Issue Brief | June 2021

Oregon leverages Medicaid to address social determinants of health and health equity

By promoting health-related services and adding a profit reinvestment initiative, the state is pushing to put more dollars towards health equity and social needs

Challenges with food insecurity, housing, non-medical transportation and other social needs impact members' health and well-being and may lead to inefficient use of health care services.[1] State Medicaid programs are increasingly seeking ways to address these non-medical social determinants of health (SDOH), exploring flexibility to fund solutions through state plan amendments and waivers.[2] One lever of change is states' contracting arrangements with Medicaid managed care organizations (MCOs), which now cover over two-thirds of enrollees.[3]

Through successive Section 1115 waivers spanning 2012-2022, Oregon has encouraged its Medicaid plans — regional MCO-like entities known as "coordinated care organizations" (CCOs) — to invest in SDOH initiatives with current-year global budget dollars and past-year revenues. Oregon's 2020 managed care contracts included new incentives and requirements for spending to address SDOH, as well as new initiatives for health equity and consumer engagement.[4]

In this brief, we outline SDOH- and health equity-related provisions in Oregon's new contracts, known as "CCO 2.0." We also share mixed-methods findings on SDOH-related investments to date from our work as external evaluators of Oregon's 2017-2022 waiver and as grantees for a related study supported by the Robert Wood Johnson Foundation.

KEY FINDINGS

- By promoting use of health-related services and adding a profit reinvestment mandate, Oregon is using managed care contracting to expand Medicaid spending on social determinants of health and health equity.
- Oregon's coordinated care organizations increased health-related services spending from 2014-2019, though it remains a small portion (0.36%) of total health-plan spending.
- Obtaining and integrating data on race, ethnicity and member social needs presented challenges in designing and assessing programs.

OHSU

Definitions

Health-Related Services

Services beyond members' covered benefits to improve care delivery and support overall member and community health and well-being.

Flexible Services

Cost-effective services delivered to an individual Medicaid member to supplement covered benefits and improve their health and well-being.

Community Benefit Initiatives

Community-level interventions that include (but are not limited to) Medicaid members and are focused on improving population health.

SDOH, health equity elements in Oregon's new waiver and managed care contracts

Oregon's 2017-2022 Section 1115 waiver continued to build out mechanisms and incentives for SDOH investments and health-equity initiatives from the first waiver, adding requirements in some areas that had previously been voluntary for CCOs. Many of these provisions were implemented through Oregon's 2020 2.0 contracting process.[4]

Health-related services expansion

Federal regulation allows use of Medicaid plan dollars for qualifying non-clinical activities that "improve health care quality."[5] Oregon leveraged that option to create a CCO budget category called "health-related services" (HRS) separate from medical and administrative expenses. This category allows CCOs to spend current-year plan dollars on addressing individual health-related needs not covered by Oregon's Medicaid plan ("flexible services"), or making community-level investments targeting SDOH ("community benefit initiatives").

Oregon includes health information technology (HIT) investments, such as electronic health records systems (EHRs) or community information exchange costs, under community benefit initiatives.

Oregon's Medicaid agency provided CCOs with several guidance documents promoting HRS as its preferred mechanism for SDOH spending.[6] CCOs must report their HRS expenditures annually, providing service categories, member IDs where relevant, and anticipated horizon of resulting cost savings. Oregon also confirmed that HRS spending counts on the "medical" side of CCOs' medical loss ratios, a point of confusion during the 2012-17 waiver that may have inhibited HRS spending.

Health equity, traditional health worker and community engagement infrastructure

Applications for new contracts required prospective CCOs to detail plans on engaging Medicaid members, community partners, tribal liaisons and others in decision-making on SDOH spending.[4] In the first year of the contract, CCOs submitted formal plans for work on health equity, community engagement and the traditional health worker workforce, which includes community health workers, peer wellness and support specialists, personal health navigators and doulas.[7] In addition, each CCO was required to employ a dedicated health equity administrator.

SDOH screening incentive metric

The state is developing a metric on social needs screening for potential inclusion in CCOs' pay-for-performance metrics set. If approved, this incentive would go live in 2023.[8]

Performance-based rewards

The waiver allows for the Medicaid agency to pay a variable profit margin to CCOs showing favorable cost and quality outcomes. This provision was intended to offset fears of "premium slide" among high-performing CCOs and to reward effective investments in

What is a CCO? CCOs are regional Medicaid managed care organizations that receive annual risk-adjusted global budgets to meet beneficiaries' medical, oral, and behavioral health care needs in a coordinated fashion. Oregon has 16 CCOs currently. CCOs are accountable for meeting quality metrics and receive bonuses from withheld funds if performance benchmarks are met.[9,10]

SDOH.[6] (This provision has yet to be added to CCO contracts, but is expected by 2022.)

The SHARE Initiative: Reinvesting in social determinants and equity

Passed by Oregon's legislature in 2018, this unique initiative (Supporting Health for All through Reinvestment, or "SHARE") requires CCOs to reinvest a percentage of net revenues each year in SDOH and health equity projects. For 2020-21, CCOs set their own "SHARE designation" (proportion of profits to reinvest in SDOH initiatives, beyond required reserves). By the 2022 plan year, however, the percentage will be defined in administrative rule. CCOs' first annual SHARE spending plans are due in September 2021.[11]

Guidance for SDOH investment areas

Oregon's new waiver also increased CCOs' requirement for engaging members and community and agency partners in planning SDOH investments. Each CCO has a community advisory council made up of more than 50% Medicaid members that leads creation of a Community Health Improvement Plan in collaboration with local partners.[12] CCOs must align community benefit initiative spending with community health plan priorities and involve community advisory councils in SHARE investment planning.

In addition, Oregon's Health Policy Board identified four SDOH domains for SHARE investments, selecting housing-related services and supports as its priority for the first two years of the SHARE Initiative.

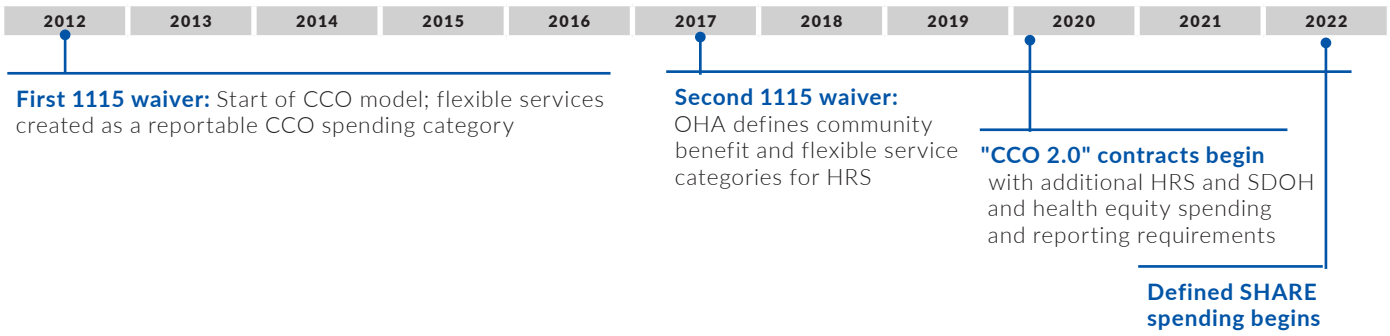
Early impacts of CCO 2.0 and the new waiver

To assess how Oregon's new waiver and CCO contract provisions were affecting Medicaid-funded work on SDOH, our team analyzed data on HRS reported to the state by CCOs from 2014-2017 (during Oregon's first waiver) and in 2018-19 (Oregon's new waiver). In addition, we completed qualitative interviews in fall 2020 with representatives of 13 CCOs. These occurred during the first year of the CCO 2.0 contracts with new SDOH and health equity requirements.

Interviews focused on CCOs' use of funds in SDOH initiatives, including project selection, partnerships, funding structures, and project evaluation. We also asked about CCOs' approach to addressing health equity in relation to social determinants projects.

Covid-19 engendered delays in several CCO 2.0 elements slated for spring 2020. Responding to delivery system stresses of the pandemic, Oregon's Medicaid agency pushed back health equity and THW plan deadlines for CCOs to December 2020, as well as specification of a reinvestment percentage for SHARE. Nonetheless, our fall 2020 interviews were able to capture early planning activities by CCOs in these areas and initial outcomes.

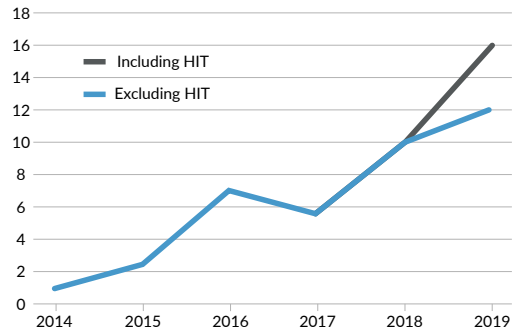
Exhibit 1: Oregon 1115 waivers and social determinants spending measures, 2012-2022



Slow but steady uptick in health-related services spending

During the first three years of the new waiver, CCOs increased their spending on HRS by 120%, from $7.2 million ($0.66 PMPM) in 2016 to $16.2 million ($1.51 PMPM) in 2019. However, this still remained a small portion (0.36%) of overall spending on Medicaid members.

Figure 1: CCOs increased overall HRS spending from $1 million to $16 million between 2014 and 2019, with HIT reported separately starting in 2019.

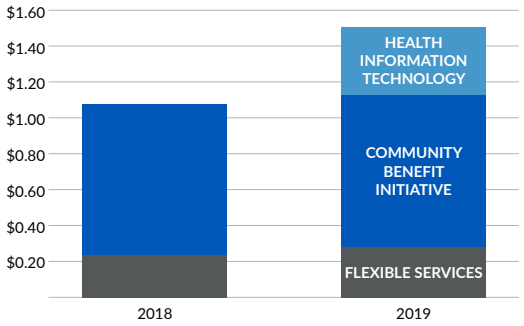


Total HRS spending varied widely among CCOs, from an average of $0.04 per member to $10.30 in 2019. Interviews suggested two reasons behind this: CCOs were at different levels in developing their processes and infrastructure for HRS spending, and some CCOs were supporting SDOH work through other spending mechanisms, such as using quality incentive bonuses or prior-year profits.

Most spending is community-level

Community benefit initiative spending, including HIT projects, made up the bulk of overall HRS spending. HIT projects comprised 25% of spending, and another 57% went to other community benefit projects. The remaining 24% went to individual-level services.

Figure 2: Community Benefit Initiative spending made up the majority of HRS



SDOH decision-making and focus areas

CCOs reported relying on their community health improvement plans and their community advisory councils for prioritizing SDOH spending, aligning with CCO 2.0 requirements. However, interviews indicated that many larger decisions were made by CCO leaders and also prioritized saving costs, meeting incentive metric targets, and addressing identified needs of particular member subgroups, such as racial or ethnic minorities and members with particular needs, such as new mothers or those with chronic health conditions. Many CCOs offered grants allowing local agencies to propose projects to be selected by the community advisory council.

Although the state required CCOs to report HRS spending by category, approximately half of community benefit investments were not differentiated into social need domains. Among those that were, common focus areas were housing (e.g. case management programs or other supports provided through community housing partners), training and education (e.g. cooking classes for community members with diabetes), food security (support for farmers' markets or "Veggie Rx" programs), and support of capacity building within community partner organizations to help them effectively seek external funding or expand programming. While most CCOs were supporting programs to address a range of social determinants,

some had identified particular areas – for example, early childhood and family supports, transportation, or housing – as strategic investment priorities.

Categorical reporting on individual flexible services was more defined and showed high levels of variation among CCOs. CCOs doing the most overall flexible services spending concentrated the majority of it in one or two categories (training/education, transportation, or case management, predominantly), with smaller proportions in other areas (food or social supports, home services, housing, or "other").

SDOH Partnerships

Community benefit initiatives involved partnerships with community organizations, whether local public agencies or community-based nonprofits. While some individual-level flexible services were delivered through CCO staff directly (for example, a care coordinator providing a cell phone), others were provided through community partners. HRS partners included public agencies, community-based organizations and, in some cases, larger foundations. CCOs selected and engaged with SDOH partners through a variety of mechanisms.

Financial arrangements with partners ranged from grant-like mechanisms to service-based contracts; in one case, a CCO had helped a community partner that constructed house entry ramps to obtain a Medicaid provider number so it could bill directly for services. Some partnerships were continuing from the 2012-17 waiver, while others were newly formed.

Health equity plans

While submission of formal health equity plans had been delayed, most CCOs had begun work on these, and leaders perceived interconnections between the work on health equity and social determinants of health. Several CCOs viewed the state's expanded definition of health equity as advancing their work and helping them align staff, board members, and community partners in a common understanding. This included building their own capacity and that of their partners in identifying health disparities using data and offering HRS or other CCO funding for health equity projects.

Data, reporting, and outcomes assessment

For most CCOs, accessing data on members' social needs for planning and interventions presented significant challenges. Providers or community agencies might collect this information through ICD-10 Z codes or other screening and reporting tools. But CCOs and partners frequently lacked shared platforms that would allow combination of data on particular social needs. When community benefit initiative projects were funded, community partners might lack the capacity to share services and outcomes data that would allow CCOs to assess return on project investments.

> ***We think there's an increasing number of social screenings that are happening in clinical settings, but there's no unified way of collecting that information.***
>
> **- CCO representative**

Examples of CCO health-related services expenditures

- Blood-pressure cuff to help member better manage hypertension
- Cell phones and minutes for telehealth visits
- Home goods: air filter, crockpot
- Spanish-language course on nutrition and wellness for members with diabetes
- Non-medical transportation
- Temporary housing or rental supports

An inability to access data on race, ethnicity, language and disability status (REALD) hampered efforts of CCOs to identify disparities and target SDOH projects to particular racial or ethnic subgroups. These data were typically incomplete in Medicaid enrollment files, and not all CCOs had platforms to integrate data obtained from partners. Data on preferred language were used as a proxy by some CCOs.

By early 2021, nine CCOs had joined a community information exchange platform, ConnectOregon, which several viewed as a potential tool for accessing, tracking and storing SDOH-related service and outcomes data. One other CCO made a large investment to supply providers and partners with an interoperable EHR to increase its capacity to integrate social need, REALD, and health services data.

Challenges in use of HRS

CCOs faced other challenges in their SDOH-related efforts.

Community capacity challenges. For some CCOs, particularly those in smaller and more rural communities, a lack of community partners with the capacity to carry out initiatives (for example, for housing supports) limited the potential impact of HRS investments. A couple of CCOs had invested in consultants to help local community organizations build capacity to deliver services, seek other funding, and receive training on topics like trauma-informed care.

One SDOH priority, housing, was in critically short supply in many communities, and CCOs noted their inability (per federal policy) to use HRS to support the creation of new housing infrastructure.

> ***One of the places that we're getting a little stymied is when we have a clear need … I'm talking specifically about housing services here. Building an apartment building isn't something the CCO can do. How do we come in and support our partners doing that?***
>
> **- CCO representative**

Reporting burden for HRS. Oregon's requirement for CCOs to provide detailed, member-level reporting on HRS expenditures – at least for flexible services – created significant administrative burdens, according to CCOs. The need to specify an expected time frame for cost reductions resulting from expenditures also led some representatives to question whether HRS was the best mechanism for SDOH projects with longer horizons for returns.

While reported levels of HRS spending increased markedly from the start of Oregon's 2012 waiver through 2019, CCOs indicated (to varying degrees) still channeling SDOH-related spending outside of HRS. Several CCOs described funding most SDOH- and health equity-related projects through other sources (e.g., prior-year profits) rather than through current-year HRS spending. These non-HRS expenditures could be captured through SHARE reporting starting with 2020.

> ***It just hasn't made a lot of sense for us all the time to go through every single investment we're making in every single region to figure out if it fits into a health-related services rubric, because I don't think the benefit of doing that is aligned with the urgency of the work.***
>
> **- CCO representative**

Covid-19 and fires: payoffs of partnerships

The summer of 2020 put Oregon's social supports network to the test. Not only was a pandemic raging, but a series of destructive wildfires raced across the state, leaving many communities in crisis.

After the state decided to release 2020 CCO quality incentive funds early, CCOs used the structures created through earlier SDOH work to quickly channel resources to partners who could meet members' needs for emergency housing, food, and other supports. Several CCOs expanded partnerships to organizations serving communities of color that normally were hard for medical systems to reach and created websites for members to make direct requests for flexible services.

Implications

Oregon's new waiver and CCO 2.0 contract model show early success in sharpening CCO's focus on SDOH and health equity needs. CCOs' investments in HRS, while still modest overall, have increased steadily since the state's initial Section 1115 waiver. Health equity elements in the CCO 2.0 model, as well as the SHARE reinvestment initiative and other SDOH-focused contract elements, remain in development.

Development of data platforms for integrating REALD, social needs, and health services data is a key facilitator for managed care organizations' work with partners on SDOH and health equity. Whether a community information exchange or EHR, a shared platform is a prerequisite for identifying member needs and tracking delivered services. Between 2019-2020, the state made legislative and administrative changes to facilitate collection of REALD data by health systems within the state.[13,14]

Optimal data for evaluating outcomes of Oregon's new model may be hard to obtain. While the state's required HRS reporting aims to accommodate evaluation of impacts at the member level where relevant, reporting to date lacks necessary detail in many instances. Balancing this need for quality evaluation data with reporting burdens will present a challenge for states working with health plans to address SDOH.

Variations in CCOs' SDOH spending practices may offer opportunities for evaluation. Spending on HRS varied from $0.04 to $10.30 per Medicaid member per month among CCOs. Categories of services CCOs emphasized for their investments varied greatly as well. As the CCO 2.0 model continues, the potential exists to assess the impacts of more significant SDOH expenditures on both individual and community health and service utilization outcomes.

Oregon's use of HRS spending, plus the requirement to reinvest profits, offer examples to other states of ways to leverage Medicaid funding to address SDOH and health equity. Oregon's other requirements focused around health equity planning, community engagement, and SDOH-related metrics offer additional options for states to explore in their managed care contracts.

References

1 Center for Medicare & Medicaid Services. RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH) [Internet]. Baltimore (MD): CMS; 2021 Jan 7 [cited 2021 Jun 2]. Available from: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf

2 Harrod, C. S., Obley, A., George, R., & McConnell, K. J. Health disparities and social determinants of health activities in Medicaid. Portland (OR): Center for Evidence-based Policy and Center for Health Systems Effectiveness, Oregon Health & Science University; 2017. [cited 2021 Jun 8]. Available from: https://www.ohsu.edu/sites/default/files/2021-06/Health%20Disparities%20and%20SDH%20in%20Medicaid_FINAL.pdf

3 Center for Medicare & Medicaid Services. Medicaid Managed Care Enrollment and Program Characteristics, 2018 [Internet]. Baltimore (MD): CMS; 2020 [cited 2021 Jun 1]. Available from: https://www.medicaid.gov/medicaid/managed-care/downloads/2018-medicaid-managed-care-enrollment-report.pdf

4 Oregon Health Authority, Oregon Health Policy Board. CCO 2.0 Request for Applications [Internet]. Portland, (OR): OHA; 2019 [cited 2021 Jun 1]. Available from: https://www.oregon.gov/oha/OHPB/Pages/CCO2-0-RFA.aspx

5 Activities that improve health care quality, 45 C.F.R. §158.150, (2012).

6 Oregon Health Authority, Health Policy and Analytics Division. Health-Related Services Brief [Internet]. Portland (OR): OHA; 2020 Mar [cited 2021 Jun 2]. Available from: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-Health-Related-Services-Brief.pdf

7 Traditional Health Workers 410 O.R. Code § 410-180-0305 [code on the Internet]. [cited 2021 Jun 9]. Available from https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1741

8 Oregon Health Authority, Health Policy and Analytics Division. Social Determinants of Health Measurement Workgroup [Internet]. Portland (OR): OHA; 2021 [cited 2021 Jun 2]. Available from: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx

9 Oregon Health Authority, Health Policy and Analytics Division. 2020 CCO Incentive Measures [Internet]. Portland (OR): OHA; 2020 Oct 1 [cited 2021 Jun 8]. Available from: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-CCO-incentive-measures-updated-10.2020.pdf

10 Oregon Health Authority, Health Policy and Analytics Division. Updated 2020 Quality Pool Estimated Amounts by CCO [Internet]. Portland (OR): OHA; 2020 April 30 [cited 2021 Jun 8]. Available from: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-Quality-Pool-Updated-Estimates-4.30.2021.pdf

11 Oregon Health Authority. SHARE Initiative Guidance for CCOs. Oregon Health Authority [Internet]. Portland (OR): OHA; 2021 Apr 28 [cited 2021 Jun 4]. Available from: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/SHARE-Initiative-Guidance-Document.pdf

12 Community Advisory Councils 414 O.R.S. § 414.575, (2020) [statute on the Internet]. [cited 2021 Jun 2]. Available from: https://www.oregonlaws.org/ors/414.575

13 Oregon Health Authority, Office of Equity and Inclusion. REALD Rules and Policies [Internet]. Portland (OR): OHA 2021 [cited 2021 Jun 8]. Available from: https://www.oregon.gov/oha/OEI/Pages/REALD-Rules.aspx

14 Allen, P., McGee, M., Collins, J. Race, Ethnicity, Language and Disability (REALD) Data, Health Equity and CCO 2.0. Testimony presented at: Oregon House Committee on Health Care [Internet]. Salem (OR): Oregon Health Authority 2019 May 7 [cited 2021 Jun 8]. Available from: https://olis.leg.state.or.us/liz/2019r1/Downloads/CommitteeMeetingDocument/197792

CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

Cite as: Oregon leverages Medicaid to address social determinants of health and health equity. Center for Health Systems Effectiveness, Oregon Health & Science University; 2021.

Support for this brief was provided in part by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation. We thank the Oregon Health Authority for allowing evaluation data to be incorporated in this brief.

www.ohsu.edu/chse | CHSE-info@ohsu.edu | @OHSU_CHSE