

Reinvesting Savings in Communities - Concept Paper

1115 Waiver Demonstration

Summary of Request

Oregon will request CMS approval to enter a new “shared savings” arrangement, wherein Oregon commits to a more inclusive and aggressive cap on total Medicaid spending growth, and CMS provides an upfront and ongoing investment of the projected savings to support Oregon’s health equity initiatives during the waiver period, including pilots of new “health equity zones.”

Problem and Background

Under its 1115 waivers in 2012 and 2017, Oregon committed to reducing the per member per month (PMPM) Medicaid spending growth rate by two percentage points - from a projected national average of 5.4% to 3.4%. To date, Oregon has succeeded in meeting this commitment, holding spending at or below 3.4%, and efforts to “bend the cost curve” remain a top priority for the state. Oregon has historically met this spending target through its innovative health reform model, as implemented by Coordinated Care Organizations (CCOs), which are incentivized to maintain high-quality care delivery while containing system costs in the short and long term.

Oregon has since spread this model into the commercial market, using a statewide Sustainable Health Care Cost Growth Target, which began implementation in 2021. This legislatively-mandated commitment will result in substantial savings to the federal government by slowing the rate of growth for Medicaid and Medicare Advantage health care expenditures— savings beyond Oregon’s historic commitment to a 3.4% rate of growth within Medicaid. In turn, this will lead to a marked decrease in federal funds coming into Oregon’s health system—funds which would have been used to provide innovative services and programs to the most vulnerable people living in Oregon.

In parallel, the Oregon Health Authority (OHA) has set a strategic goal of eliminating health inequities by 2030. Achieving this goal will require an immediate and significant shift in the programs and services supporting those experiencing health inequities. Social issues that cause health inequities often extend beyond the scope of the health care system, and large-scale investments can improve health and wellbeing for entire communities.

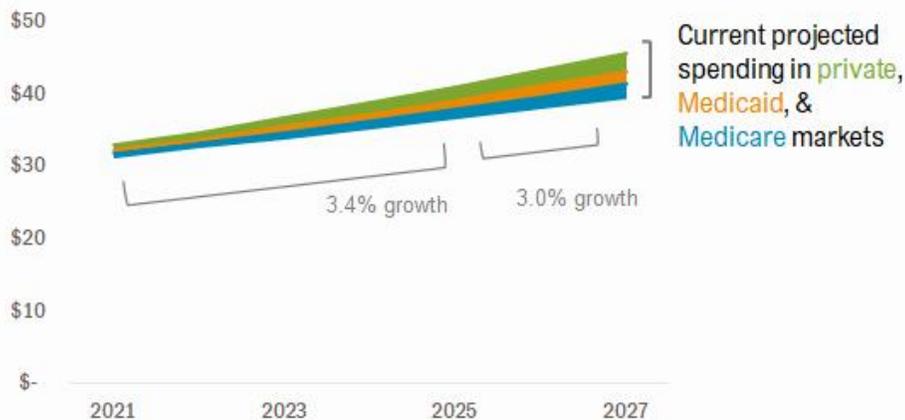
What is the Sustainable Health Care Cost Growth Target Program?

In 2019, Oregon expanded cost containment efforts beyond Medicaid to all payers, establishing the Sustainable Health Care Cost Growth Target Program, with the goal of holding all payers and large provider organizations in the state accountable to sustainable cost growth.

The Program Implementation Committee established a cost growth target to serve as a budget target for the annual per-capita rate of growth of total health care spending in the

Figure 1.

Oregon's cost growth target could save \$16 billion in state, federal and private health care costs over the next 6 years.



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Vision, Goals and Process:

Vision:

Reinvest Oregon-generated federal savings into communities to reduce health inequities.

Goals

- Reinvest savings generated through health reform toward communities to improve the social, economic and physical environment.
- Focus on large-scale investments that are targeted toward eliminating health inequities.
- Partner with community leaders to identify and operationalize strategies to eliminate health inequities

Process and Potential Strategies to Achieve Goal

The steps below outline how Oregon expects to achieve goals. This process will be achieved through a combination of waiver and non-waiver strategies.

Step 0 (in progress). Implement the Sustainable Health Care Cost Growth Target Program

The Sustainable Health Care Cost Growth Target Implementation Committee issued a report in January 2021 enumerating recommendations for implementing the program. OHA will collaborate with payer and provider organizations to implement the recommendations outlined by the committee.

Step 1. Retain the savings achieved through slowing the rate of health care cost growth for Medicaid and Medicare Advantage

OHA will work with partners and CMS to propose a methodology that accounts for savings to the federal government. Those savings will then be shared back with the state. Without such an arrangement, the statewide commitment to lower cost growth across markets, and the aggressive commitment to a lower rate of growth in Medicaid, would result in a loss of federal dollars coming to Oregon.

Total Medicaid savings over the five-year waiver period resulting from the cost growth target are estimated to be upwards of \$350 million in the Medicaid market alone; and may be doubled if Medicare Advantage is included.

Step 2. Leverage community leadership to invest those dollars in innovative models that extend across populations experiencing inequities

Health inequities can often be traced back to unequal access to power and decision-making. Communities most impacted by health inequities have been historically denied a role in deciding where and how to invest public dollars. This historic oppression and systemic racism have resulted in generations of community underinvestment. Adopting an approach wherein communities play a leadership role in reinvesting these shared savings will shift the balance of power and increase historically oppressed communities' access to resources that address the social determinants of health and equity.

Policies and Strategies:

Below is a list of potential policies and strategies.

Proposed waiver strategies

Establish a methodology for projected savings to Medicaid and Medicare Advantage Programs in Oregon and retain those savings within the state.

Oregon requests CMS approval to enter a new arrangement, wherein Oregon commits to a more inclusive and aggressive cap on total Medicaid spending growth, and CMS provides an upfront and ongoing investment of the projected savings to support Oregon's health equity initiatives during the waiver period. This will build on Oregon's original "2 percent test" (the PMPM cap on Medicaid growth) from the 2012 and 2017 waivers and align with Oregon's new statewide sustainable health care cost growth target program.

Methodology:

Oregon's proposed methodology is more inclusive in terms of which Medicaid costs will be subject to the cost growth target (see below) and more aggressive because the cost growth target decreases to 3% in 2026 and 2027. Oregon additionally requests CMS approval to enter a shared savings arrangement, in which CMS will provide a portion of realized cost savings from reduced cost growth of Medicare Advantage plans' bid price to CMS as a result of Oregon's cost growth target. The shared savings will also support Oregon's health equity initiatives.

Process:

OHA and CMS will measure Oregon's overall performance relative to the cost growth target for Medicaid across the five years of the waiver demonstration period as part of the evaluation. Oregon will have achieved the goal if, at the end of the waiver period, it has kept the compounded Medicaid cost growth at or below the target.

The Medicaid and Medicare Advantage savings models need to be further refined internally and in partnership with external subject matter experts. Additional conversations with budget and agency leaders are needed to determine the impacts of cost growth target reporting to CMS, as well as the implications and risks of the shared savings and investment options under consideration. It will be important to decide whether to include fee-for-service (Open Card) in the projected savings.

What does this mean for OHP members?

OHP members should not see any negative impacts to their care as a result of this agreement and methodology for calculating projected savings. The commitment to the cost growth target may incentivize providers and CCOs to increase services that are high-value and/or low-cost to achieve the cost growth target. The Sustainable Health Care Cost Growth Target Program is in the process of establishing a Monitoring and Oversight Framework to ensure that the quality of care remains the same or improves.

Reinvest savings by piloting new "health equity zones"

To effectively move money into historically under-resourced areas, Oregon intends to pilot a new investment approach in which the state would establish "health equity zones." These community-identified zones within defined geographic areas would leverage local partnerships to enhance community members' physical and behavioral health by working to improve outcomes at a cross section of equity and health, with an overall goal of eliminating health inequities. The process of designing health equity zones may generate a plan for a coordinated, statewide investment, or it may point to regionalized investments that tailor interventions to community needs.

Methodology and examples:

The community will design the investments and the metrics used to track success. To design their health equity zone priorities, communities may use their local Community Health Assessments and Community Health Improvement Plans to identify a comprehensive range of approaches that, woven together, will substantially improve community health. Examples could include enhancing

green space and making improvements in the built environment; increasing access to social and mental health supports; and expanding availability of affordable childcare and/or housing. Further, depending on a community's needs, they may focus interventions on a specific population, such as children. By allowing communities to invest in the range of supports they know are of highest priority, health equity zones will create community agency and resilience.

For example, addressing factors related to climate change may be a priority for some Oregon communities. Climate change--a major factor in Oregon's unprecedented 2020 wildfire season--often disproportionately affects communities of color. The Oregon wildfires of 2020 decimated communities across the state, including the communities of Talent and Phoenix, which were 90% Latinx. Increasing green space and other built-environments can ameliorate the impact of climate change. Further, the evidence linking time outdoors with better health is substantial (<https://willamettepartnership.org/wp-content/uploads/2014/06/HealthFramework-Final-Reduced.pdf>)

Community engagement:

Achieving Oregon's goal to eliminate health inequities by 2030 will require new, intentional approaches to centering community voice in decision-making. To that end, OHA will thoughtfully engage the public to identify how local communities can lead resource distribution efforts to improve the health of priority and underserved populations living in their geographic area.

The process and strategy for conducting this public engagement will be co-created in partnership with Oregon's Regional Health Equity Coalitions (RHECs) and other entities representing marginalized and historically oppressed communities, CCOs, hospitals, local public health agencies, social service organizations, other community-based organizations.

What does this mean for OHP members? OHP members could participate in, or delegate other community-based organizations and advocates, to design a process for establishing Health Equity Zones in the state. For some OHP members and other members of the public who live in those communities (yet to be determined), investments will lead to better health and wellbeing outcomes.

Regional Health Equity Coalitions (RHECs)

In July 2011, OHA established the RHEC initiative to support local, community-driven, culturally specific activities to reduce health inequities and address social determinants of health in Oregon.

Currently six RHECs reach 11 Oregon counties and the Confederated Tribes of Warm Springs. The work of the coalitions covers a wide range of underserved communities, including people of color, immigrants, refugees, migrant and seasonal farmworkers, low-income populations, individuals with disabilities, and LGBTQ communities in rural and urban areas. Communities of color are a leading priority for RHECs.

Reinvest savings in statewide equity priorities

To eliminate health inequities, social issues that extend beyond the scope of the health care system must be addressed. This requires largescale, broad investment that cannot be achieved by smaller investments at a local level. The state will conduct a public engagement process to determine the statewide equity initiatives that would benefit most from these funds.

Examples:

As a starting place, public input to date has highlighted the significant need to **enhance the health care workforce to provide culturally responsive care.**

According to a recent [OHA Health Care Workforce Needs Assessment](#), Oregon's health care workforce needs to be diversified and geographically distributed. The racial and ethnic diversity of the health care workforce does not match the diversity of the Oregon population, with Hispanic/Latinx, African American/Black, and American Indian/Alaska Native providers underrepresented in most licensed health care professions. Throughout Oregon's health care system, more diversity among both front-line workers and management is needed to support equitable programs and policies. Further, the number of health care providers varies greatly across the state, with rural/frontier areas more likely to be underserved compared to urban areas.

Community partners could assess the workforce needs of their communities--with data and other support provided by OHA, as necessary--to determine how to invest toward a culturally responsive workforce that will serve people who have not historically had access to providers who reflect their racial and ethnic backgrounds.

Some communities may have significant behavioral health needs. The [OHA Health Care Workforce Needs Assessment](#) found the distribution of licensed behavioral health providers varies widely across the state, with fewer providers per capita in rural/frontier areas, and that people of color are underrepresented among nearly all segments of the behavioral health workforce. Communities with a behavioral health workforce need may choose to focus on expanding behavioral health providers, such as psychiatrists and psychologists, who reflect the community's diversity. Increasing the availability and utilization of Peer Wellness Specialists is another possible approach to address a community's behavior health needs in a culturally supportive way. These investments would complement significant behavioral health workforce incentive dollars that may become available to Oregon communities via legislation currently under consideration.

Communities experiencing workforce needs beyond those related to behavioral health may choose to invest in strategies that increase the availability of Traditional Health Workers beyond Peer Wellness Specialists, such as peer Community Health Workers or Peer Navigators. A key approach to increasing THW supply may be to support the pipeline for those getting into the THW field through education, mentorship, and recruitment within high schools or community colleges.

What does this mean for OHP members? Investing statewide in programs or activities that improve health equity would improve the experience, quality and access to care for members. This is

especially true if there are supports for a health care workforce that is more culturally responsive. That means that members would be more easily able to find providers that look and sound like them, speak their languages, and understand their experiences.

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