

# Oregon Builds on CCO Model under 2017 Waiver Renewal

In 2017, Oregon renewed its Section 1115 Medicaid waiver with CMS to continue the goals of the Coordinated Care Organization (CCO) model. In the ensuing three years, the state made progress on promoting CCO spending on health-related services (HRS) and integrating oral health with physical health care. In contrast, progress on behavioral health integration was mixed.

**Under Oregon's 2017-2022 Medicaid waiver demonstration, the state continued with the goals of the CCO model, including a commitment to limit increases in per capita spending and advance health care access and quality.** Every five years, the state applies for a waiver – also known as an 1115 Demonstration – which allows the state to pay for and organize care differently. The 2017-2022 renewal featured a strengthened focus on integrating physical, behavioral, and oral health care while encouraging more significant investments in HRS, previously known as “flexible services,” to address social determinants of health (SDOH). The renewal also moved Medicare and Medicaid dually eligible individuals from an “opt-in” to an “opt-out” model of CCO enrollment.

**An interim evaluation of the demonstration assessed performance on behavioral health integration, oral health integration, CCO spending on HRS, and outcomes for Medicare and Medicaid dual-eligible members.** The evaluation team analyzed health care claims data from 2011 to 2019 to measure outcomes since the initiation of the CCO model under the 2012-2017 waiver and including three years (2017-2019) under the renewal. To assess CCOs' spending on HRS, the team analyzed financial reporting data and interviewed CCO representatives.

**The evaluation relied on claims data through 2019, prior to the implementation of new CCO contracts and the COVID-19 pandemic.** As such, evaluation findings reflected early successes and challenges in implementing the provisions of the waiver renewal.

Grunditz J, McConnell KJ, Daly A et al. *Evaluation of Oregon's 2017-2022 Medicaid Waiver: Interim Report*. Center for Health Systems Effectiveness, Oregon Health & Science University; 2021.

[Access to full report](#)

## KEY POINTS

- Measures of behavioral health integration indicated mixed results for the first three years of the waiver renewal. Despite progress on several initiatives, Oregon lacked a clear roadmap to guide and coordinate this work.
- Oregon saw improvements in measures of oral health integration, including increases in access to dental procedures and lower ED use for non-traumatic dental conditions.
- CCO spending on HRS increased, although HRS remained a small share of total spending on member services. CCOs were challenged by the high administrative burden associated with HRS reporting requirements.



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## What is a 111 Medicaid demonstration waiver?

Medicaid waivers are agreements between states and CMS, typically spanning five years, that give states flexibility to test new approaches to health care delivery and payment, with the goal of learning lessons to improve Medicaid.

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## Waiver Renewal Aimed to Build on Strengths of CCO Model, Address Shortcomings

### The CCO Model

The creation of CCOs under Oregon's 2012-2017 Medicaid waiver marked the beginning of a major transformation of the state's Medicaid program. Some CCOs formed from a single managed care organization (MCO), maintaining their contractual relationships with health care providers. Other CCOs formed from partnerships among MCOs, health systems, mental health organizations, dental care organizations, and county health departments. Ultimately, sixteen CCOs were approved to provide comprehensive care for Medicaid members across the state.

The CCO model has similarities to both MCOs and Medicare accountable care organizations (ACOs). However, it is unique among Medicaid delivery systems and includes a number of distinguishing characteristics:

- Local governance with representation from health care providers, Medicaid members, and other community members.
- Global budgets covering physical, behavioral, and oral health care.
- Flexibility to use funds to address SDOH.
- Payment for performance.
- Accountability for health care access and quality.
- Accountability for the growth in health care spending.

Oregon committed to implementing the CCO model to achieve two primary goals: limit increases in per capita spending and improve health care access and quality.

### The 2017 Waiver Renewal

The state's 2017-2022 waiver demonstration aimed to build on the strengths of the CCO model while addressing some of its shortcomings. The demonstration would focus on four key goals:

- 1 Strengthen the integration of behavioral, oral, and physical health care through a performance-driven system.
- 2 Encourage CCOs to address SDOH and improve health equity.
- 3 Commit to an ongoing sustainable rate of growth and adopt a payment methodology and contracting protocol for CCOs that promotes HRS investments and advances the use of value-based payment (VBP).
- 4 Increase the involvement of Medicare and Medicaid dual-eligible members in the CCO model.

Oregon used the introduction of new five-year CCO contracts, "CCO 2.0" effective 2020-2024, as a key mechanism for implementing program changes needed to achieve these goals.

### Evaluation

Oregon selected the Center for Health Systems Effectiveness (CHSE) to conduct an independent evaluation of its 2017-2022 Medicaid demonstration and deliver two reports; an interim report in 2021 and a summative report in 2023. This brief summarizes key findings from the interim report.

The interim evaluation assessed the state's performance on behavioral health integration, oral health integration, HRS spending, and outcomes for dual-eligible members. The evaluation used claims data from 2011-2019 to track performance on access, quality, and spending measures, analyzing changes since the initiation of the CCO model and including three years of experience under the renewal. To assess CCOs' spending on HRS, the evaluation relied on CCO financial reporting and interviews with CCO representatives.

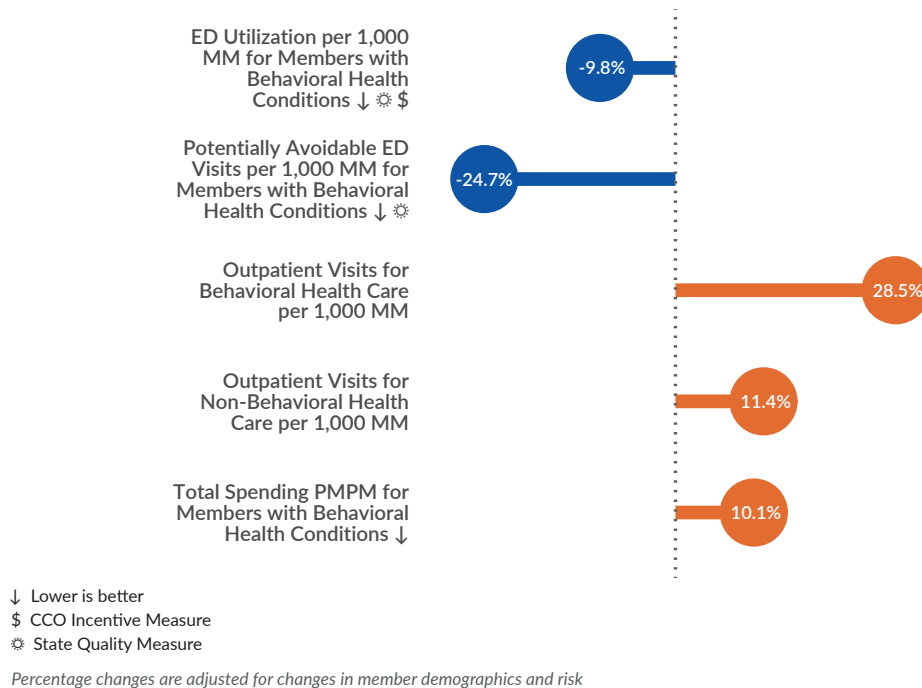
The summative evaluation will include data through 2021 to assess how CCO 2.0 and the COVID-19 pandemic impacted outcomes under the waiver renewal.

## Progress on Behavioral Health was Mixed

Some measures of behavioral health integration moved in the desired direction, whereas others worsened or did not change significantly in the first three years of the renewal. At the time of this writing, Oregon lacked a clear roadmap to guide and coordinate this work.

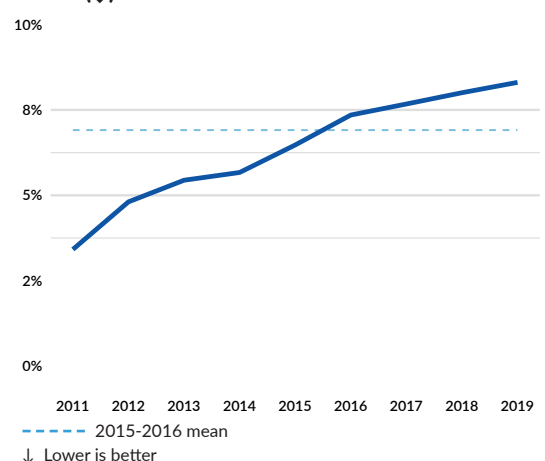
Analysis of claims data showed ED use among members with behavioral health conditions declined (Figure 1), as did the number of ED visits considered “avoidable” (preventable or treatable with appropriate primary care). Outpatient visits increased among members with behavioral health conditions, particularly for behavioral health services. Expenditures for members with behavioral health conditions increased at an annualized rate of approximately 3% between 2016 and 2019.

**Figure 1: Adjusted Percentage Change (2016-2019) in Behavioral Health Integration Measures**

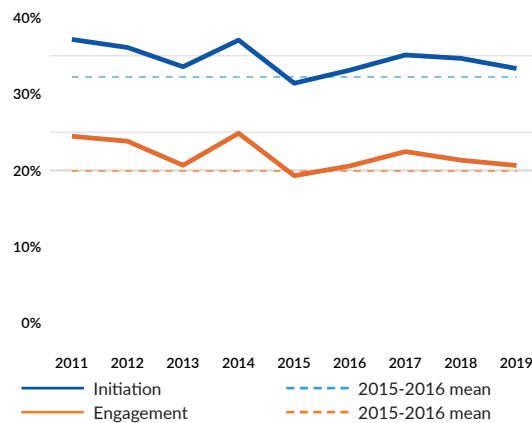


The percentage of Medicaid members diagnosed with substance use disorder (SUD) increased from 7.3% in 2016 to 8.3% in 2019 (Figure 2). The rate of initiation of alcohol or other drug treatment remained close to 33%, whereas the rate of treatment engagement hovered at 21% (Figure 3) throughout the evaluation period. Measures of care coordination and access worsened for members whose primary language was not English, relative to members with English as their primary language. For example, outpatient visits for behavioral health decreased for non-English speaking members with behavioral health conditions compared to English speaking members (Figure 4).

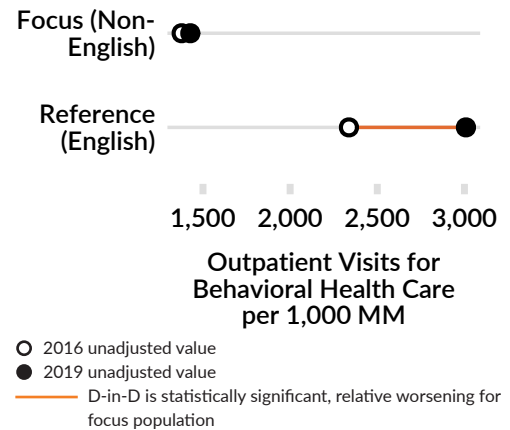
**Figure 2: Percentage of Members with SUD (↓)**



**Figure 3: Initiation and Engagement of Alcohol and other Drug Treatment**



**Figure 4: Outpatient visits for behavioral health care increased more for English speaking members compared to non-English speaking members between 2016 and 2019**

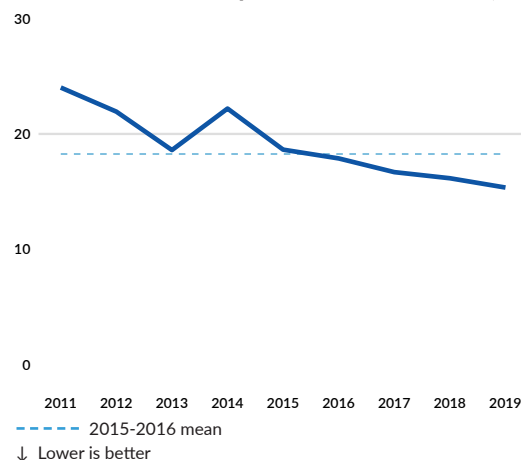


**Oral Health Integration Measures Improved**

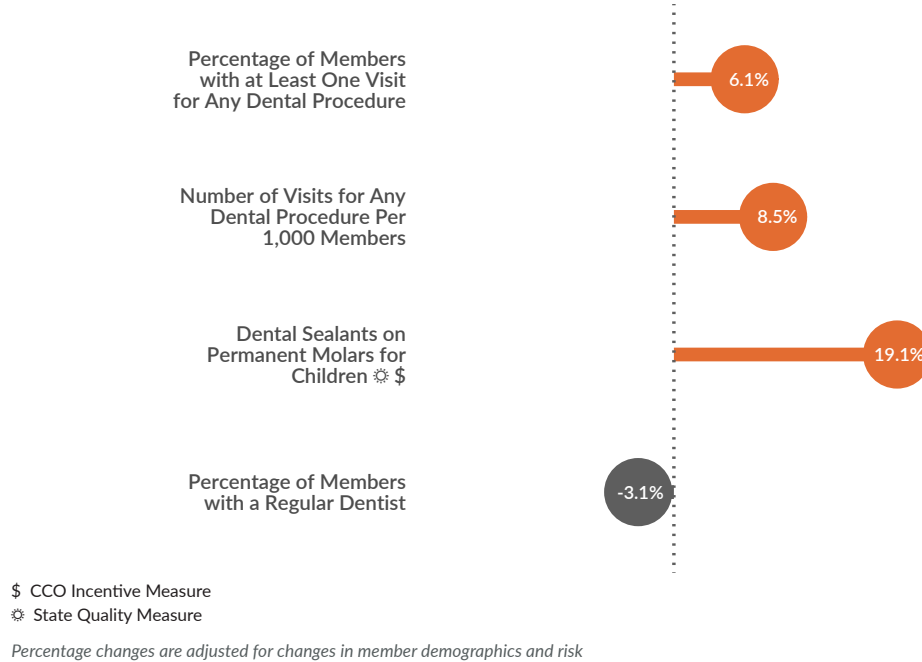
Claims-based measures of oral health integration showed favorable trends in 2016-2019. The Oregon Health Authority (OHA) worked to address access barriers associated with oral health provider shortages and member awareness of dental benefits. In 2019, OHA collaborated with staff at Patient-Centered Primary Care Homes (PCPCHs) to develop standards for oral health integration and implement pilot projects. Other efforts included increases in payment rates, expansion of teledentistry, and new CCO incentive metrics for oral health.

ED use for non-traumatic dental conditions declined by 36% between 2016 and 2019 from 17.9 to 15.3 visits per 1,000 members (Figure 5). Measures of access and utilization of dental services improved; for example, the percentage of members with at least one dental visit annually increased by 6.1% from 2016 to 2019 (Figure 6). The percentage of members with a regular dentist declined by 3.1%, but this was not statistically significant. Access improvements were greater among children than adults (Figure 7). Spending on dental services outside the ED increased between 2018 and 2019, reflecting an increase in dental provider payment rates implemented in 2018 (Figure 8).

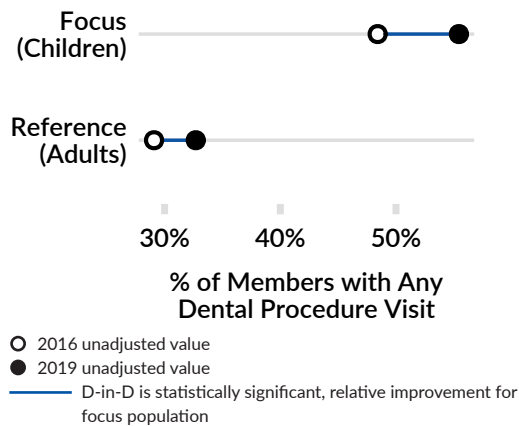
**Figure 5: ED Visits for Non-Traumatic Dental Conditions per 1,000 Members (↓)**



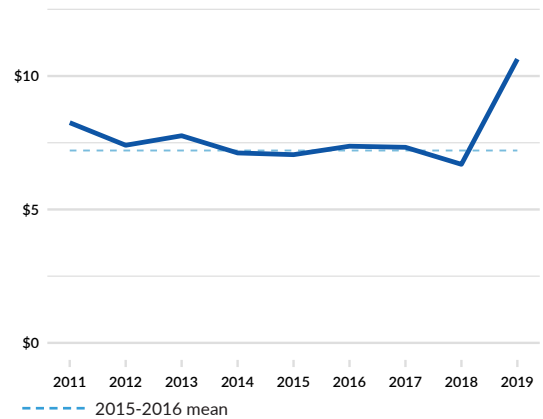
**Figure 6: Adjusted Percentage Change (2016-2019) in Oral Health Integration Measures**



**Figure 7: The percentage of members accessing dental services increased more for children than adults**



**Figure 8: Spending (\$) PMPM on Dental Services Excluding ED Visits for Dental Conditions**



### CCOs Expanded Spending on Health-Related Services, Despite Challenges

In the initial years of the waiver renewal, the state worked to support CCO spending on HRS (formerly known as “flexible services”) as the key mechanism for addressing SDOH, with a focus on housing-related services and supports. Oregon clarified that, in addition to member-level expenditures, HRS could include community-level interventions intended to improve population health, including expenditures related to health information technology (HIT). OHA issued extensive guidance and provided technical assistance to CCOs explaining the criteria for HRS spending and the treatment of HRS in the Medical Loss Ratio (MLR).

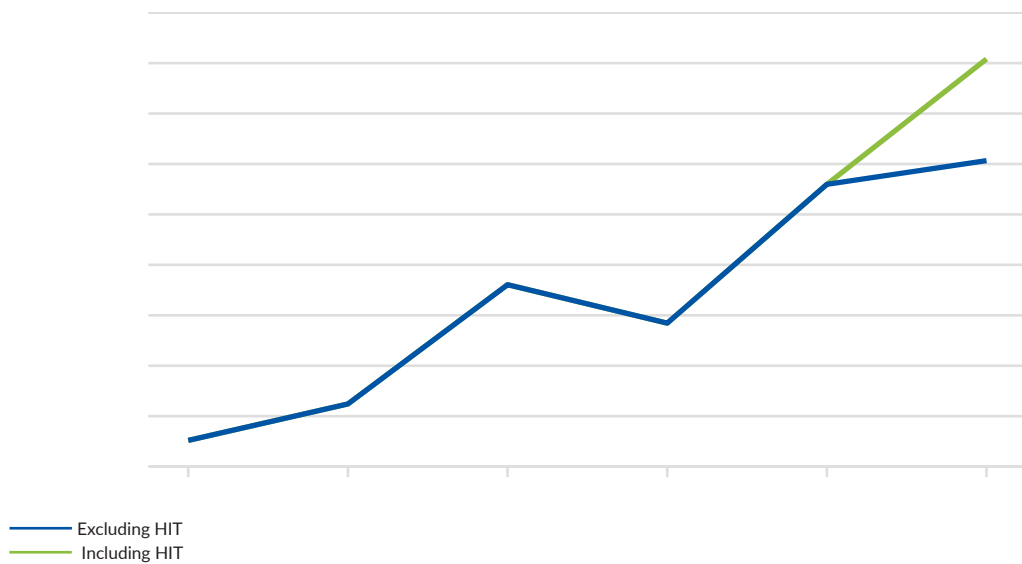
These efforts appear to have yielded results. CCO spending reported as HRS increased from \$7.2 million or \$0.66 per member per month (PMPM) in 2016 to \$16.2 million or \$1.51PMPM in 2019 (Figure 9). In interviews, CCOs indicated that much of this growth was due to increased reporting of existing community-level SDOH programs as HRS. CCOs also made deeper

connections with community-based organizations and expanded their toolkits to gather information about the best ways to deploy HRS funding. However, as of 2019, HRS remained a small share (0.36%) of total spending on member services.

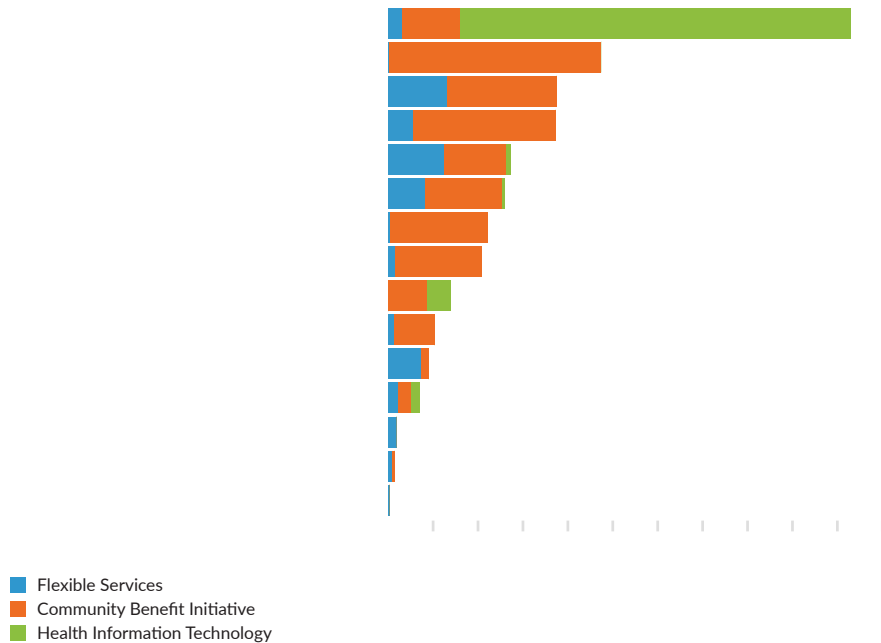
Figure 10 displays HRS spending by CCO in 2019, categorized as community benefit initiatives, flexible services, and HIT. Total HRS spending levels varied considerably across CCOs, ranging from \$0.04 to \$10 PMPM. Overall, community benefit initiatives accounted for the largest portion (57%) of CCOs' HRS spending in 2019, followed by HIT (25%) and flexible services (18%).

Despite advancements in the use of HRS, CCOs identified a number of challenges, most notably the high administrative burden associated with HRS reporting requirements. In some cases, the burden may have been large enough to deter accurate reporting or impede more expansive spending

**Figure 9: Total Health-Related Services Spending (\$ Million), 2014-2019**



**Figure 10: Types of Health-Related Services Spending (\$PMPM) by CCO, 2019**



## Implications

**Further improvement on behavioral health integration at the financial and delivery system levels will require a clear vision and strategic plan**, including milestones for progress and consideration for the needs of multiple populations, particularly communities most impacted by health inequities. Oregon is currently working to implement a range of ambitious programs that address mental health and SUD. Coordination and accountability within and outside OHA will be necessary to ensure these initiatives achieve their aims and that funds are deployed efficiently.

**Oregon is making steady progress on the integration of oral health care with physical health care.** Overall, claims- and survey-based measures suggested that access to services and the quality of oral health care have improved.

**CCOs have increased their spending on HRS**, aided by clearer guidance and technical assistance from OHA. Reporting requirements

for HRS should be further streamlined to reduce the administrative burden for CCOs, while considering the need for data to understand the impact of HRS on outcomes for the Medicaid population.

**The evaluation did not stratify analyses by race and ethnicity due to the lack of reliable data.** Like other states, health outcomes in Oregon are marked by persistent racial and ethnic disparities. As part of the state's goal of eliminating health inequities by 2030, Oregon should continue to prioritize the collection of Race, Ethnicity, Language, and Disability (REALD) data and ensure that resources are available to manage and maintain these data.

## Future Evaluation Work

The summative evaluation of the 2017-2022 waiver will include data through 2021 and assess the impacts of new CCO contract provisions implemented in 2020 and the COVID-19 pandemic. Oregon is currently developing the application for its next 1115 waiver, expected to be submitted to CMS in early 2022.

## CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

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