible members

Analysis of CCOs’ “Exhibit L” HRS spending reports

Interviews with CCOs on HRS adoption
Claims analysis

Adjusted change in outcome measure from 2016 to 2019 and 2011 to 2019

Performance by subgroup (age, gender, geography, disability, chronic condition)

Performance for “focus” populations (children, non-English speaking members) relative to “reference” populations
Future reports

Final 1115 summative evaluation: 9/30/2023
Key Findings
Key findings

Oral Health Integration
Health-Related Services
Behavioral Health Integration
Dual-Eligible Members
Limitations
Oral Health Integration
Key findings - quantitative

Measures of oral health quality, access, and integration generally improved

Continued decline in ED use for non-traumatic dental conditions

Rise in spending on dental services outside the ED as reimbursement rates increased
Access and utilization

Figure 5.7: Percentage of Members with at Least One Visit for Any Dental Procedure and Core Dental Procedures

Figure 5.8: Number of Visits for Any Dental Procedure and Core Dental Procedures per 1,000 Members
ED visits for Dental Conditions

Figure 5.1: ED Visits for Traumatic Dental Conditions per 1,000 Members (↓)

Figure 4.2: ED Visits for Non-Traumatic Dental Conditions per 1,000 Members (↓)

2015-2016 mean
Children vs. Adults

Figure 5.16: The percentage of members accessing dental services increased more for children than adults.

Figure 5.18: The number of visits for dental procedures increased more among children than adults.

- Focus (Children)
- Reference (Adults)

% of Members with Any Dental Procedure Visit:
- 30%
- 40%
- 50%

No. of Visits for Any Dental Procedure per 1,000 Members:
- 750
- 950
- 1,150

○ 2016 unadjusted value
● 2019 unadjusted value

D-in-D is statistically significant, relative improvement for focus population.
Expenditures

Figure 5.22: Spending ($) PMPM on ED Visits for Dental Conditions ($)

Figure 5.23: Spending ($) PMPM on Dental Services Excluding ED Visits for Dental Conditions

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2015-2016 mean
Health-Related Services
Key changes

HRS includes flexible services (FS) and community based initiatives (CBI)

Guidance on the treatment of HRS in the Medical Loss Ratio (MLR) calculation

Clarifying that HRS could count toward rate development

Technical assistance to support CCOs’ use of HRS In response
Key findings - quantitative

Spending on HRS increased between 2016 and 2019, from $7.2 million ($0.66 PMPM) to $16.2 million ($1.51 PMPM)

As of 2019, HRS remained a small share (0.36%) of total spending on member services.

Variability in reported spending across CCOs
Total HRS spending

Figure 6.2: Total Health-Related Services Spending ($ Million), 2014-2019
HRS Spending by CCO and by Type

Figure 6.5: Types of Health-related Services Spending ($ PMPM) by CCO, 2019

- Umpqua Health Alliance
- Columbia Pacific
- Yamhill Community Care
- PacificSource Gorge
- Jackson Care Connect
- AllCare CCO
- Advanced Health
- Trillium Community Health Plan
- InterCommunity Health Network
- Cascade Health Alliance
- Primary Health of Josephine County
- Health Share of Oregon
- PacificSource Central
- Eastern Oregon CCO
- Willamette Valley Community Health

Legend:
- Flexible Services
- Community Benefit Initiative
- Health Information Technology
Flexible services spending

Figure 6.6: Monthly Flexible Services Spending ($ per 1,000 Members) by Category, 2018-2019
Key findings - qualitative

HRS has been helpful in responding to COVID-19 and wildfires

Use of HRS requires new relationships, data, and tools

CCOs are challenged by high administrative burden in tracking and reporting data

Some CCOs may opt to spend on SDOH but not report as HRS because cost of reporting outweighs benefits
Behavioral Health Integration
Progress to date

1. Investments in primary care (PCPCH)
2. Support from Transformation Center
3. Emergency Department Information Exchange (EDIE) and PreManage
4. Certified Community Behavioral Health Clinics (12 clinics at 21 sites)
5. Disallow subdelegation of BH in CCO 2.0 contracts
Key findings - quantitative

A variety of measures improved
Many quality measures remained unchanged
Large increase in % of enrollees diagnosed with SUD
Expenditures for individuals with BH conditions increased
Emergency Department utilization

Figure 4.1: ED Utilization per 1,000 MM for Members with Behavioral Health Conditions (↓ $)

Figure 4.2: Potentially Avoidable ED Visits per 1,000 Members for Members with Behavioral Health Conditions (↓ ☯)
SUD prevalence and treatment

Figure 4.11: Percentage of Members with SUD

Figure 4.12: Initiation of Alcohol or Other Drug Dependence Treatment, 13-64 years
Utilization and expenditures

Figure 4.17: Outpatient Visits for Behavioral Health Care per 1,000 MM

Figure 4.29: Total Spending ($) PMPM for Members with Behavioral Health Conditions
Key findings - qualitative

Lack of publicly available information
Roadmap missing/definitions unclear
Many initiatives; are they coordinated?
Lack of clarity about what the end state would look like or how close we are
Dual-Eligible Members
Key findings

2019 – shift from “opt in” to CCOs to “opt out” of CCOs
Current analyses assess data up to 2018
No large changes observed from 2016-2018
Enrollment and primary care use

Figure 7.1: Percentage of Oregon Dual-Eligible Members Enrolled in CCOs

Figure 7.2: Percentage of Dual-Eligible Members with Any Primary Care
Expenditures

Figure 7.9: Total Spending PMPM for Dual-Eligible Members (↓)
Limitations
Limitations

Broad assessment of progress: did not evaluate merits of specific CCO practices or approaches

No stratification by race/ethnicity

Outcome metrics use pre-CCO 2.0 data

Spending measures rely on imputed prices

Inconsistencies in HRS spending data
Recommendations
Dual-Eligible Members

Use data from 2019 and on to assess impacts of 2019 passive enrollment

Monitor enrollment and outcomes in “aligned” plans that hold risk for Medicaid and Medicare Advantage
Oral Health Integration

Build on apparent success

Empower incoming Dental director to strengthen communication and coordination across OHA, putting forth strategic plan and vision
Health-Related Services

Refine guidance on reporting of HRS expenditures, to promote consistency

Monitor administrative burden

Continue to develop evidence base for investments in SDOH

Identify areas where CCOs are limited in addressing SDOH – e.g., housing shortages.
Behavioral Health Integration

Put forth strategic plan and vision for BHI

Clarify accountability for BH, including coordination among multiple initiatives

Consider needs of different populations, including children, adults, serious mental illness vs mild or moderate, and communities of color
Health Equity

Provide guidance on terminology (SDOE, SDOH-E, Health Equity)

Support CCOs in collecting Race, Ethnicity, Language, and Disability (REALD) data. Monitor % of members for whom data are collected
Questions?