Senate Bill 967: Advancing Health Equity through the Oregon Health Plan

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Oregon Health Authority

OHA goal to eliminate health inequities by 2030

Health Equity Definition

- Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.
- Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
  - The equitable distribution or redistribution of resources and power; and
  - Recognizing, reconciling and rectifying historical and contemporary injustices.

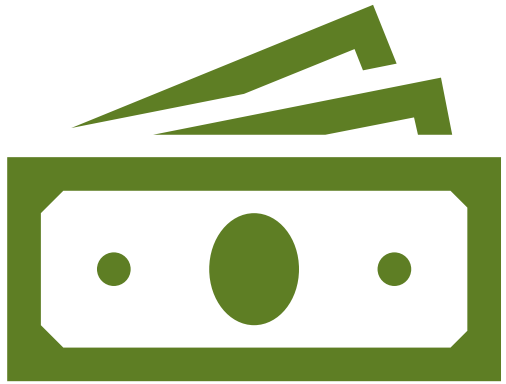
CCO Quality Incentive Program

Coordinated Care Organizations earn bonus money by providing high-quality care

Health care quality measures

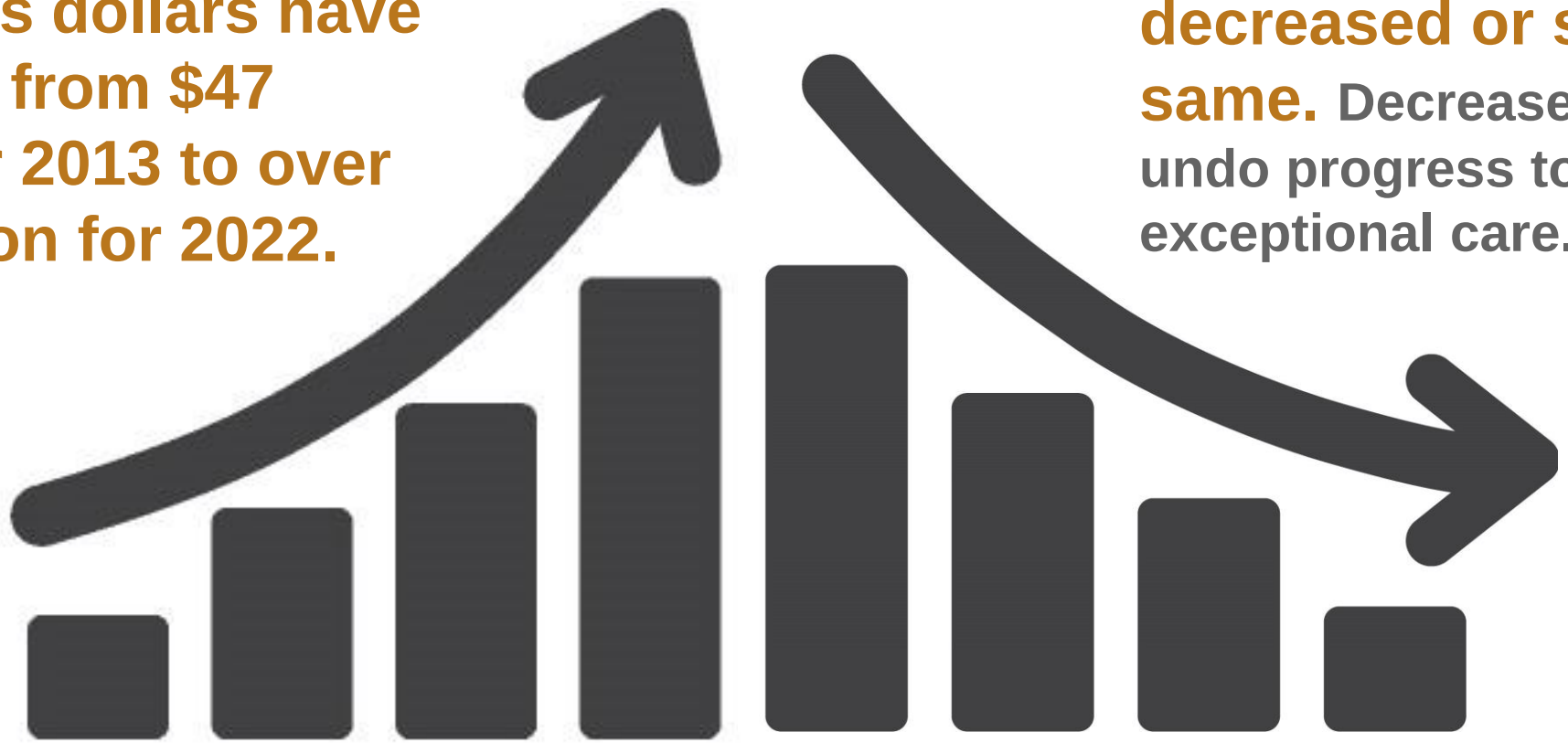
- Diabetes
- Immunizations for kids
- Dental care for kids and adults
- Well child visits
- Postpartum/post-pregnancy care
- Meaningful language access

And more…



CCO Quality Incentive Program – Current State

The bonus money that CCOs receive has increased over time. **Bonus dollars have increased from $47 million for 2013 to over $300 million for 2022.**



Between 2022 and 2023, about **one third of benchmarks decreased or stayed the same.** Decreased benchmarks undo progress toward exceptional care.

CCO Quality Incentive Program – Current State

- **To get credit for a measure, CCOs performance can vary widely.** A CCO can meet either improvement targets or benchmarks and still receive their entire QIP bonus.
- **OHA distributes all funds** allocated to the QIP each year regardless of CCO performance; no funds are held back or carried over.

Equity Impact Assessment: key findings

Populations most impacted by measures **should have a say** in what is incentivized and how measures are operationalized.

Ensure quality improvement activities are **implemented** using equity principles.

Monitoring incentive measures **by REALD categories is needed** to ensure inequities for priority populations are not masked.

Meaningful access to health care with **appropriate language services** remains a **key area** to be addressed.

Due to **data limitations**, some inequities can't be reduced by incentivizing measures—in fact, incentivizing **may cause harm**.

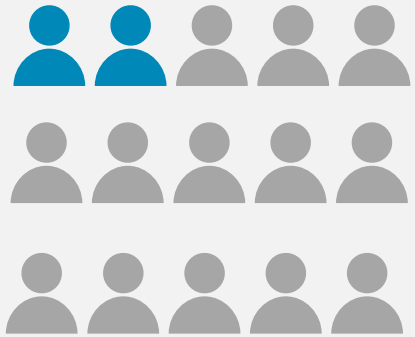
Equity Impact Assessment

SB 967: Shifting decision-making power to the people the incentive program is designed to serve

Current state

Health Plan Quality Metrics Committee

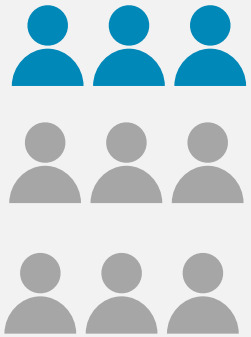
Community



Majority of members: *Health care system employees*

Metrics and Scoring Committee

"Members at large"

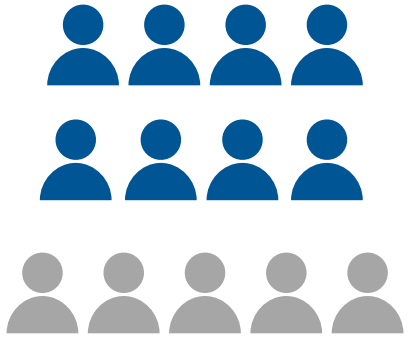


Majority of members: *Health care system employees*

Future state

Health Equity Metrics Committee

Majority community & equity experts



Remaining members: *Providers, CCOs*

What will the new HEQMC do?

- Create equity-focused measure selection criteria for CCO Quality Incentive Program.
- Gather community feedback and set priorities for CCO incentive metrics.
- Choose CCO incentive metrics and benchmarks.
- Send federal government feedback on CMS Child & Adult Core Sets.
- Identify concepts for upstream metric development (one to two additional metrics in the 2022 to 2027 waiver period).
- Provide ongoing equity lens for upstream metrics, including measure retirement.

SB 967 – Financial Flexibility

Chelsea Guest, MBI

Director of the Office of Actuarial and Financial Analytics

How do we pay Coordinated Care Organizations (CCOs)?

CCOs are paid primarily by monthly capitation rates developed prospectively

Monthly capitation rates are paid to CCOs based on their membership characteristics (i.e. age, income, etc.)

CCOs use that revenue to deliver, manage and provide **physical, behavioral, dental and transportation services** to their membership

How will non-risk payments work for Health-Related Social Needs (HRSN)?

CCOs will be responsible for contracting for services; however, they will be reimbursed at a defined rate after services are paid

Members will receive HRSN services and CCOs will pay based on the defined reimbursement allowed

OHA will reimburse CCOs based on HRSN services received and paid for based on the defined reimbursement allowed

What changes happen to CCO payments if SB 967 passes?

- **No change:** CCOs will continue to be paid primarily through capitation rates (prospectively), with a few exceptions:
    - Maternity Case Rates (i.e. kick payments)
    - Quality pool incentive payments
    - Risk settlements
    - PHE-linked non-risk payments for COVID-19 vaccinations
- **Change**: OHA will use, on a limited basis, non-risk payments and other payments to incorporate services that are not prospectively developed, such as HRSN, into CCO coverage as needed to responsibly use Medicaid and other Federal funds (i.e. DSHP). The bill also clarifies state accounting rules as it relates to withholds.


Questions?

Reference Slides

The following slides will be referenced only if needed and provide additional background on the timeline for CCO Quality Incentive Program governance structure changes

Program change timeline – high level

Measurement Year	Committee Making Decisions	Scope of Decisions
MY 2024	M&SC decides	Upstream & downstream
MY 2025	M&SC decides	Downstream (upstream held constant)
MY 2026	HEQMC	Upstream & downstream

Program change timeline – detailed