

Sustainable State Spending and Reduced Health Care Costs
Maturity Assessment of CCO 1.0
January 9th 2018

Background

One of the central features of Oregon’s 2012 extension of its 1115 Medicaid demonstration waiver and the implementation of the Coordinated Care Model is the requirement that Oregon would reduce federal Medicaid spending in Oregon by 2 percentage points (3.4 percent) relative to Medicaid spending levels without the waiver. The waiver requirement to limit annual growth informed state budgetary restrictions for OHA, which in turn informed the state’s CCO rate-setting process.

A letter to the Board from Governor Brown dated September 28th 2017 asks the Board to: “provide recommendations for addressing major cost drivers in order for the health system to continue to operate within a sustainable budget, as well as recommendations for continuing financial transparency and accountability.” In response to this directive, the Board is establishing a committee to focus on sustainable pharmacy costs and has identified several policy ideas for the committee to analyze and consider whether to recommend implementation and next steps.

The broad theory of the Coordinated Care Model is that increased investment in primary care, paying for value and achievement in health care outcomes, and investing in the social determinants of health will help reduce health care costs and spending in the long run. For that reason, ongoing and future work related to other focus areas of the Governor’s letter regarding CCO 2.0 work may also help achieve goals related to controlling health care spending and costs. For example, work is underway to examine ways to build on the successes highlighted above, including the potential to better utilize the incentive pool and the payments to CCOs for their performance and achievement of several metrics, as well as ways to foster CCOs’ use of value-based payment approaches for providers.

In order to examine additional next steps and future state strategies to limit future years’ spending growth underlying growth in health care costs, first it is necessary to examine the state’s performance under the 2012 waiver extension and CCO contract period.

Oregon’s demonstration waiver and CCO contract implementation includes strategies to achieve spending growth targets

A key goal and target of the initial CCO contract period was to ensure sustainable growth in state spending on the Oregon Health Plan. Specifically, in its 1115 Medicaid waiver, the state promised that in exchange for additional federal funding in the short term, the state would reduce federal Medicaid spending in Oregon by 2 percentage points relative to Medicaid spending growth nationally on a per member per month (PMPM) basis. This became known as the 2-percent test, and has been a core measure of the cost-sustainability success of the 2012 waiver extension.

While “costs” and “spending” are often used interchangeably, in reality the two terms represent different metrics as they relate to CCOs and the waiver.

Health Care Spending represents the amounts paid for health care services, which in this case means payments made by the state to the CCOs. The CCOs are responsible for delivering care to their members within the payments limits set forth by the state.

Health Care Costs represents the underlying costs to the health care system of providing care, and includes supplies, labor, and overhead costs for providers and carriers. Underlying costs influence spending, but can ultimately grow faster or slower than state spending on health care services

Limiting state spending growth in order to meet the waiver terms and requirements has been largely a rate-setting task. Through the rate-setting process, Oregon successfully developed actuarially sound rates within budget-limits and within the parameters of the 2-percent test, avoiding any federal funding penalties.

Oregon’s efforts to limit growth in state and federal spending, on a per-member basis, is predicated on several factors, only some of which are targeted at influencing underlying health care costs:

- Oregon’s sustainable growth targets are used as a program-wide spending target and add an important layer of oversight to ensure spending remains within targeted levels. Oregon’s CCO partners are aware of the larger context and requirements of the state to maintain spending within legislatively and federal-driven spending targets.
- CCOs have substantial flexibility to deliver services to Oregon Health Plan (OHP) members within the constraints of the global budget. Although spending limits may restrict the rates paid to CCOs, the flexibility to be innovative in their care delivery is critical to ensuring their success staying within limits without compromising access to, or quality of, care for OHP members.
- Resources from the Transformation Center and other CCOs help spread effective care delivery approaches and help manage growth in health care costs. Technical assistance from the Center helps spread effective CCO practices and reduce costs. This resource is unique across state Medicaid programs and is a critical tool in the state’s efforts to limit state spending while improving CCO performance and maintaining access to care.
- Incentive payments to CCOs based on performance have shown significant ability to motivate CCOs and their provider partners to direct effort and investment to achieve performance and/or improvement goals. These CCO incentive metrics are selected by the Metrics and Scoring Committee as part of Oregon’s commitment to pay for better quality care and health outcomes, which should help reduce health care costs in the long run.
- Increased investment in primary care services should help keep people healthier and reduce the need for more costly medical interventions at a later date. People who are properly managing chronic conditions will have less needs for urgent medical treatment and other health care services that are more expensive than primary care services.

Indicators of Oregon’s performance

Several key metrics highlight Oregon’s success limiting growth in state spending and in implementing key actions that lead to smarter and more efficient use of limited health care resources which should ultimately reduce growth in per-member health care costs.

Measure	Data	Limitations/ considerations
Sustainable State Spending		
Oregon is passing the 2-percent test and successfully holding spending growth to targets in the 2012 waiver extension and within budget constraints from the Oregon Legislature. ⁱ	<ul style="list-style-type: none"> • Spending on a PMPM basis came in at or below sustainable growth targets from 2013 to 2017. 	Limiting spending growth does not automatically reduce growth in underlying health care costs.
Outside evaluation concludes that Oregon’s PMPM spending	\$15 decline in PMPM spending from 2011 to 2014 (\$13 from 2011 to	Comparing across state Medicaid programs is inherently complicated, and comparing

Measure	Data	Limitations/ considerations
declined relative to Washington Medicaid. ⁱⁱ	<p>2015) relative to WA Medicaid members.</p> <p>Inpatient facility spending declined by \$17 PMPM relative to WA for both time periods.</p>	Oregon's growth to national figures is even more difficult.
Investing in Primary Care Help Limit State Spending Growth		
Patient-Centered Primary Care Home (PCPCH) program yields positive return on investment, reduces per-person health care costs and produces state savings. ⁱⁱⁱ	<ul style="list-style-type: none"> • Reduced per-person total service expenditures by 4.2%, (about \$13.50 per month), with increased savings the longer a clinic is designated as a PCPCH. • \$13 worth of savings for each \$1 increase in primary care expenditures stemming from the PCPCH model. • \$240 million in savings in program's first three years. 	
CCOs are investing more than other carriers in primary care and are increasing investment in non-claims-based primary care spending. ^{iv}	<p>In 2015, CCOs allocated 12.5% of total medical spending to primary care, compared to 10.1% for commercial carriers, 8.9% for Medicare Advantage, and 7.9% for PEBB & OEBC. (The CCO percentage declined slightly from 2014 to 2015, though dollars invested per-member increased).</p> <p>In 2015, 64.6% of CCOs primary care spending was non-claims-based, nearly 5 points higher than 2014. Non-claims-based accounted for 39.4% of primary care spending for Medicare Advantage plans and less than 10% for commercial carriers, PEBB and OEBC.</p>	<p>Methodological improvements make comparing year to year data from the primary care spending report more complicated, but relational data from each year remains useful to compare CCOs to other insurance carriers.</p> <p>Commercial carriers spend more raw dollars on primary care services, which is likely a function of their higher provider reimbursement rates compared to those paid by Medicaid CCOs.</p> <p>Non-claims-based spending helps reward achievement and build primary care capacity.</p>
CCOs Respond to Incentive Payments by Improving Targeted Metrics		
CCOs are increasing member enrollment in PCPCHs. ^v	<p>All CCOs exceeded the 2016 target of having 60% of members enrolled in a PCPCH, with 6 exceeding 90%.</p> <p>Across all CCOs 89% of members are enrolled in PCPCH, up from 52% in 2011.</p>	<p>Incentive methodology was modified in 2017 to reflect the addition of 2 new PCPCH tiers.</p> <p>Gaps between CCOs has closed significantly since 2013, showing result of incentives.</p>

Measure	Data	Limitations/ considerations
CCOs are lowering per-member rates of avoidable or inappropriate use of emergency departments. ^{vi}	From 2015 to 2016, 12 CCOs lowered their rates of avoidable ED visits per 1,000 member months. Further, compared to 2011 the ED utilization rate across all CCOs has dropped dramatically, from more than 14 visits per 1,000 member months to seven visits.	Within context of lowering rates of inappropriate ED use, overall utilization of EDs may not be declining. The result may be “cost-avoidance” instead of net cost reduction.
Flexibility Combined with Technical Assistance from the Transformation Center Helps Spread Promising and Successful Strategies among CCOs		
The Center’s technical assistance (TA) has resulted in increases in cost-saving, preventive services. ^{vii}	Example: PrimaryHealth attributes the Center’s TA with their 9.2% colorectal cancer screening rate increase in 2016.	Anecdotal evidence relayed from TC leadership, efforts to track and potentially quantify the impact could also prove useful in the future.
Coordinated Care Model Summits provided useful information and tools for CCOs. ^{viii}	In 2014 and 2015, the Center convened a Coordinated Care Model Summit, and in both years more than 65% of attendees either agreed or strongly agreed to the statement that they “plan to implement at least one innovative practice I learned about at the summit.”	Empirical evidence examining the number of ideas that are replicated, modified, or eliminated as a result of the learning collaborative and summits convened by the Transformation Center will always be limited if not unattainable.

Lessons learned

As shown in the appendix, Oregon has achieved broad success limiting spending growth to targets established as part of the 2012 waiver extension. However, evaluating which specific CCO activities or interventions are most successful at controlling spending and costs is complicated. Data may not always be robust enough to show that a specific policy directly contributed to successful cost reduction, and anecdotal evidence highlighting success can also be limited.

Incentive payments to CCOs provide opportunities to motivate CCOs to achieve performance goals the state believes indicate increased care quality, access, value, or the achievement of another goal. The broad success of CCOs achieving targets set forth by the Metrics and Scoring Committee highlight the responsiveness of CCOs to the incentives, and should provide useful information to the committee, board, and other policy makers moving forward as additional or alternate incentives are considered.

The technical and other assistance Oregon provides through OHA’s Transformation Center is unique among state Medicaid agencies and helps spread ideas and approaches that reduce health care costs and spending.

Although the OHSU waiver evaluation found that spending declined among CCO members compared to Washington Medicaid members, the analysis also found that spending on prescription drugs increased during this time. Although some spending growth in the pharmacy space may help limit spending growth in other

clinical spending categories, it is also clear that new policy interventions are needed to rein in pharmacy costs. The board committee being formed should help inform next steps in this space.

Limiting growth in Oregon’s spending on Medicaid is as much an exercise in rate-setting as it is an effort to reduce underlying growth in the costs of health care. Furthermore, some interventions that may reduce long-term costs or increase the quality of care delivered could increase costs in the short run. Efforts to reduce spending and costs must not undermine other efforts to ensure necessary investment in policies that improve quality and pay for value, that help address social determinants of health, or that ensure Oregonians access to behavioral health care services.

CCO 2.0 Questions for 2018 Investigation

Based upon lessons learned, existing data, and subject matter expertise, the gray boxes below identify questions that could be further explored in 2018 in order to build upon the first phase of CCOs. At the 2018 OHPB retreat, board members will consider and confirm whether answering these specific questions will address the lessons learned and give them the information needed to develop final recommendations for CCO 2.0.

Workgroups, OHA staff, stakeholders, members of the public and OHPB members will all be consulted and included in the process to investigate these questions and consider next steps and potential policy options in the spring/summer of 2018.

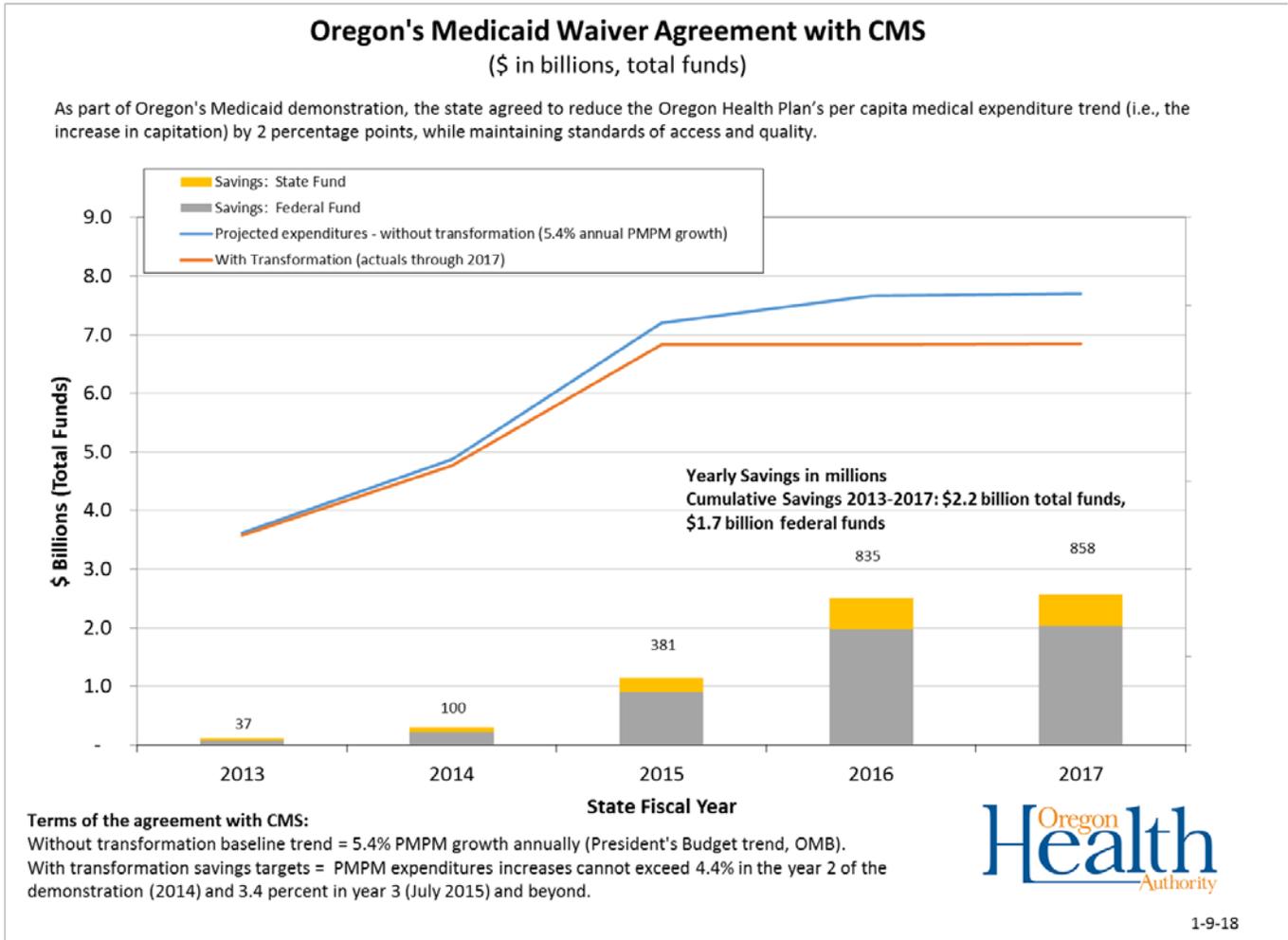
Sustainable growth target (3.4%)	
Is 3.4% growth still the proper target for the entire CCO 2.0 contract period?	<i>Policy options to investigate:</i> (1) What processes should be in place to re-evaluate and either confirm or modify the growth rate target in the middle of CCO 2.0 contract period? (2) Should target growth rates take into account larger health care inflationary context, other considerations
Cost drivers affecting ongoing achievement of sustainable growth targets	
What cost drivers threaten continued achievement of sustainable growth rate (3.4%) in future years?	<i>Policy options to investigate:</i> (1) Additional focus on specific health care services (2) Additional focus on specific health conditions (3) Additional focus on specific eligibility categories
Strategies to build upon sustainable cost achievements	
What cost drivers warrant additional analysis & focus to help OHA and CCO partners continue to meet Legislative and waiver-driven growth targets?	<i>Policy options to investigate:</i> (1) Ways to better understand CCO successes reducing costs (2) Additional or tougher-to-meet incentives to motivate spread of best practices
CCO Accountability	
What strategies could OHA pursue to increase CCO financial accountability while preserving adequate CCO flexibility to operate within global budget?	<i>Policy options to investigate:</i> (1) CCO reporting requirements (2) Best practice adherence regarding cost containment

ⁱ OHA Budget data, see appendix for more information

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- ii Summative waiver evaluation from Center for Health Systems Effectiveness
 - iii PCPCH Implementation Report, September 2016
 - iv Primary Care Spending Report to the Oregon Legislature, February 2017
 - v CCO Metric 2016 Final Report, June 2017
 - vi Ibid
 - vii Anecdotal data from Transformation Center
 - viii Data from attendee surveys conducted by Transformation Center

Sustainable State Spending and Reduced Health Care Costs: Appendix to Accompany Maturity Assessment of CCO 1.0

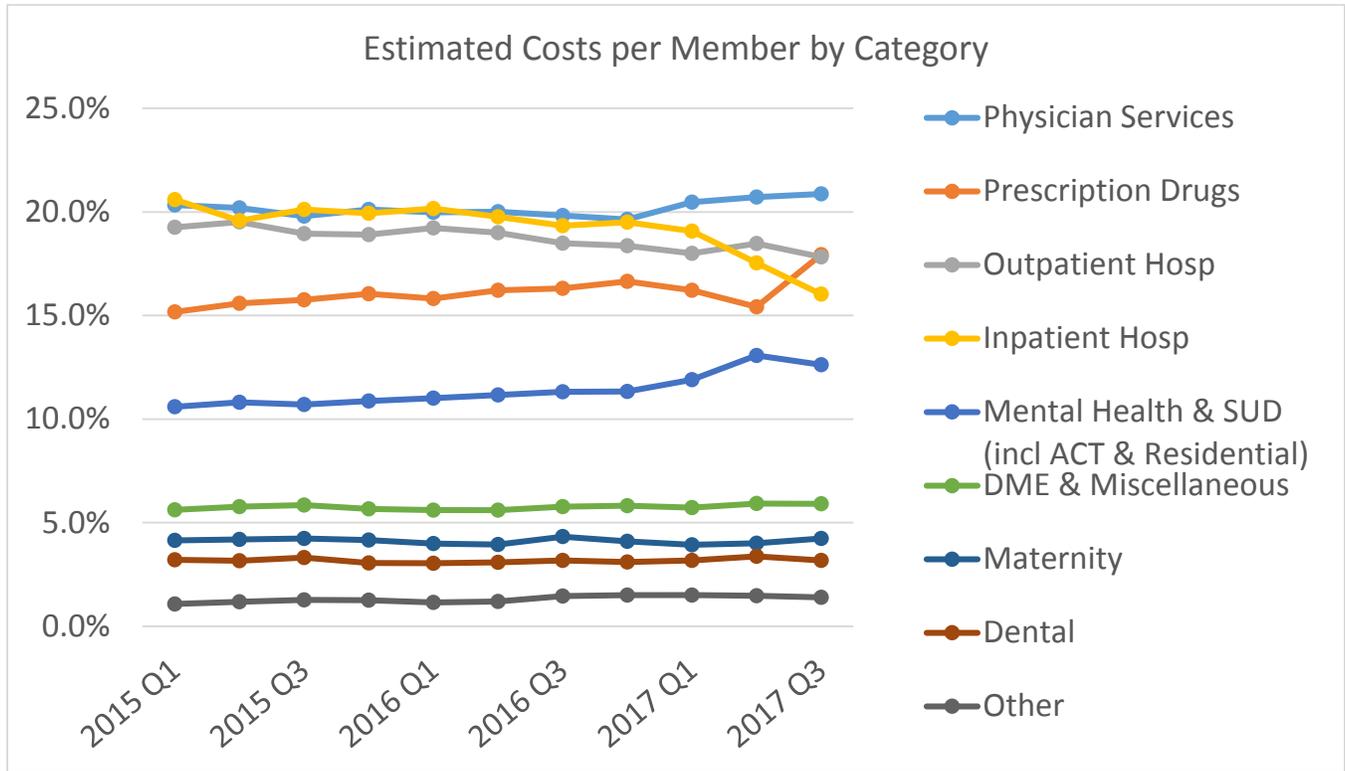
Figure 1: Highlighting Oregon’s performance relative to the 2% test:



Additional context:

- The above figures include Traditional Medicaid (pre-ACA) and the Medicaid Expansion beginning mid-year 2014.
- PM/PM targets were rebased in 2015 with approval of the Federal Centers for Medicare and Medicaid Services and while blended rates appear to have grown faster than 3.4%, the higher growth is due to changing case mix.

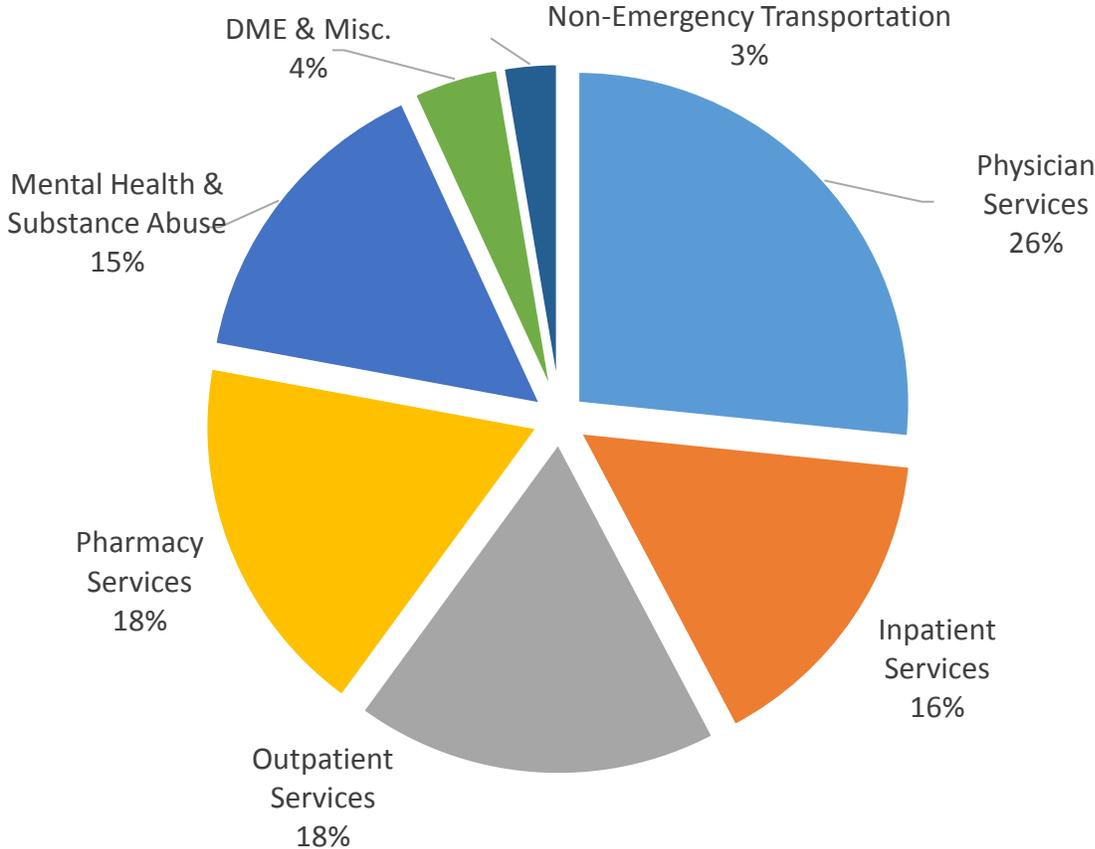
Figure 2: Distribution of health care costs per member shifts over time. The share of total costs directed to pharmacy services has grown while the share directed to inpatient and outpatient hospital services has shrunk.



Additional context:

- Data represents estimated costs based on CCO claims data and other payments, but may not include sub-capitation payments CCOs make for dental services, primary care services, inpatient hospital or other categories of service
- Reduction in inpatient hospital spending offset by increased pharmacy spending
- Growth within Mental Health & SUD category driven by spending on non-inpatient services substance use disorder services, while spending on inpatient services declined (as a share of total spending) from Q1 2015 to Q3 2017.
- In addition to shifting spending patterns on the whole, spending patterns may be shifting within each category as well.

Figure 3: Share of underlying 2016 spending by category used to inform 2018 rate development reflecting inclusion of sub-capitation arrangements of CCOs



Additional context:

- Data reflects underlying cost and utilization data used in formulating CCO capitation rates and includes subcapitated expenditures, incentive expenditures, and encounter data. The data does not include: maternity kick payments, payments for dental services, fee-for-service and quality incentive payments.

Sustainable Health Care Spending and Cost Containment CCO 1.0 Maturity Assessment

OHPB Retreat – January 16, 2018

Timothy Sweeney
Chelsea Guest
Jon Collins



OFFICE OF HEALTH POLICY
Health Policy and Analytics

Governor's Letter

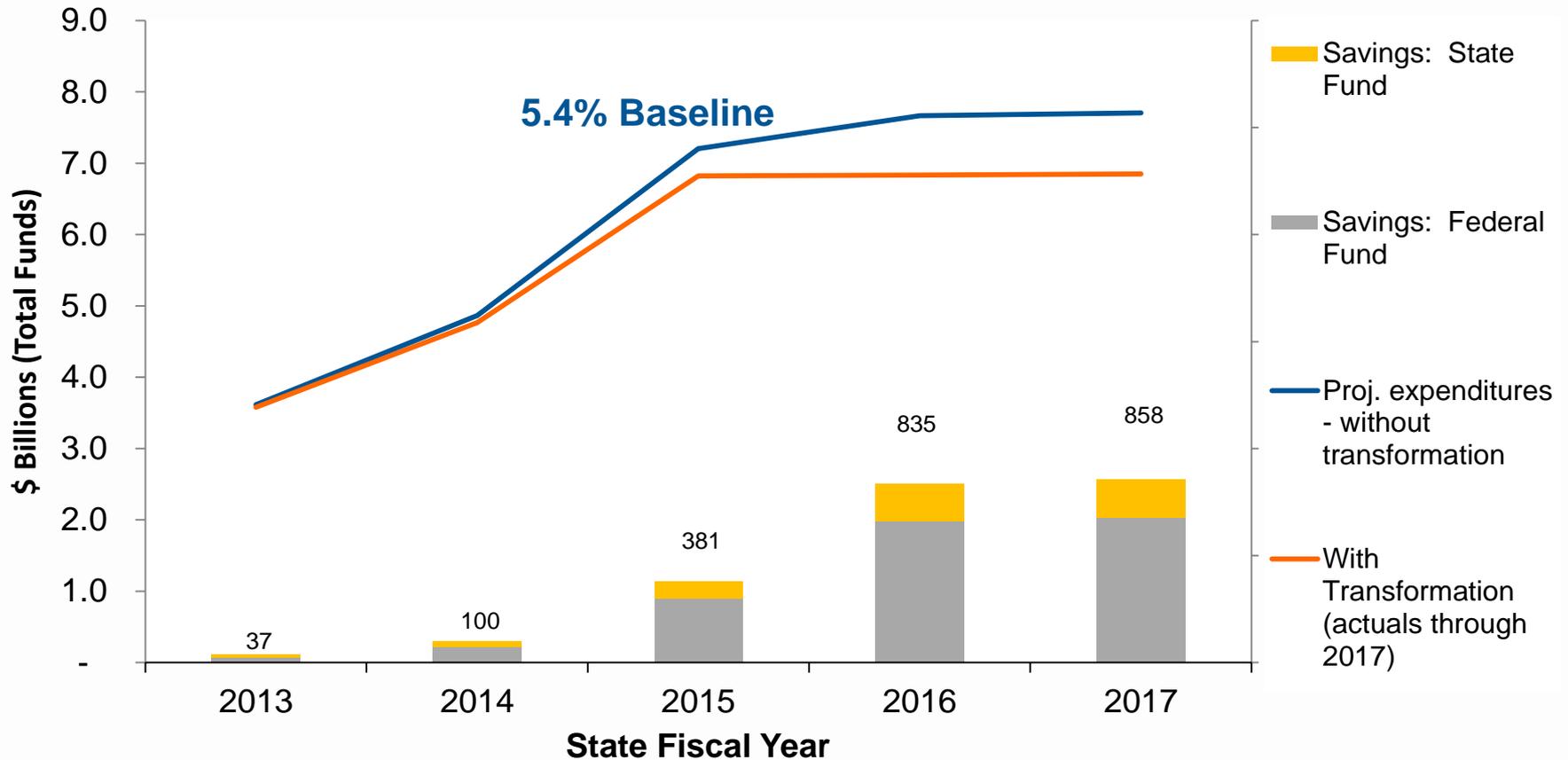
Governor Brown sent a letter to the OHPB in Sept 2017 detailing the need for continued focus on ensuring sustainable health care costs and efforts to control spending in CCO 2.0, specifically to:

- Provide recommendations for addressing major cost drivers in order for the health system to continue to operate within a sustainable budget, as well as recommendations for continuing financial transparency and accountability

Medicaid Waiver Agreement with CMS:

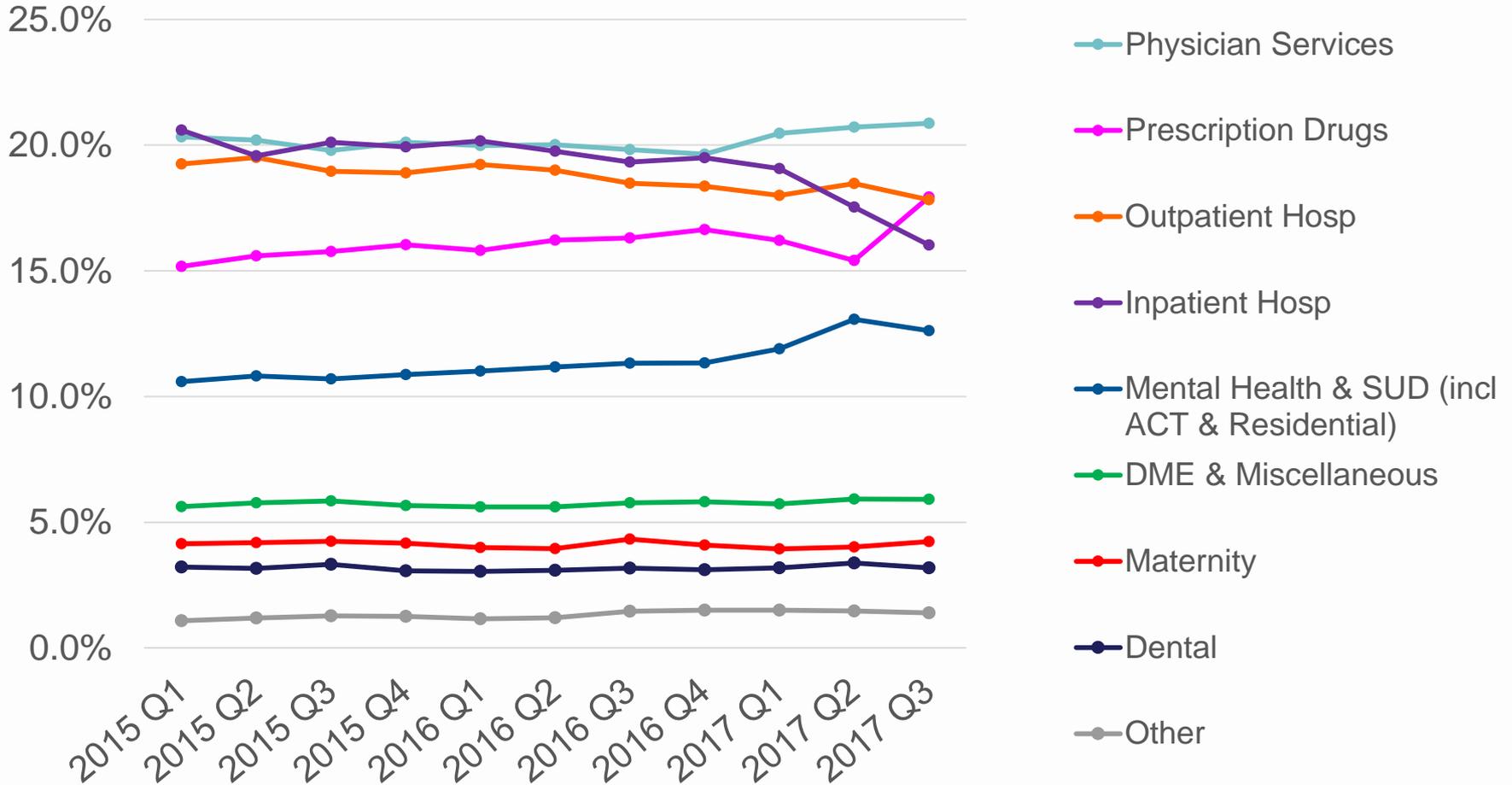
PMPM growth $\leq 4.4\%$ year 2, $\leq 3.4\%$ years 3 (2015) and beyond

Cumulative Savings 2013-2017: \$2.2 billion total funds, \$1.7 billion federal funds



Cost Patterns Shift Over Time

Estimated Costs per Member by Category



Sustainable Growth Target (3.4%)

Lesson learned: Oregon's sustainable growth targets are used as a program-wide spending target and add an important layer of oversight to ensure spending remains within targeted levels.

Key information:

- Spending on a PMPM basis came in at or below sustainable targets each year from 2013 to 2017
- Spending declined \$15 PMPM relative to Washington from 2011 to 2014 (\$13 from 2011 to 2015)

CCO 2.0 Question for 2018 Investigation:

Is 3.4% still the proper growth target for the entire CCO 2.0 contract period?

Potential next steps and policy options to consider:

- (1) Process to re-evaluate and confirm / modify growth rate target based on waiver renewal mid-CCO 2.0?
- (2) Should target growth rates take into account larger health care inflationary context, other considerations?

Cost Drivers Affecting Achievement of Sustainable Growth Targets

Lesson learned: Distribution of health care costs per member (by service category) changes over time.

- Key information:*
- CCOs invest more in primary care than commercial and other carriers
 - From 2015 to 2016, 12 CCOs lowered their rates of avoidable ED visits per 1,000 member months
 - Compared to 2011 the ED utilization rate across all CCOs has dropped from more than 14 visits per 1,000 member months to seven visits

CCO 2.0 Question for 2018 Investigation:

What cost drivers threaten continued achievement of sustainable growth rate (3.4%) in future years?

Potential next steps and policy options to consider:

- (1) Focus on specific health care services / categories?
- (2) Focus on specific health conditions?
- (3) Focus on specific eligibility categories?

Strategies to Build Upon Sustainable Cost Achievements

Lesson learned: Efforts to reduce spending and costs must not undermine other efforts to ensure necessary investment in policies that improve quality and pay for value, that help address social determinants of health, or that ensure Oregonians access to behavioral health care services.

Key information:

- In 2016, 89% of members are enrolled in PCPCH, up from 52% in 2011
- PCPCH ROI: \$13 in savings per \$1 increase in primary care expenditures stemming from PCPCH model

CCO 2.0 Question for 2018

Investigation:

What cost drivers warrant additional analysis to help OHA and CCO partners continue to meet growth targets?

Potential next steps and policy options to

consider:

- (1) How to better understand CCO success reducing costs and controlling spending
- (2) New or stricter incentives to motivate spread of best practices

CCO Accountability & Flexibility

Lesson learned: Evaluating which specific CCO activities or interventions are most successful at controlling spending and costs is complicated.

- Key information:*
- Achievement of overall waiver-driven spending targets
 - PMPM Savings relative to WA found in Waiver Summative Evaluation
 - Anecdotal evidence highlights the value of CCO flexibility

CCO 2.0 Question for 2018 Investigation:

How to increase CCO financial accountability while preserving CCO flexibility to operate within global budget?

Potential next steps and policy options to consider:

- (1) CCO reporting requirements
- (2) Best practice adherence regarding cost containment

CCO 2.0 Questions for 2018 Investigation

- Is 3.4% still the proper growth target for the entire CCO 2.0 contract period?
- What cost drivers threatens achievement of sustainable growth rate (3.4%) in future years?
- What cost drivers warrant additional analysis to help OHA and CCO partners continue to meet growth targets?
- What strategies could increase CCO financial accountability while preserving CCO flexibility to operate within global budget?