Oregon’s CCOs: what do we know so far?

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Overview

CCOs & health equity

Addressing SDOH through health related services

Our view of CCO progress

Summary of 1115 waiver evaluation

Reductions in spending

Access measures flat or slightly down relative to comparison groups

Quality mixed

Summary of 1115 waiver evaluation

Reductions in spending

Access measures flat or slightly down relative to comparison groups

Quality mixed

Successful infrastructure investments

Slower progress on integration/SDOH

Areas of focus for CCO 2.0

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Maintain sustainable cost growth

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Increase value-based payments

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Equity?

How has the state addressed equity?

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CCO transformation plans

Regional Health Equity Coalitions

Community Health Workers

Our analysis:

Medicaid claims analysis (2010-11 vs. 2013-14)

Compare changes in existing disparities (access, utilization, quality) for

- white vs. black enrollees
- white vs. American Indian/Alaska Native enrollees

Findings

McConnell et al. Health Affairs, 2018

	Pre-intervention measures for white enrollees (unadjusted)	White-black or white-AI/AN disparity (adjusted)		
		Pre-intervention period	Post-intervention period	Change over time
WHITE-BLACK DIFFERENCES				
Utilization measures (per 1,000 member months)				
Primary care visits	335.7	−39.8****	−25.4****	14.4****
Other outpatient visits[a]	307.8	−30.7****	−17.2****	13.5****
ED visits	64.0	15.9****	16.0****	0.1
Potentially avoidable ED visits, ages 18 and older	13.9	4.0****	3.5****	−0.5
Quality measures				
Access to preventive/ambulatory services, ages 45–64	89.0%	−2.5%***	−0.4%	2.1%***
Access to preventive/ambulatory services, ages 1–6	86.6%	−2.5%****	−0.1%	2.4%****
Unplanned 30-day all-cause readmission rate	13.6%	1.8%	—[b]	—[b]
Preventable hospital admissions for chronic conditions[c]	2,086.1	1,858.9****	1,183.1****	−675.7

	Pre-intervention measures for white enrollees (unadjusted)	White-black or white-AI/AN disparity (adjusted)		
		Pre-intervention period	Post-intervention period	Change over time
WHITE–AMERICAN INDIAN/ALASKA NATIVE DIFFERENCES				
Utilization measures (per 1,000 member months)				
Primary care visits	335.7	−15.2****	−2.9	12.2****
Other outpatient visits[a]	307.8	−9.2****	−2.6	6.6**
ED visits	64.0	6.0****	4.8****	−1.2
Potentially avoidable ED visits, ages 18 and older	13.9	1.6**	0.9**	−0.7
Quality measures				
Access to preventive/ambulatory services, ages 45–64	89.0%	−1.0%	—[b]	—[b]
Access to preventive/ambulatory services, ages 1–6	86.6%	−0.9%	—[b]	—[b]
Unplanned 30-day all-cause readmission rate	13.6%	3.1%**	1.1%	−2.0%
Preventable hospital admissions for chronic conditions[c]	2,086.1	570.2	—[b]	—[b]

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Notable feature CCO 1.0 was ability to use “flexible spending” on services not “medically necessary”


LG
TEMP
Mode
Timer
Fan Speed
Power

Social determinants of health

Major goal of CCOs was ability to use “flexible spending” on services not “medically necessary”

Now known as “health related spending”

Flexible Services

Cost-effective and health-related

Alternatives to Medicaid state plan services

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Cost-effective and health-related

Alternatives to Medicaid state plan services

Lack traditional billing or encounter codes

Provided to individuals or communities

Examples of Flexible Services Provided by CCOs

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Individuals
Blood pressure cuffs
Medication dispensers
Gym memberships
Small construction projects

Examples of Flexible Services Provided by CCOs

Individuals	Communities
Blood pressure cuffs	Cooking classes
Medication dispensers	Farmer’s market
Gym memberships	Community health worker hub
Small construction projects	Homeless shelter funding

Flexible Services Spending was Low Overall

Year	Health care	Flexible services	Percentage
2014, Q1-Q4	$2.4 B	$1.7 M	0.07%
2015, Q1-Q4	$2.9 B	$1.7 M	0.06%
2016, Q1-Q2	$1.9 B	$1.4 M	0.07%

Oregon Health Authority, CCO quarterly financial reports

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Oregon Health Authority, CCO quarterly financial reports

Challenge #1

Definitions and Guidance

Areas of Confusion

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Community-level services

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Care coordination and disease management

Areas of Confusion

Community-level services

Care coordination and disease management

Services provided outside capitation rates

Areas of Confusion

Community-level services

Care coordination and disease management

Services provided outside capitation rates

Services not tied to diagnoses or billing codes

Challenge #2

Funding

Funding Challenges

Treatment of flexible services in rate setting

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Treatment of flexible services in rate setting

Confusion about *rate-setting* versus *MLR* rules

Funding Challenges

Treatment of flexible services in rate setting

Confusion about *rate-setting* versus *MLR* rules

Concern about funding community-level investments

Challenge #3

Data and Evaluation

Data and Evaluation Challenges

Variation in ability to track and report data

Data and Evaluation Challenges

Variation in ability to track and report data

Tying flexible services *use* to *outcomes*

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Small number of observations

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Tying flexible services *use* to *outcomes*

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Difficulty finding a good comparison group

Flexible services are now part of “health related services”

HRS = flexible services + community benefit initiatives

Health related services

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2. Directed toward individuals or populations

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3. Grounded in evidence

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1. Should improve health quality
2. Directed toward individuals or populations
3. Grounded in evidence
4. Should increase the likelihood of desired outcomes in ways that can be objectively measured and produce verifiable results

Lessons for Providers

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1. Advocate early for definitions and guidance

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2. Respect (but challenge) need for interventions that are “evidence-based” and “verifiable”

Example: shower guardrail

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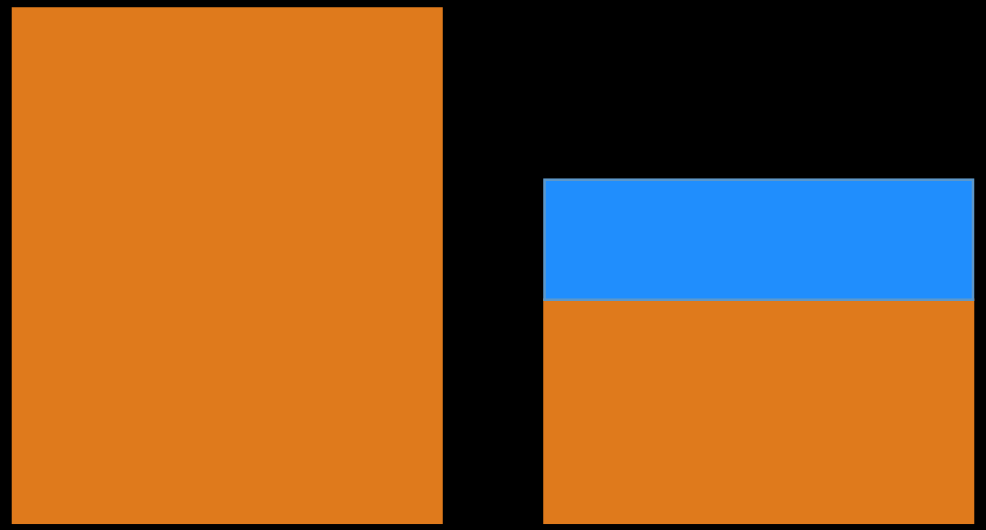
2. Respect (but challenge) need for interventions that are “evidence-based” and “verifiable”

   Example: shower guardrail

3. Look for alignment with Medicare Advantage

Getting from here to there:



Current state

Future state

Your experiences and lessons will guide the nation