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April 17, 2023

Senator Wlnsvey Campos, Co-Chair
Representative Andrea Valderrama, Co-Chair
Joint Ways and Means Human Services Sub-Committee
900 Court Street NE
State Capitol
Salem, OR 97301

Dear Co-Chairs and Committee Members:

Please find below information requested by members of the Joint Ways and Means Human Services Sub-Committee at the April 3 meeting related to Key Performance Measures (KPMs) and to new investments in the proposed OHA budget.

1. Who defines quality of life and defines premature death in the context of disabilities?

The KPMs discussed in the subcommittee meeting – *Quality of Life-Poor Physical Health* and *Quality of Life-Poor Mental Health* – are *not* related to Quality-Adjusted Life Years (QALY).

Quality of life (QOL) measures are broad constructs which aim to capture the well-being, whether of a group or individual, regarding both the positive and negative experiences of their health. For example, these frequently show up in research showing a person's reported quality of life before and after receiving a medical service. They are based on standardized surveys filled out by individuals with a particular condition about their ability to perform important life functions such as being able to work, perform household tasks and participate in social activities. If the post-treatment survey responses indicate improvement in these areas, the treatment is considered effective in improving QOL. QOL is often an important health outcome used in evaluating services, especially for people with disabilities. It can also be an important reason to cover supportive services, medical equipment and palliative services.

The two recommended KPMs will measure QOL by asking individuals to self-report the number of physically or mentally unhealthy days they have experienced in the past 30 days. These KPMs will include disparity categories, including disability, to allow for better identification of health inequities and thus inform efforts to improve the health of populations reporting worse quality of life. This would likely lead to more focus and resources for such populations. Furthermore, OHA's Equity & Inclusion Division will consult with experts in the field of disability and Quality of Life to ensure that these KPMs do not perpetuate bias by measuring quality of life based on the experiences of non-disabled people.

For comparison, Quality-Adjusted Life Year (QALY) is an econometric tool used in comparative-effectiveness research that aims to compare improvements in health across different interventions for a particular condition or population. QALYs can be calculated to compare benefits across different treatments within the same patient population, or across different populations. Potential for discriminatory impact occurs when the QALY is used to compare treatments across different populations, introducing a measurement bias that favors a return to what is considered "full health." Again, QALY are *not* a part of OHA's proposed KPMs.

2. Please explain why OHA would drop illicit drugs from KPMs with the issues Oregon is facing, but keep tobacco measures?

OHA proposes deleting three KPMS: *30 Day Alcohol Use Among 6th Graders*, *30 Day Illicit Drug Use Among 11th Graders*, and *30 Day Alcohol Use Among 11th Graders*. OHA recommends keeping KPMs on *30 Day Illicit Drug Use Among 8th Graders* and *30 Day Alcohol Use Among 8th Graders*, so substance use by youth will remain in focus.

For all these KPMs, the current rates are lower (better) than the target goal. Also, the rates are very similar to each other and do not change significantly over time. In such circumstances, having multiple KPMs measuring nearly the same thing is of limited benefit. Like the other KPMs proposed to be deleted, OHA will continue to track each measure for use by individual OHA programs.

OHA proposes to add a KPM on *Tobacco Use-Teens*, which includes use of nicotine products such as vaping devices. Cigarette smoking is the most common cause of preventable death and disease. After years of declining, overall use rates among teens increased in recent years due to introduction of e-cigarettes and other synthetic nicotine products. Most people who use tobacco and nicotine products start when they are teenagers (or sometimes younger). A critical public health goal is to prevent the initiation of use in youth, which if successful will likely lead to the individual not using these products as an adult.

There is already a KPM on *Rate Of Tobacco Use (Population)*, which measures use by adults. A key goal for adults is to promote quitting use of these products, more so than preventing initiation of use. Also, efforts to reduce tobacco and nicotine use usually employ very different messages, media, and activities for teens as compared to for adults. Therefore, there is benefit in measuring and tracking usage by teens and by adults separately.

3. Please provide information on other states that currently have programs like Healthier Oregon.

The best summary on this topic is a Kaiser Family Foundation article about Healthier Oregon-like programs, available here: https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-and-care-of-immigrants/. The most directly applicable portion is toward the end of the article, in a section titled *State Funded Coverage for Immigrants*. The key paragraph is:

A few states have also expanded fully state-funded coverage to adult immigrants. Through its longstanding locally funded Healthcare Alliance program, the District of Columbia provides health coverage to low-income residents regardless of immigration status. In January 2020, California extended state-funded Medicaid coverage to young adults ages 19-26 regardless of immigration status, and adults ages 50 and older became eligible on May 1, 2022. The state will further extend coverage to income-eligible adults ages 26 to 49, regardless of immigration status, no sooner than January 1, 2024. In December 2020, Illinois extended state-funded coverage to low-income individuals ages 65 and older who were not eligible for Medicaid due to their immigration status. As of July 2022, coverage was also extended to low-income immigrants ages 42 to 64, regardless of status, and proposed legislation would further expand this coverage to all adults ages 19 and older. In Oregon, the Cover All People Act extended state-funded coverage to all low-income adults who are not eligible due to immigration status, subject to available funding. As of July 1, 2022, coverage was available to those ages 19-25 or 55 and older. New York plans to extend state-funded Medicaid coverage to individuals ages 65 and older regardless of immigration status beginning in 2023. Some additional states cover some income-eligible adults who are not otherwise eligible due to immigration status using state-only funds, but limit coverage to specific groups, such as lawfully present immigrants who are in the five-year waiting period for Medicaid coverage, or provide more limited benefits.

4. **What is the utilization of health services by the Healthier Oregon population versus the general Oregon Health Plan population?**

   OHA recently reviewed preliminary 2022 data and found that Healthier Oregon (HOP) member utilization was substantially lower than for comparable Medicaid members. Some of this underutilization was already priced into Healthier Oregon capitation rates, but not to the extent we are seeing at this point in time.

   These 2022 data are not ready to publish. The “ramp-up” effect of Healthier Oregon members navigating new coverage and accessing new services significantly complicates data. The gap with Medicaid spending is expected to close over time. Furthermore, the preliminary data are not complete due to lag time in medical billing.

   Likewise, the Cover All Kids population has had a history of lower utilization, ranging from approximately 60% to 85% of levels expected for Medicaid children. While there could be underlying differences in health between populations, much of the difference may be due to barriers to care, including challenges accessing culturally and linguistically appropriate care. For example, dental and primary care spending for Cover All Kids/Healthier Oregon children tend to be close to Medicaid levels, but specialist and behavioral health care spending tend to be markedly lower. In light of this experience and other benchmarks, OHA reflected an 85% of Medicaid utilization factor in many components of Healthier Oregon adult capitation rates.

Because Healthier Oregon underutilization relative to Medicaid is likely to be significantly driven by health inequities (as opposed to better health status), OHA has been cautious about further reducing capitation rates. OHA continues to review HOP utilization, in order to discern and remediate its causes, but that will be a multi-year effort.

To ensure that OHA is not overpaying CCOs, risk corridors are established that reconcile CCOs' HOP expenditures against HOP revenues and apply a settlement that recovers most of the impact of underutilization. We anticipate significant recoveries for CY22, and that may continue into CY23.

5. Are all Healthier Oregon members in CCOs or are there any Fee-For-Service?

When Healthier Oregon expansion occurred on July 1, 2022, age-eligible individuals who were enrolled in CWM automatically moved to full OHP, and the vast majority of them were enrolled in a CCO. Similar to other OHP members, most Healthier Oregon members are enrolled in CCOs. OHA worked closely with CMS to enable Oregon to integrate Healthier Oregon into managed care, while continuing to claim federal match. We are the first state in the country to successfully do so.

As of April 3, 2023, there are about 25,000 people in the Healthier Oregon population, and roughly 4% of those are on Fee-For-Service (FFS), or about 1,000. The precise number varies whenever someone is enrolled or unenrolled. Since this data comes from a point-in-time report, FFS numbers may include those in the process of transitioning to a CCO.

Included with this letter are:

- Slides with additional information on the KPMs OHA proposes to add
- The most recent KPM Annual Performance Progress Report, from September 2022
- A briefing paper on how OHA collects and uses disability data in the context of REALD

We also received a question about the regulatory history of Trillium Family Services. This information is taking longer to compile. I will send it as soon as possible.

Please do not hesitate to reach out if you have any further questions or clarifications.

Sincerely,

Dave Baden
Interim Director