Health-Related Services Summary

2021 CCO Health-Related Services Spending

September 2022

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

2021 Spending Summary Purpose

This summary provides an overview 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 2022 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 and the health-related social needs of their members. This flexibility to focus on activities beyond direct medical care improves CCOs' impact on member and community health.

CCO HRS Reporting

CCOs are not required to utilize HRS, but all CCOs did spend a small proportion of their global budget on HRS in 2021. CCOs are required to submit annual HRS spending reports to OHA, and OHA reviews the reports to ensure all spending meets HRS criteria. HRS spending that was accepted by OHA as meeting HRS criteria for 2021 was included in the CCOs' performance-based reward calculations for setting 2023 capitation rates.

Highlights

Total accepted HRS spending decreased in 2021, but remained a substantial increase from 2019 spending levels. From 2020 to 2021, accepted HRS spending decreased from $34,153,552 to $31,137,862.

Per member per month (PMPM) HRS spending also decreased slightly from $2.93 PMPM in 2020 to $2.35 PMPM in 2021. Individual CCO HRS spending ranged from $0.51 PMPM to $10.70 PMPM.

- Total accepted HRS spending decreased in 2021, but remained a substantial increase from 2019 spending levels.
- The top three areas of 2021 CCO HRS spending were health information technology ($9,574,160), housing ($5,974,372), and prevention ($3,559,410).

HRS spending on health information technology, housing, prevention, education, family resources, substance misuse and addiction, and food access accounted for 84% of all HRS spending in 2021. Another 3% of CCO HRS spending was used to address community and member needs exacerbated by COVID-19, as well as emergency needs related to ongoing wildfire relief.

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 originally defined as flexible services (FS), but through the 1115 Medicaid demonstration waiver for 2017-2022, Oregon Health Authority (OHA) clarified that HRS includes both FS and community benefit initiatives (CBI).

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 1) a contractual requirement to maintain a minimum medical loss ratio, and 2) a performance-based reward (PBR) component of CCOs' capitation rates that includes HRS spending. 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 (FS) are defined as cost-effective services offered to an individual CCO member to supplement covered benefits.

Community benefit initiatives (CBI) 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.

Health information technology (HIT) spending is included in the definition of CBI spending, but is reported separately from CBI in Exhibit L.

This summary provides an overview 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 2022 HRS reporting to OHA.

OHA Review of CCO HRS Spending

Spending Assessment

All CCOs are contractually required to submit annual reports of their HRS spending to OHA. The annual financial reporting template, Exhibit L, includes dollars spent, detailed descriptions of HRS spending (Report L6.21), and descriptions of HRS services provided to individual members who received more than $200 in flexible services (FS) for the year (Report L6.22). The annual Exhibit L financial report with 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 Report 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 as to whether that spending meets HRS criteria. HRS spending prior to 2019 is not comparable to current data because OHA did not begin soliciting this additional information until 2019.

CCO spending on HRS does not reflect all CCO spending on social determinants of health (SDOH). The Supporting Health for All through Reinvestment (SHARE) Initiative provides another funding mechanism for upstream investing in community health. More information about CCO spending through SHARE is available on the OHA SHARE webpage. CCOs may also use other funding to support SDOH initiatives and have shared that they have invested more broadly in SDOH than what is reflected in 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, percentage 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 2021, many CCOs continued to allocate a portion of HRS spending to focus on pandemic and wildfire response and relief. To account for this, the 2021 qualitative code set continues to include COVID-19 and wildfire-related codes.

HRS Spending Highlights

Spending Acceptance Rates

The percentage of spending accepted as meeting HRS criteria decreased from 87% in 2020 to 80% in 2021. Despite this decrease, 2021 accepted spending remained a notable increase from the 62% of spending accepted as meeting HRS criteria in 2019. OHA encourages CCOs to report for consideration all potential expenses that could meet the definition of HRS, and acknowledges that changing contractual requirements and guidance revisions from year-to-year may affect acceptance rates.

Total Spending

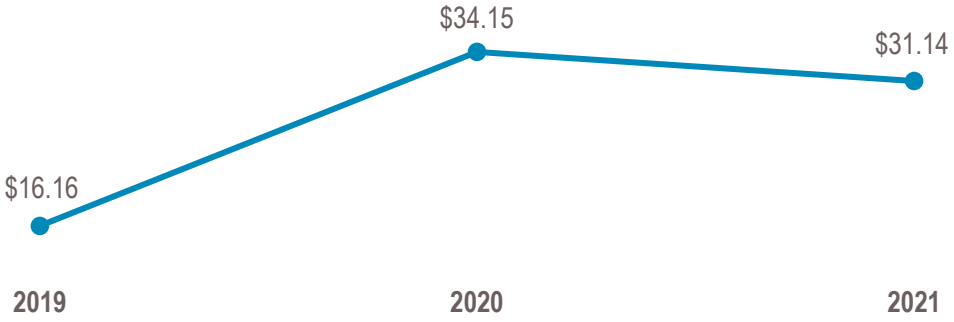
Total HRS spending decreased in 2021, but remained a substantial increase from 2019 spending levels ($16,163,747). From 2020 to 2021, HRS spending decreased by 9% from $34,153,552 to $31,137,862. From 2019 to 2020, CCO HRS spending increased by 111%. From 2019 to 2021, it increased by 93%. Additionally, when COVID-19 and wildfire-related expenses are excluded, total spending increased between 2020 and 2021 from $26,453,006 to $30,182,961, respectively. Across CCOs, total 2021 spending ranged from $102,832 to $6,043,414. See Figures 1 and 2 below, and Appendix B, Table 1 for total HRS spending by year and total HRS spending by CCO and year.

HRS SPENDING ANALYSIS NOTES

- **All analyses in following sections** will focus only on the 80% of spending that was accepted as meeting HRS criteria in 2021.
- **All CCO names** within figures are abbreviated as described in Appendix A, Table 1.
- **Trillium Community Health Plan** (TCHP) entered into a second region for reporting purposes in 2021. TCHP now reports as TCHP-Metro and TCHP-Lane and comparative spending cannot be presented for 2021. TCHP spending data for 2019 and 2020 are available in the 2020 CCO HRS Spending Summary. All figures will report 2021 TCHP-Lane and TCHP-Metro only.

Figure 1: Total HRS spending* by year

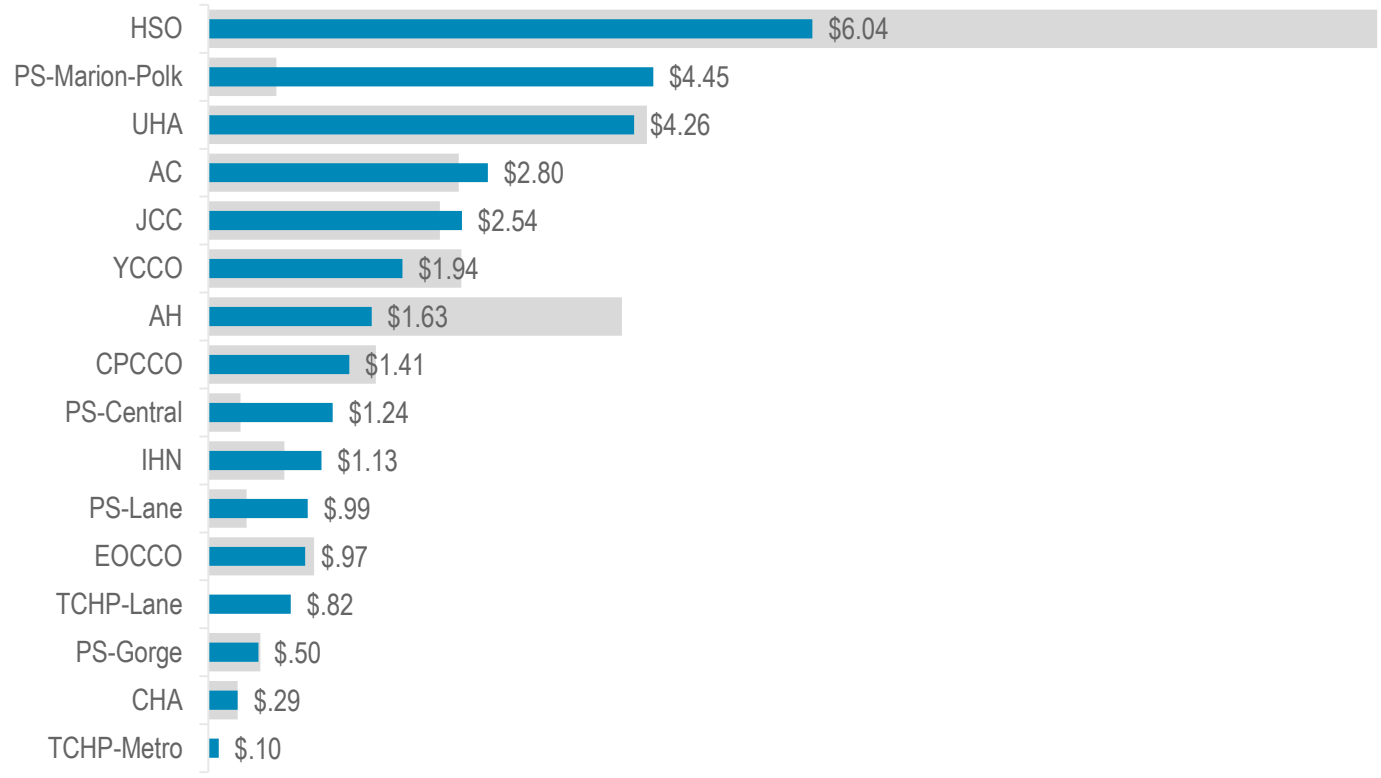
Total HRS spending decreased in 2021, but maintained substantial increase from 2019.



* All values shown are in millions of dollars

Figure 2: Total HRS spending* by CCO and year

HRS spending increased for ten CCOs that reported HRS spending in 2020 and 2021.



* All values shown are in millions of dollars

Total 2021 HRS spending accounted for an average 0.56% of total CCO spending, which is a decrease from 0.70% in 2020. Across CCOs, HRS spending as a percent of total CCO spending ranged from 0.19% to 2.68%. See Figures 3 and 4 below, and Appendix B, Table 2 for average HRS spending as percent of total spending by year and CCO.

Figure 3: Average CCO HRS spending as a percent of total CCO spending by year

Average percentage of total spending on HRS decreased in 2021, but maintained an increase from 2019.

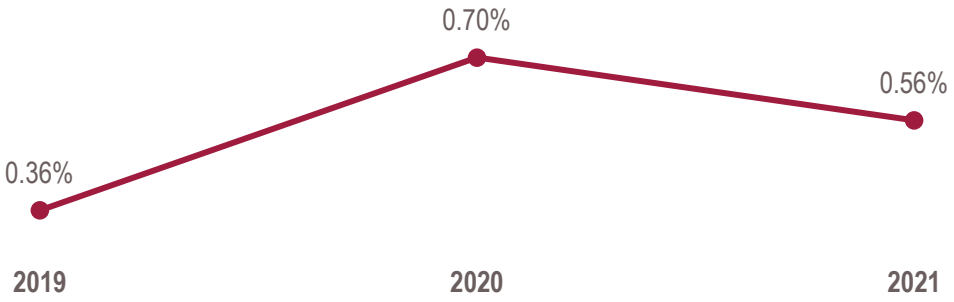
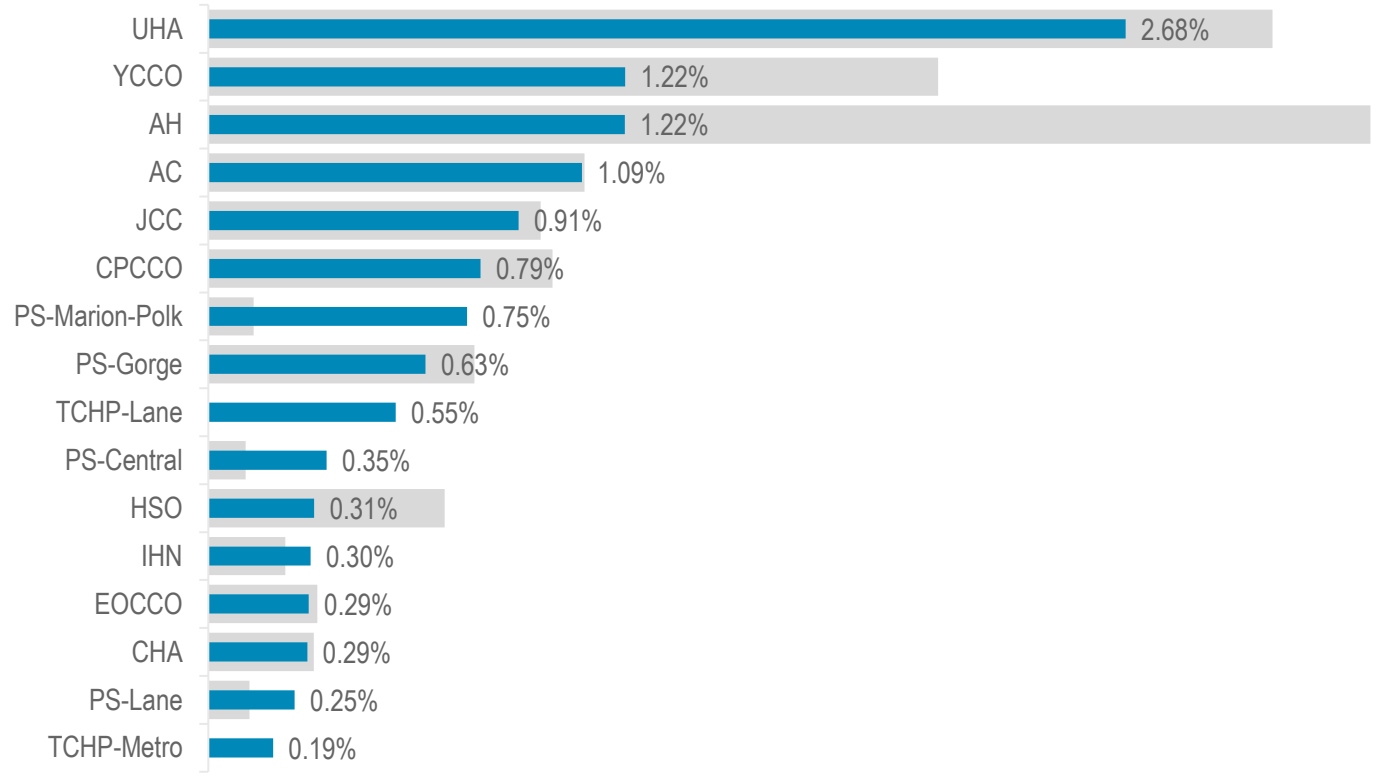


Figure 4: Total HRS spending as a percent of total spending by CCO and year

Percent of total spending on HRS decreased for ten CCOs that reported HRS spending in 2020 and 2021.



Average per member per month (PMPM) HRS spending across all CCOs decreased slightly from 2020 to 2021 from $2.93 PMPM to $2.35 PMPM. However, 2021 average PMPM HRS spending remained higher than the 2019 average (see Figure 5 for average PMPM HRS spending by year). This continues to demonstrate that CCO HRS spending increases from 2019 were not solely due to increases in CCO membership as more individuals became eligible for Medicaid early in the pandemic. While enrollment in CCOs increased by approximately 29% from December 31, 2019 to December 31, 2021, average PMPM HRS spending increased by 56%. Across CCOs, the PMPM HRS spending ranged from $0.51 PMPM to $10.70 PMPM in 2021. See Figure 6 below and Appendix B, Table 3 for HRS PMPM spending data by CCO and year.

Figure 5: Average PMPM HRS spending by year

Average PMPM HRS spending decreased in 2021, but maintained an increase from 2019.

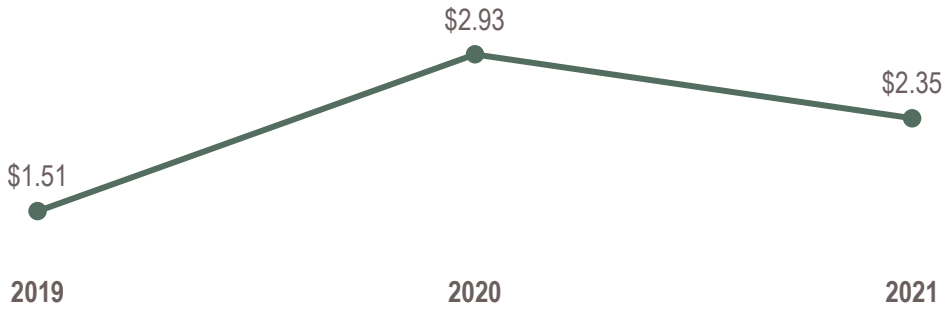
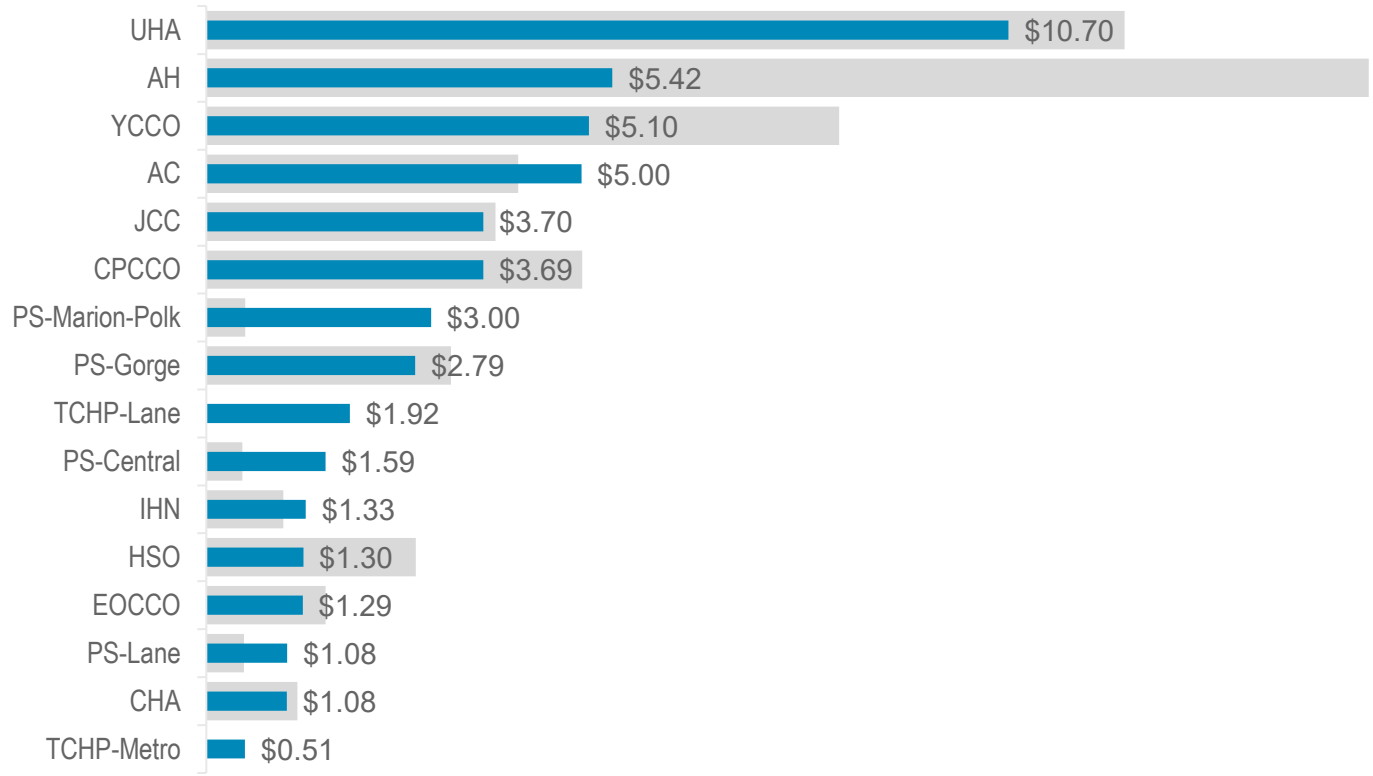


Figure 6: HRS per member per month (PMPM) spending by CCO and year

PMPM HRS spending increased for five CCOs that reported HRS spending in 2020 and 2021.

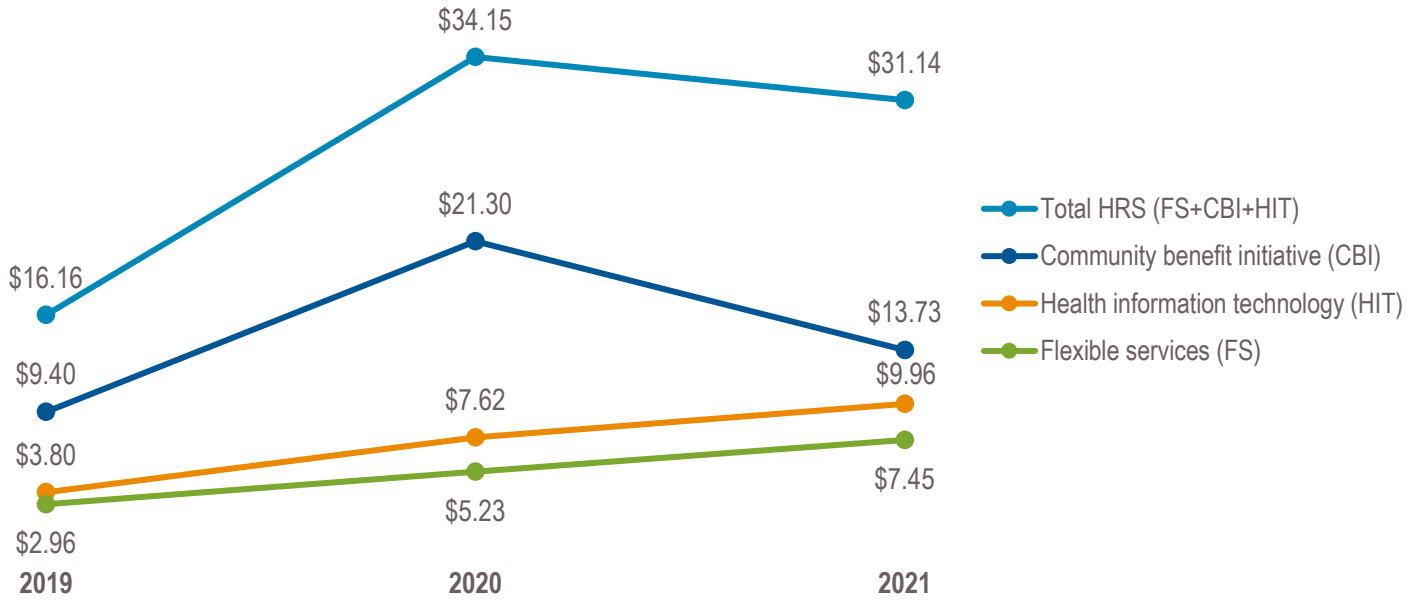


Spending Types

While community benefit initiatives (CBI) remained the largest spending type, the proportion of HRS spending shifted in 2021 to more flexible services (FS) and health information technology (HIT) investments. In 2021, 44% of HRS spending was provided to the broader community through CBI spending. This is a substantial decrease from 2020, when CBI accounted for 62% of total HRS spending. Meanwhile, FS spending on individual members increased notably from 15% of total HRS spending in 2020 to 24% of total HRS spending in 2021. HIT spending is allowed under the definition of CBI spending, but it is reported separately from CBI in Exhibit L. HIT spending increased significantly, from 22% of total HRS spending in 2020 to 32% of total HRS spending in 2021. See Figure 7 below for spending by type and year.

Figure 7: Total HRS spending by type and year*

FS and HIT spending types continued to increase from 2019 to 2021.

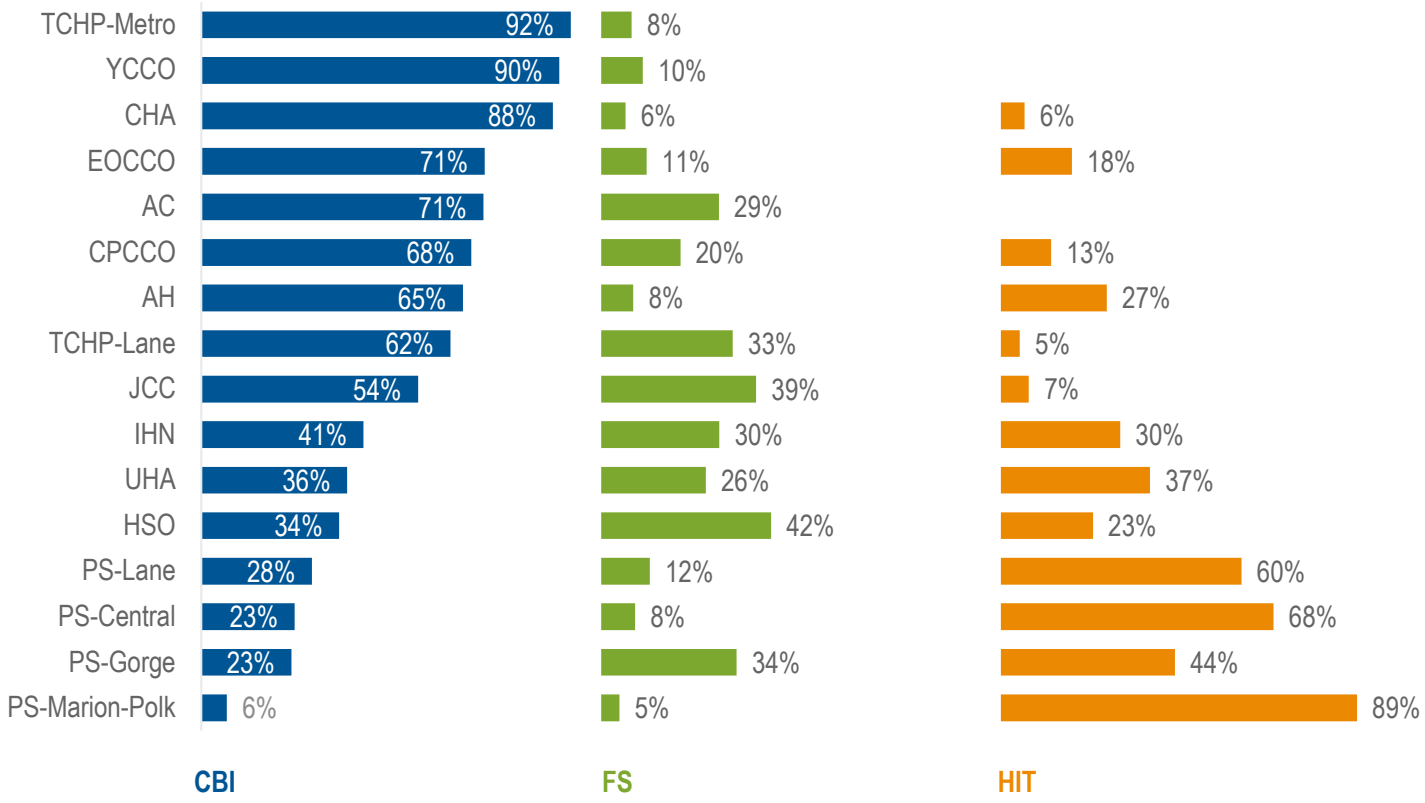


* All values shown are in millions of dollars

Across CCOs, the distribution of HRS spending types varied considerably. The majority of CCOs continued to spend the largest proportion of their HRS dollars on CBI. See Figure 8 below for details.

Figure 8: 2021 HRS spending distribution by type and CCO

Majority of CCOs continued to spend the majority of HRS on CBI



Average PMPM HRS spending across all CCOs also varied in terms of CBI, FS and HIT. See Figures 9, 10 and 11 below for PMPM HRS spending by type and CCO.

Figure 9: CBI per member per month (PMPM) spending by CCO and year

PMPM CBI spending increased for six CCOs that reported HRS spending in 2020 and 2021.

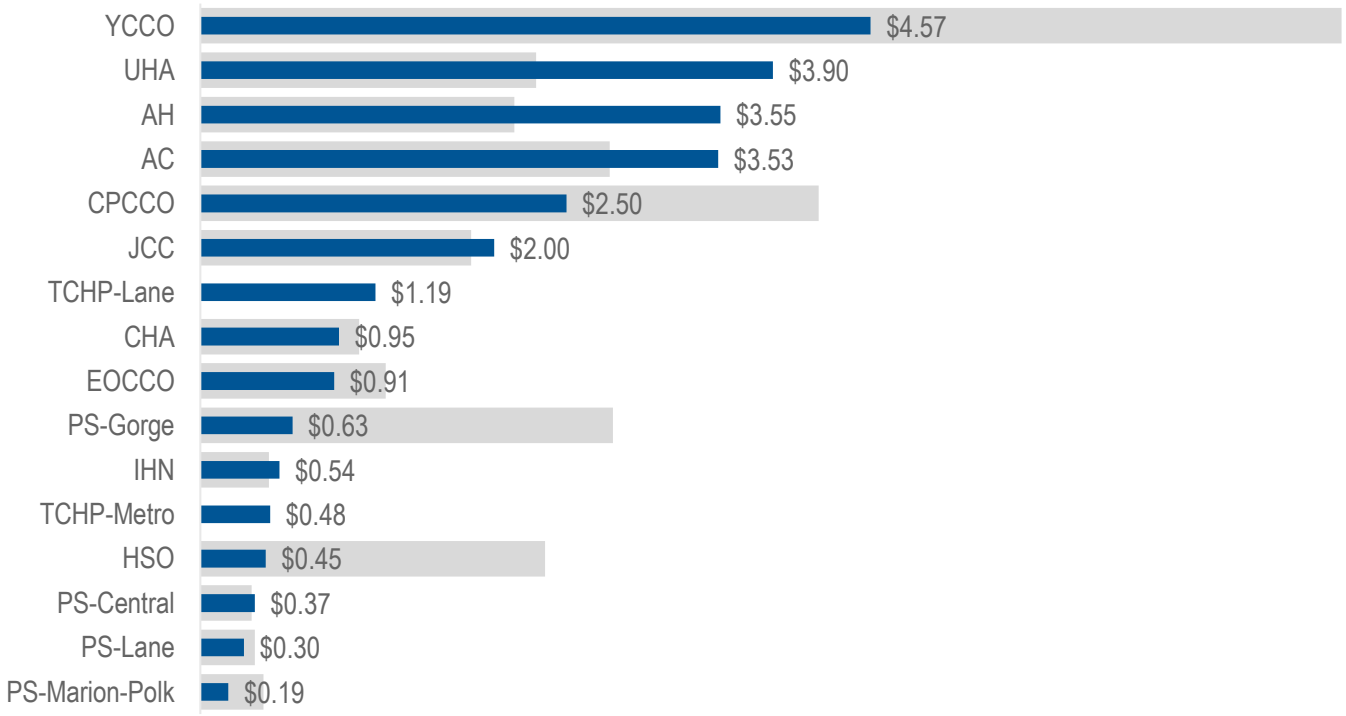


Figure 10: FS per member per month (PMPM) spending by CCO and year

PMPM FS spending increased for eight CCOs that reported HRS spending in 2020 and 2021.

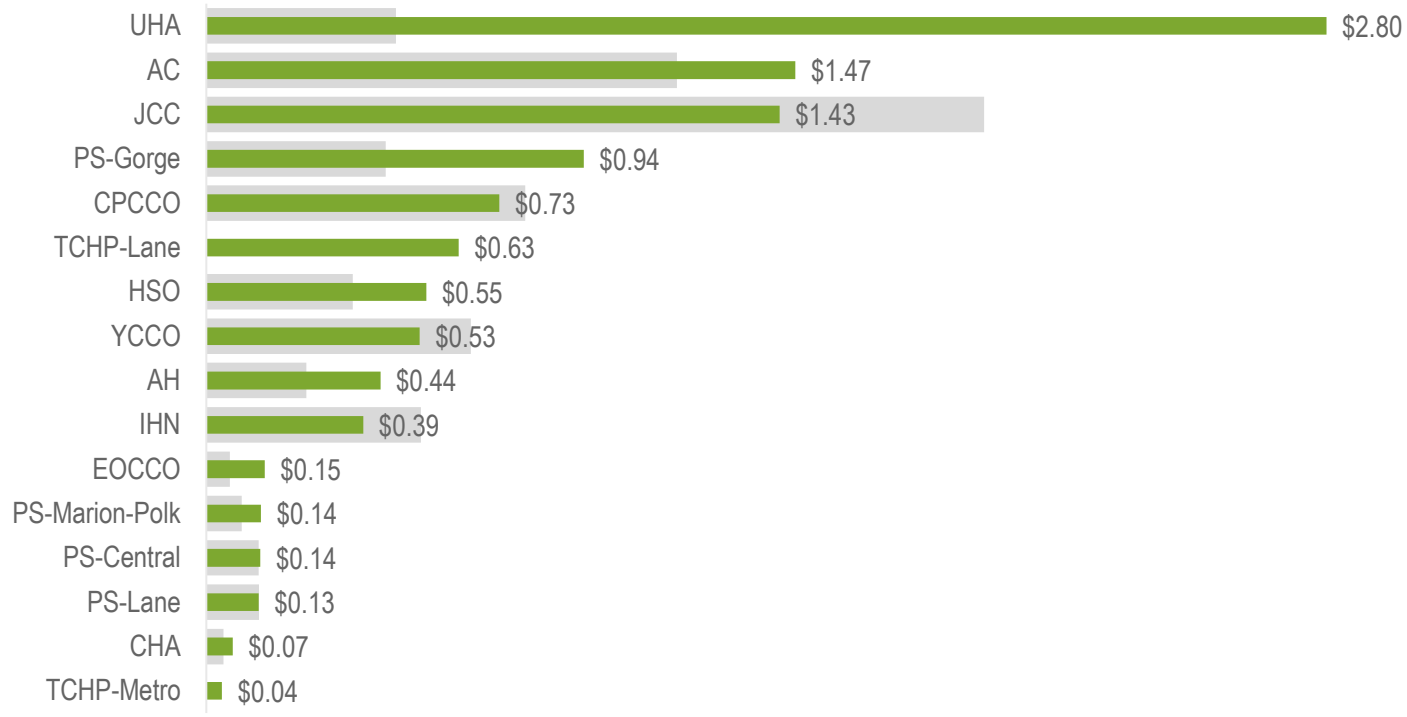
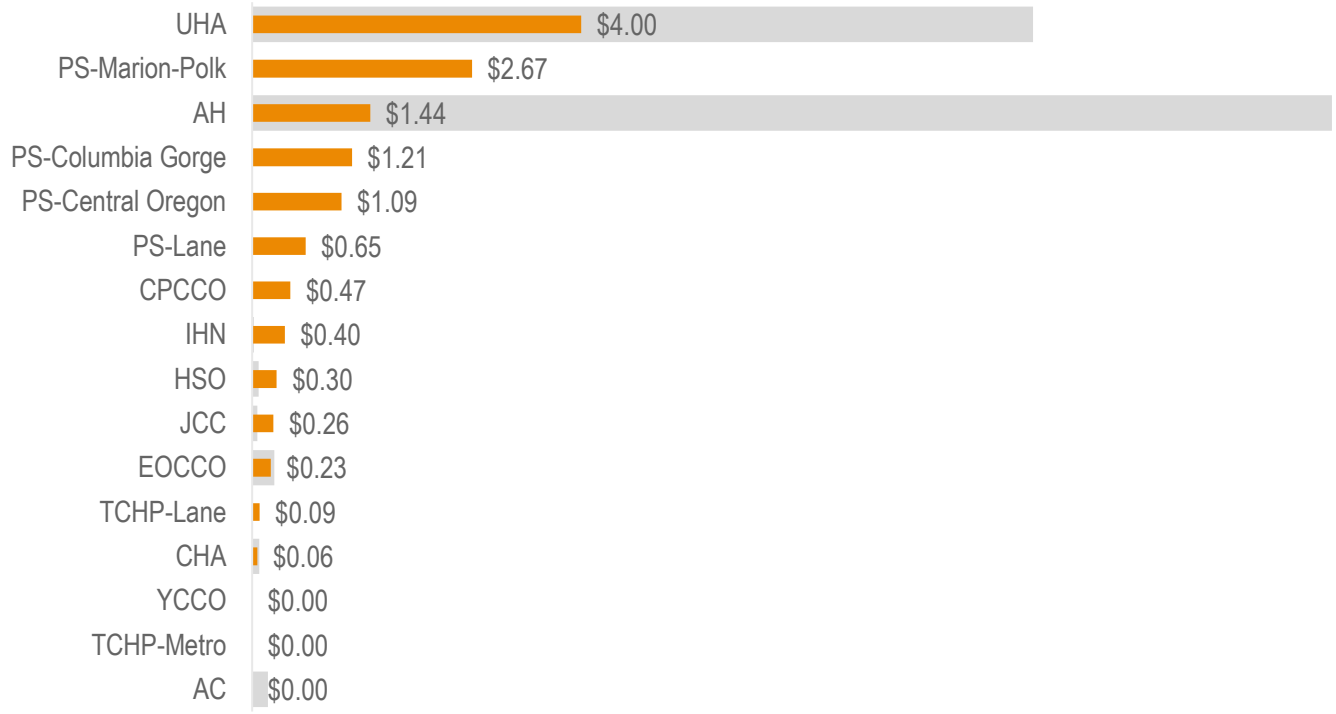


Figure 11: HIT per member per month (PMPM) spending by CCO and year

PMPM HIT spending increased for ten CCOs that reported HRS spending in 2020 and 2021.



Spending Recipients

In 2021, HRS continued to be the primary funding method for CCOs to address the social determinants of health (SDOH). To better address SDOH, CCOs are able to, but not required to provide HRS funding to SDOH partners, public health entities, and clinical providers.

In 2021, the largest proportion of HRS funding went to SDOH partners (38%), followed by clinical providers (12%), and public health entities (10%).[1] See Tables 1 and 2 below for details. This represents up to 60% of all HRS spending with the remaining spending going to provide FS to members and other entities outside of those noted.

Table 1: HRS funding recipients by year

Funding Recipient	2019	2020	2021
Social determinant of health partner	$5,684,476	$16,845,416	$11,840,082
Public health entity	$2,057,255	$718,070	$3,227,527
Clinical provider	$2,820,380	$4,598,543	$3,761,905

Table 2: HRS funding recipients as a percent of total HRS spending by year

Funding Recipient	2019	2020	2021
Social determinant of health partner	35%	49%	38%
Public health entity	13%	2%	10%
Clinical provider	17%	13%	12%

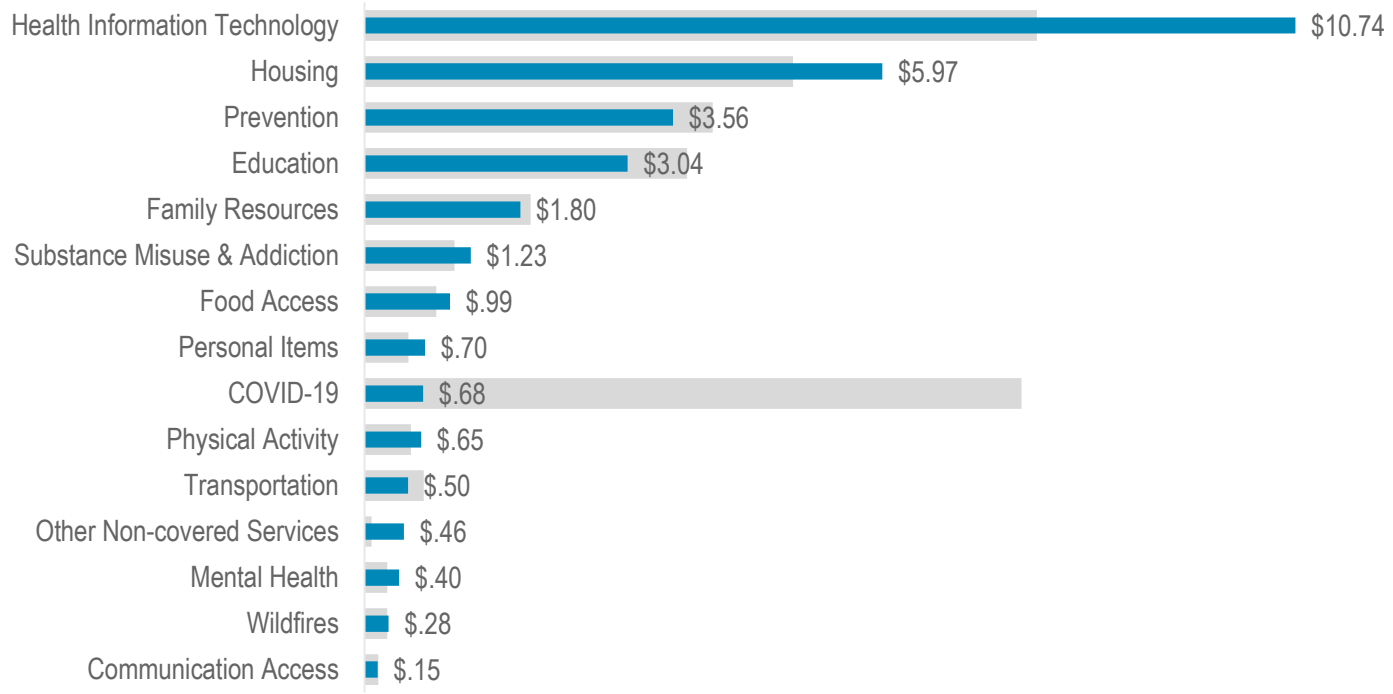
[1] The funding amounts include an over report because several expenditures were attributed to more than one entity.

Spending in Key Areas

Nine areas of HRS spending increased from 2020 to 2021.[2] These include HIT, housing, substance misuse and addiction, food access, personal items, physical activity, mental health, wildfires, and other non-covered services. The three highest spending areas were HIT ($10,741,235), housing ($5,974,372), and prevention ($3,559,410). See Figure 12 below for total spending by area and year. The four highest percent increases in spending from the prior year were other non-covered services (449%), mental health (52%), HIT (38%) and personal items (38%). See Appendix B, Table 4 for total spending and percent change by area and year.

Figure 12: HRS spending by category in 2020 and 2021*

Top three spending categories for 2021 included HIT, Housing and Prevention



* All values shown are in millions of dollars

Spending areas of interest for OHA include housing, food access, transportation, and substance misuse and addiction. The majority of housing-related spending ($5,452,215) went towards temporary housing, homelessness, and rental assistance. In the category of food access, the majority of spending ($539,710) went to groceries and pantry items, representing a very small increase from 2020.[3] The majority of substance misuse and addictions-related spending ($809,361) went to recovery support while the majority of transportation-related spending ($481,625) went to SDOH-related transportation. The majority of HIT spending ($3,842,055) went to electronic health records with community information exchange spending ($3,262,275) coming in second. Community

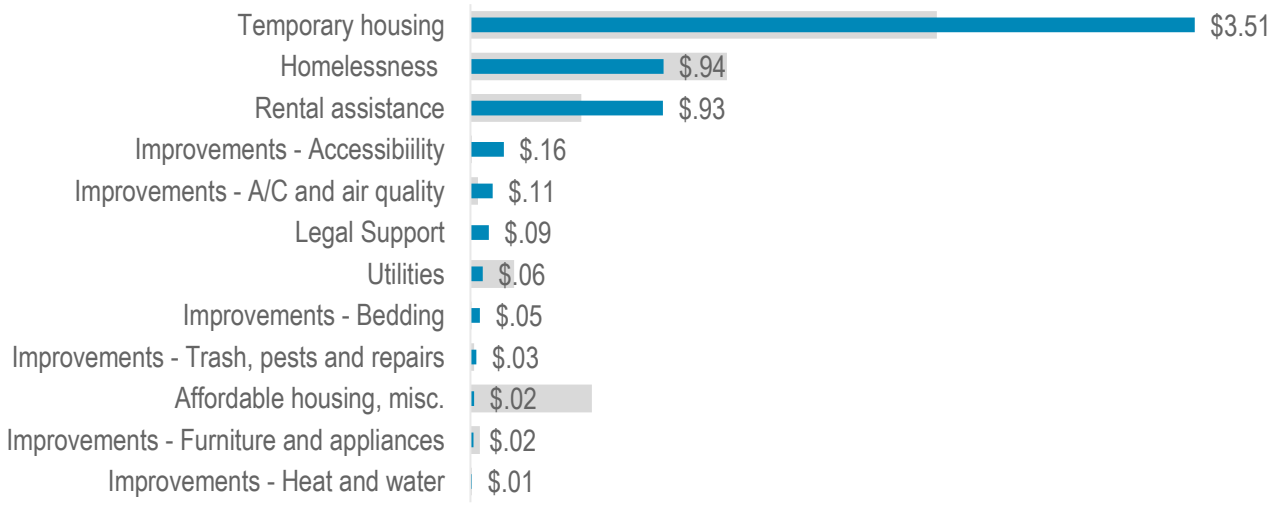
[2] The analysis of key spending areas is based on qualitative data from the Oregon Rural Practice-Based Research Network. This results in a different total spent on HRS HIT in the qualitative data versus the CCO reported HRS HIT spending.

[3] In the housing and food access categories, spending is undercounted. COVID-19 and wildfire-related spending categories both included spending on housing on food. Because each data point could only be counted once, they were attributed to these two emergency-related categories.

information exchange is integral to addressing members' health-related social needs. See Figures 13-17 below for spending details in these areas of interest.

Figure 13: HRS spending on housing in 2020 and **2021***

Temporary housing assistance led HRS housing spending with a 54% increase from 2020.



* All values shown are in millions of dollars

Figure 14: HRS spending on food access in 2020 and **2021**

Assistance with grocery and pantry items led HRS food access spending, while script spending increased by over 700%.

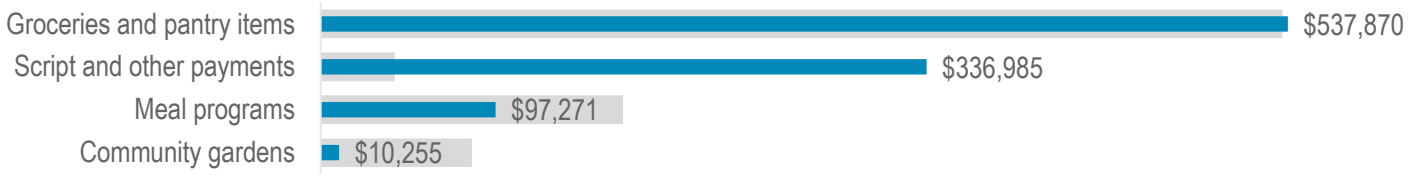


Figure 15: HRS spending on substance misuse and addictions in 2020 and **2021**

Recovery support led HRS substance misuse and addiction spending with a 29% increase.

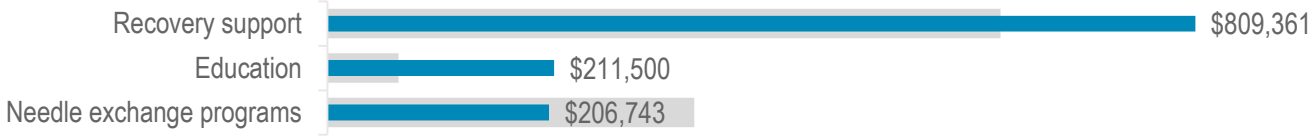


Figure 16: HRS spending on transportation in 2020 and **2021**

Transportation to help members meet their SDOH needs led HRS transportation spending, but decreased by 16%.

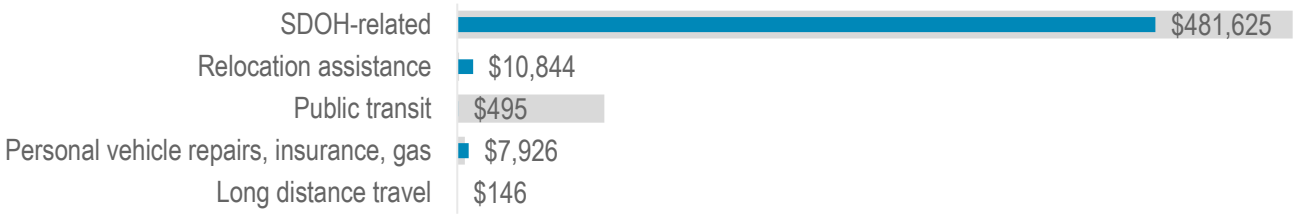


Figure 17: HRS spending on HIT in 2020 and 2021*

Electronic health records led HRS HIT spending with community information exchange and provider network close behind.

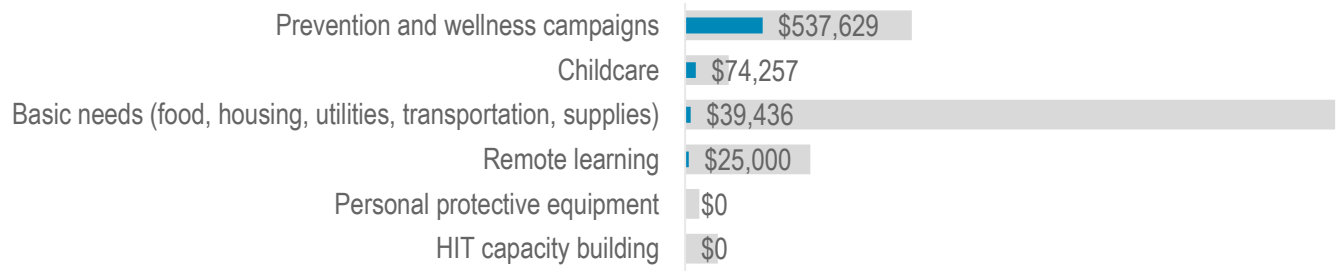
* All values shown are in millions of dollars

Spending on COVID-19 and Wildfire Response

As the COVID-19 pandemic continued, CCOs continued to utilize HRS spending to address COVID-19-related needs in their communities. CCO HRS spending on COVID-19-related services decreased significantly from $7.5 million in 2020 to $676,322 in 2021. This may be due to 1) an increase in federal pandemic-related funding that flowed to state and local agencies, as well as 2) a recharacterization of HRS spending as a housing or food access effort, rather than a COVID-19 relief effort. The majority of 2021 COVID-19 HRS spending covered COVID-19 prevention and wellness campaigns, with more limited spending on childcare, basic needs, and remote learning. See Figure 18 below for COVID-19-related spending details.

Figure 18: HRS spending on COVID-19 related services in 2020 and 2021*

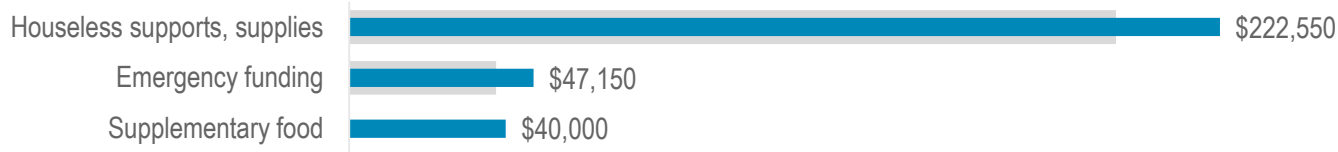
The majority of assistance related to COVID-19 was in prevention and wellness campaigns



In addition to COVID-19 related needs, some Oregon communities continued to experience needs related to the 2020 summer wildfires. In the regions affected, CCOs used $309,700 of HRS funds for houseless supports and supplies, emergency funding, and supplementary food. See Figure 19 below for information about wildfire related spending.

Figure 19: HRS spending on wildfire related services in 2020 and 2021*

The majority of funds were spent on houseless supports and supplies for wildfire relief



Next Steps for CCO HRS Reporting

In 2023, OHA will follow the same process and timeline to assess and provide feedback to CCOs on their 2022 HRS spending reports:

- October 2022: The Office of Actuarial and Financial Analytics releases the 2023 Exhibit L annual reporting template. Any updates to HRS Reports L6.21 and L6.22 may affect internal tracking for CCOs and subcapitated entities that administer HRS.
- January 2023: Quarterly CCO HRS office hours begin Friday, January 6. Details are available on the HRS webpage.
- April 30, 2023: CCOs submit annual Exhibit L report with details covering 2022 HRS spending.
- May – June 2023: OHA assesses 2022 CCO HRS spending to confirm whether spending meets HRS criteria.
- May 16 – June 30, 2023: 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, 2023: OHA finalizes 2022 HRS spending assessment decisions and releases them to CCOs and OHA's Office of Actuarial and Financial Analytics (OAFA). The final OHA spending determinations will then 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. Questions about HRS or this spending summary document can be directed to the OHA HRS team at Health.RelatedServices@dhsoha.state.or.us.

Appendix A

Table 1: CCO name abbreviations

CCO name	Abbreviation
Advanced Health	AH
AllCare CCO	AC
Cascade Health Alliance	CHA
Columbia Pacific CCO	CPCCO
Eastern Oregon CCO	EOCCO
Health Share of Oregon	HSO
InterCommunity Health Network	IHN
Jackson Care Connect	JCC
Pacific Source - Lane	PS-Lane
Pacific Source - Central Oregon	PS-Central
Pacific Source - Columbia Gorge	PS-Gorge
Pacific Source - Marion/Polk	PS-Marion-Polk
Trillium Community Health Plan - Lane	TCHP-Lane
Trillium Community Health Plan - Metro	TCHP-Metro
Umpqua Health Alliance	UHA
Yamhill Community Care	YCCO

Appendix B

Table 1: Total HRS spending by CCO and year

CCO	2019	2020	2021
AC	$1,570,634	$2,504,212	$2,797,002
AH	$526,357	$4,137,699	$1,634,265
CHA	$224,683	$293,905	$293,593
CPCCO	$1,461,059	$1,676,501	$1,409,903
EOCCO	$89,284	$1,056,939	$970,201
HSO	$2,716,625	$11,693,408	$6,043,414
IHN	$956,546	$760,984	$1,133,006
JCC	$1,044,211	$2,317,577	$2,537,147
PS-Central	$113,254	$322,746	$1,244,377
PS-Gorge	$540,260	$520,603	$499,938
PS-Lane	$0	$382,329	$994,041
PS-Marion-Polk	$0	$680,449	$4,450,980
TCHP	$2,308,466	$885,733	N/A
TCHP-Lane	N/A	N/A	$824,166
TCHP-Metro	N/A	N/A	$102,832
UHA	$3,330,102	$4,389,113	$4,259,883
YCCO	$1,125,717	$2,531,355	$1,943,113
All CCOs	$16,163,747	$34,153,552	$31,137,862

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

CCO	2019	2020	2021
AC	0.68%	1.10%	1.09%
AH	0.49%	3.39%	1.22%
CHA	0.26%	0.31%	0.29%
CPCCO	1.01%	1.00%	0.79%
EOCCO	0.03%	0.32%	0.29%
HSO	0.17%	0.69%	0.31%
IHN	0.32%	0.22%	0.30%
JCC	0.70%	0.97%	0.91%
PS-Central	0.05%	0.11%	0.35%
PS-Gorge	0.92%	0.78%	0.63%
PS-Lane	0.00%	0.12%	0.25%
PS-Marion-Polk	0.00%	0.13%	0.75%

CCO	2019	2020	2021
TCHP	0.50%	0.51%	N/A
TCHP-Lane	N/A	N/A	0.55%
TCHP-Metro	N/A	N/A	0.19%
UHA	2.76%	3.11%	2.68%
YCCO	0.95%	2.13%	1.22%
CCO average	0.36%	0.70%	0.56%

Table 3: HRS per member per month spending by CCO and year

CCO	2019	2020	2021
AC	$2.60	$4.16	$5.00
AH	$2.21	$15.51	$5.42
CHA	$1.04	$1.21	$1.08
CPCCO	$4.74	$5.01	$3.69
EOCCO	$0.15	$1.59	$1.29
HSO	$0.71	$2.80	$1.30
IHN	$1.39	$1.03	$1.33
JCC	$2.72	$3.86	$3.70
PS-Central	$0.19	$0.48	$1.59
PS-Gorge	$3.73	$3.26	$2.79
PS-Lane	$0.00	$0.50	$1.08
PS-Marion-Polk	$0.00	$0.52	$3.00
TCHP	$2.08	$1.88	N/A
TCHP-Lane	N/A	N/A	$1.92
TCHP-Metro	N/A	N/A	$0.51
UHA	$10.29	$12.25	$10.70
YCCO	$3.75	$8.44	$5.10
CCO average	$1.51	$2.93	$2.35

Table 4: HRS spending areas by year and percent change

Spending Area	Total Spending			Percent Change		
	2019	2020	2021	2019 to 2020	2020 to 2021	2019 to 2021
Communication Access	$72,059	$157,683	$152,487	119%	-3%	112%
COVID-19	$0	$7,578,071	$676,322	n/a	-91%	n/a
Education	$2,041,177	$3,720,500	$3,036,293	82%	-18%	49%
Family Resources	$2,488,742	$1,915,207	$1,797,732	-23%	-6%	-28%

Spending Area	Total Spending			Percent Change		
	2019	2020	2021	2019 to 2020	2020 to 2021	2019 to 2021
Food Access	$220,225	$828,143	$985,446	276%	19%	347%
Health Information Technology	$3,748,827	$7,756,901	$9,574,160	107%	38%	187%
Housing	$2,925,764	$4,944,757	$5,974,372	69%	21%	104%
Mental Health	$559,353	$264,298	$400,772	-53%	52%	-28%
Other Non-covered Services	$0	$83,131	$1,623,210	n/a	449%	n/a
Personal Items	$350,967	$506,613	$697,388	44%	38%	99%
Physical Activity	$680,866	$537,507	$653,051	-21%	21%	-4%
Prevention	$1,728,508	$4,017,873	$3,559,410	132%	-11%	106%
Substance Misuse & Addiction	$686,676	$1,036,294	$1,227,604	51%	18%	79%
Transportation	$660,584	$684,099	$501,036	4%	-27%	-24%
Wildfires	$0	$261,325	$278,579	n/a	7%	n/a

HEALTH POLICY AND ANALYTICS
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