Waiver Evaluation

Stakeholder Information Meeting
Agenda

1. Introductions
2. Waiver background
3. Evaluation goals
4. Timeline and reporting
5. Questions
Oregon’s Medicaid waiver establishes health system transformation.

• Sets Triple Aim goals of better health, better care, and lower costs.

• Commits Oregon to reducing spending while maintaining quality and access.

• Enabled Oregon to launch coordinated care organizations (CCOs).
The waiver establishes six “levers” for transforming Medicaid.

- Lever 1: Improving care coordination
- Lever 2: Implementing alternative payment methodologies
- Lever 3: Integrating physical, behavioral, and oral health care
- Lever 4: Increased efficiency through administrative simplification and a more effective model of care
- Lever 5: Implementation of flexible services
- Lever 6: Testing, accelerating, and spreading effective innovations and best practices
The waiver requires Oregon to conduct a summative evaluation.*

- The evaluation must answer specific questions listed in the waiver.
- The evaluation must meet standards of leading academic institutions and peer-reviewed journals.
- Oregon must provide CMS a draft evaluation report within 120 days of waiver expiration.
- Oregon must contract with an independent third-party to conduct the evaluation.

OHA engaged OHSU’s Center for Health Systems Effectiveness (CHSE) to conduct the summative evaluation.
The Evaluation will accomplish three goals:

1. Assess the waiver’s effects on key outcomes.
2. Assess the relationship between specific activities to transform health care and outcomes.
3. Provide recommendations to continue health care transformation beyond the current waiver.
Goal 1:
Assess the waiver’s effects on key outcomes.
The evaluation will assess the effect of the waiver in five areas:

• Spending
• Quality of Care
• Access to Care
• Member Experience of Care
• Health Status
The evaluation will answer three types of questions about each area:

1. Were outcomes improved or maintained over time?
2. Have outcomes varied for any subgroups?
3. Did the waiver result in improved outcomes?
Summative Evaluation
Questions
Spending

1. How does annual change in per-capita Medicaid spending during demonstration period compare to projected trend?

2. Which beneficiary subpopulations deviate from the statewide trends?

3. How does spending change for behavioral health compare to overall trends and physical health spending changes?

4. How does spending change for primary care services compare?

5. Are “flexible services” deterring higher-cost care?
Quality of Care

6. Is quality of care for Medicaid beneficiaries improved or at least maintained over time?

7. Is coordination of care for Medicaid beneficiaries improved or at least maintained over time?

8. Have there been variations in the quality of care or care coordination for any beneficiary subpopulations?

9. Did Medicaid system transformation result in improved quality of care or care coordination?
Access to Care

10. Has access to care for Medicaid beneficiaries improved or at least maintained over time?

11. Has the rate of change in access to behavioral health kept pace with physical health access improvements?

12. Have there been variations in any of the access to care measures for any beneficiary subpopulations?

13. Did Medicaid system transformation result in improved access to care?
Member Experience of Care

14. Has beneficiary experience of care improved or at least maintained over time?

15. Have there been variations in experience of care measures for any beneficiary subpopulations?

16. Did Medicaid system transformation result in improved experience of care?
Health Status

17. Is beneficiary health status improved or at least maintained over time?

18. Have there been variations in health status measures for any beneficiary subpopulations?

19. Did Medicaid system transformation result in improved health status?
Example measures for each outcome area:

<table>
<thead>
<tr>
<th>Outcome Area</th>
<th>Measure Description</th>
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<tbody>
<tr>
<td>Spending</td>
<td>Total per-member, per-month spending</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Follow-up after hospitalization for mental illness</td>
</tr>
<tr>
<td>Access to Care</td>
<td>Primary care visits per 1,000 member months</td>
</tr>
<tr>
<td>Member Experience of Care</td>
<td>How people rated their health care (from CAHPS survey*)</td>
</tr>
<tr>
<td>Health Status</td>
<td>Member rating of health status (from CAHPS survey*)</td>
</tr>
</tbody>
</table>

* Consumer Assessment of Healthcare Providers and Systems
CHSE will compare outcome measures before and after the waiver.

CHSE will use statistical models with controls for member demographics, health status, and community characteristics.
In addition to overall change, CHSE will assess change for specific subgroups of Medicaid members.
Examples of subgroups for analysis:

<table>
<thead>
<tr>
<th>Race/Ethnicity*</th>
<th>Age</th>
<th>Geography†</th>
</tr>
</thead>
<tbody>
<tr>
<td>• American Indian or Alaska Native</td>
<td>• Under 18</td>
<td>• Urban</td>
</tr>
<tr>
<td>• Asian</td>
<td>• 18 to 34</td>
<td>• Rural</td>
</tr>
<tr>
<td>• Black or African American</td>
<td>• 35 to 64</td>
<td>• Isolated</td>
</tr>
<tr>
<td>• Hispanic</td>
<td>• 65 and over</td>
<td></td>
</tr>
<tr>
<td>• Native Hawaiian or Pacific Islander</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Unknown/Other</td>
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**Gender**
- Male
- Female

* Race/ethnicity categories are mutually exclusive. Members with an entry of Hispanic for ethnicity will be excluded from other categories. † Rural-Urban Community Area (RUCA) definitions.
CHSE will use comparison groups to assess whether the waiver resulted in improved outcomes.

CHSE will compare change in outcomes for Oregon Medicaid members to change outcomes for two comparison groups:

- Propensity-score-weighted commercial members.
- Medicaid members from another state.
Evaluation results will differ from OHA’s Health System Transformation reports

• HST reports present change in outcome measures without controlling for changes in member or community characteristics.

• Goal: monitor CCO progress and ensure quality and access are maintained for Medicaid members.
Evaluation results will differ from OHA’s Health System Transformation reports

- The evaluation will estimate change controlling for changes in member and community characteristics.
- It will also account for change that would have happened in the absence of the waiver.
- Goal: quantify changes attributable to the waiver vs other factors.
Goal 2:
Assess the relationship between specific activities to transform Medicaid and outcomes.
CHSE will use two approaches to evaluate OHA’s and CCOs’ actions to transform Medicaid.
1. Review of existing studies

CHSE will review and synthesize existing studies assessing activities under each lever and the waiver overall.

Examples:

<table>
<thead>
<tr>
<th>Lever</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lever 3</td>
<td>OHSU School of Family Medicine, in press. “Integrating Behavioral Health under an ACO Global Budget: Barriers and Progress in Oregon.”</td>
</tr>
<tr>
<td>Lever 6</td>
<td>OHSU School of Family Medicine. Transformation Center Evaluation for OHA.</td>
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</table>
2. Quantitative assessment of activities

CHSE will assess the relationship between specific activities under each lever and select outcomes.

Example:

What is the relationship between percentage of members enrolled in a PCPCH and access to primary care?
The waiver requires Oregon to evaluate the effect of flexible services.

- **Question 5:** Are flexible services deterring higher-cost care?
- There is no standard dataset on flexible services provided by all CCOs.
OHSU will reach out to CCOs for help evaluating flexible services.

- OHA’s Transformation Center interviewed CCOs in mid-2015 to fill the gap.
- CHSE plans follow-up interviews in partnership with OHSU’s Department of Family Medicine.
### Timeline for follow-up interviews:

<table>
<thead>
<tr>
<th>Month</th>
<th>Activity</th>
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<tbody>
<tr>
<td>January 2017</td>
<td>Work with OHA to identify CCO staff involved with flexible services.</td>
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<tr>
<td>February 2017</td>
<td>Reach out to person by email request interview.</td>
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<tr>
<td>March – April 2017</td>
<td>Conduct phone interviews (45 minutes – 1 hour).</td>
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Goal 3: Provide recommendations to continue with Medicaid transformation beyond the current waiver.
## Evaluation timeline:

<table>
<thead>
<tr>
<th>Date</th>
<th>Task</th>
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<tbody>
<tr>
<td>August 7, 2017</td>
<td>Deliver Draft 1 of evaluation report to OHA</td>
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<tr>
<td>September 11, 2017</td>
<td>Deliver Draft 2 of evaluation report to OHA</td>
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<tr>
<td>December 18, 2017</td>
<td>Deliver final evaluation report to OHA</td>
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<tr>
<td>January – May 2018</td>
<td>Delivers briefs and presentations</td>
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Reporting:

- CCOs will not be identified in reports, briefs, or presentations.

- Public-facing reports will show the range of results for all CCOs (results for the highest and lowest CCO) but will omit results for each CCO.
Questions?
Waiver Evaluation Resources

OHA’s Office Of Health Analytics Webpage
www.oregon.gov/oha/analytics/Pages/Evaluation.aspx

Email us!
OHAevaluation.questions@state.or.us
Thank You