

# Oregon's Health System Transformation

 2014 Mid-Year Report

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# METRIC QUICK GUIDE



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# EXECUTIVE SUMMARY

## Incentives for better services

This report lays out the progress of Oregon's coordinated care organizations (CCOs) on quality measures from July 1, 2013 through June 30, 2014. This is the fifth such report since coordinated care organizations were launched in 2012. It is also the first report to include data on some key measures for the more than 380,000 additional Oregonians who have enrolled in the Oregon Health Plan since the Affordable Care Act (ACA) took effect January 1, 2014. The Oregon Health Plan (OHP) is now open to more adults as allowed under the Affordable Care Act. Today, approximately 990,000, Oregonians are enrolled in the Oregon Health Plan.

The coordinated care model is progressing beyond the first year and continues to show improvements in a number of areas of care such as reductions in emergency department visits; and increases in developmental screening, follow-up after hospitalization for mental illness, and hospital readmissions -- even with the significant addition of new Oregon Health Plan members. These areas of care represent positive changes toward better care coordination and integration of services. Additionally, new and existing members continue to be connected with health care teams that are part of patient centered primary care homes (PCPCHs).

The coordinated care model continues to show large improvements in the following areas for the state's Oregon Health Plan members:

**Decreased emergency department visits.** Emergency department visits by people served by CCOs have decreased 21 percent since 2011 baseline data.

**Decreased hospital admissions for short-term complications from diabetes.** The rate of adult patients (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease dropped by 9.3 percent since 2011 baseline data.

**Decreased rate of hospital admissions for chronic obstructive pulmonary disease.** The rate of adult patients (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma decreased by 48 percent since 2011 baseline data.

**Patient-centered Primary Care Home (PCPCH) enrollment continues to increase.** Coordinated care organizations continue to increase the proportion of members enrolled in a patient-centered primary care homes -- indicating continued momentum even with the new members added since January 1. PCPCH enrollment has increased 55 percent since 2011. Additionally, primary care costs continue to increase, which means more health care services are happening within primary care rather than other settings such as emergency departments.

# EXECUTIVE SUMMARY

We're also continuing to see improvement in the Screening, Brief Intervention, and Referral to Treatment measure, also referred to as "SBIRT." This measures the percentage of adult patients (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse. One coordinated care organization has -- for the first time -- exceeded the benchmark, and another is close to achieving it. While there is still much progress to be made, the data point to progress across all CCOs. Initiation of alcohol and drug treatment has also increased. However, engagement of treatment has room to improve.

For the first time, core metrics are reported. The core performance metrics are a third set of metrics included in Oregon's 1115 demonstration waiver. OHA reports these measures to CMS (Center for Medicare and Medicaid Services) each year. There are no financial incentives or penalties associated with them. The core performance measures have more focus on population health, including the prevalence of obesity and tobacco use among Oregon Health Plan members. Both of these metrics show areas where improvements can be made.

With the significant increase in new Oregon Health Plan members through the Affordable Care Act, this report also includes a special section on these new enrollees. This section highlights emergency department usage of those newly enrolled through the Affordable Care Act compared to those who were enrolled in the Oregon Health Plan prior to January 1, 2014, and compared to those who had been enrolled in the Oregon Health Plan in recent years. Statewide, newly enrolled ACA members use emergency rooms less frequently than other members. Newly enrolled Affordable Care Act members also have fewer avoidable emergency room visits than other members.

Additionally, financial data indicates coordinated care organizations are continuing to hold down costs. Oregon is staying within the budget that meets its commitment to the Centers for Medicare and Medicaid Services to reduce the growth in spending by two percentage points per member, per year.

Oregon is continuing its efforts to transform the health delivery system. By measuring our progress, sharing it publicly and learning from our successes and challenges, we can see clearly where we started, where we are, and where we need to go next.

# UPDATES TO THIS REPORT

OHA has made a number of updates to this report to improve data presentation and provide information on several new measures that have not been included in previous reports

## **New Measures**

This performance report is the to include the core performance measures, a third set of metrics included in Oregon's 1115 demonstration waiver. Core performance measures included in this report are:

- Ambulatory care: avoidable emergency department utilization
- Health status
- Initiation and engagement of alcohol or other drug treatment (initiation and engagement rates)
- Low birth weight
- Obesity prevalence
- Tobacco use prevalence

OHA has also included previously unreported calendar year 2013 data by race and ethnicity for the Medical Assistance with Smoking Cessation measure

## **New Section**

With the Affordable Care Act (ACA) coverage expansion, an increasing number of Oregonians receive public health insurance through the Oregon Health Plan (Medicaid). This increase in enrollment changed the demographic composition of the Medicaid population in Oregon. A new section of the report (pp 73-80) highlights changes in demographics and use of some services such as Emergency Department visits specific to OHP members in 2014.

## **Reporting Period**

This report lays out the progress of Oregon's CCOs between July 1, 2013 through June 2013, 2014. New data included in this report reflects a full 12-month measurement period and is directly comparable to calendar years 2011 and 2013. Future reports will continue to include a full twelve months of data.

# UPDATES TO THIS REPORT

## Data Layout: Icons

To help readers identify which metrics belong in which measure set, each metric is accompanied by up to three icons that denote the measure set:



This icon indicates the measure is one of the 17 CCO incentive metrics. CCOs receive quality pool funding based on their performance on these measures.



This icon indicates the measure is one of the 33 state performance metrics (also known as quality and access metrics). OHA is accountable to CMS for statewide performance on these metrics.



This icon indicates the measure is one of the core performance metrics. There are no financial incentives or penalties for performance on these measures.

## Data Layout: Cost and Utilization

This report includes new charts to display cost and utilization data. See pages 81-86.

Icon(s) indicate which measure set(s) the measure is part of. See page viii for icon legend.

# \$ MEASURE TITLE

## Measure title

### Measure description:

Brief description of the measure.

### Purpose:

Brief summary of the importance of the measure.

### July 2013 - June 2014 data

(n=xx,xxx)

Summary of most recent data compared to 2013 performance and the benchmark;

Overall comments on statewide and CCO performance.

Data source, benchmark source, and additional information.

## Statewide, [description]

Data source:  
Benchmark source:

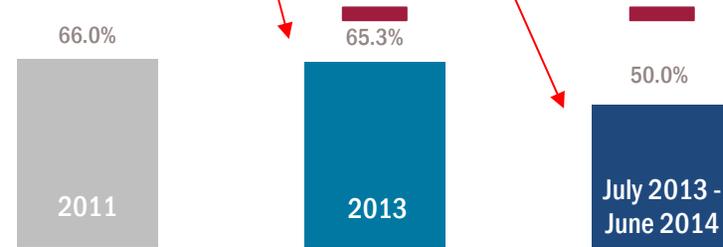
2011 baseline year in grey

2013 year in lighter shade.

Most recent rolling twelve month data in darker shade.

Statewide benchmark bar for each year.

2014 Benchmark: 82.0%

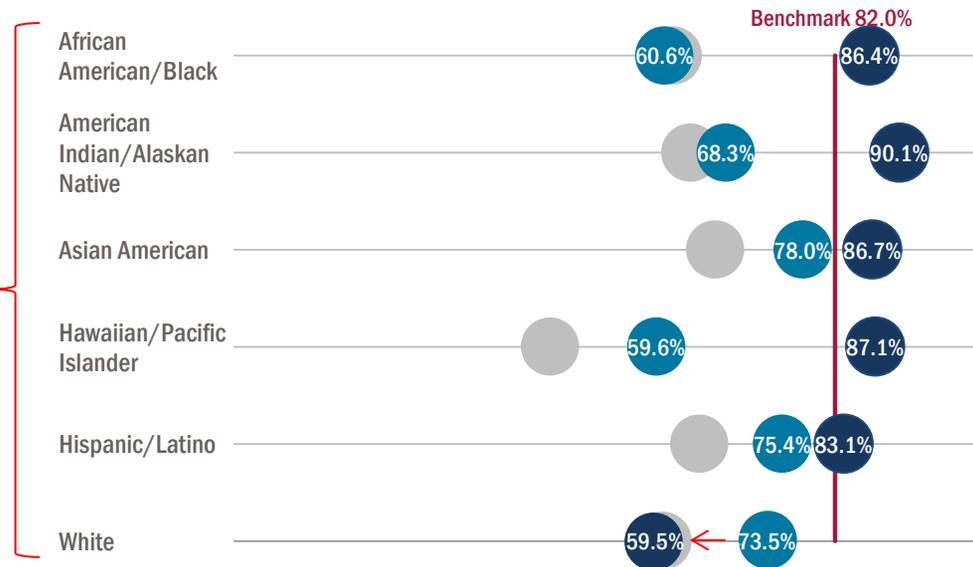


## [Brief description of what happened] between 2013 & June 2014.

Gray dots represent 2011. Data missing for x.x% of respondents. Each race category excludes Hispanic/Latino.

Percent of respondents with missing race/ethnicity data; additional information.

Categories are sorted by amount of change between 2013 - mid 2014. That is, the racial or ethnic groups with the most improvement in June 2014 are listed first.



Arrows highlight negative change (away from the benchmark).



# ADOLESCENT WELL-CARE VISITS

## Adolescent Well-Care Visits

**Measure description:** Percentage of adolescents and young adults (ages 12-21) who had at least one well-care visit.

**Purpose:** Youth who can easily access preventive health services are more likely to be healthy and able to reach milestones such as high school graduation and entry into the work force, higher education or military service.

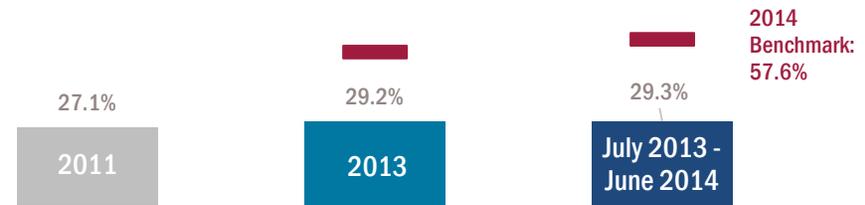
### July 2013 - June 2014 data (n=109,652)

Performance on the adolescent well care visits is holding steady at 29.3 percent with gains observed among Hawaiians/Pacific Islanders, American Indian/Alaska natives and whites. In 2013, 29.2 percent of adolescents ages 12-21 received a qualifying well-care visit compared to 27.1 percent in 2011.

Half of CCOs (8) are making progress over their 2013 levels even with new OHP members enrolled through ACA included in the measure. The mid-year denominator has increased by 13,000 members (a 13 percent increase) from the 2013 progress report. While we are making progress in this measure, we still have improvement to be made to reach the benchmark of 53.2 percent

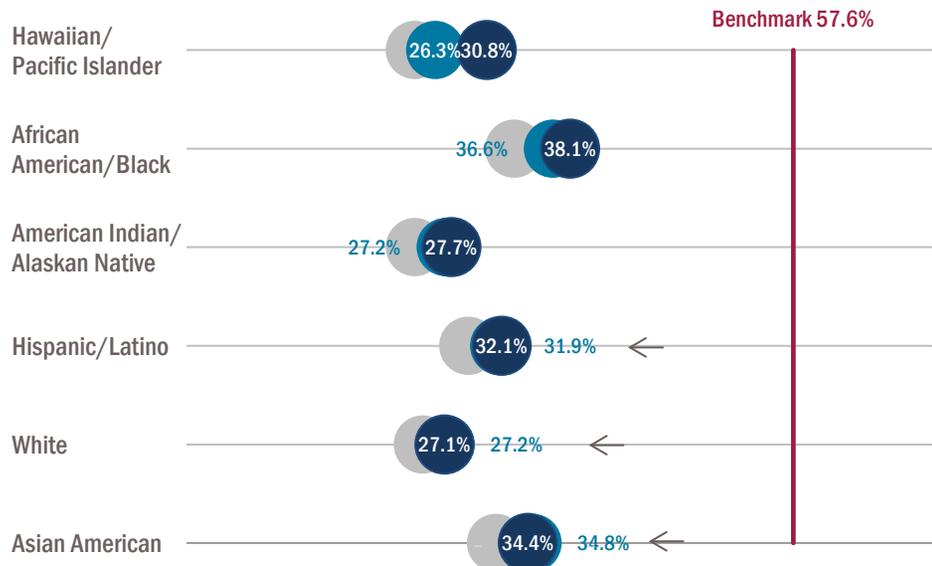
Statewide, adolescent well-care visits have remained fairly steady.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 National Medicaid 75th percentile (administrative data only)



## Improvement in adolescent well care visits was mixed across racial/ethnic groups between 2013 & June 2014.

Gray dots represent 2011. Data missing for 7.0% of respondents. Each race category excludes Hispanic/Latino.



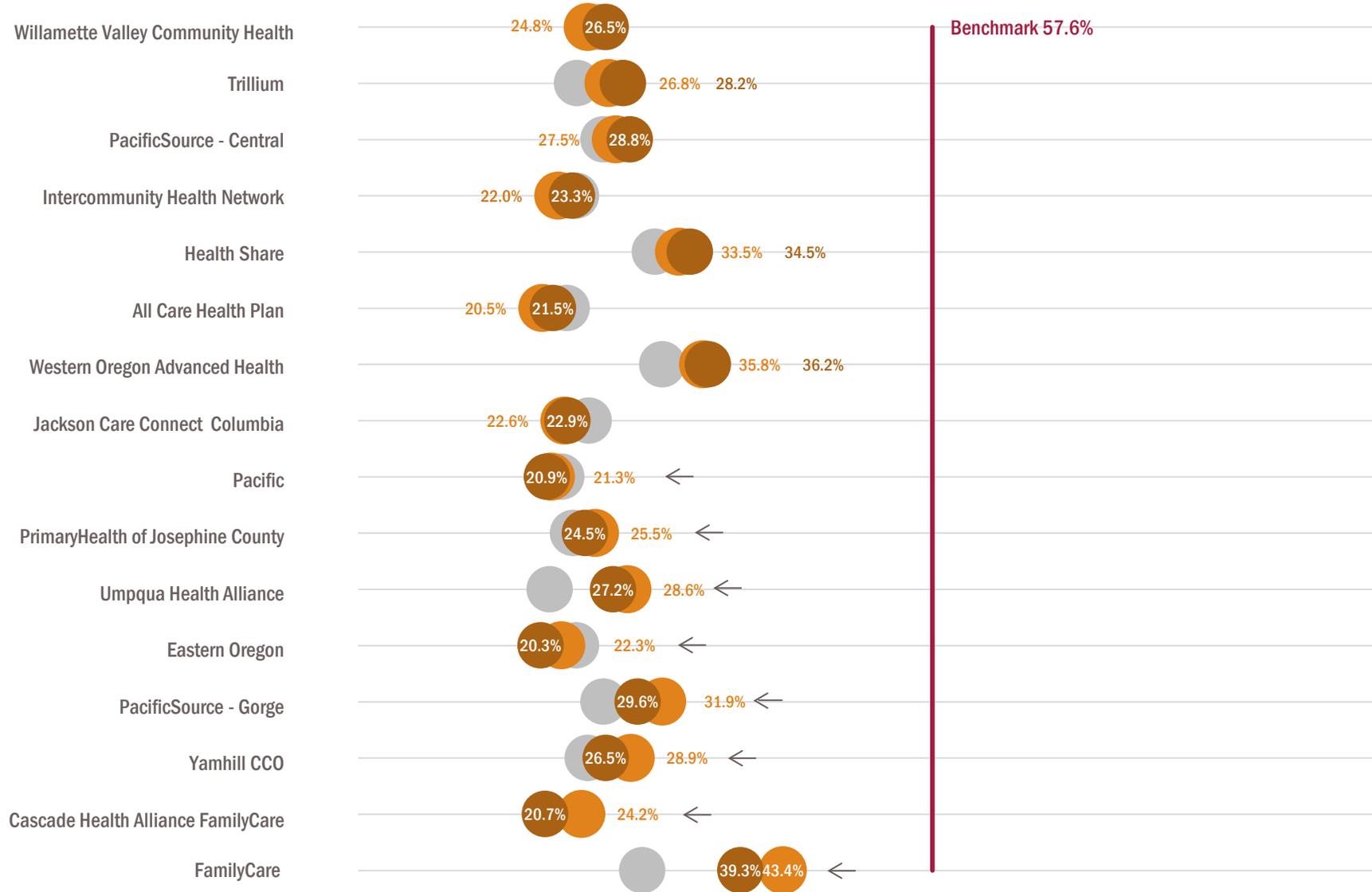


# ADOLESCENT WELL-CARE VISITS

## Changes in adolescent well-care visits were small between 2013 & June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.





# SCREENING FOR ALCOHOL OR OTHER SUBSTANCE MISUSE (SBIRT)

## Screenings for alcohol or other substance misuse (SBIRT)

**Measure description:** The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of adult patients (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse.

**Purpose:** By offering a simple but effective screening for alcohol or drug abuse during an office visit, providers can help patients get the care and information they need to stay healthy. If risky drinking or drug use is detected, a brief intervention, and in some cases referral, helps the patient recover more quickly and avoid serious health problems.

### June 2013 - July 2014 data (n=309,902)

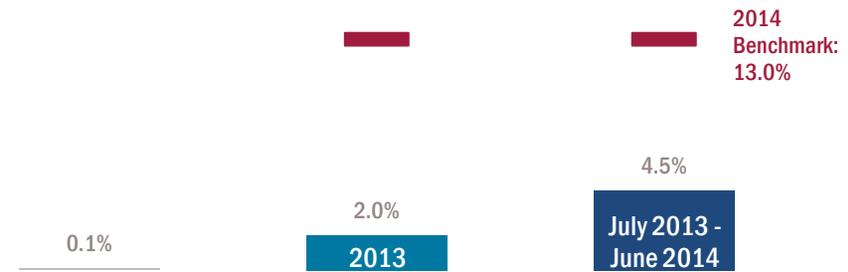
Performance on screening for alcohol or other substance misuse (SBIRT) is steadily improving. Screening has improved among all racial and ethnic groups as well as all 16 CCOs between 2013 and June 2014. Providers are continuing to learn more about this measure and how to include screening in their daily practice and billing processes. The metric more than doubled between 2013 and June 2014 (2.0 percent to 4.5 percent), a marked increase but with much improvement still possible.

Since SBIRT is based on the number of members receiving an outpatient service; the new ACA population is included in the measure. The mid-year denominator has increased by 100,000 (55 percent increase) compared to 2013, but due to continued quality improvement initiatives and coding, SBIRT screening is higher in 2014.

## Statewide, appropriate screening and intervention for alcohol or substance abuse has increased steadily each year.

Data source: Administrative (billing) claims

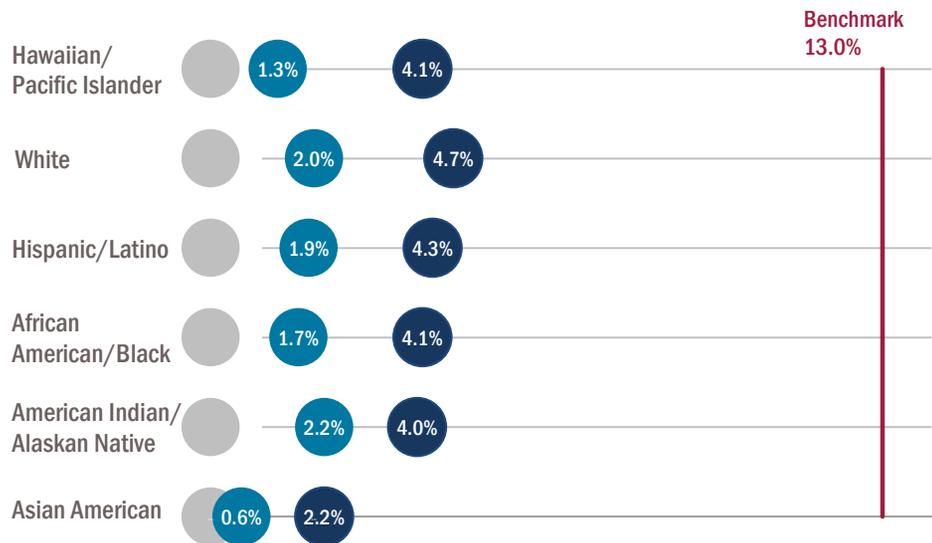
2014 benchmark source: Metrics and Scoring Committee consensus



## SBIRT rates improved for all racial/ethnic groups between 2013 & June 2014.

Gray dots represent 2011.

Data missing for 8.5% of respondents. Each race category excludes Hispanic/Latino.

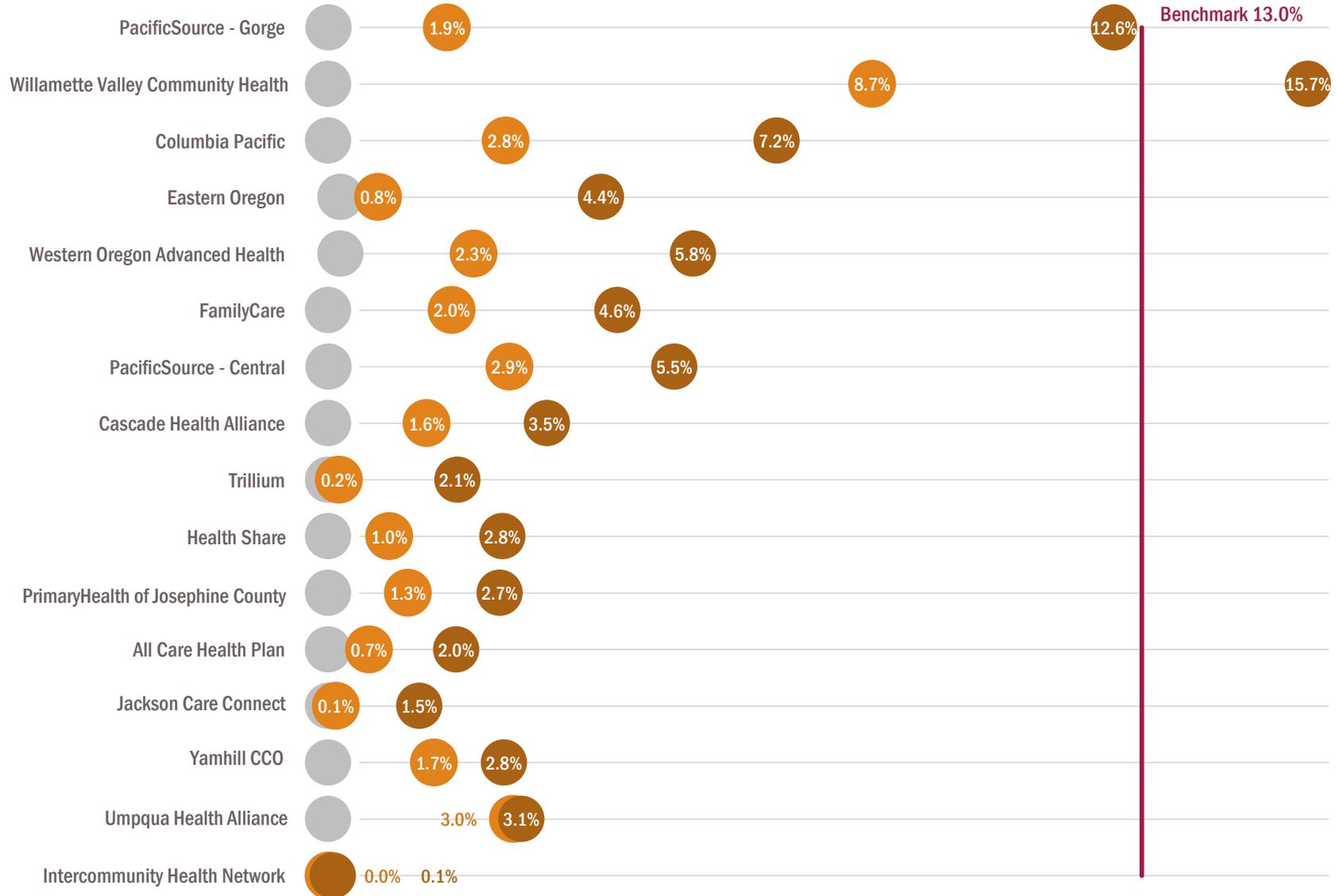




# SCREENING FOR ALCOHOL OR OTHER SUBSTANCE MISUSE (SBIRT)

## CCOs continued to improve SBIRT between 2013 & June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.  
 Baseline data for PacificSource Central and Gorge are combined.





# ALL-CAUSE READMISSION

## All-cause readmission

**Measure description:** Percentage of adult patients (ages 18 and older) who had a hospital stay and were readmitted for any reason within 30 days of discharge. A lower score for this measure is better.

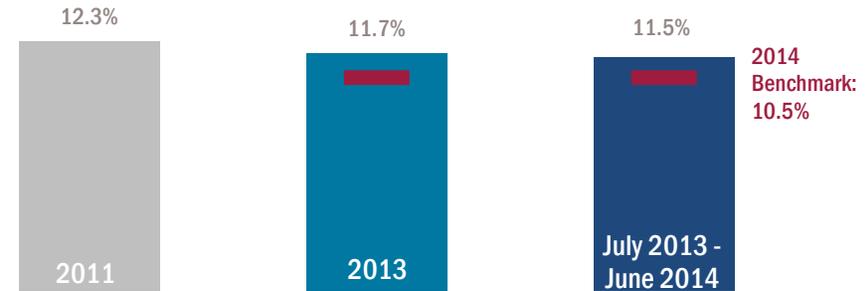
**Purpose:** Some patients who leave the hospital end up being admitted again shortly thereafter. Often times, these costly and burdensome "readmissions" are avoidable. Reducing the preventable problems that send patients back to the hospital is the best way to keep patients at home and healthy.

### July 2013 - June 2014 data (n=25,028)

Hospital readmissions continue to fall (lower is better). The percentage of adults who had a hospital stay and were readmitted for any reason within 30 days of discharge dropped from a 2011 baseline of 12.3 percent to 11.5 percent by June 2014, a reduction of 6.5 percent. This is encouraging since this mid-year report shows an increase of 26 percent in the denominator and the rate continues to improve.

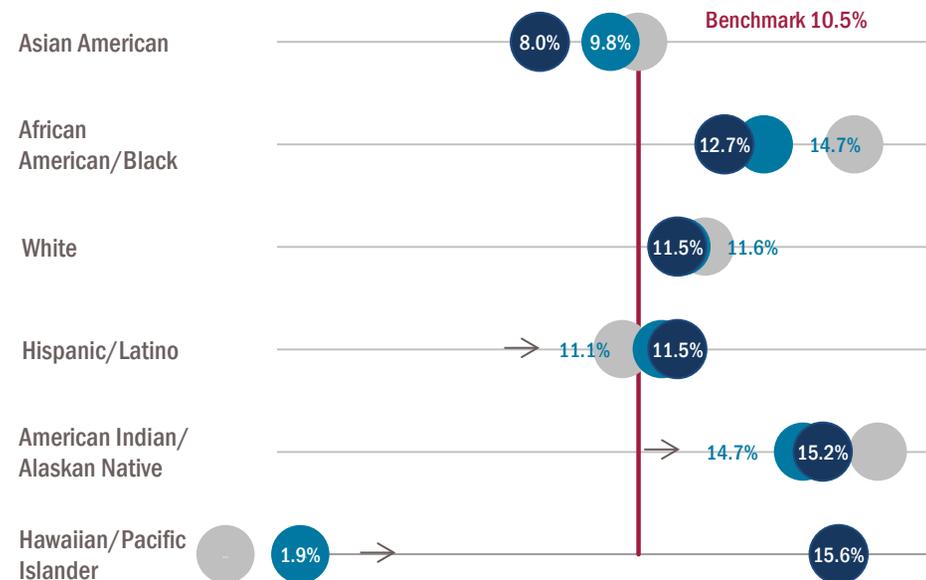
Statewide, hospital readmissions declined slightly, but still have not met the benchmark.

(Lower scores are better)  
Data source: Administrative (billing) claims



Asian American members are the only group to have met the benchmark in both 2013 & June 2014.

(Lower scores are better)  
Gray dots represent 2011.  
Data missing for 4.7% of respondents. Each race category excludes Hispanic/Latino.



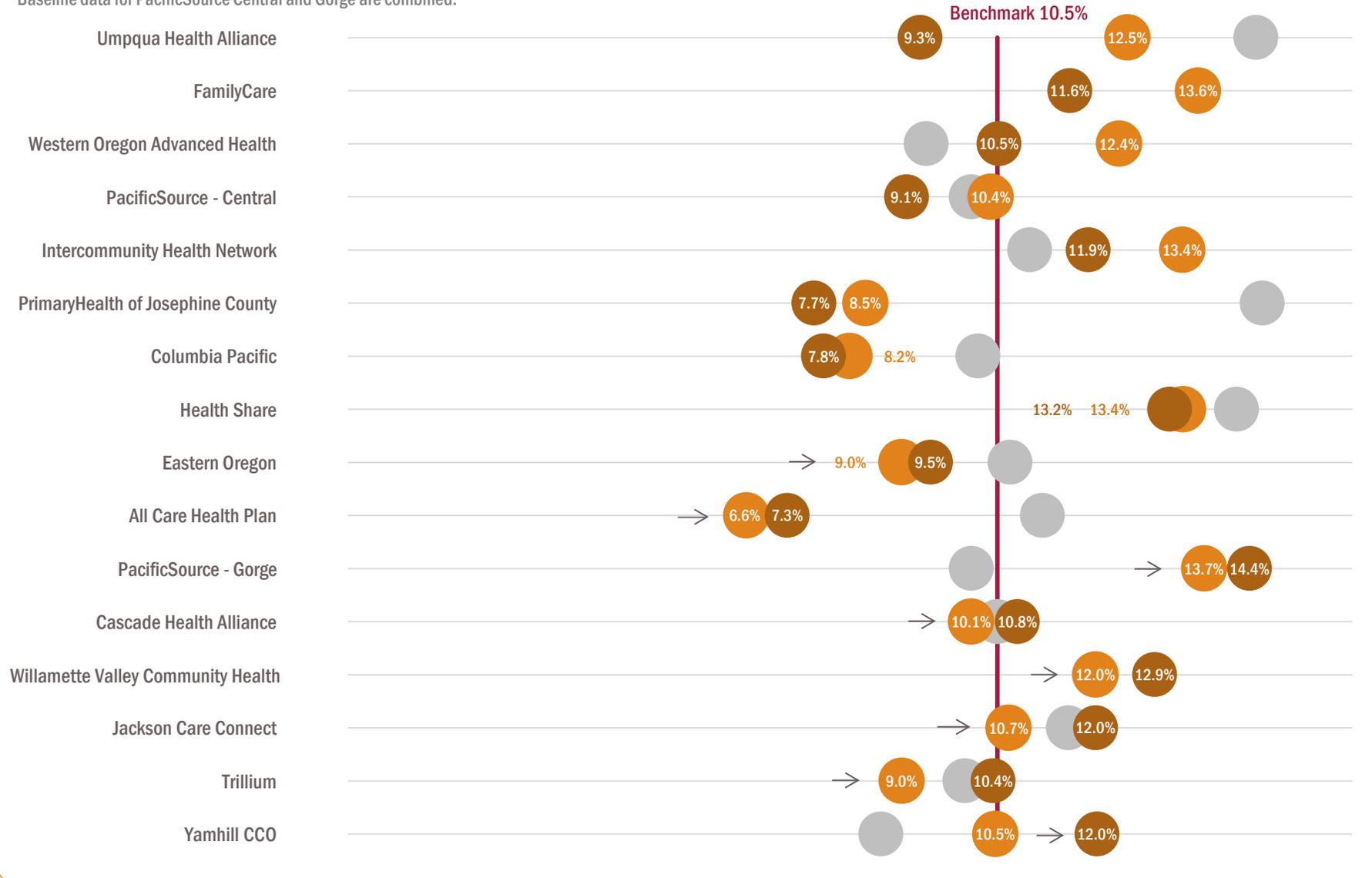
# ALL-CAUSE READMISSION

## Readmission was mixed among CCOs between 2013 & June 2014.

(Lower scores are better)

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.





# AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

## Avoidable emergency department utilization

**Measure description:** Rate of patient visits to an emergency department for conditions that could have been more appropriately managed by or referred to a primary care provider in an office or clinic setting. Rates are derived from the ambulatory care: emergency department utilization measure and are reported per 1,000 member months. A lower number suggests more appropriate emergency department utilization.

**Purpose:** Many patients use emergency departments for conditions that could be treated, or prevented, in a different care setting. Reducing avoidable emergency department utilization is an opportunity to improve care coordination, address high utilization, and explore innovative programs like health navigators.

### July 2013 - June 2014 data

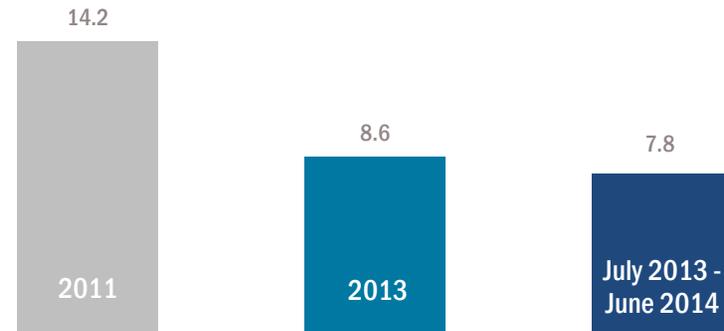
(n= 7,808,536)

This is the first time avoidable Emergency Department visits have been included in a progress report. Avoidable emergency department visits have declined markedly between 2011 and June 2014 with an almost 50 percent reduction. Despite an influx of 20 percent new enrollment from ACA expansion, new members are not using the emergency department for conditions that could be treated by a primary care office at high rates (see pages 73-74 for more information about avoidable emergency department visits and Medicaid membership).

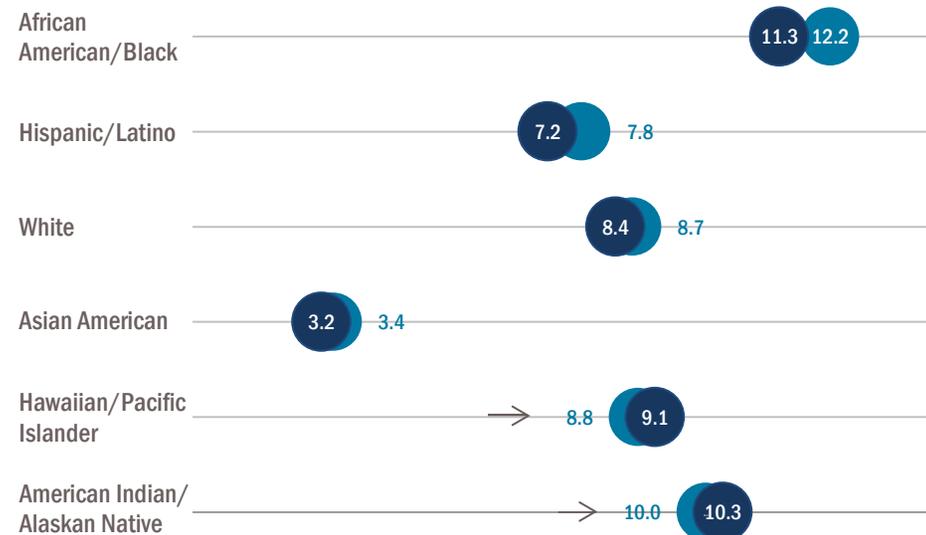
## Statewide, avoidable emergency department utilization continues to decline.

(Lower scores are better)

Data source: Administrative (billing) claims



## African Americans experienced the greatest improvement in avoidable emergency department utilization between 2013 & June 2014.





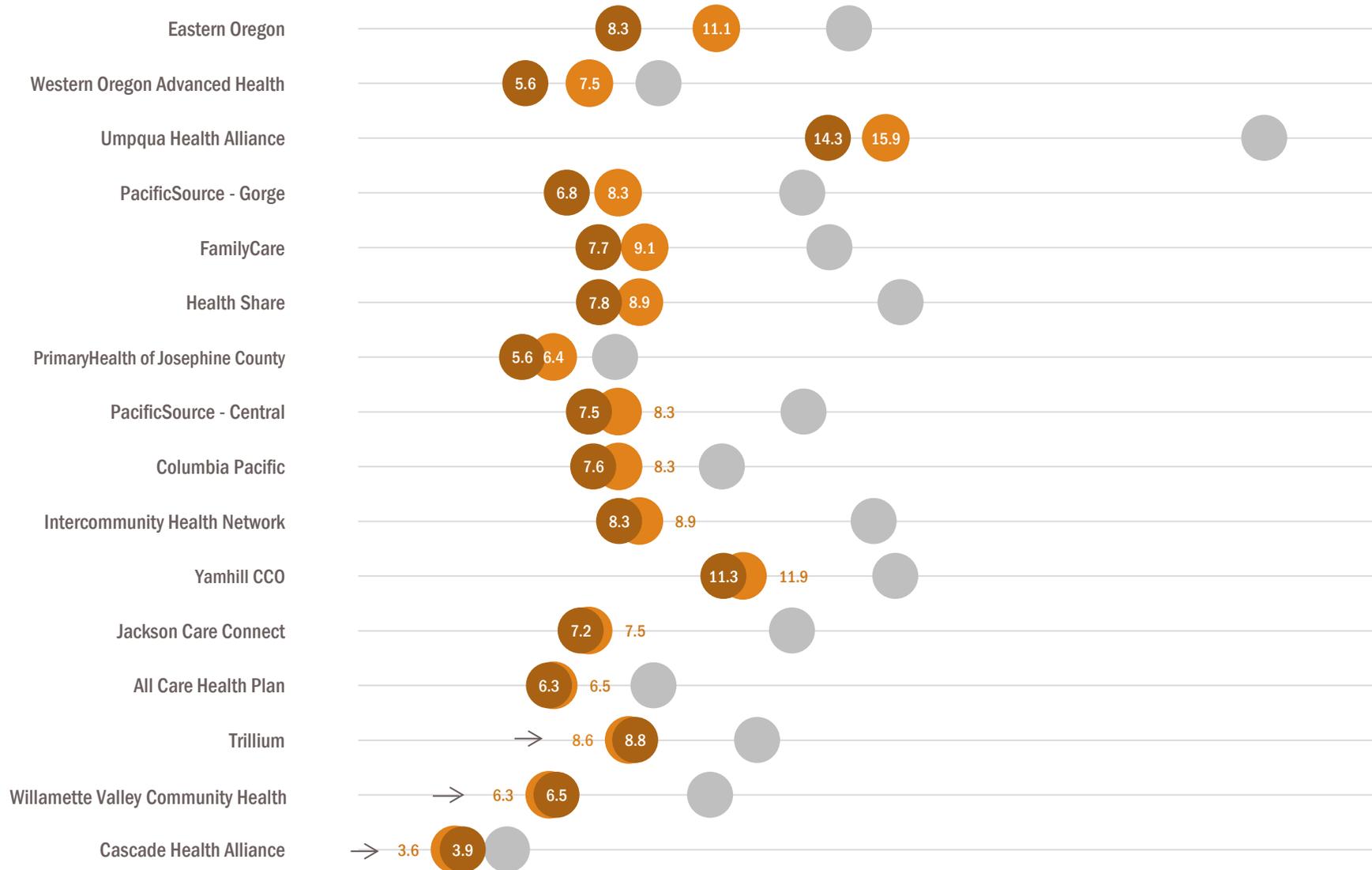
# AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Twelve out of 15 CCOs reduced avoidable emergency department utilization between 2013 & June 2014.

(Lower scores are better)

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.





# AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

## Ambulatory care: emergency department utilization

**Measure description:** Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of this care.

**Purpose:** Emergency departments are sometimes used for problems that could have been treated at a doctor's office or urgent care clinic. Reducing inappropriate emergency department use can help to save costs and improve the health care experience for patients.

### July 2013 - June 2014 data (n=7,808,526 member months)

Emergency department visits by people served by CCOs have continued to decrease since 2011 baseline. Emergency department visits have decreased 21 percent between baseline and June 2014. Financial data (pages 85-86) is consistent in showing reduced emergency department costs.

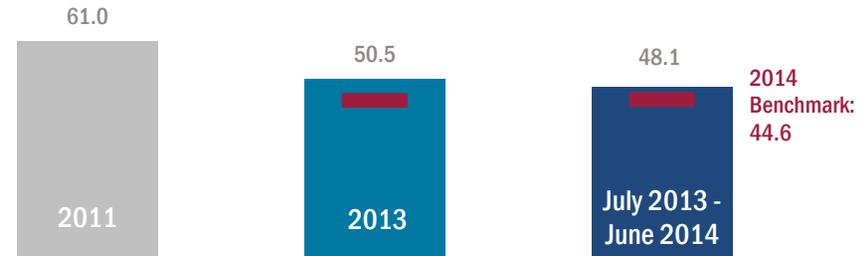
The continued reduction in emergency department visits is exciting news. Despite an influx of 20 percent new enrollment from ACA expansion, new members are not using the emergency department at high rates (see pages 75-76 for more information about emergency department visits and Medicaid membership). Twelve CCOs observed lower emergency department visit rates between 2013 and June 2014 and three of those who increased are below the benchmark. However, emergency department visit rates have not decreased among all racial ethnic groups.

## Statewide, emergency department utilization has continued to decline.

(Lower scores are better)

Data source: Administrative (billing) claims

2014 benchmark source: 2013 National Medicaid 90th percentile

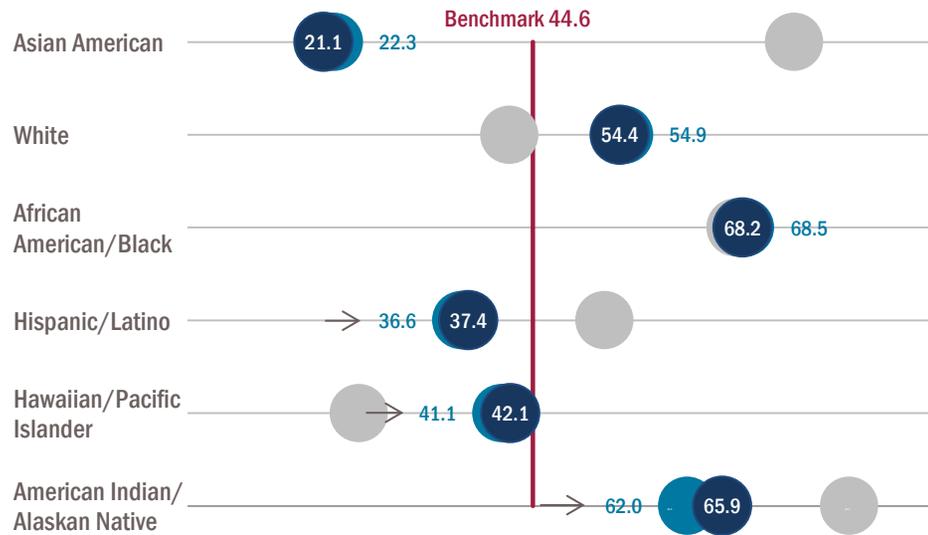


## Asian Americans used the emergency department least frequently in June 2014 and experienced the greatest improvement since 2013.

(Lower scores are better)

Gray dots represent 2011.

Data missing for 8.9% of respondents. Each race category excludes Hispanic/Latino





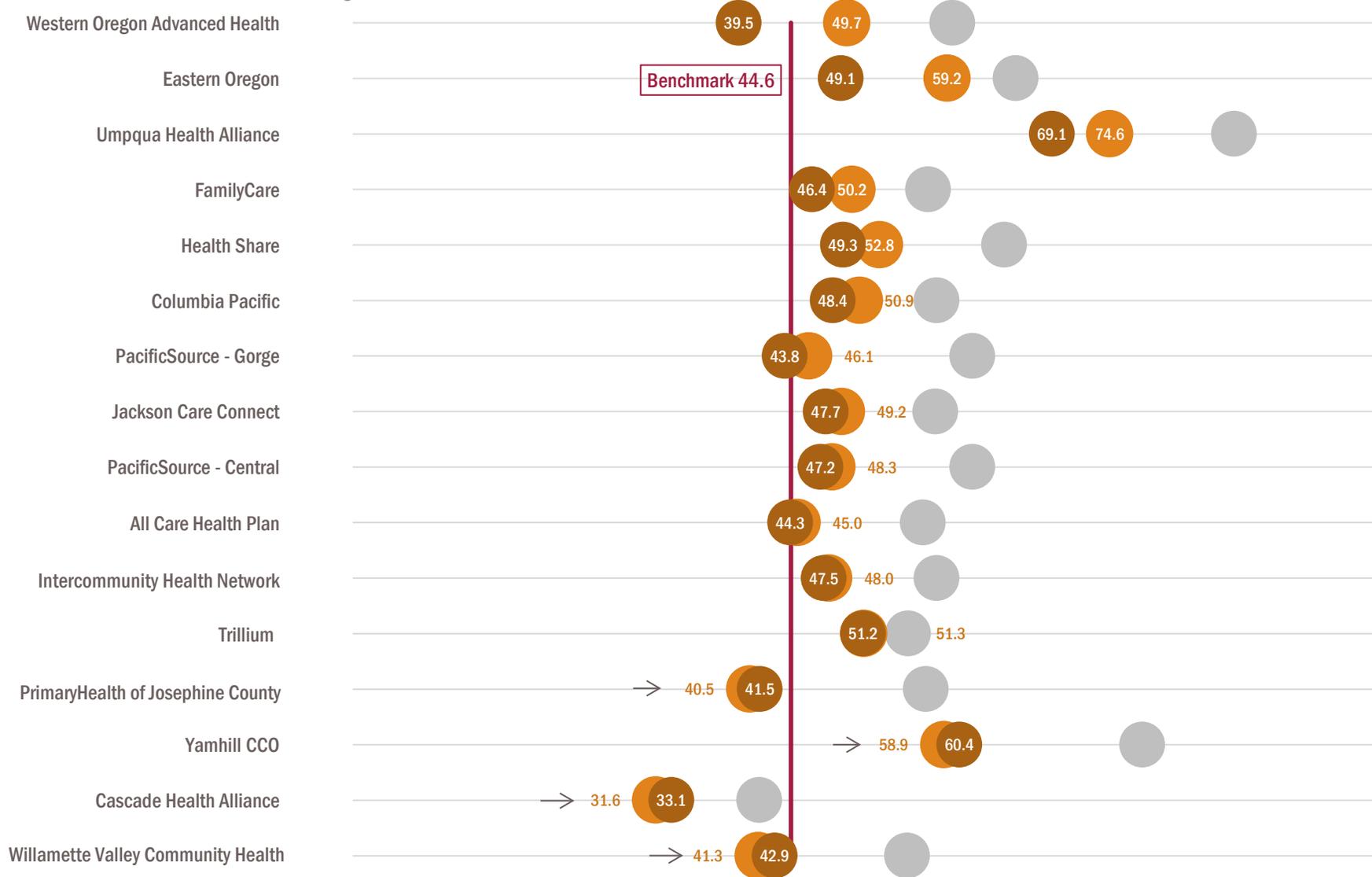
# AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Emergency department utilization continued to decline for many CCOs between 2013 & June 2014.

(Lower scores are better)

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.





# AMBULATORY CARE: OUTPATIENT UTILIZATION

## Ambulatory care: outpatient utilization

**Measure description:** Rate of outpatient services, such as office visits, home visits, nursing home care, urgent care and counseling or screening services. Rates are reported per 1,000 member months.

**Purpose:** Promoting the use of outpatient settings like a doctor's office or urgent care clinic is part of Oregon's goal of making sure patients are getting the right care in the right places and at the right times. Increasing the use of outpatient care helps improve health and lower costs by promoting prevention and keeping down rates of unnecessary emergency department use.

### July 2013 - June 2014 data

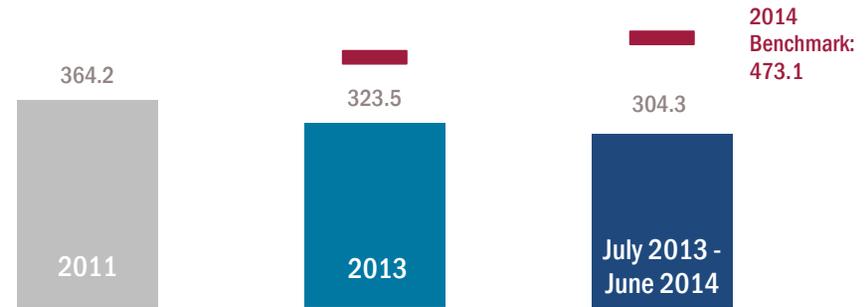
(n=7,808,526 member months)

This metric shows a trend toward fewer outpatient visits since 2011. Outpatient visits include all visits to primary care and specialists as well as home and nursing home visits. This report shows an influx of 20 percent new enrollment from ACA expansion.

## Statewide, outpatient utilization has declined.

Data source: Administrative (billing) claims

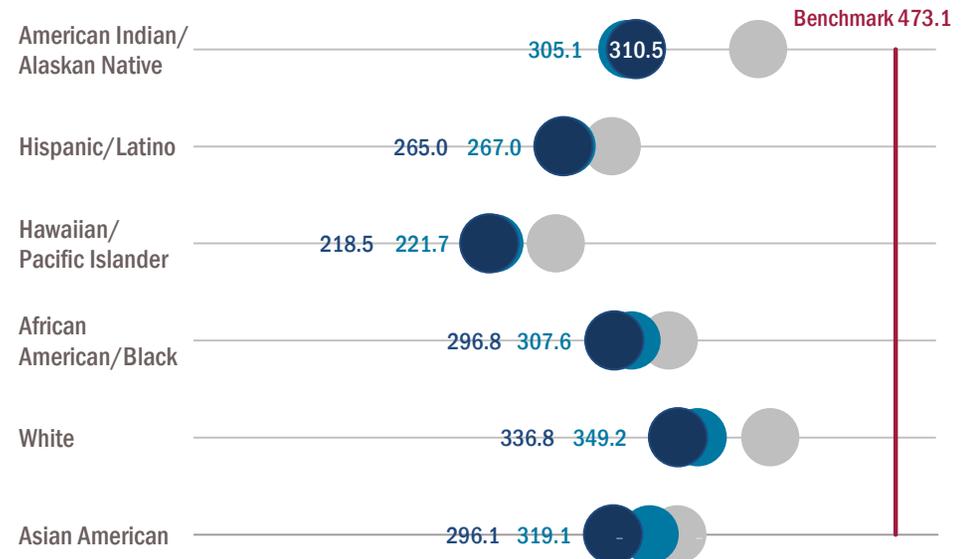
2014 benchmark source: 2013 National Medicaid 90th percentile



## Outpatient utilization has declined for almost all racial and ethnic groups between 2013 & June 2014.

Gray dots represent 2011.

Data missing for 8.9% of respondents. Each race category excludes Hispanic/Latino.

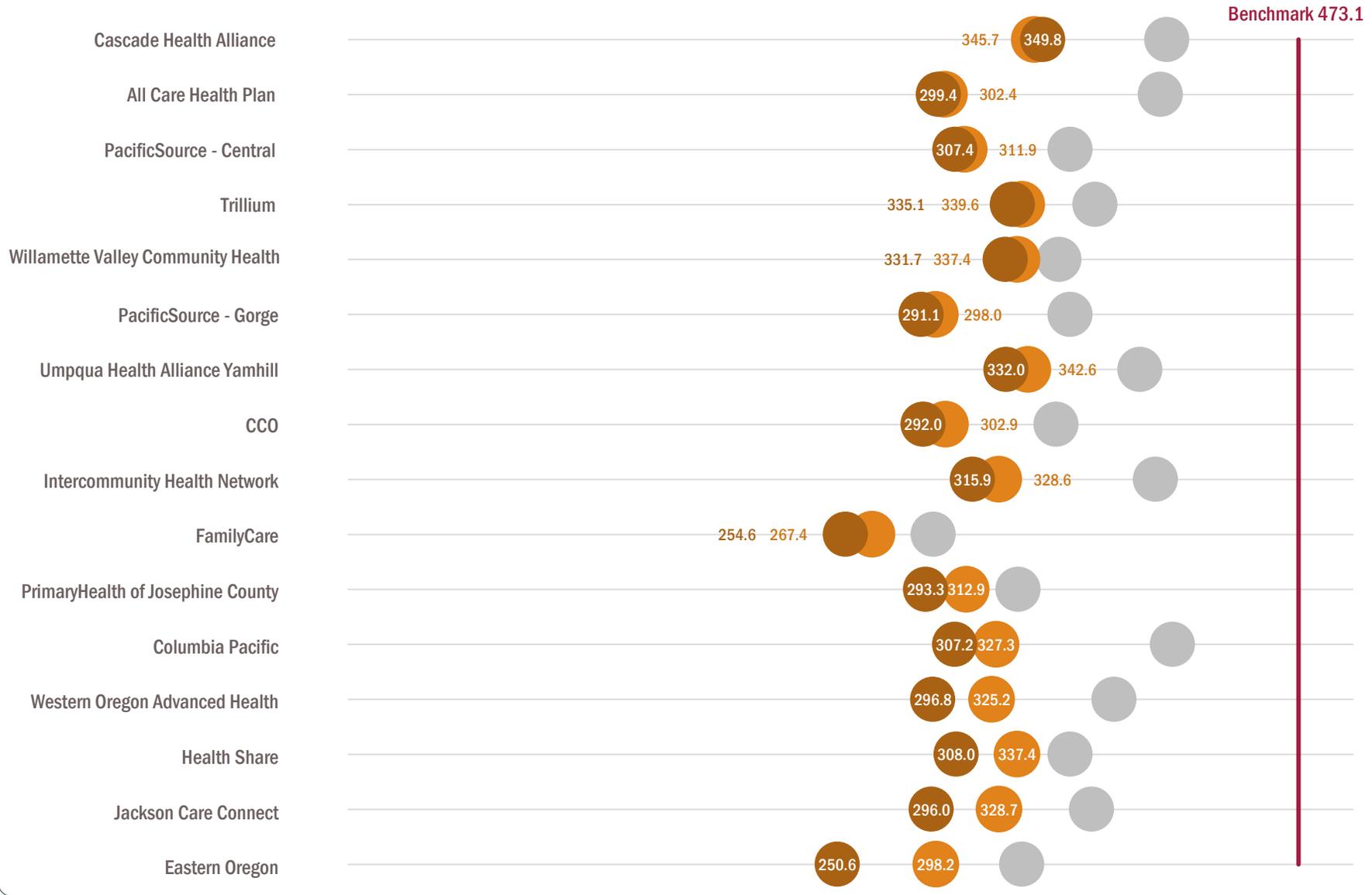




# AMBULATORY CARE: OUTPATIENT UTILIZATION

Outpatient utilization rates declined at a slower rate between **2013 & June 2014** than in previous years.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.  
 Baseline data for PacificSource Central and Gorge are combined.





# APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

## Appropriate testing for children with pharyngitis

**Measure description:** Percentage of children with a sore throat (pharyngitis) who were given a strep test before getting an antibiotic.

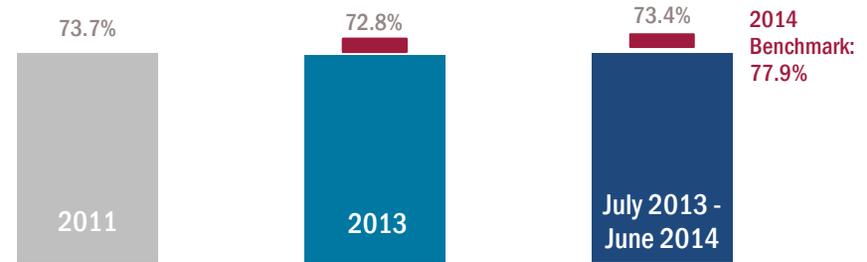
**Purpose:** A strep test helps determine whether or not a child will benefit from antibiotics for a sore throat (pharyngitis). This test can help reduce the overuse of antibiotics, which can improve care quality and ensure that antibiotics continue to work when they are needed.

### July 2013 - June 2014 data (n=8,133)

This metric tracks the percentage of children with a sore throat (pharyngitis) who had a strep test before being prescribed antibiotics. The 2014 data is comparable to baseline and increased slightly between 2013 and June 2014. CCOs show mixed results and statewide levels are well below the benchmark.

## Statewide, appropriate testing for children with pharyngitis has remained fairly steady.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 National Medicaid 75th percentile



## Changes varied across racial/ethnic groups between 2013 & June 2014.

Gray dots represent 2011.  
Data missing for 8.6% of respondents. Each race category excludes Hispanic/Latino.  
~ Data suppressed (n<30)



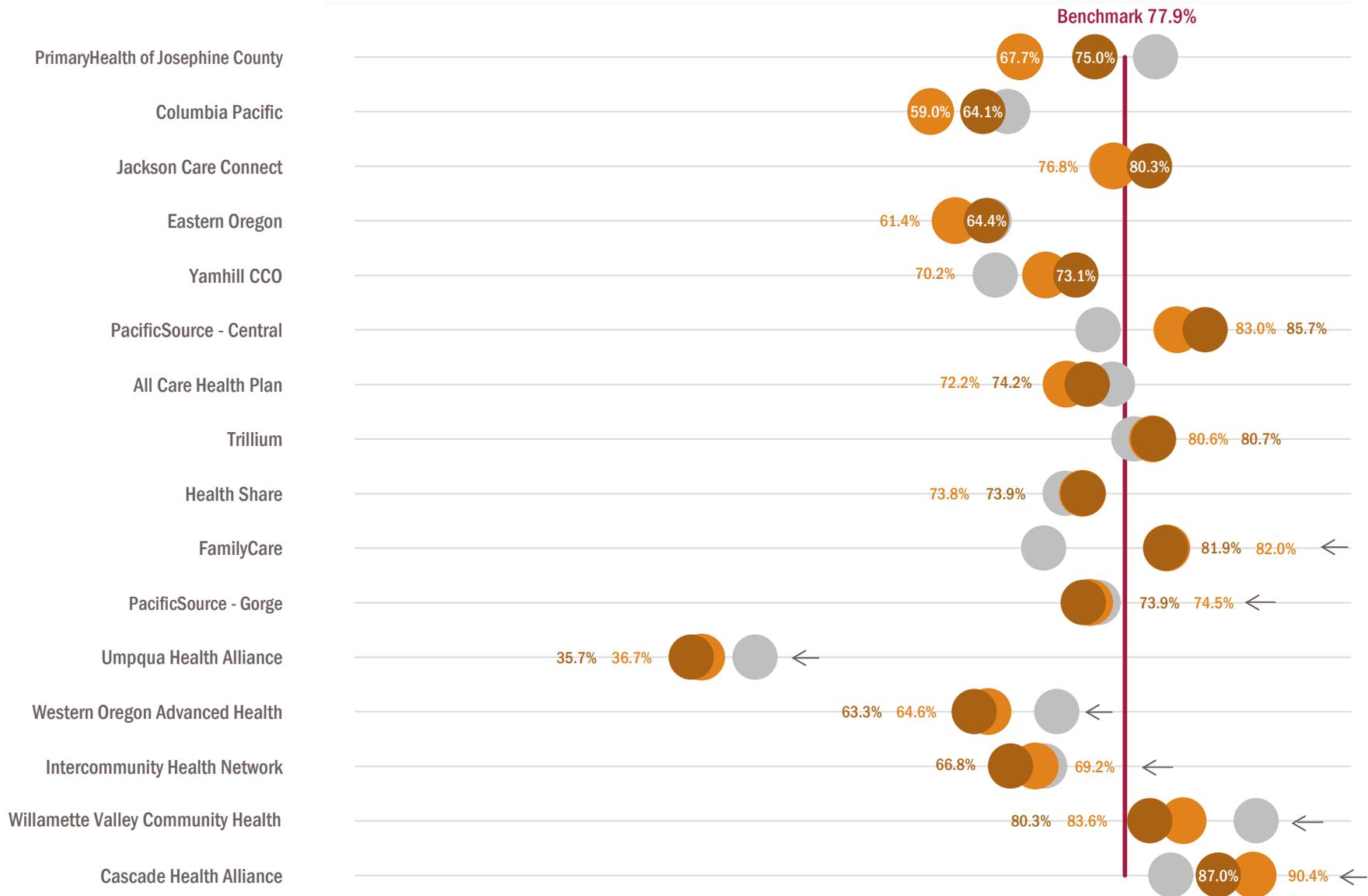


# APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

CCOs showed mixed improvement on appropriate testing for children with pharyngitis between 2013 & June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.





# CERVICAL CANCER SCREENING

## Cervical cancer screening

**Measure description:** Percentage of women patients (ages 21 to 64) who received one or more Pap tests for cervical cancer during the past three years.

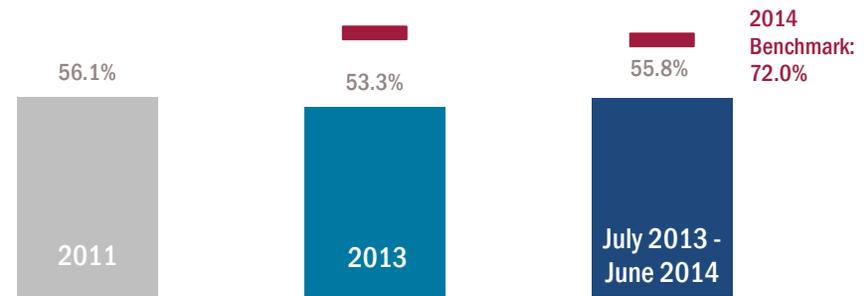
**Purpose:** A Pap test helps find early signs of cancer in the cervix when the disease is easier and less costly to treat. Treating cervical cancer in its earliest stages also increases the five-year survival rate to 92 percent, according to the American Cancer Society.

### July 2013 - June 2014 data (n=40,895)

The June 2014 metric increased over 2013 but continues to show there is room for further development and attention for cervical cancer screening when comparing current performance to the benchmark. The June 2014 percentage is lower than the percentage of women screened in 2011 but includes a 9 percent increase in the denominator due to the new ACA population. The lowered screening rates may be due to a number of factors including national guideline changes reported in 2012 for cervical cancer screening and new members not yet being screened.

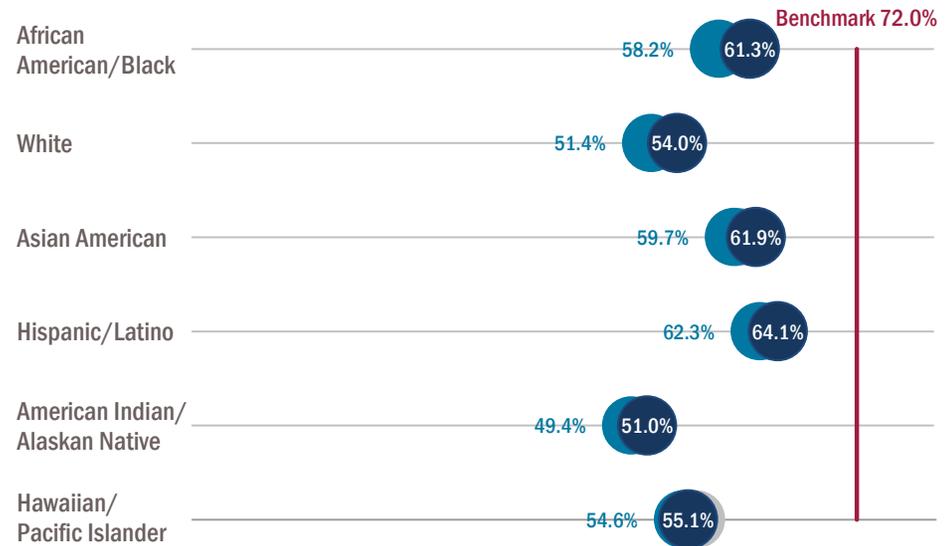
Statewide, cervical cancer screening has remained fairly steady.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 National Medicaid 75th percentile



Cervical cancer screening improved slightly for all racial/ethnic groups between 2013 & June 2014.

Gray dots represent 2011. Data missing for 6.1% of respondents. Each race category excludes Hispanic/Latino.

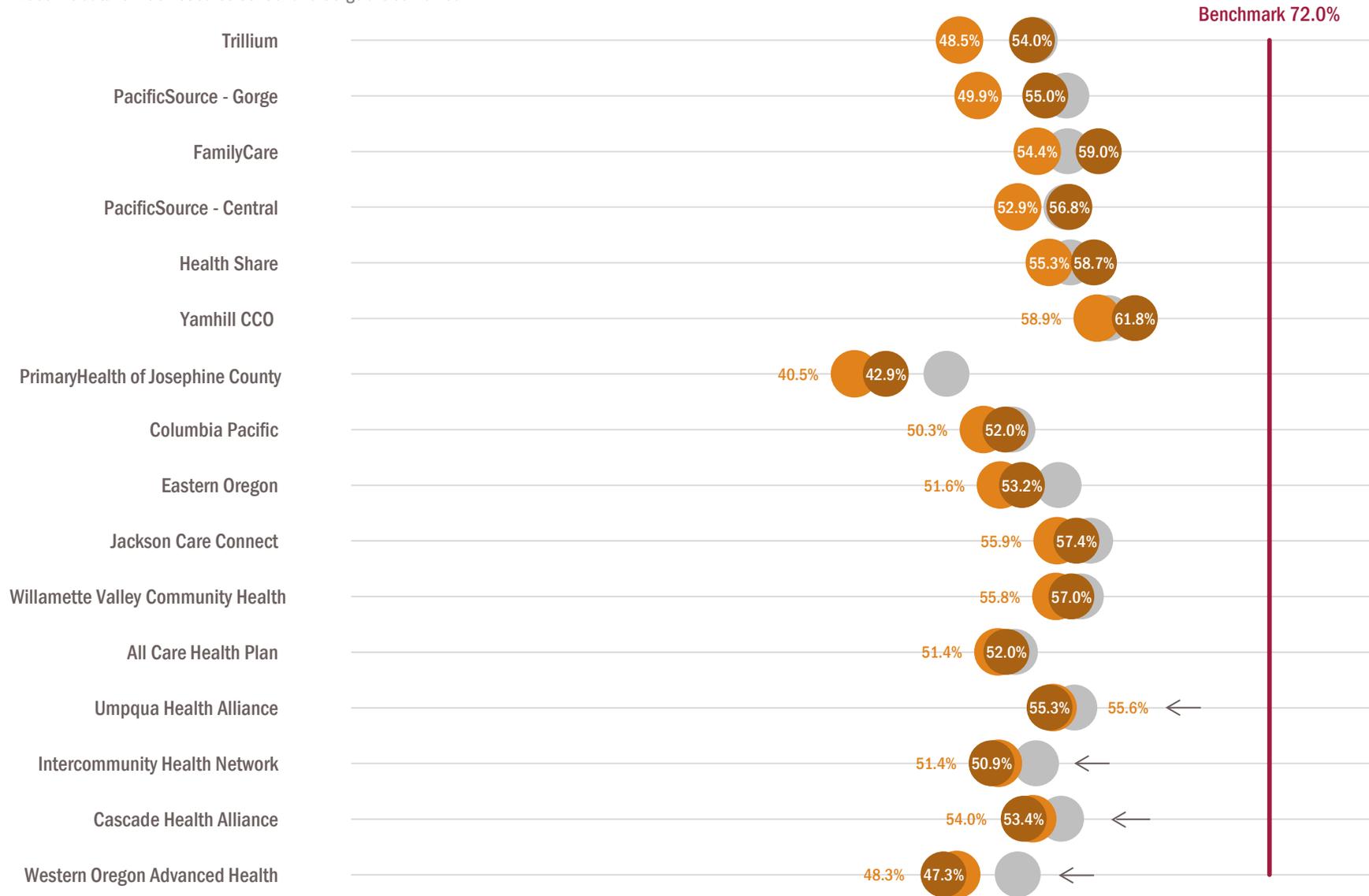




# CERVICAL CANCER SCREENING

After performance dropped in 2013, most CCOs are showing improvement in cervical cancer screening in June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.  
Baseline data for PacificSource Central and Gorge are combined.





# CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (ALL AGES)

## Childhood and adolescent access to primary care providers (all ages)

**Measure description:** Percentage of children and adolescents (ages 12 months – 19 years) who had a visit with a primary care provider.

**Purpose:** Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

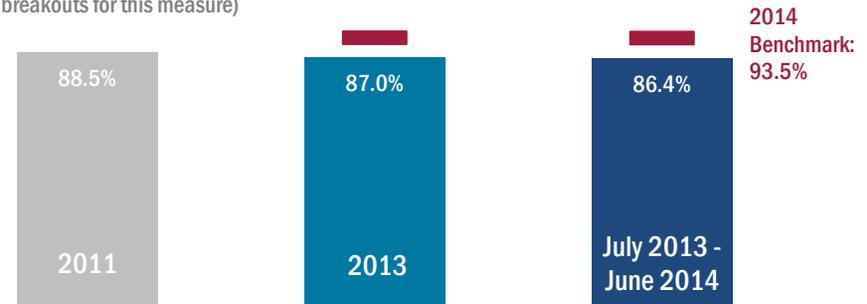
### July 2013 - June 2014 data (n=309,364)

This measure tracks child and adolescent access to primary care providers by measuring the percentage of children who had a visit with a primary care provider during the last year. This set of metrics is an area with an opportunity for improvement since access to primary care providers has declined across all age categories. In particular, the youngest children experienced the greatest decline perhaps due to the new ACA members not yet having a primary care visit. In June 2014, there has not been improvement on these measures when compared to 2011 or 2013. Hispanic/Latino members experienced the greatest decline in access between 2013 and June 2014.

Any children ages 1-6 who are new ACA members are included in the measure but older children and adolescents ages 7-19 are not included due to measure criteria.

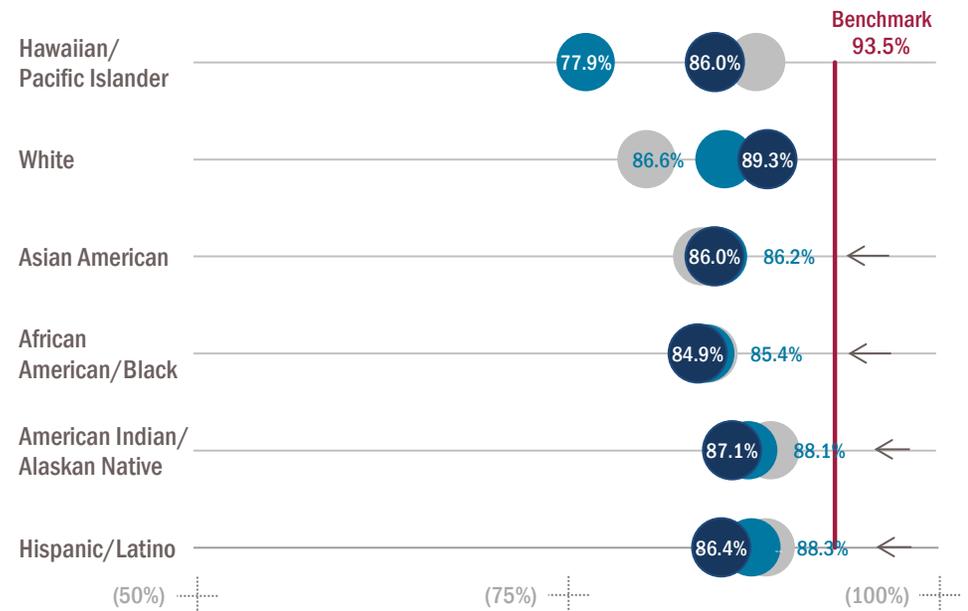
## Statewide, childhood and adolescent access to primary care providers continues to decline slightly.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 National Medicaid 75th percentile (average of the four age breakouts for this measure)



## Access declined for all groups except Hawaiian/Pacific Islanders and whites between 2013 & June 2014.

Gray dots represent 2011.  
Data missing for 8.4% of respondents. Each race category excludes Hispanic/Latino.





# CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (12-24 MONTHS)

## Childhood and adolescent access to primary care providers (12-24 months)

**Measure description:** Percentage of children and adolescents (ages 12-24 months) who had a visit with a primary care provider.

**Purpose:** Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

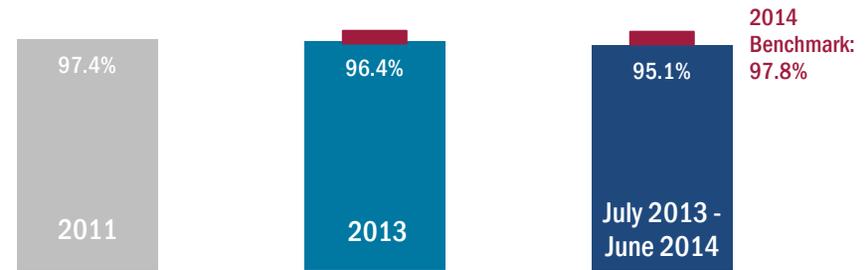
### July 2013 - June 2014 data (n=23,089)

This measure tracks child and adolescent access to primary care providers by measuring the percentage of children who had a visit with a primary care provider during the last year. This set of metrics is an area with an opportunity for improvement since access to primary care providers has declined across all age categories. In particular, the youngest children experienced the greatest decline perhaps due to the new ACA members not yet having a primary care visit. In June 2014, there has not been improvement on these measures when compared to 2011 or 2013. Hispanic/Latino members experienced the greatest decline in access between 2013 and June 2014.

Any children ages 1-6 who are new ACA members are included in the measure but older children and adolescents ages 7-19 are not included due to measure criteria.

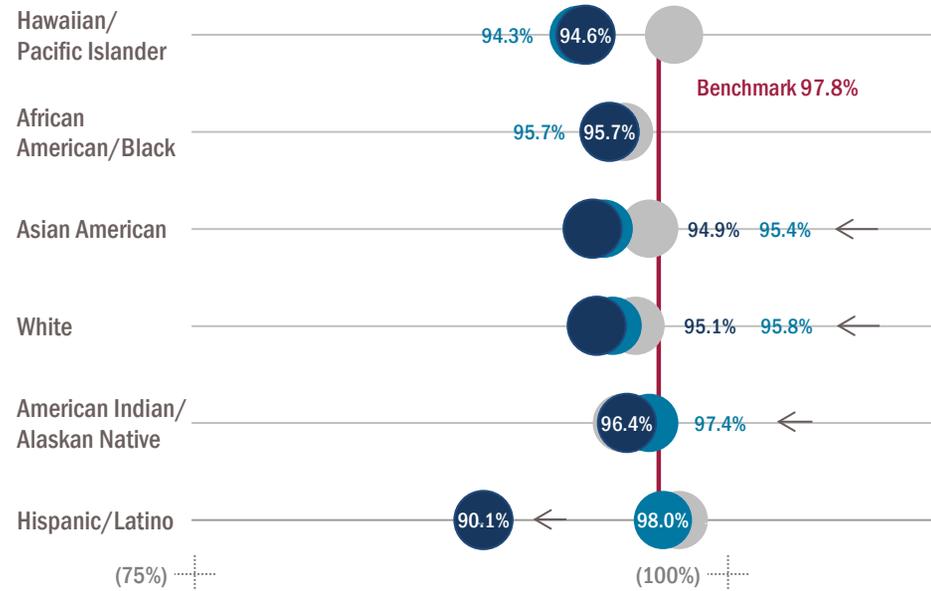
Statewide, children aged 12-24 months experienced a slight decline in access to primary care providers.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 National Medicaid 75th percentile



## Hispanic/Latino children experienced the greatest decline in access to PCP between 2013 & June 2014.

Gray dots represent 2011.  
Data missing for 10.4% of respondents. Each race category excludes Hispanic/Latino.





# CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (25 MONTHS-6 YEARS)

## Childhood and adolescent access to primary care providers (25 months - 6 years)

**Measure description:** Percentage of children and adolescents (ages 25 months - 6 years) who had a visit with a primary care provider.

**Purpose:** Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

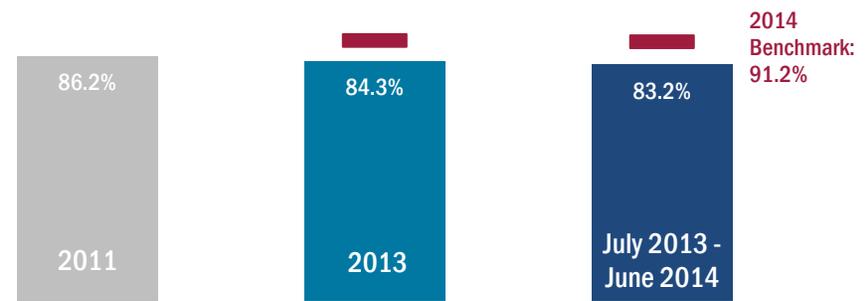
### July 2013 - June 2014 data (n=103,921)

This measure tracks child and adolescent access to primary care providers by measuring the percentage of children who had a visit with a primary care provider during the last year. This set of metrics is an area with an opportunity for improvement since access to primary care providers has declined across all age categories. In particular, the youngest children experienced the greatest decline perhaps due to the new ACA members not yet having a primary care visit. In June 2014, there has not been improvement on these measures when compared to 2011 or 2013. Hispanic/Latino members experienced the greatest decline in access between 2013 and June 2014.

Any children ages 1-6 who are new ACA members are included in the measure but older children and adolescents ages 7-19 are not included due to measure criteria.

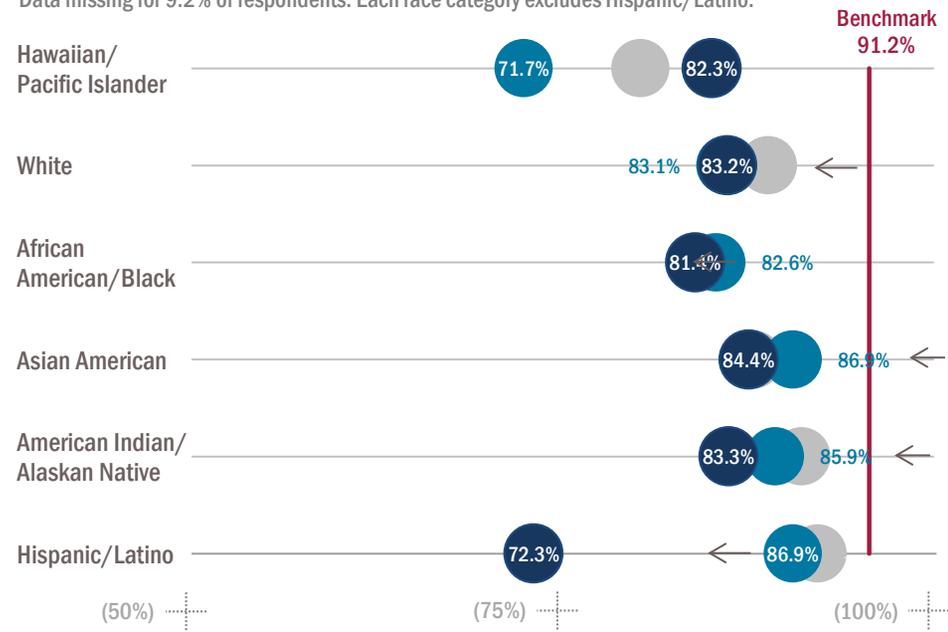
## Statewide, access to primary care providers declined for children ages 25 months to 6 years.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 National Medicaid 75th percentile



## Access to primary care declined the most for Hispanic/Latino children between 2013 & June 2014.

Gray dots represent 2011. Data missing for 9.2% of respondents. Each race category excludes Hispanic/Latino.





# CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (7-11 YEARS)

## Childhood and adolescent access to primary care providers (7-11 years)

**Measure description:** Percentage of children and adolescents (ages 7-11 years) who had a visit with a primary care provider.

**Purpose:** Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

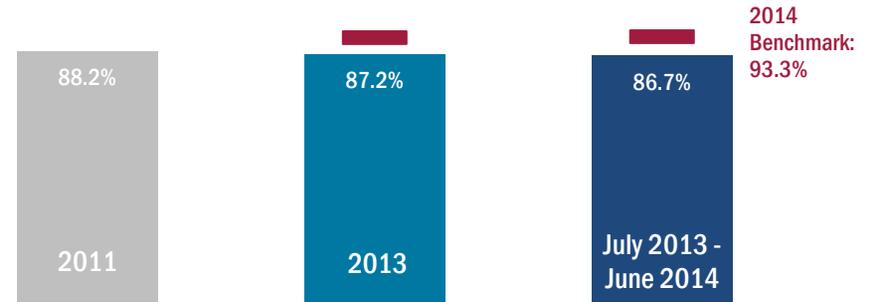
### July 2013 - June 2014 data (n=81,561)

This measure tracks child and adolescent access to primary care providers by measuring the percentage of children who had a visit with a primary care provider during the last year. This set of metrics is an area with an opportunity for improvement since access to primary care providers has declined across all age categories. In particular, the youngest children experienced the greatest decline perhaps due to the new ACA members not yet having a primary care visit. In June 2014, there has not been improvement on these measures when compared to 2011 or 2013. Hispanic/Latino members experienced the greatest decline in access between 2013 and June 2014.

Any children ages 1-6 who are new ACA members are included in the measure but older children and adolescents ages 7-19 are not included due to measure criteria.

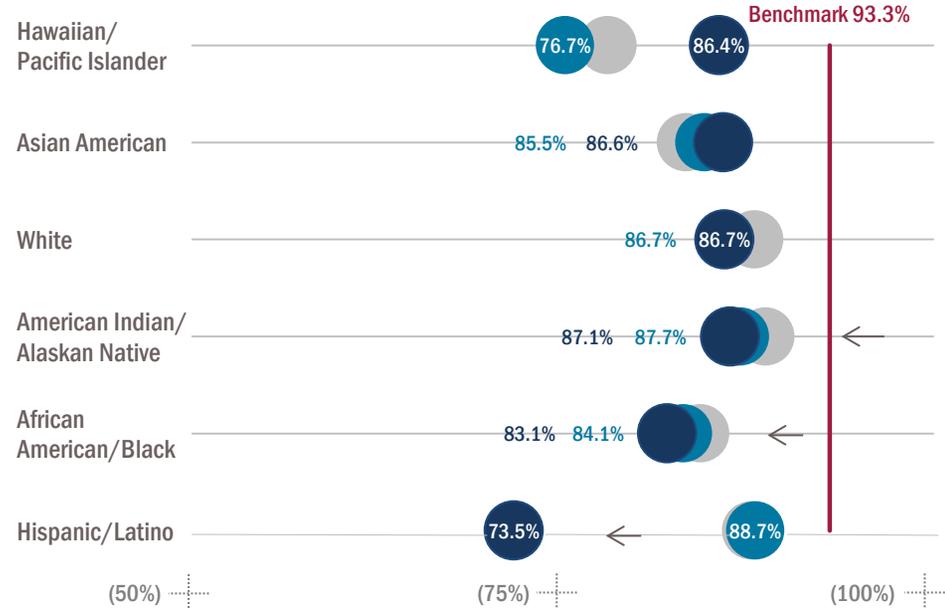
## Statewide, access has declined slightly for children ages 7-11 years.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 National Medicaid 75th percentile



## Hispanic/Latino children experienced the greatest decline in access to primary care between 2013 & June 2014.

Gray dots represent 2011.  
Data missing for 8.1% of respondents. Each race category excludes Hispanic/Latino.





# CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (12-19 YEARS)

## Childhood and adolescent access to primary care providers (12-19 years)

**Measure description:** Percentage of children and adolescents (ages 12-19 years) who had a visit with a primary care provider.

**Purpose:** Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

### July 2013 - June 2014 data (n=100,793)

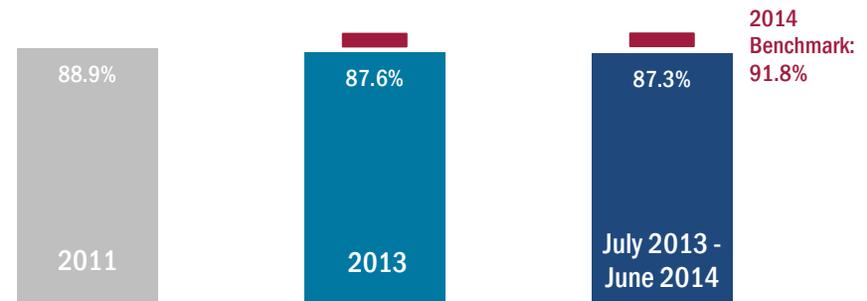
This measure tracks child and adolescent access to primary care providers by measuring the percentage of children who had a visit with a primary care provider during the last year. This set of metrics is an area with an opportunity for improvement since access to primary care providers has declined across all age categories. In particular, the youngest children experienced the greatest decline perhaps due to the new ACA members not yet having a primary care visit. In June 2014, there has not been improvement on these measures when compared to 2011 or 2013. Hispanic/Latino members experienced the greatest decline in access between 2013 and June 2014.

Any children ages 1-6 who are new ACA members are included in the measure but older children and adolescents ages 7-19 are not included due to measure criteria.

Statewide, access has declined very slightly for adolescents ages 12-19 years.

Data source: Administrative (billing) claims

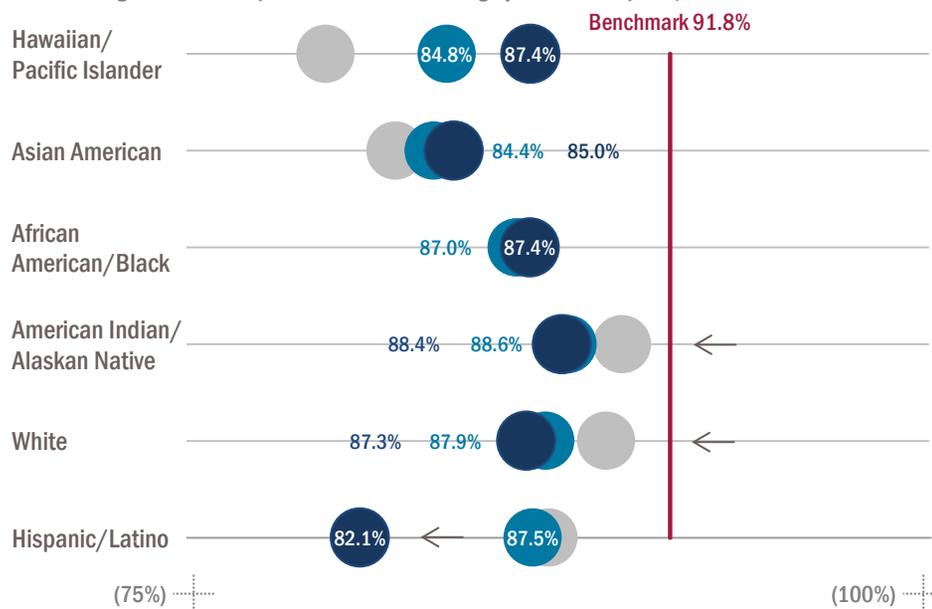
2014 benchmark source: 2013 National Medicaid 75th percentile



## Hispanic/Latino children experienced the greatest decline in access to primary care between 2013 & June 2014.

Gray dots represent 2011.

Data missing for 7.4% of respondents. Each race category excludes Hispanic/Latino.





# CHILDHOOD IMMUNIZATION STATUS

## Childhood immunization status

**Measure description:** Percentage of children who received recommended vaccines before their second birthday.

**Purpose:** Vaccines are one of the safest, easiest and most effective ways to protect children from potentially serious diseases. Vaccines are also cost-effective tools that help to prevent the spread of serious diseases which can sometimes lead to widespread public health threats.

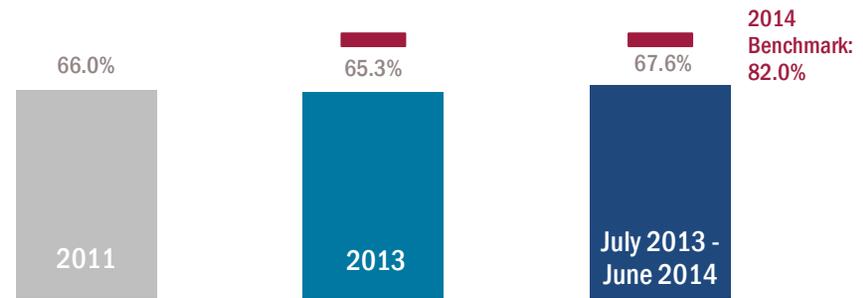
### July 2013 - June 2014 data (n=14,507)

Childhood immunization remains fairly steady since 2011 baseline. Statewide performance in June 2014 is still well below the benchmark of 82.0 percent. Childhood immunization improved slightly for African Americans and American Indian/Alaskan Natives since 2013, but decreased slightly for other racial/ethnic groups.

Childhood immunization improved for all but two CCOs between 2013 and June 2014.

## Statewide, childhood immunizations continue to increase.

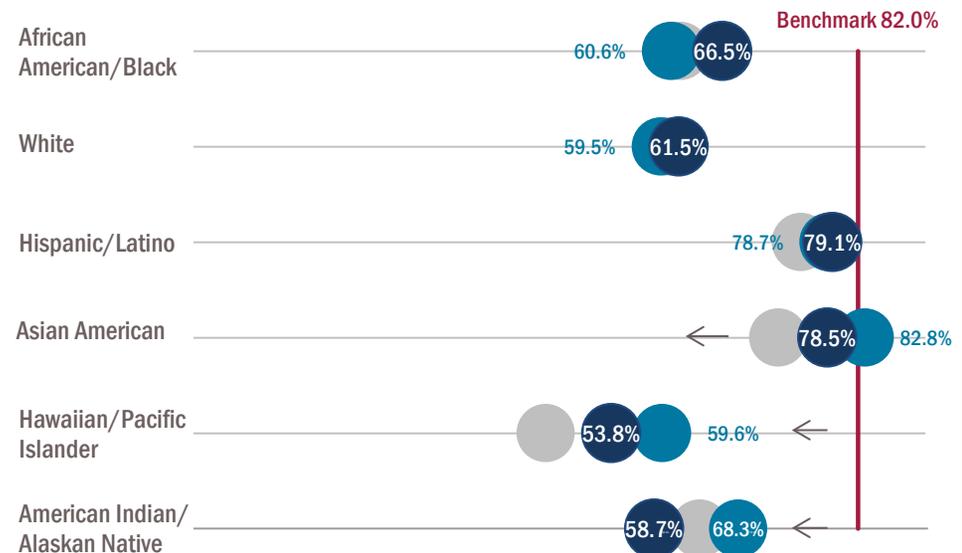
Data source: Administrative (billing) claims and ALERT Immunization Information System



## Childhood immunization varied across groups between 2013 & June 2014.

Gray dots represent 2011.

Data missing for 8.9% of respondents. Each race category excludes Hispanic/Latino.

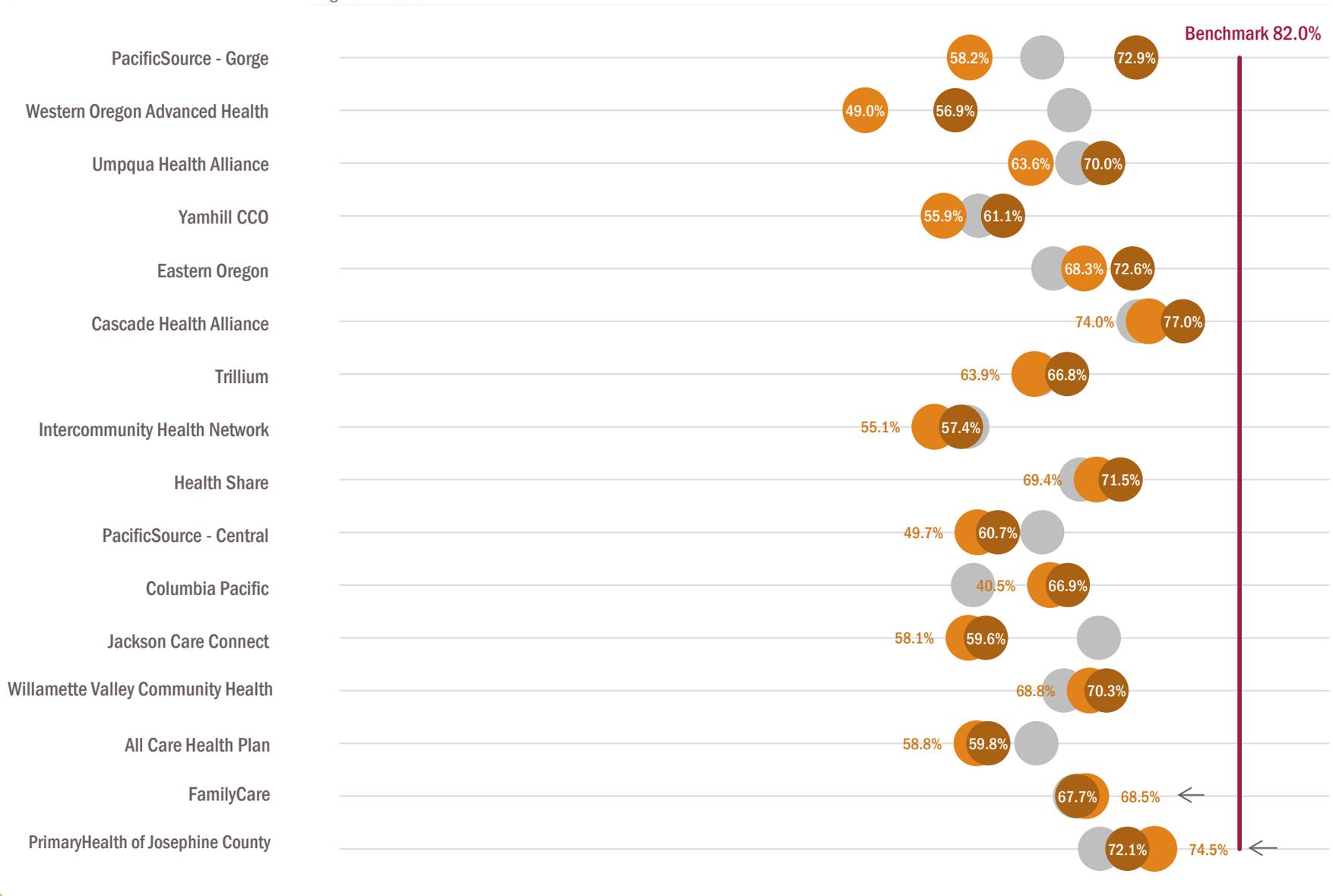




# CHILDHOOD IMMUNIZATION STATUS

## Fourteen of 16 CCOs improved on childhood immunization status between 2013 & June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.  
Baseline data for PacificSource Central and Gorge are combined.





# CHLAMYDIA SCREENING IN WOMEN AGES 16-24

## Chlamydia screening in women ages 16-24

**Measure description:** Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection.

**Purpose:** Chlamydia is the most common reportable illness in Oregon. Since there are usually no symptoms, routine screening is important to find the disease early so that it can be treated and cured with antibiotics. If chlamydia is not found and treated, it can lead to pelvic inflammatory disease, which can cause infertility.

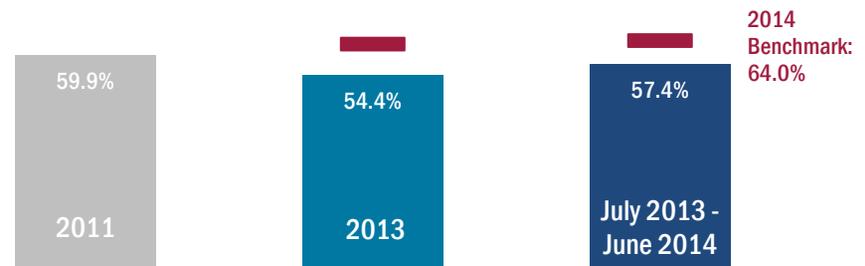
### July 2013 - June 2014 data (n=21,674)

While still below the benchmark, Chlamydia screening increased between 2013 and June 2014 by three percentage points. Thirteen CCOs increased since 2013 despite a 16-percent increase in the number of eligible members.

Statewide, chlamydia screenings have increased this year, but are still below the benchmark.

Data source: Administrative (billing) claims

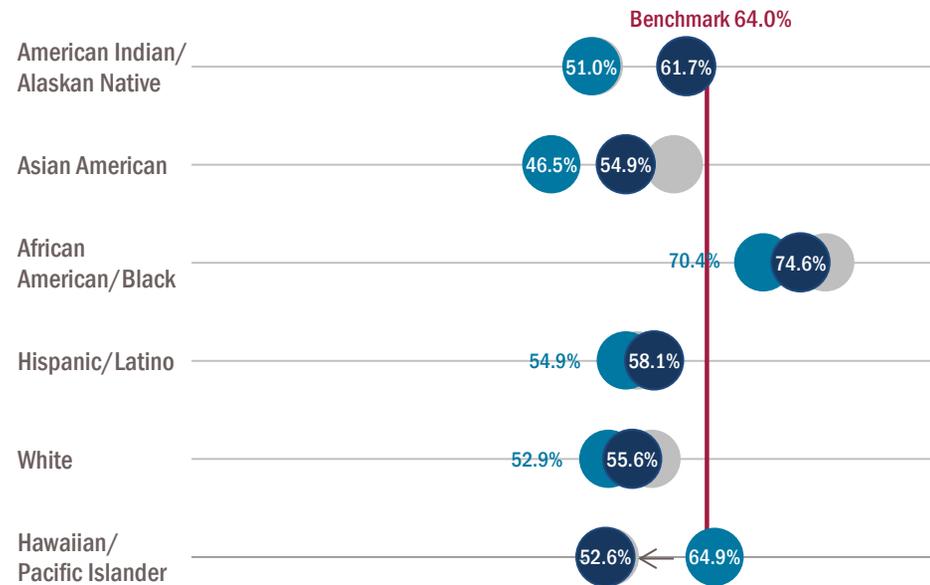
2014 benchmark source: 2013 National Medicaid 75th percentile



## Chlamydia increased for all racial/ethnic groups except Hawaiian/Pacific Islanders between 2013 and June 2014.

Gray dots represent 2011.

Data missing for 7.0% of respondents. Each race category excludes Hispanic/Latino.

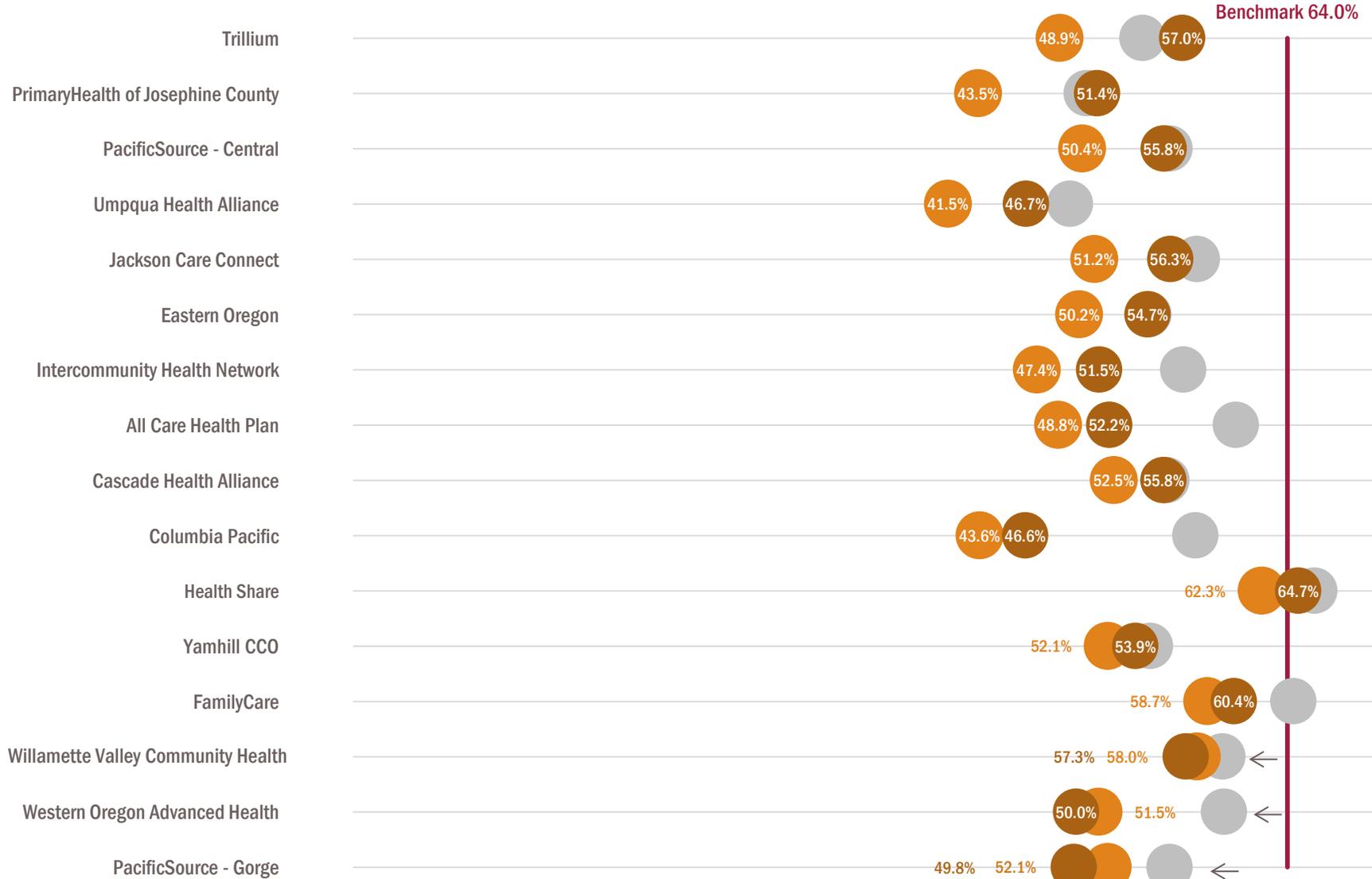




# CHLAMYDIA SCREENING IN WOMEN AGES 16-24

After decreasing in 2013, most CCOs are showing improvements in chlamydia screening rates in June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.





# COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

## Comprehensive diabetes care: HbA1c testing

**Measure description:** Percentage of adult patients (ages 18-75) with diabetes who received at least one A1c blood sugar test.

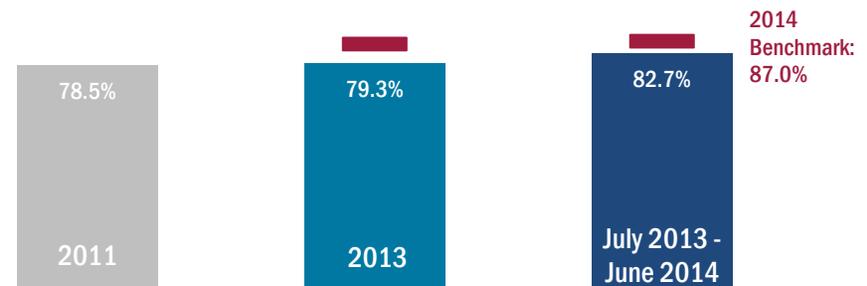
**Purpose:** Controlling blood sugar levels is important to help people with diabetes manage their disease. It is also a key way to assess the overall effectiveness of diabetes care in Oregon. By improving the quality of care for diabetes, Oregon can help patients avoid complications and hospitalizations that lead to poor health and high costs.

### July 2013 - June 2014 data (n=21,160)

Testing for blood sugar (HbA1c) among members with diabetes has shown continual improvement since 2011. HbA1c testing has approached the benchmark across all racial and ethnic groups. All CCOs improved from 2013 to June 2014 with the denominator increasing by 5 percent due to the new ACA population.

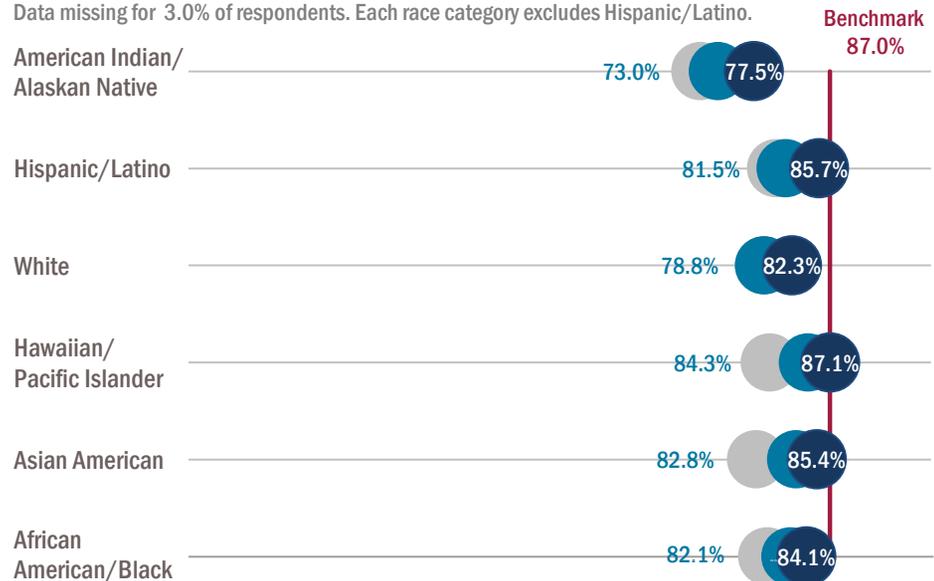
## Statewide, HbA1c testing for members with diabetes has continued to improve.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 National Medicaid 75th percentile



## HbA1c testing has approached the benchmark across all racial/ethnic groups between 2013 & June 2014.

Gray dots represent 2011. Data missing for 3.0% of respondents. Each race category excludes Hispanic/Latino.



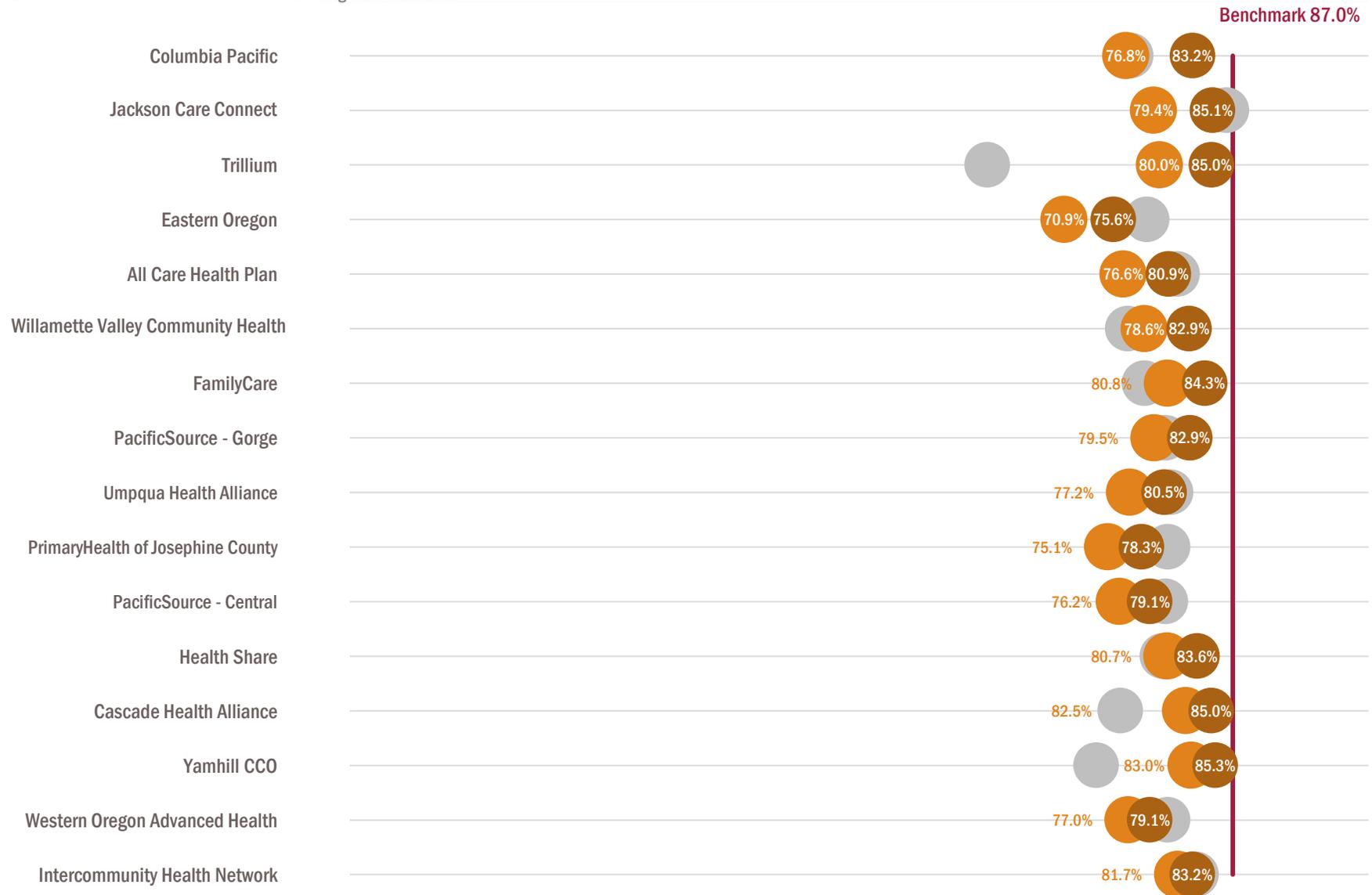


# COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

All sixteen CCOs improved HbA1c testing rates for patients with diabetes between 2013 & June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.





# COMPREHENSIVE DIABETES CARE: LDL-C SCREENING

## Comprehensive diabetes care: LDL-C screening

**Measure description:** Percentage of adult patients (ages 18-75) with diabetes who received an LDL-C (cholesterol) test.

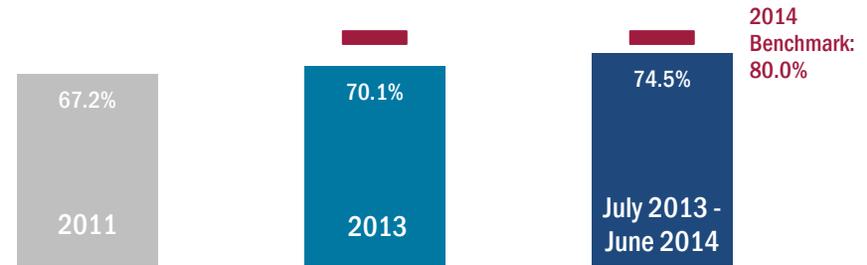
**Purpose:** This test helps people with diabetes manage their condition by measuring the level of 'bad cholesterol' (LDL-C) in the blood. Managing cholesterol levels can help people with diabetes avoid problems such as heart disease and stroke.

### July 2013 - June 2014 data (n=21,160)

This metric follows the same trend as testing for HbA1c, testing for cholesterol (LDL-C) among members with diabetes has shown continual improvement (11 percent) since 2011. LDL-C screening has approached the benchmark across all racial and ethnic groups. All CCOs improved from 2013 to June 2014 with the denominator increasing by 5 percent due to the new ACA population. One CCO surpassed the benchmark.

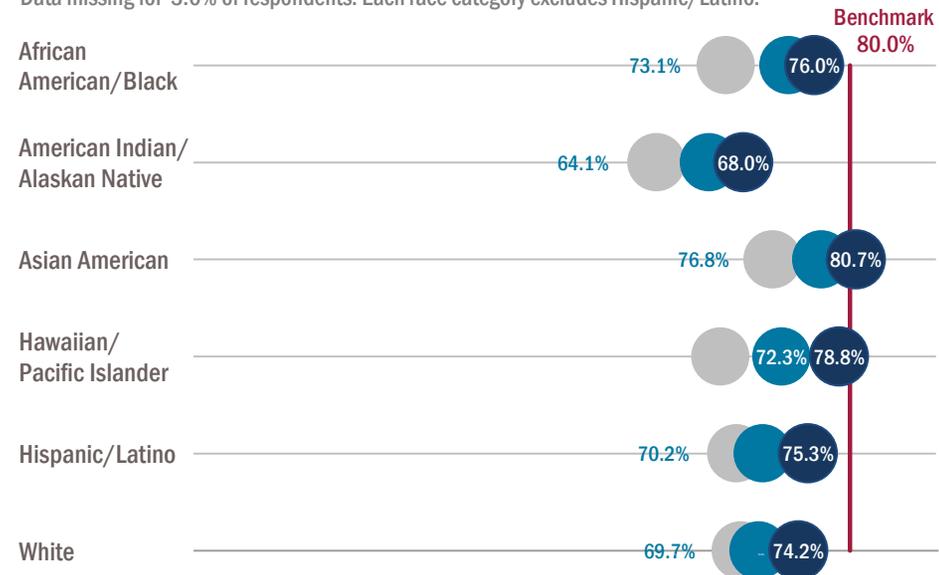
## Statewide, LDL-C screening for members with diabetes has continued to improve.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 National Medicaid 75th percentile



## LDL-C screening approached the benchmark across all racial/ethnic groups between 2013 & June 2014.

Gray dots represent 2011. Data missing for 3.0% of respondents. Each race category excludes Hispanic/Latino.



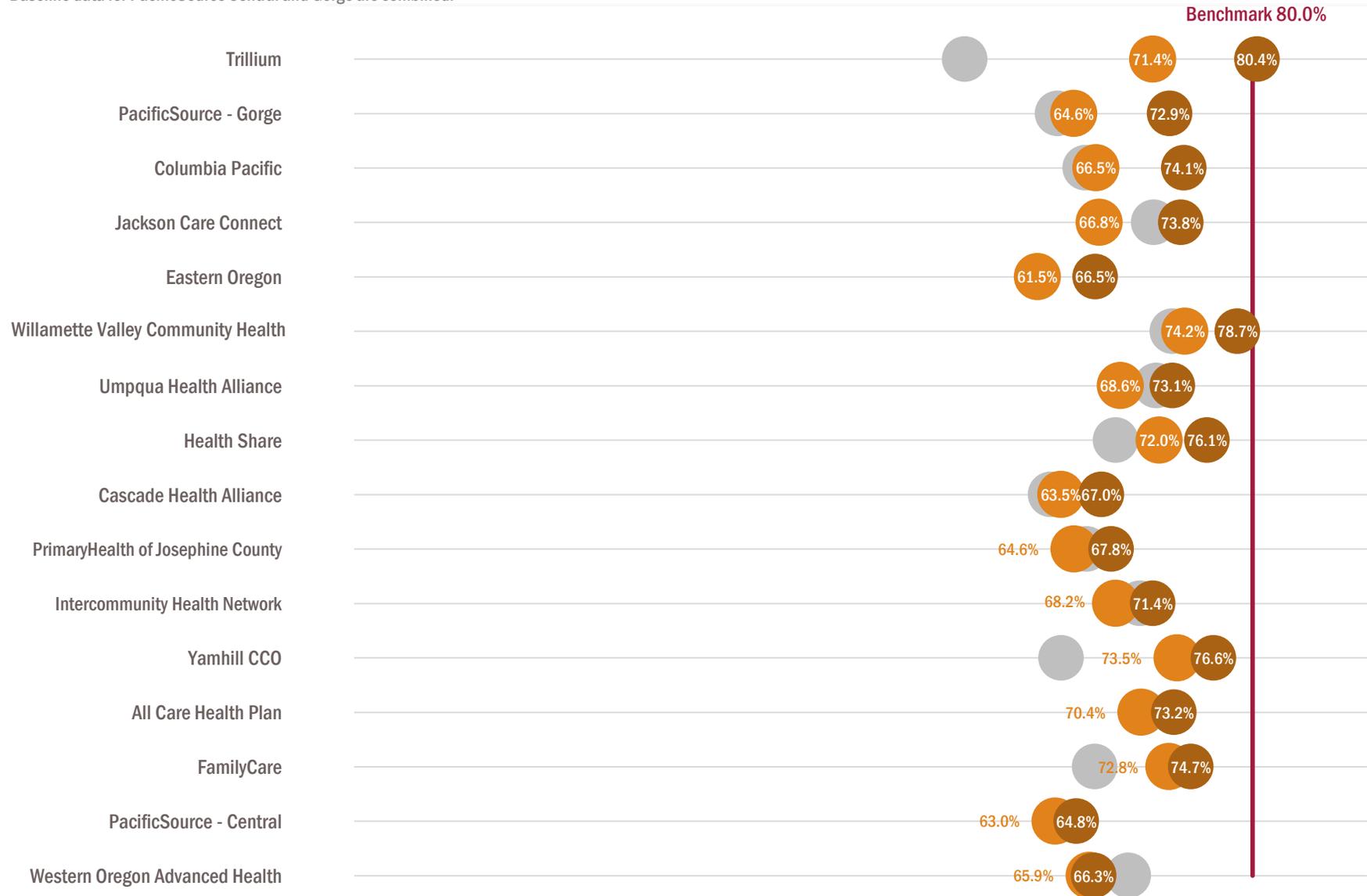


# COMPREHENSIVE DIABETES CARE: LDL-C SCREENING

All sixteen CCOs improved LDL-C screening for patients with diabetes between 2013 & June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.





# DEVELOPMENTAL SCREENINGS IN THE FIRST 36 MONTHS OF LIFE

## Developmental screening in the first 36 months of life

**Measure description:** Percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday.

**Purpose:** Early childhood screening helps find delays in development as early as possible, which leads to better health outcomes and reduced costs. Early developmental screening provides an opportunity to refer children to the appropriate specialty care before problems worsen. Often, developmental delays are not found until kindergarten or later – well beyond the time when treatments are most helpful.

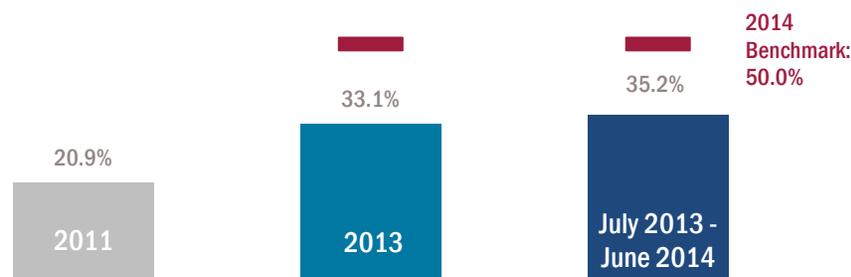
### July 2013 - June 2014 data (n=49,267)

The percentage of children who were screened for the risk of developmental, behavioral and social delays continues to increase from a 2011 baseline of 21 percent to 35 percent in June 2014, an increase of 68 percent. There continues to be marked gains in developmental screening across Oregon.

The new ACA population will not be included in this metric for 2014 due to continuous enrollment criteria. However, this mid-year report shows 30,000 additional children in the denominator compared to 2013. The increase is due to adding children who didn't qualify for the denominator in 2013 because of their birthdate and continuous enrollment.

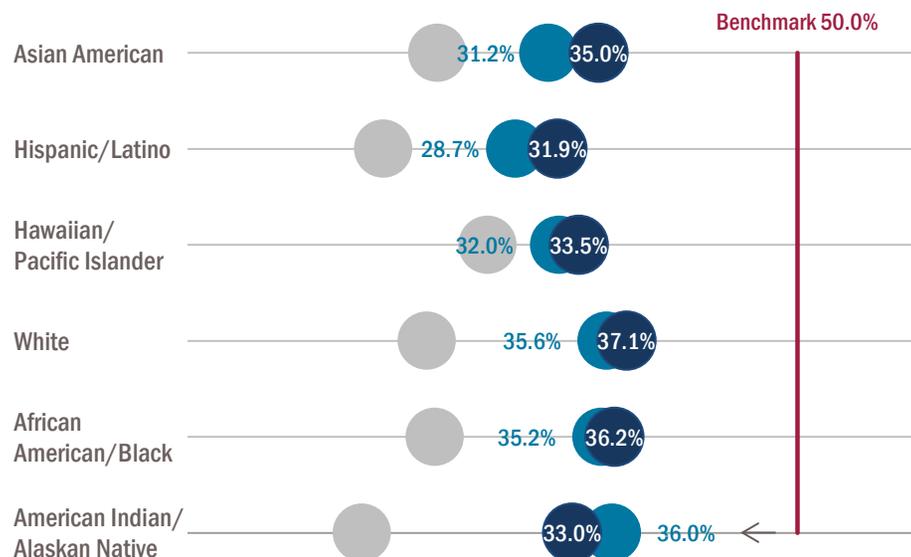
## Statewide, developmental screening continues to increase.

Data source: Administrative (billing) claims  
2014 benchmark source: Metrics and Scoring Committee consensus



## All racial and ethnic groups except American Indian/Alaskan Natives show increased developmental screenings between 2013 & June 2014.

Gray dots represent 2011.  
Data missing for 9.7% of respondents. Each race category excludes Hispanic/Latino.



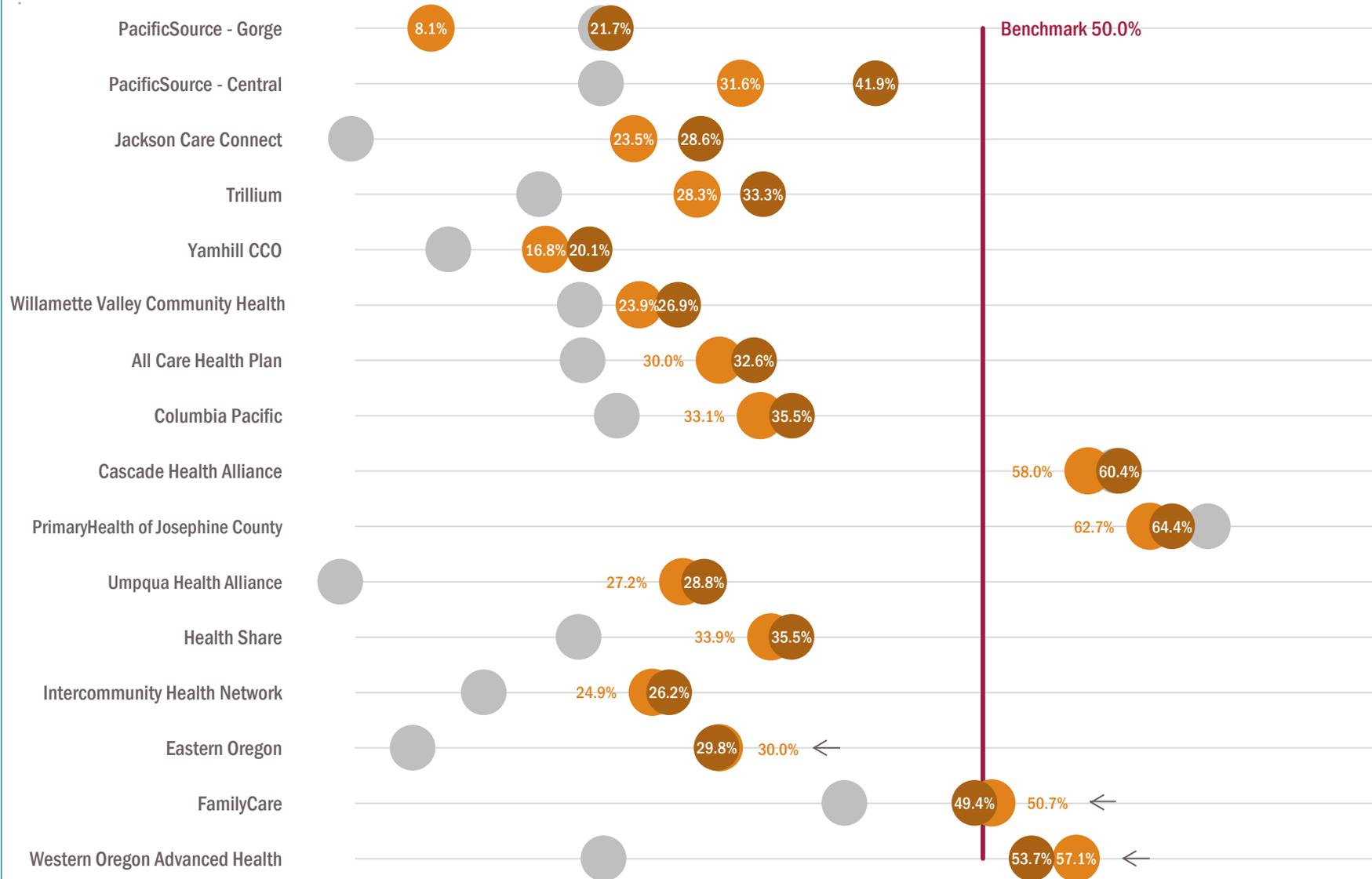


# DEVELOPMENTAL SCREENINGS IN THE FIRST 36 MONTHS OF LIFE

## Developmental screenings increased in nearly all CCOs between 2013 & June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.





# ELECTRONIC HEALTH RECORD ADOPTION

## Electronic Health Record (EHR) adoption

**Measure description:** Percentage of eligible providers within a CCO’s network and service area who qualified for a “meaningful use” incentive payment during the measurement year through Medicaid, Medicare, or Medicare Advantage EHR Incentive Programs.

**Purpose:** Electronic health records have the potential to improve coordination of care, increase patient safety, reduce medical error, and contain health care costs by reducing costly, duplicative tests. Physicians who use electronic health records use information available to make the most appropriate clinical decisions.

### July 2013 - June 2014 data

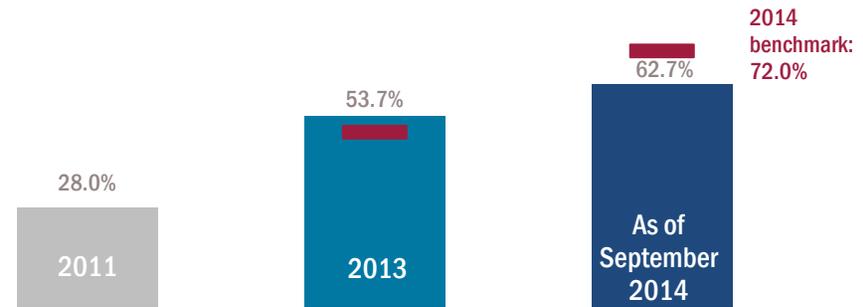
(n=9,227, total number of eligible providers)

Electronic health record adoption among measured providers continues to increase dramatically across Oregon. In 2011, 28 percent of eligible providers had adopted certified EHRs. By June 2014, 63 percent of eligible providers had adopted certified EHRs, an increase of 124 percent. All CCOs improved electronic health record adoption between 2013 and June 2014.

## Statewide, electronic health record adoption continues to increase.

Data source: State and Federal EHR Incentive Program

2014 benchmark source: Committee consensus, based on highest performing CCO in July 2013.



## Race and ethnicity data.

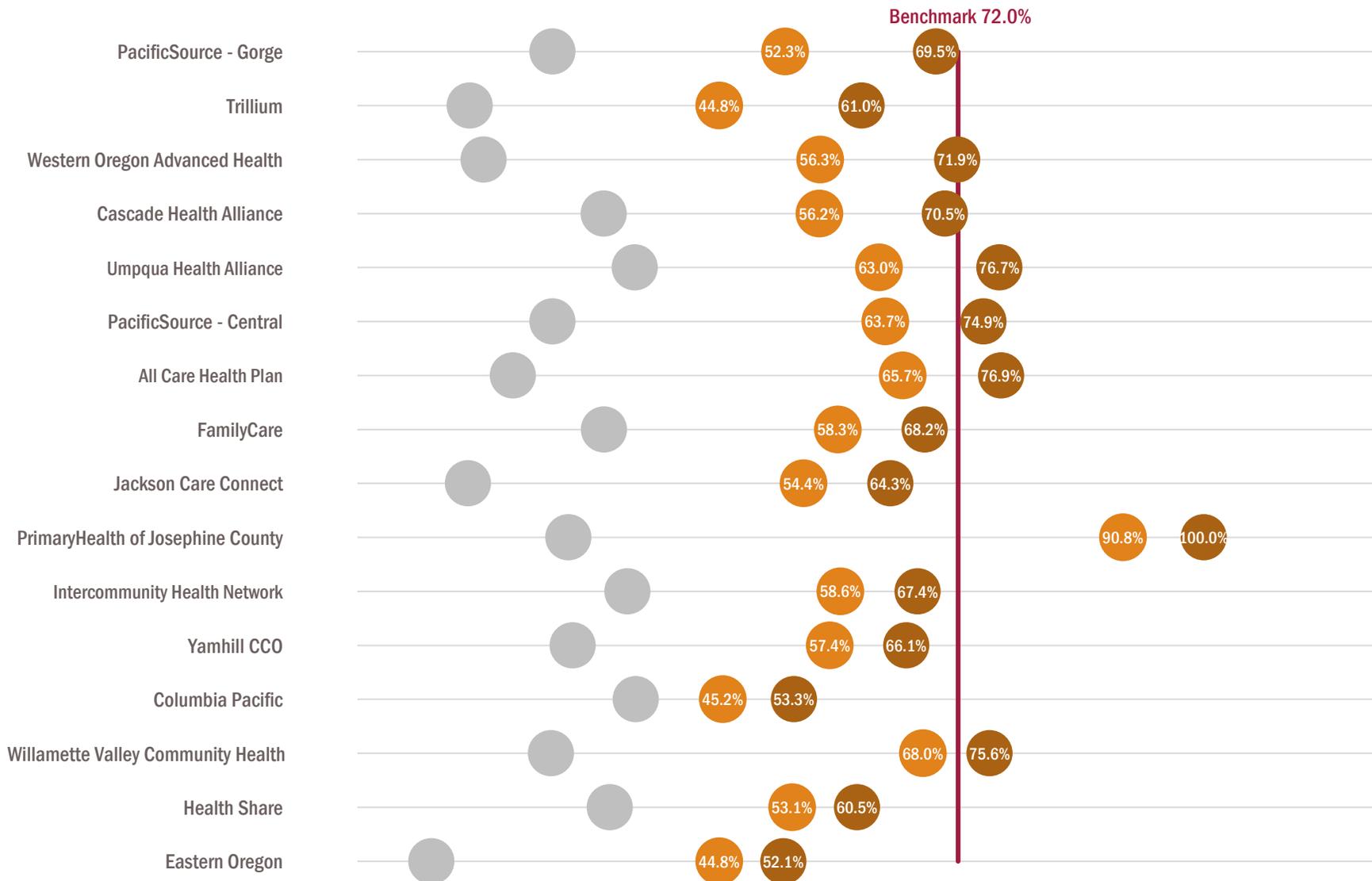
Electronic health record adoption will not be stratified by race and ethnicity.



# ELECTRONIC HEALTH RECORD ADOPTION

CCOs continued to improve electronic health record adoption between 2013 & June 2014, and several have met the benchmark.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. 2011 baseline data for PacificSource Central and Gorge are combined.





# FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

## Follow-up after hospitalization for mental illness

**Measure description:** Percentage of patients (ages 6 and older) who received a follow-up with a health care provider within seven days of being discharged from the hospital for mental illness.

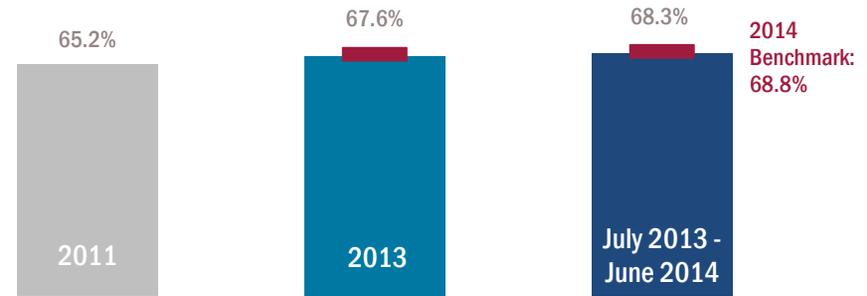
**Purpose:** Follow-up care is important to help patients make progress and feel better after being in the hospital for mental illness. This measure addresses an emerging issue for children and adults by suggesting follow up for patients ages 6 and up. Additionally, research shows that follow-up care helps keep patients from returning to the hospital, providing an important opportunity to reduce health care costs and improve health.

### July 2013 - June 2014 data (n=2,259)

This mid-year report shows follow-up after hospitalization for mental illness continues to improve and statewide performance continues to approach the benchmark. The success may be partly the result of allowing community providers to complete the follow-up which promotes behavioral and physical health care integration. This modification was developed by the Metrics Technical Advisory Group and approved by Metrics and Scoring Committee but is not part of the national HEDIS measure specifications.

## Statewide, follow-up care after hospitalization for mental illness has improved.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 National Medicaid 90th percentile



## Follow-up care after hospitalization for mental illness decreased for all racial/ethnic groups between 2013 and June 2014.

Gray dots represent 2011.  
Data missing for 6.5% of respondents. Each race category excludes Hispanic/Latino.





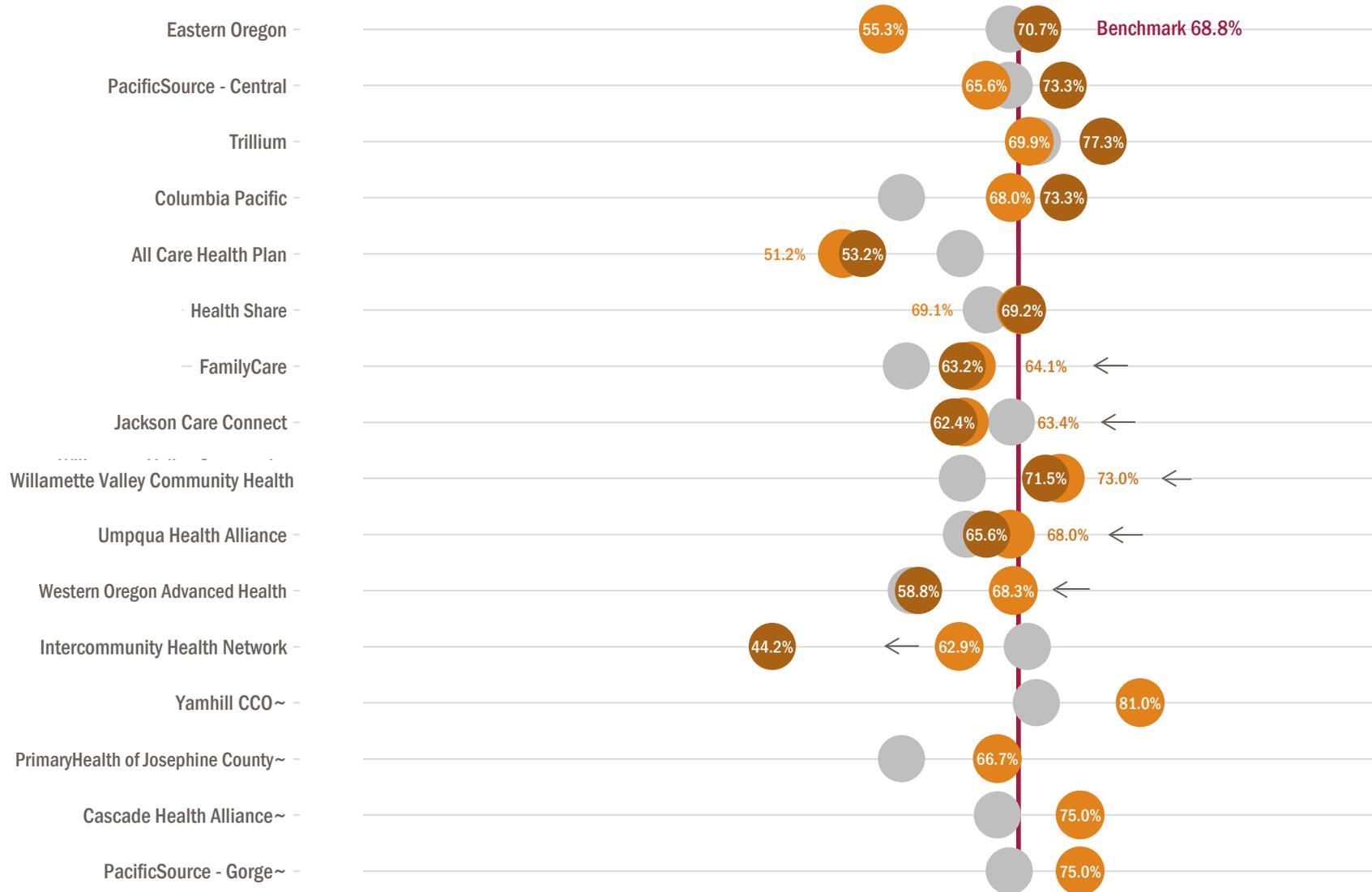
# FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

CCOs have mixed results between 2013 & June 2014 in providing timely follow-up after hospitalization for mental illness.

Gray dots represent 2011 baselines, which are pre-CCO & based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.

~ Data suppressed (n<30)



# \$ FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

## Follow-up care for children prescribed ADHD medication (initiation phase)

**Measure description:** Percentage of children (ages 6-12) who had at least one follow-up visit with a provider during the 30 days after receiving a new prescription for attention deficit hyperactivity disorder (ADHD) medication.

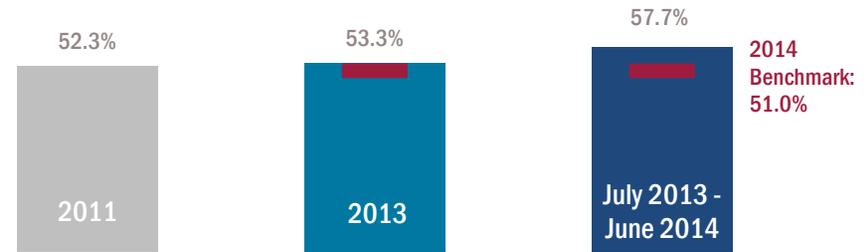
**Purpose:** Children with attention deficit hyperactivity disorder can be greatly helped by ADHD medication. One critical component of care is that children have follow-up visits once they are on the medication. After a child receives ADHD medication, a primary care provider should continue to assess learning and behavior and help manage the condition. ADHD treatment is an important emerging issue for children.

### July 2013 - June 2014 data (n=2,395)

Statewide, the follow-up for children prescribed ADHD medication has continued to improve and remains above the benchmark (57.7 percent versus 51.0 percent). All but three CCOs exceed the benchmark and follow-up care is above the benchmark for all racial and ethnic groups. New ACA members receiving a new prescription after April 2014 are included in this metric.

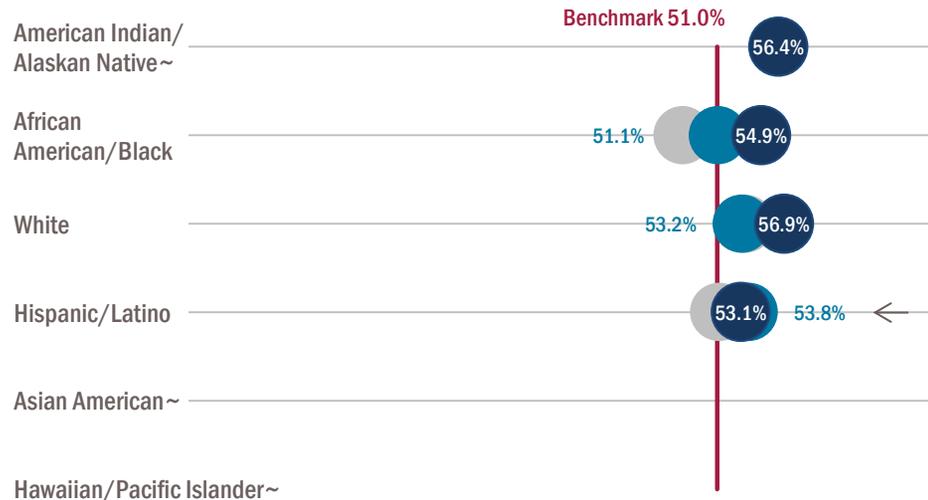
Statewide, Oregon has surpassed the benchmark in initiating follow-up care for children prescribed ADHD medication.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 National Medicaid 90th percentile



Follow-up care for children prescribed ADHD medication is above the benchmark for all racial and ethnic groups in both 2013 & June 2014.

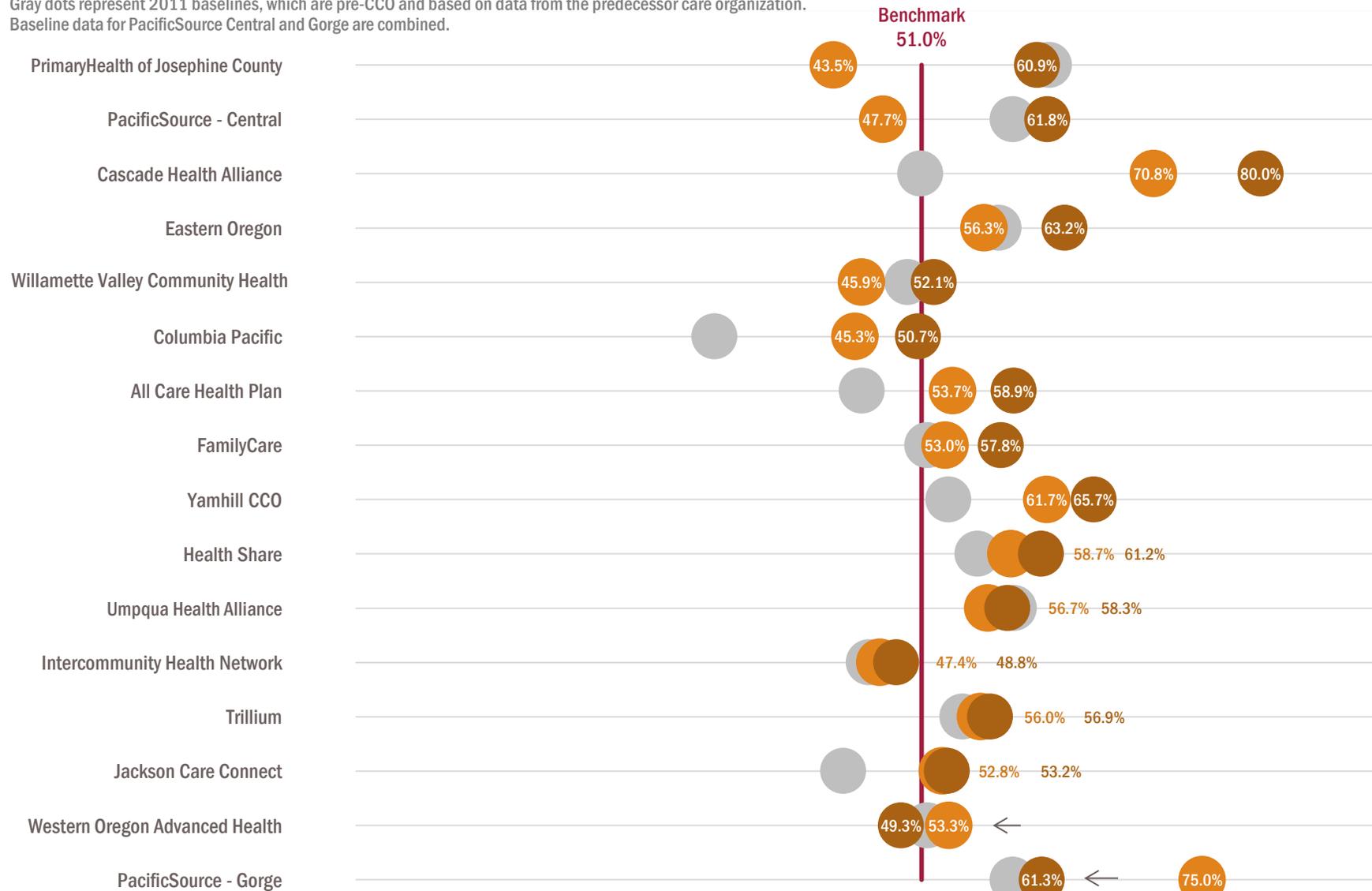
Gray dots represent 2011.  
Data missing for 8.9% of respondents. Each race category excludes Hispanic/Latino.  
~Data suppressed.



# \$ FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

## Fourteen of 16 CCOs met the benchmark for initiating follow-up care for children prescribed ADHD medication between 2013 & June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



# HEALTH STATUS (CAHPS)

## Health Status (CAHPS)

**Measure description:** Percentage of Medicaid members (adults and children) who self-report their overall health as excellent or very good.

**Purpose:** Self-reported health status is a good predictor of future disability, hospitalization, and mortality. Programs to prevent or manage diseases and increase healthy behaviors can all lead to improved health status.

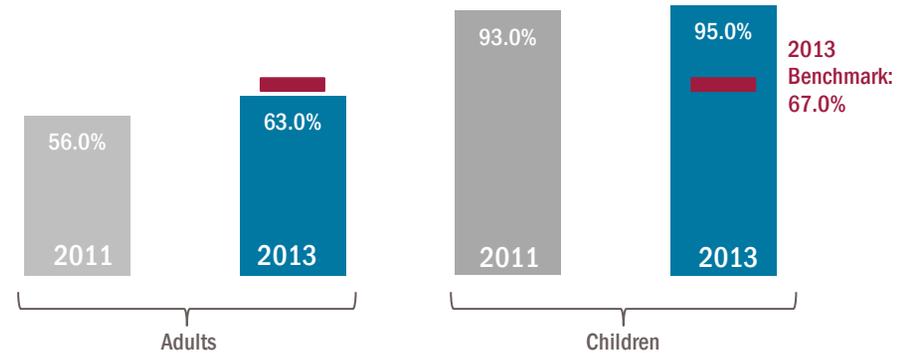
### Calendar year 2013 data

(n=4,889 adults, 5,387 children)

The percentage of Medicaid members who report their overall health is good or excellent improved from 2011 before the Coordinated Care Model was in existence to 2013. This is self-reported information from members who were enrolled in Medicaid during 2013 so does not include new ACA enrollees.

Statewide, the percentage of Medicaid members who feel healthy increased between 2011 and 2013.

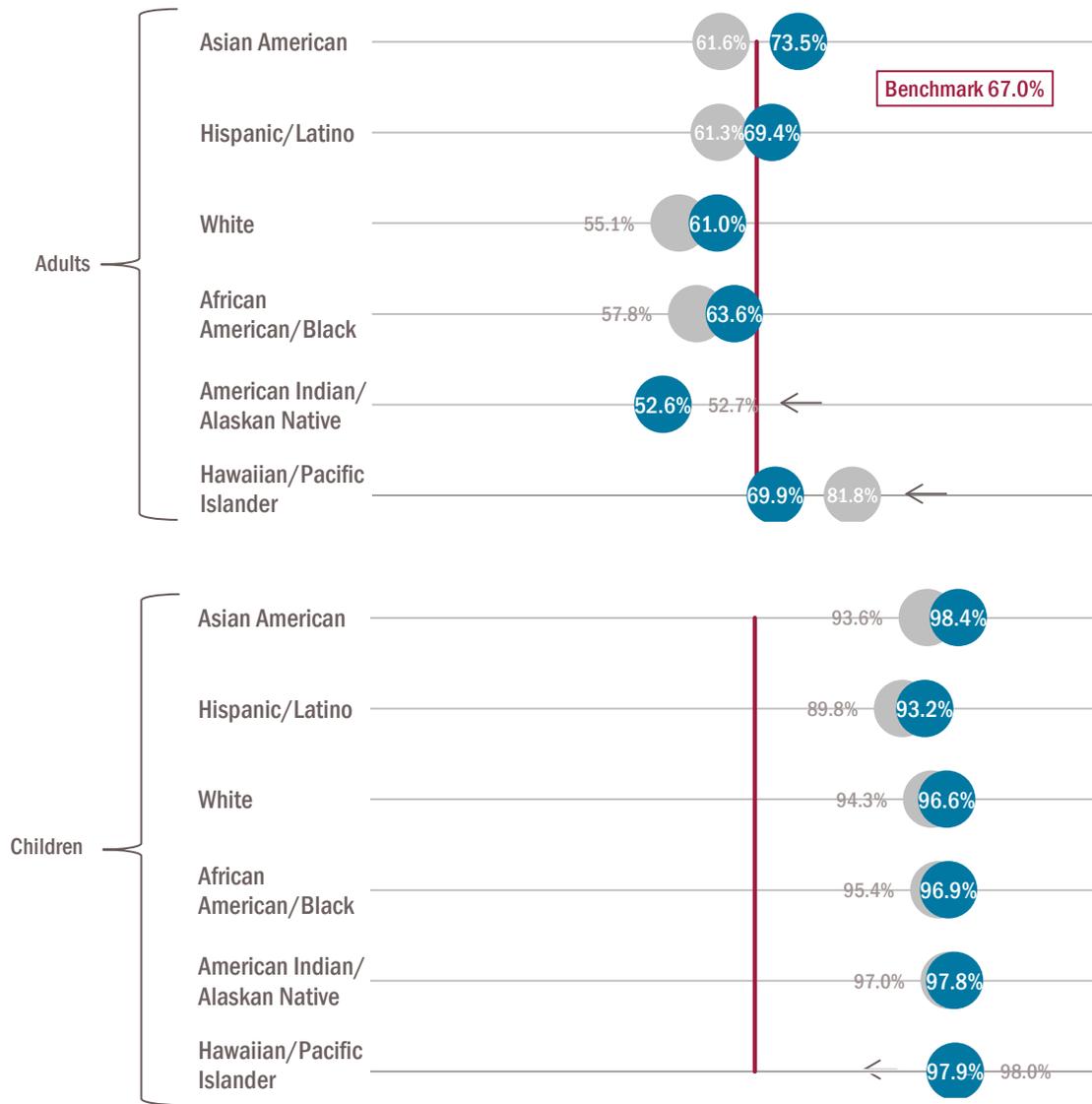
Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)  
2013 benchmark source: National CAHPS comparative data.





# HEALTH STATUS (CAHPS)

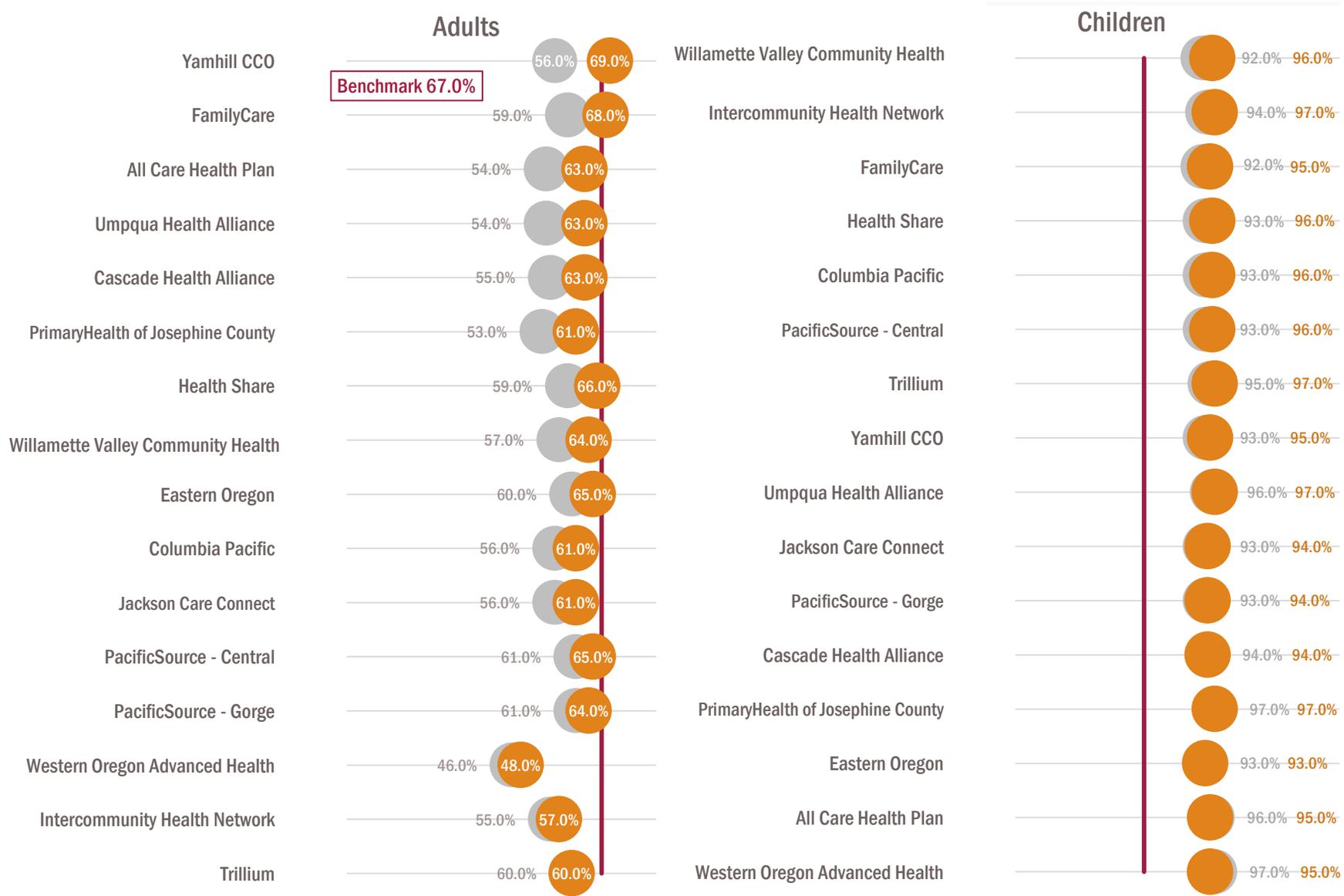
While most racial/ethnic groups felt healthier in 2013 than 2011, Hawaiian/Pacific Islander children and adults felt less healthy.



# HEALTH STATUS (CAHPS)

All CCOs showed improvement in member health status between 2011 & 2013.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.





# IMMUNIZATION FOR ADOLESCENTS

## Immunization for adolescents

**Measure description:** Percentage of adolescents who received recommended vaccines before their 13th birthday.

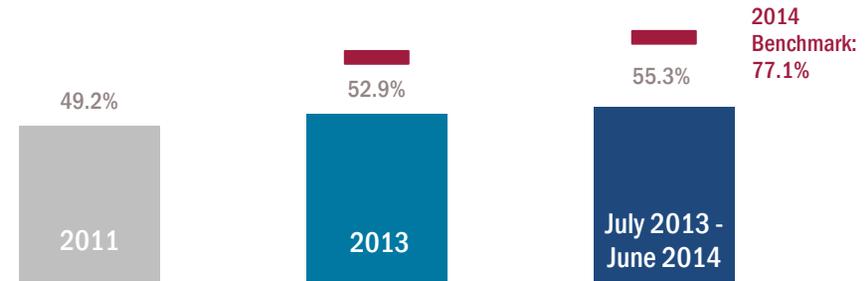
**Purpose:** Like young children, adolescents also benefit from immunizations. Vaccines are a safe, easy and cost-effective way to prevent serious disease. Vaccines are also cost-effective tools that help to prevent the spread of serious and sometimes fatal diseases.

### July 2013 - June 2014 data (n=12,595)

Adolescent immunizations continued to increase over 2011 baseline and reached 55.3 percent in June 2014. However, there is still room for improvement. Adolescent immunizations improved for all racial/ethnic groups since 2013 and most CCOs. However, even the highest performing CCOs are still 10 percentage points below the benchmark.

## Statewide, adolescent immunizations continue to increase in June 2014.

Data source: Administrative (billing) claims and ALERT Immunization Information System



## Adolescent immunization increased for all racial/ethnic groups between 2013 & June 2014.

Gray dots represent 2011. Data missing for 7.2% of respondents. Each race category excludes Hispanic/Latino. ~Data suppressed (n<30)

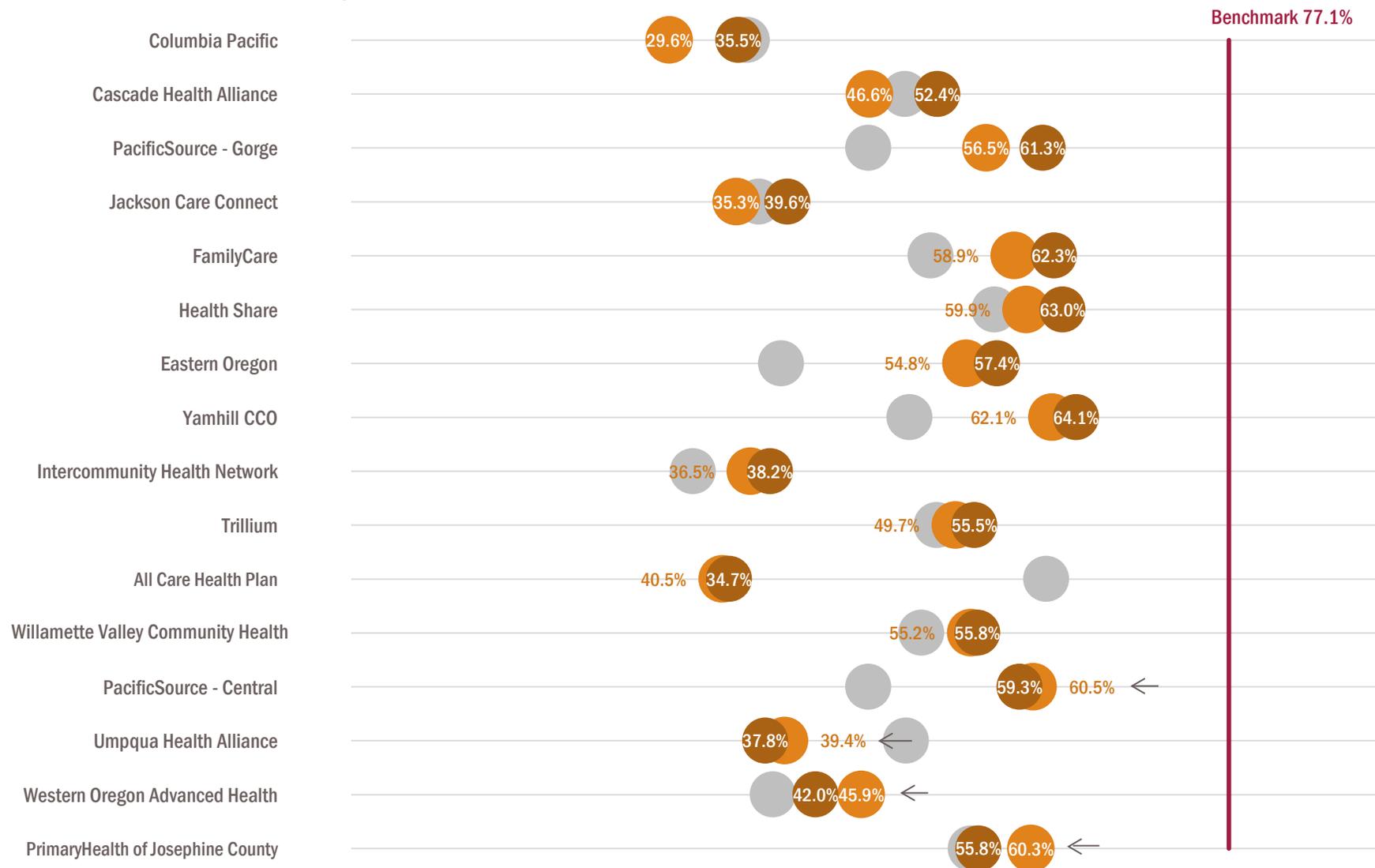




# IMMUNIZATION FOR ADOLESCENTS

While many CCOs improved adolescent immunizations between 2013 & June 2014, no CCOs have met the benchmark.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.





# INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)

## Initiation and engagement of alcohol or other drug treatment (initiation phase)

**Measure description:** Percentage of patients (ages 13 and older) newly diagnosed with alcohol or other drug dependence and who began treatment within 14 days of the initial diagnosis.

**Purpose:** There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition.

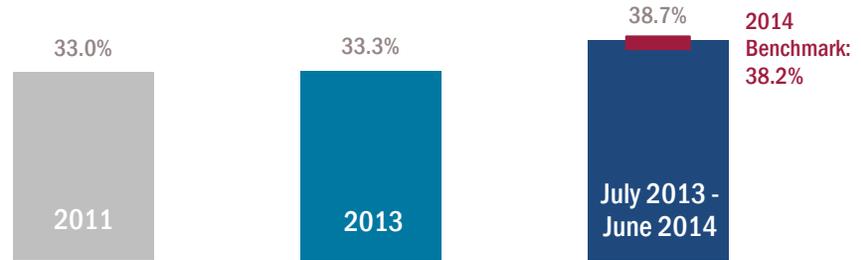
Deliberate efforts to reach those with alcohol or other drug dependence and keep them engaged in treatment can improve health outcomes and save on health care costs.

### June 2013 - July 2014 data (n=11,596)

Statewide the percentage of patients ages 13 and older newly diagnosed with alcohol or drug dependence who began treatment within 14 days of diagnosis surpassed the benchmark in June 2014. Eight of 16 CCOs performed above the benchmark (2013 national Medicaid median). However, with less than 40 percent of newly diagnosed patients receiving timely alcohol or drug treatment, there is much room for improvement.

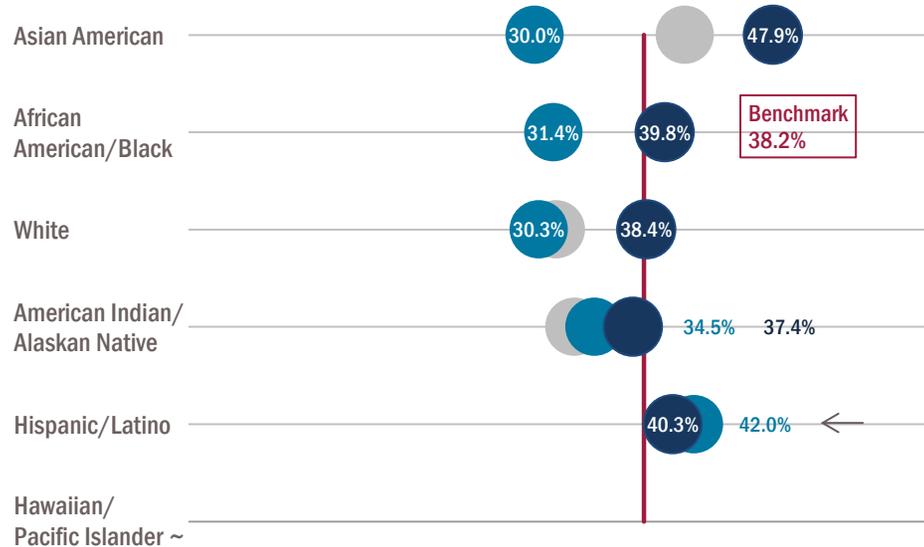
## Statewide, initiation of alcohol or other drug treatment has increased.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 national Medicaid median



## Initiation has improved for every group except Hispanic/Latinos between 2013 & June 2014.

Gray dots represent 2011.  
Data missing for 8.0% of respondents. Each race category excludes Hispanic/Latino.  
~ Data suppressed due to small denominator.



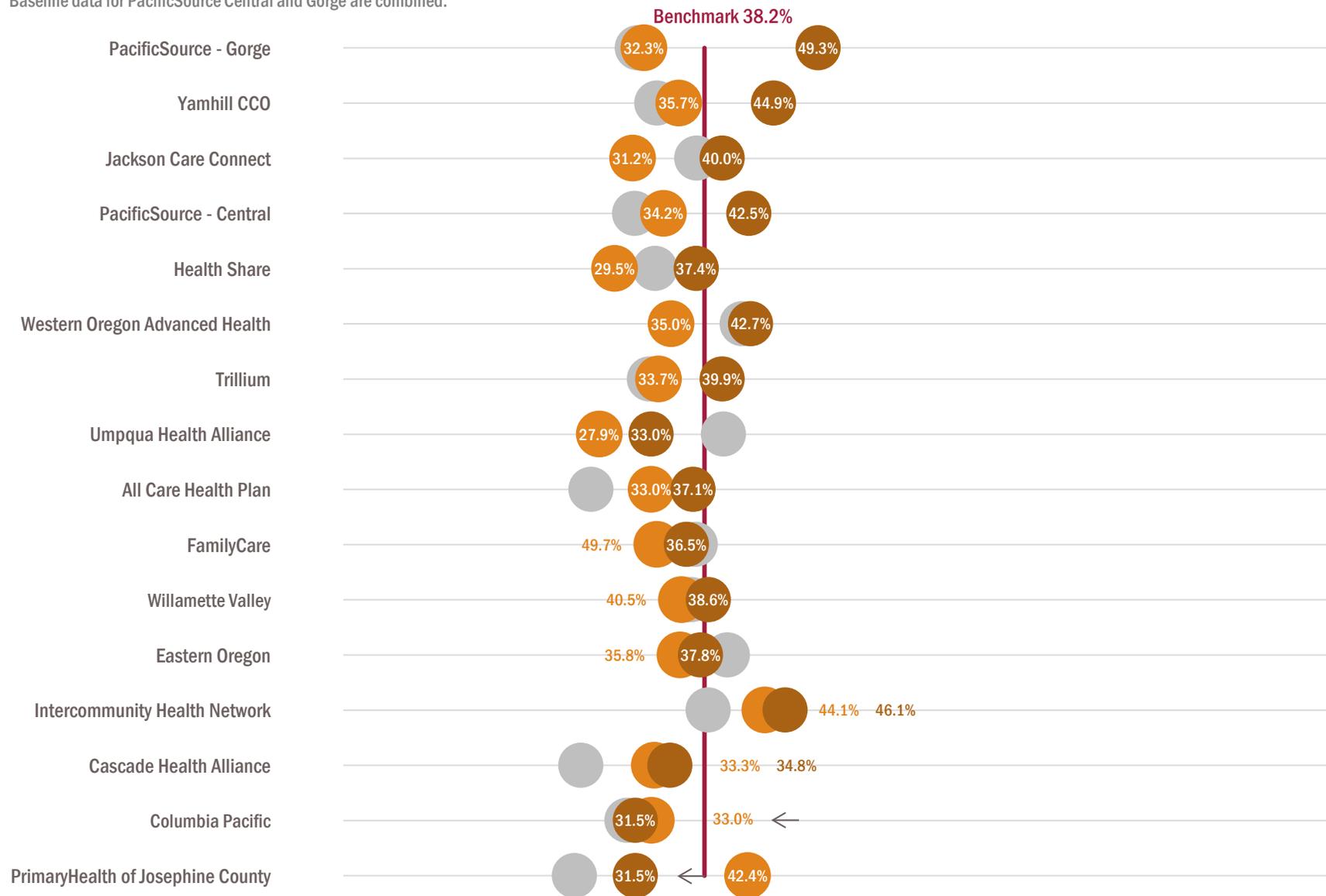


# INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)

## Initiation rates improved for most CCOs between 2013 & June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.





# INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

## Initiation and engagement of alcohol or other drug treatment (engagement phase)

**Measure description:** Percentage of patients (ages 13 and older) who had two or more additional services for alcohol or other drug dependence within 30 days of their initial treatment.

**Purpose:** Many individuals with alcohol and other drug disorders leave treatment prematurely, even though individuals who remain in treatment longer have better outcomes. Ongoing engagement is an important step between the first visit and completing a full treatment.

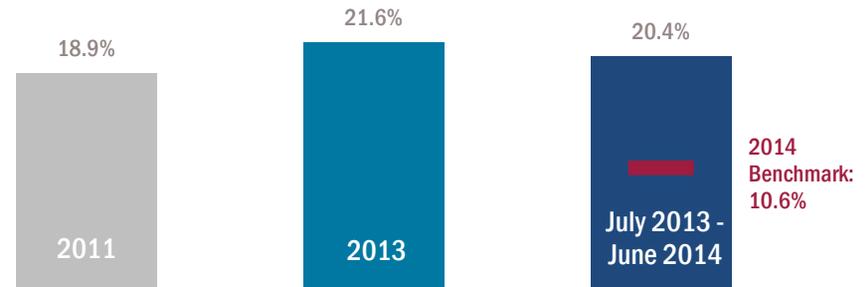
Deliberate efforts to reach those with alcohol or other drug dependence and keep them engaged in treatment can improve health outcomes and save on health care costs.

### June 2013 - July 2014 data (n=11,596)

Statewide the percentage of patients ages 13 and older with two or more services for alcohol or drug dependence within 30 days of initial treatment dropped from 2013 to June 2014. This metric decreased among all racial and ethnic groups as well as 11 CCOs. This metric shows an area of behavioral health integration that needs focus for future improvements. Nationally, performance on this metric is low with a Medicaid median of 10.6 percent.

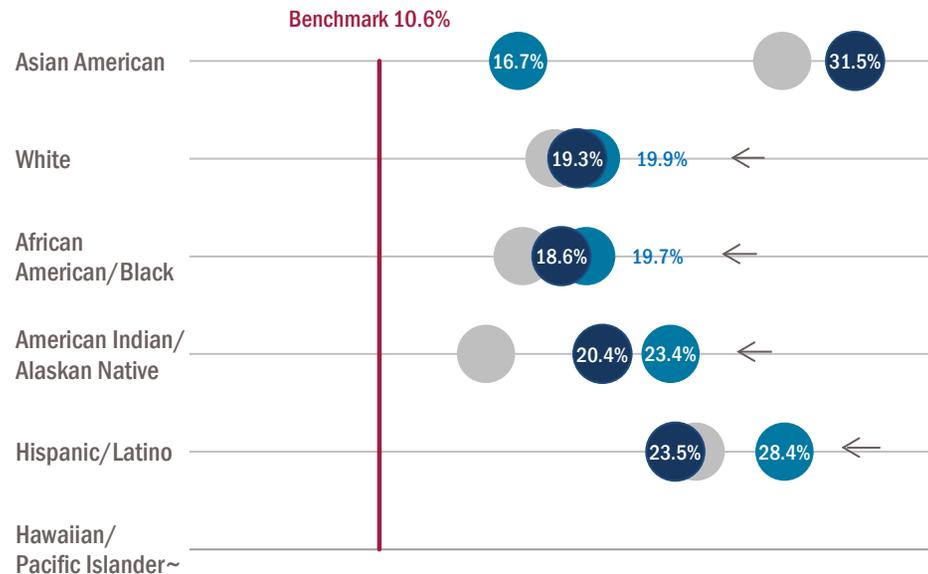
## Statewide, engagement of alcohol or other drug treatment has fallen slightly this year.

Data source: Administrative (billing) claims  
2014 benchmark source: 2013 national Medicaid median



## Engagement has fallen for all racial/ethnic groups between 2013 and June 2014.

Gray dots represent 2011.  
Data missing for 8.0% of respondents. Each race category excludes Hispanic/Latino.  
~ Data suppressed (n<30)





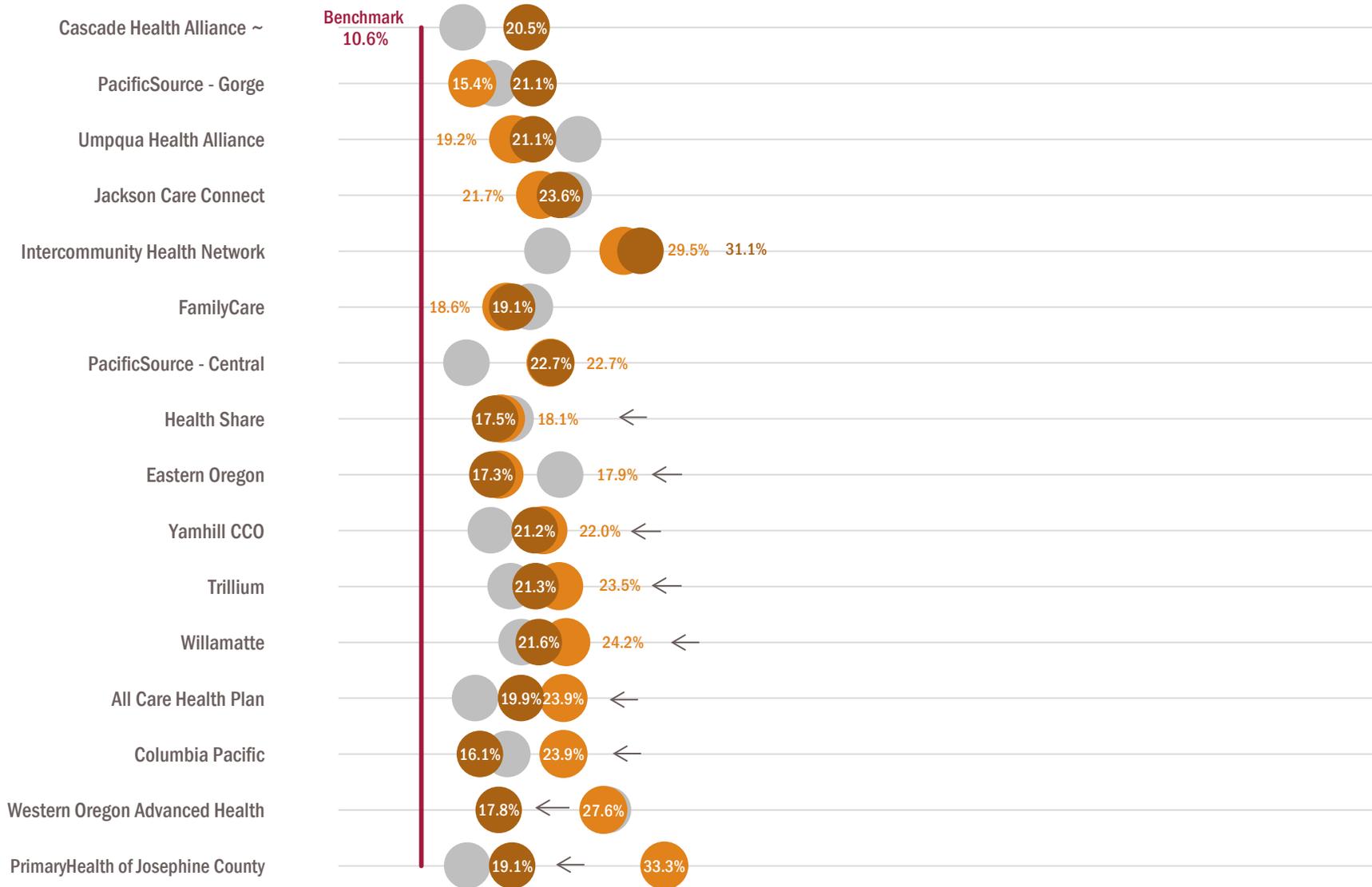
# INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

## Engagement has declined slightly in many CCOs between 2013 & June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.

~ Data suppressed (n<30)





# LOW BIRTH WEIGHT PREVALENCE

## Low birth weight prevalence

**Measure description:** Percentage of live births that weighed less than 2,500 grams (5.5 lbs)

**Purpose:** Low birth weight babies are more likely than babies with normal weight to have health problems as a newborn and may be more likely to have chronic health conditions later in life. Some risk factors for low birth weight can be identified through timely prenatal care and can be addressed through behavioral changes and treatment of the mother's chronic conditions.

### July 2013 - June 2014 data (n=12,185)

The percentage of live births with low birth weight remained roughly the same between 2013 and June 2014 at 5.6 percent. CCOs ranged from 3.8 percent to 7.8 in June 2014.

Statewide, low birth weights have remained steady and are below the benchmark.

(Lower scores are better)

Data source: Administrative (billing) claims

2014 benchmark source: County health rankings 90th percentile

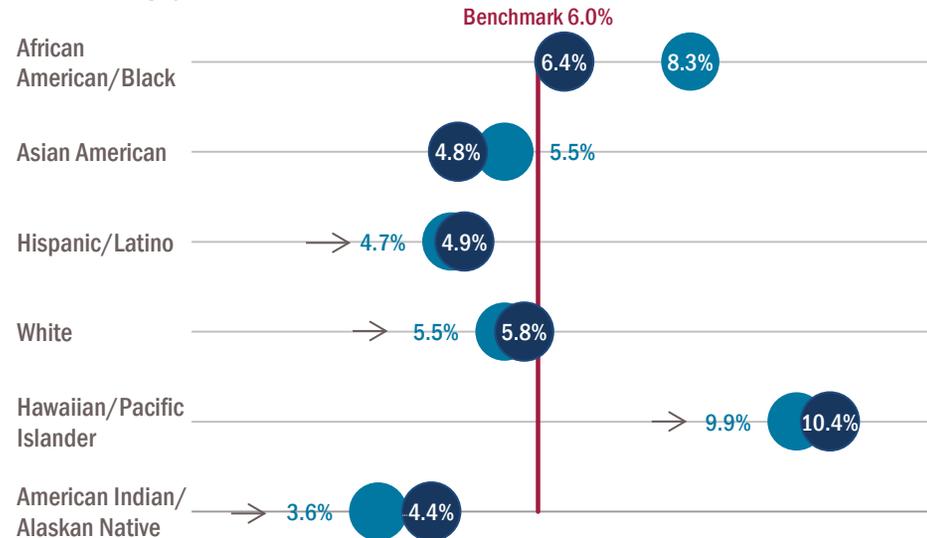


## African Americans experienced the greatest improvement in reducing low birth weights between 2013 & June 2014.

(Lower scores are better)

Data missing for 14.3% of respondents.

Each race category excludes Hispanic/Latino.





# LOW BIRTH WEIGHT PREVALENCE

## CCO performance reducing on low birth weight was mixed between 2013 & June 2014.

(Lower is better)

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.





# MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (PART 1)

## Medical assistance with smoking and tobacco use cessation

**Component 1:** Percentage of adult tobacco users advised to quit by their doctor.

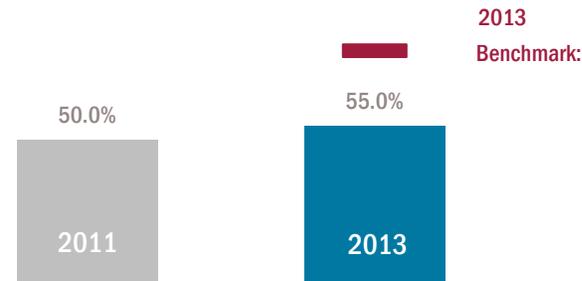
**Purpose:** Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

### Calendar year 2013 data:

Statewide, doctors were more likely to advise smokers to quit in 2013 than in 2011. While a promising increase, there is still room for improvement as providers should advise all tobacco users to quit. Asian American and Hawaiian/Pacific Islander tobacco users were most likely to receive advice to quit in 2013. Most CCOs showed small improvements in providers advising tobacco users to quit.

Statewide, doctors were more likely to advise smokers to quit in **2013** than in **2011**.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)  
2013 benchmark source: 2012 National Medicaid 90th percentile



Asian American and Hawaiian/Pacific Islander adult tobacco users were least likely to receive advice to quit in **2011** but most likely in **2013**.

Each race category excludes Hispanic/Latino.



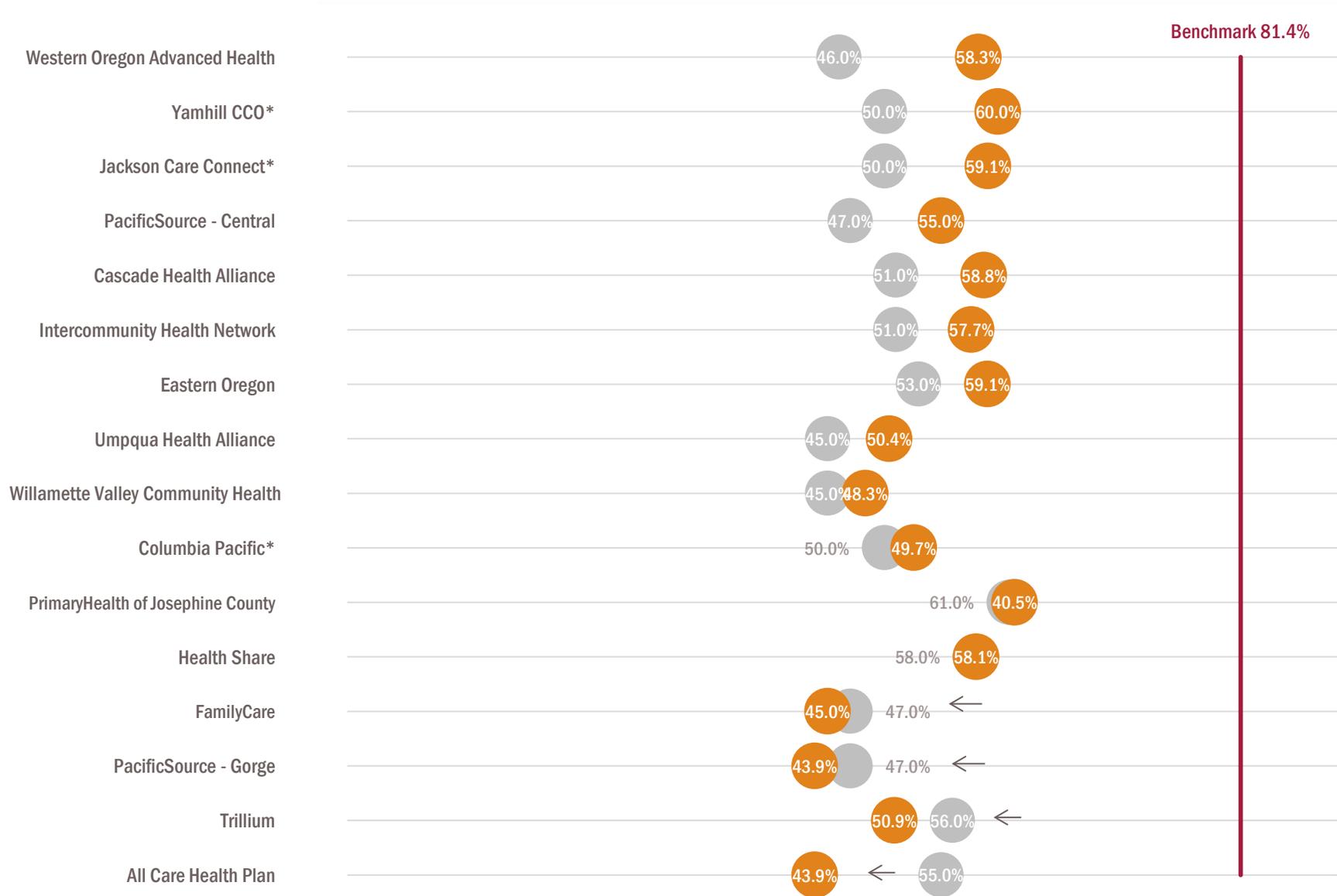


# MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (PART 1)

Twelve of 16 CCOs improved on this metric between 2011 and 2013, however nobody has reached the benchmark.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

\*CCO baseline could not clearly be attributed to past FCHP; baseline provided is state average.





# MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (PART 2)

## Medical assistance with smoking and tobacco use cessation

**Component 2:** Percentage of adult tobacco users whose doctor discussed or recommended medication to quit smoking.

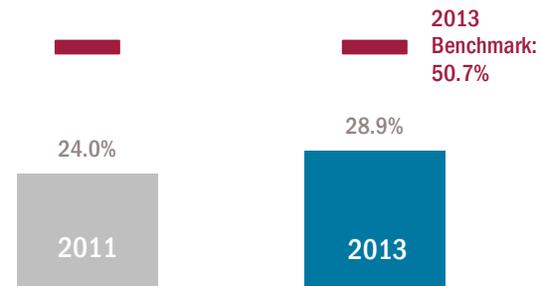
**Purpose:** Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

### Calendar year 2013 data:

Statewide, doctors were more likely to recommend medication to quit smoking in 2013 than in 2011. However, statewide performance is still well below the benchmark. Asian American tobacco users were most likely to receive advice on cessation medications in 2013. CCOs ranged from 16.8 percent to 41.9 percent in 2013.

## Statewide, doctors were more likely to recommend medications to quit smoking in 2013 than in 2011.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)  
2013 benchmark source: 2012 National Medicaid 90th percentile.



## Most racial/ethnic groups were more likely to receive advice on cessation medications in 2013 than 2011.

Each race category excludes Hispanic/Latino.  
2013 benchmark source: 2012 National Medicaid 90th percentile



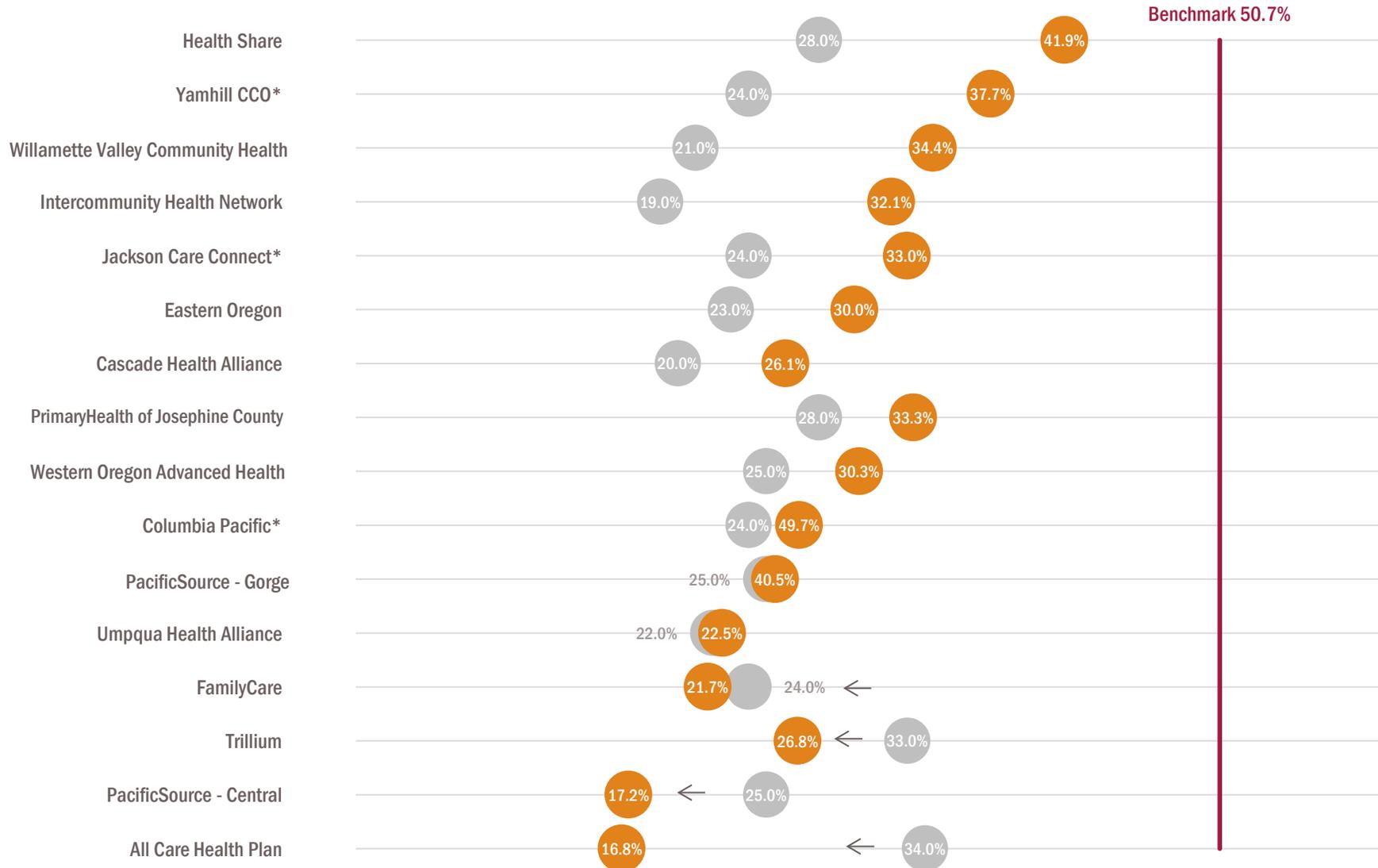


# MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (PART 2)

Tobacco users across 12 CCOs were more likely to be recommended cessation medications by their doctor in 2011 than 2013.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

\*CCO baseline could not clearly be attributed to past FCHP; baseline provided is state average.





# MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (PART 3)

## Medical assistance with smoking and tobacco use cessation

**Component 3:** Percentage of adult tobacco users whose doctor discussed or recommended strategies to quit smoking.

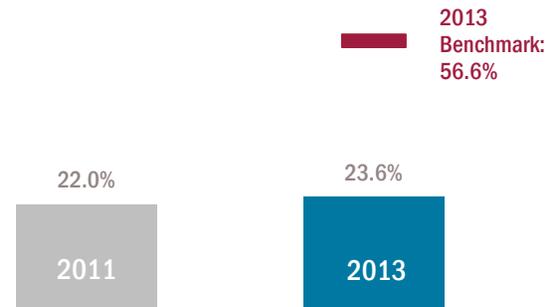
**Purpose:** Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

### Calendar year 2013 data:

While there was slight increase between 2011 and 2013, there is still considerable room for improvement on the percentage of doctors who discuss or recommend strategies to quit smoking. Hawaiian/Pacific Islander and Asian American tobacco users were least likely to receive recommendations on strategies to quit in 2011, but most likely 2013.

Statewide, there is much for improvement toward the benchmark.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)  
2013 benchmark source: 2012 National Medicaid 90th percentile



Asian American and Hawaiian/Pacific Islander tobacco users were least likely to receive advice to quit in 2011 but most likely in 2013.

Each race category excludes Hispanic/Latino.



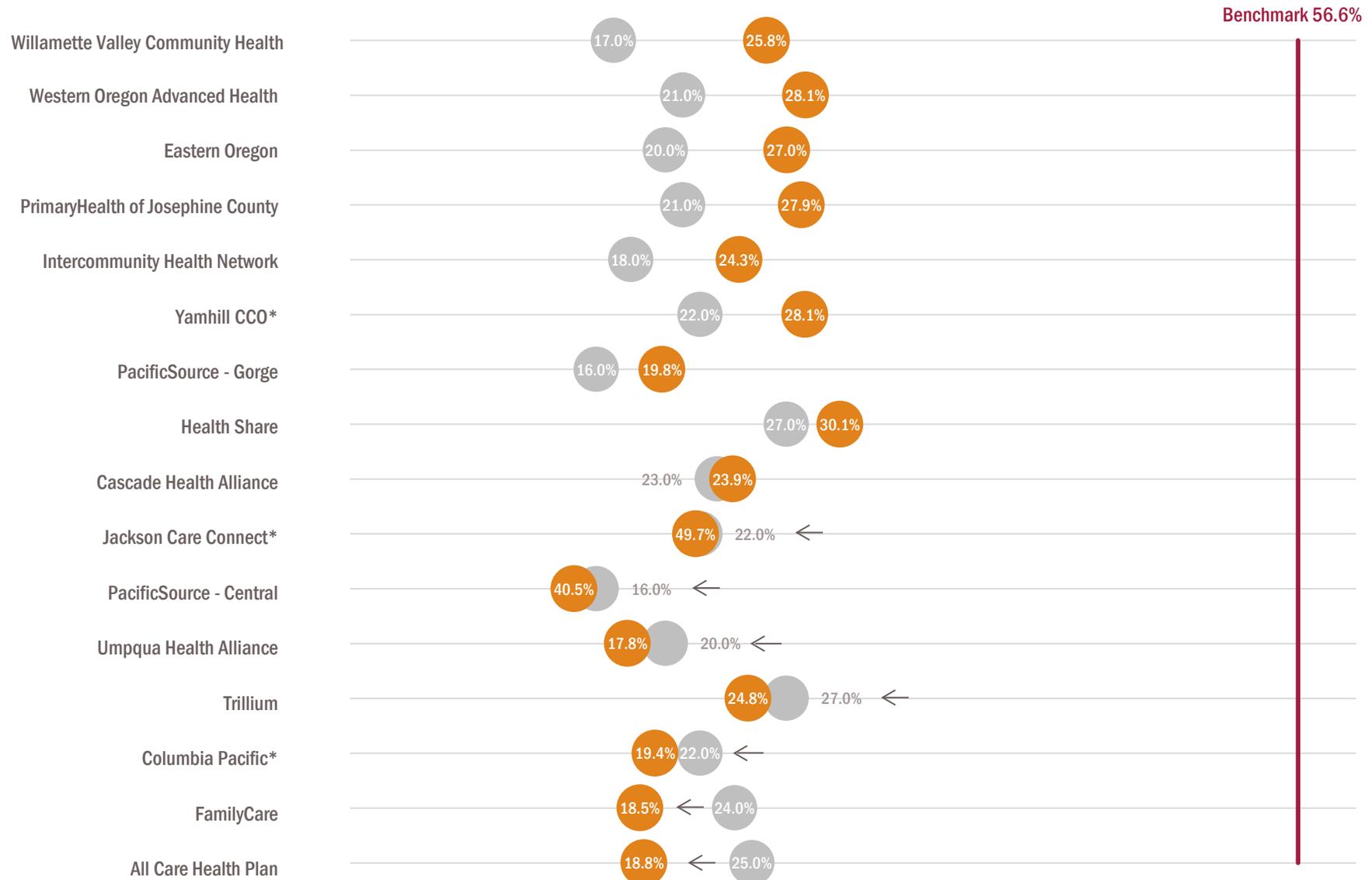


# MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (PART 3)

The likelihood of doctors recommending cessation medications was mixed between 2011 and 2013.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

\*CCO baseline could not clearly be attributed to past FCHP; baseline provided is state average.





# MENTAL AND PHYSICAL HEALTH ASSESSMENTS WITHING 60 DAYS FOR CHILDREN IN DHS CUSTODY

## Mental and physical health assessments within 60 days for children in DHS custody

**Measure description:** Percentage of children age 4+ who receive a mental health assessment and physical health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care). Physical health assessments are required for children under age 4, but not mental health assessments.

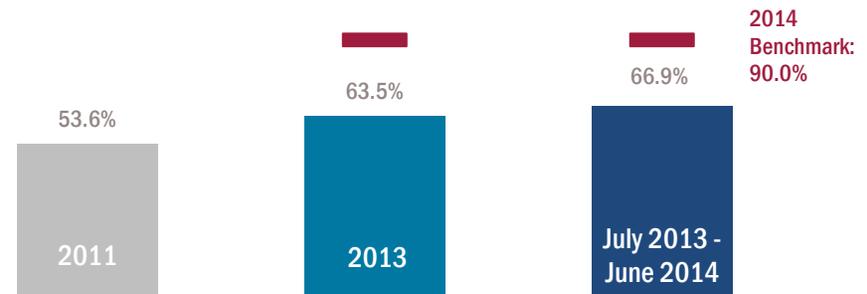
**Purpose:** Children who have been placed in foster care should have their mental and physical health checked so that an appropriate care plan can be developed. Mental and physical health assessments are a requirement for the foster program because of their importance to improving the health and well-being of a child in a trying situation.

### July 2013 - June 2014 data (n=1,034)

This measure has continued systematic challenges that can make it difficult to measure and report by CCO. Despite these challenges, the percentage of children receiving timely physical and mental health assessments has continually increased. Since 2011, the percentage has grown by nearly 25 percent. This means that more children entering the foster care system are receiving needed assessments to help improve their health and well-being. OHA and the CCOs are continuing to work together on the methodology to improve data collection and reporting for this measure. Nonetheless, assessments across all race and ethnicity groups have increased since 2011.

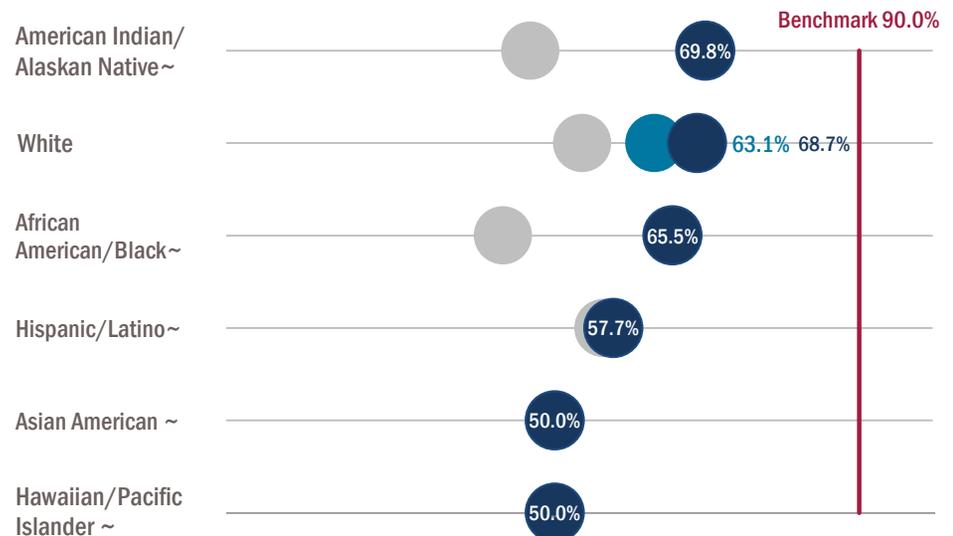
## Statewide, health assessments for children in foster care are improving slightly.

Data source: Administrative (billing) claims + ORKids  
2014 benchmark source: Metrics and Scoring Committee consensus



## American Indian/Alaskan Native children in foster care were most likely to receive comprehensive health assessments in June 2014.

Gray dots represent 2011.  
Data missing for 1.6% of respondents. Each race category excludes Hispanic/Latino.  
~Data suppressed (n<30)





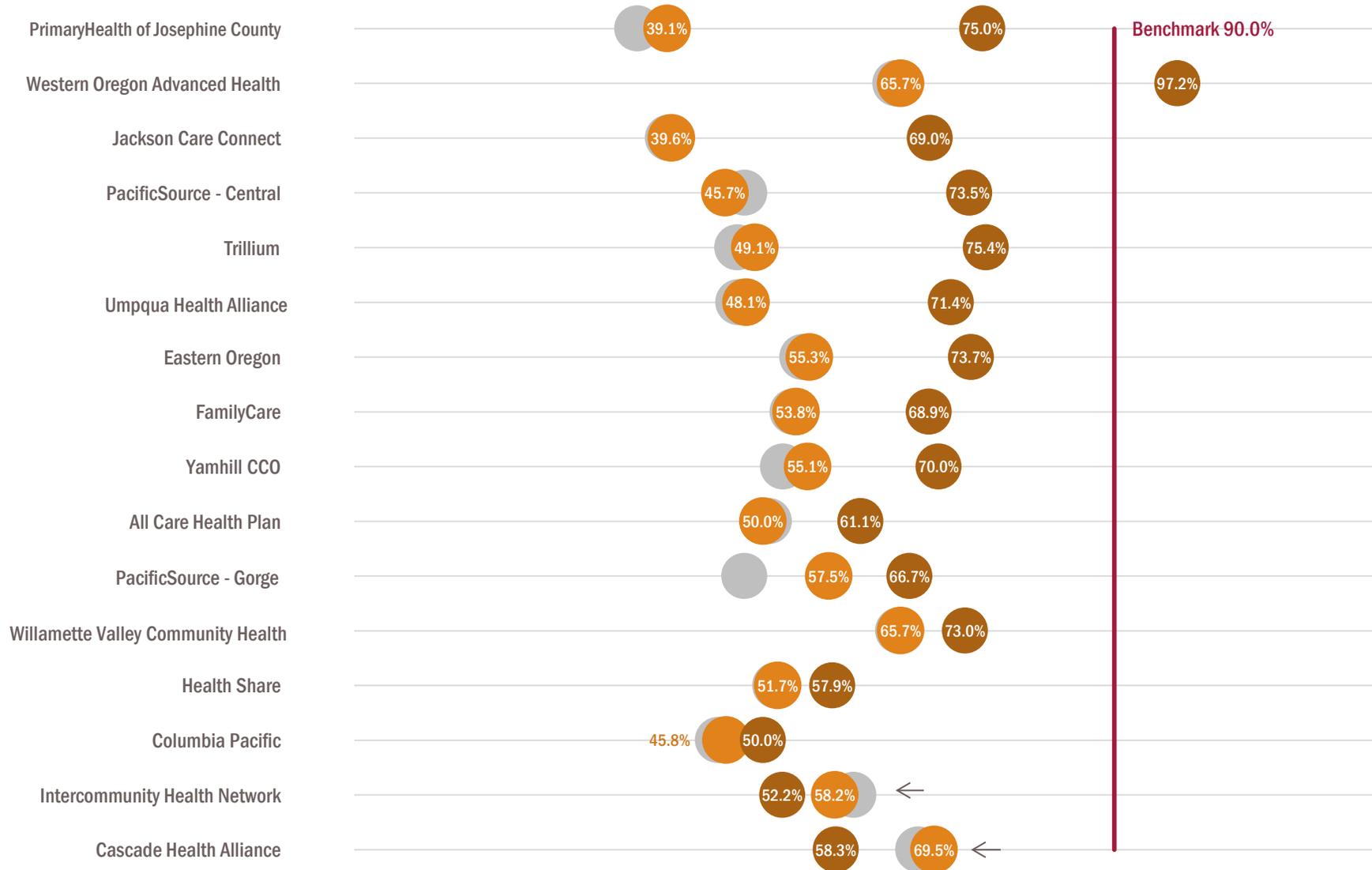
# MENTAL AND PHYSICAL HEALTH ASSESSMENTS WITHING 60 DAYS FOR CHILDREN IN DHS CUSTODY

## Fourteen of 16 CCOs improved on mental and physical health assessments for children in foster care between 2013 & June 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.

2013 data have been refreshed to reflect combined 2011 and 2013 performance. This combined data provides larger denominators and is more comparable to 2014 performance.





# OBESITY PREVALENCE

## Obesity prevalence

**Measure description:** Percentage of adult Medicaid members (ages 18 and older) who are obese, defined as body mass index greater than 30.

**Purpose:** Obesity is the second leading cause of preventable death in Oregon and is a major risk factor for many conditions like diabetes, cancer, and heart disease. In addition to improving health outcomes, helping people reach a healthy weight can reduce health care costs.

### 2012 data

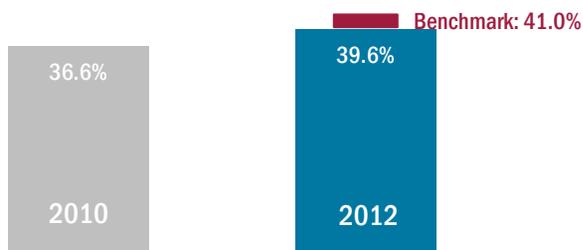
The prevalence of obesity among Medicaid members increased slightly but remained below the benchmark established in Oregon's waiver (lower is better). Updated obesity prevalence at the state, race/ethnicity, and CCO level from a Medicaid Behavioral Risk Factor Surveillance Survey will be available in the next performance report.

Statewide, obesity prevalence increased slightly between 2010 and 2012.

(Lower is better)

Data source: Oregon Behavioral Risk Factor Surveillance System (BRFSS)

2014 benchmark source: Oregon's 1115 demonstration waiver goals





# PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

## Patient-centered primary care home enrollment

**Measure description:** Percentage of patients who were enrolled in a recognized patient-centered primary care home (PCPCH).

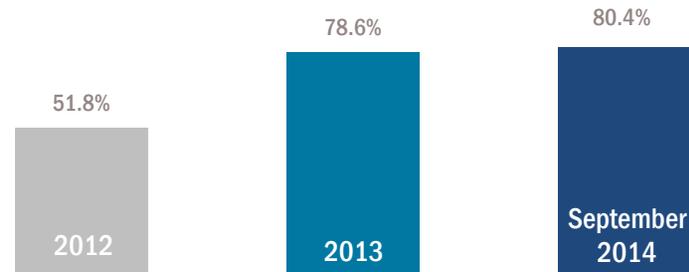
**Purpose:** Patient-centered primary care homes are clinics that have been recognized for their commitment to quality, patient-centered, coordinated care. Patient-centered primary care homes help improve a patient's health care experience and overall health.

### Data as of September 2014 (n=868,392)

Enrollment in patient-centered primary care homes has increased by 55 percent since 2012, the baseline year for that program. Enrollment continued to improve through June 2014 despite large increases in CCO enrollment due to the new ACA population. PCPCH enrollment dipped in the first quarter of 2014 but by the third quarter of 2014 the drop had been made up by CCOs enrolling new members into PCPCHs.

## Statewide, patient-centered primary care home enrollment continues to increase.

Data source: CCO quarterly report  
2014 benchmark source: n/a



## Race and ethnicity data.

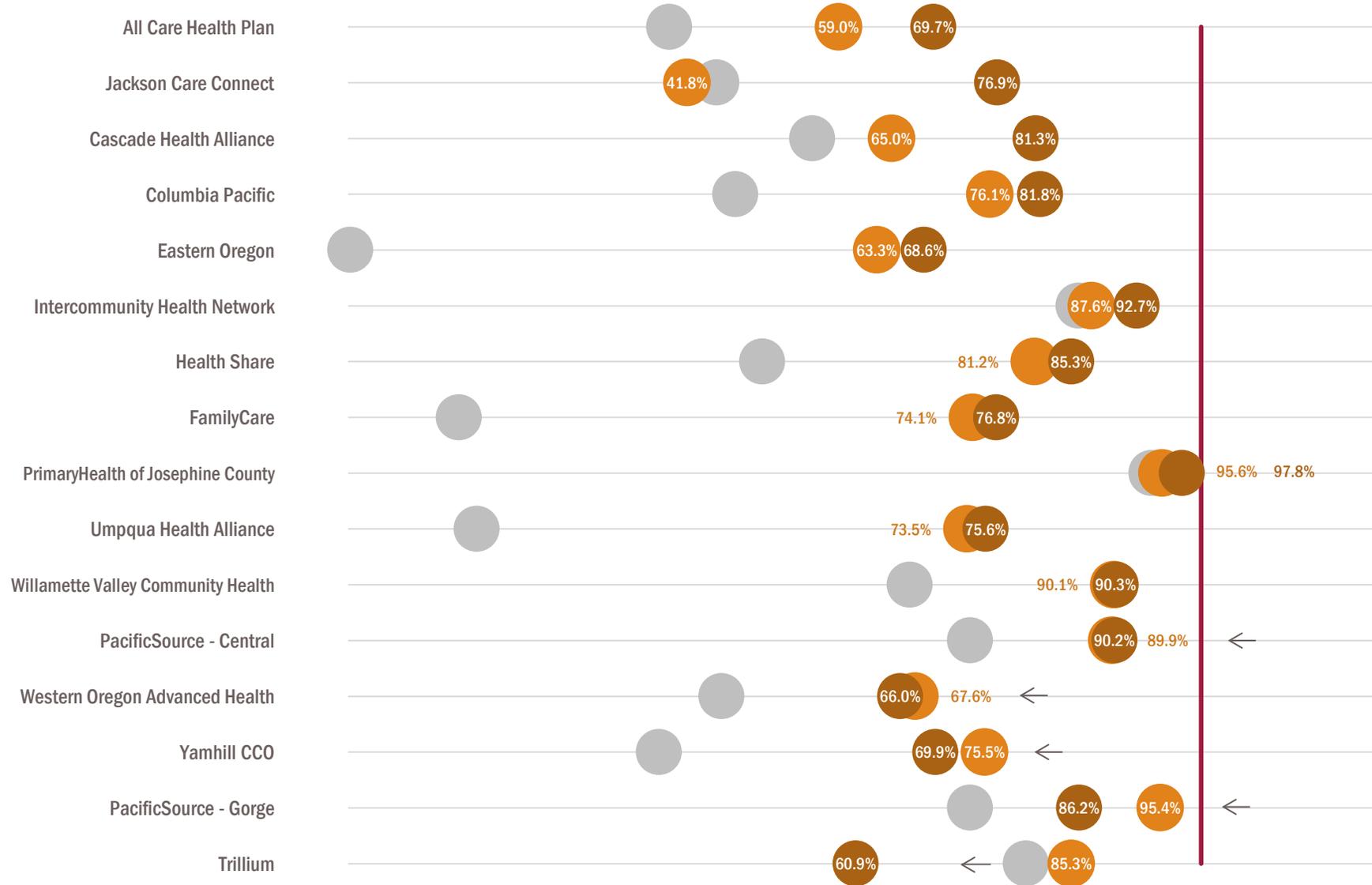
Patient-centered primary care enrollment will not be stratified by race and ethnicity.



# PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Overall, PCPCH enrollment continues to increase between 2013 & September 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.  
 Baseline data for PacificSource Central and Gorge are combined.





# DIABETES SHORT-TERM COMPLICATION ADMISSION RATE (PQI 01)

## Diabetes short term complications admission rate

**Measure description:** Rate of adult patients (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease. Rates are reported per 100,000 member years. A lower score is better.

PQIs (prevention quality indicators) come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

**Purpose:** Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce the costs of health care.

### July 2013 - June 2014 data (n=3,835,271 member months)

The 2013 rate shows a modest increase compared to 2011 and the June 2014 rate shows a marked decline (9 percent reduction since 2011).

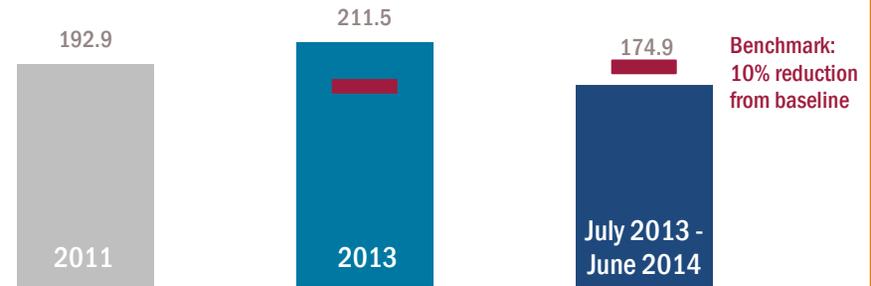
All of the expansion population is included in the PQI measures, and the denominator has increased by 44 percent. While the number of numerator events has increased, the influx of new members in the denominator has increased at a faster pace, resulting in a continued drop in the PQI rates (lower is better).

## Statewide, hospital admission rates due to diabetes complications have declined.

(Lower scores are better)

Data source: Administrative (billing) claims

2014 benchmark source: OHA consensus, based on prior performance trend



## American Indian/Alaskan Natives experienced the most improvement between 2013 and June 2014, yet hospital admission rates remain higher than other groups.

(Lower scores are better.)

Gray dots represent 2011. Data missing for 8.7% of respondents.

Each race category excludes Hispanic/Latino.





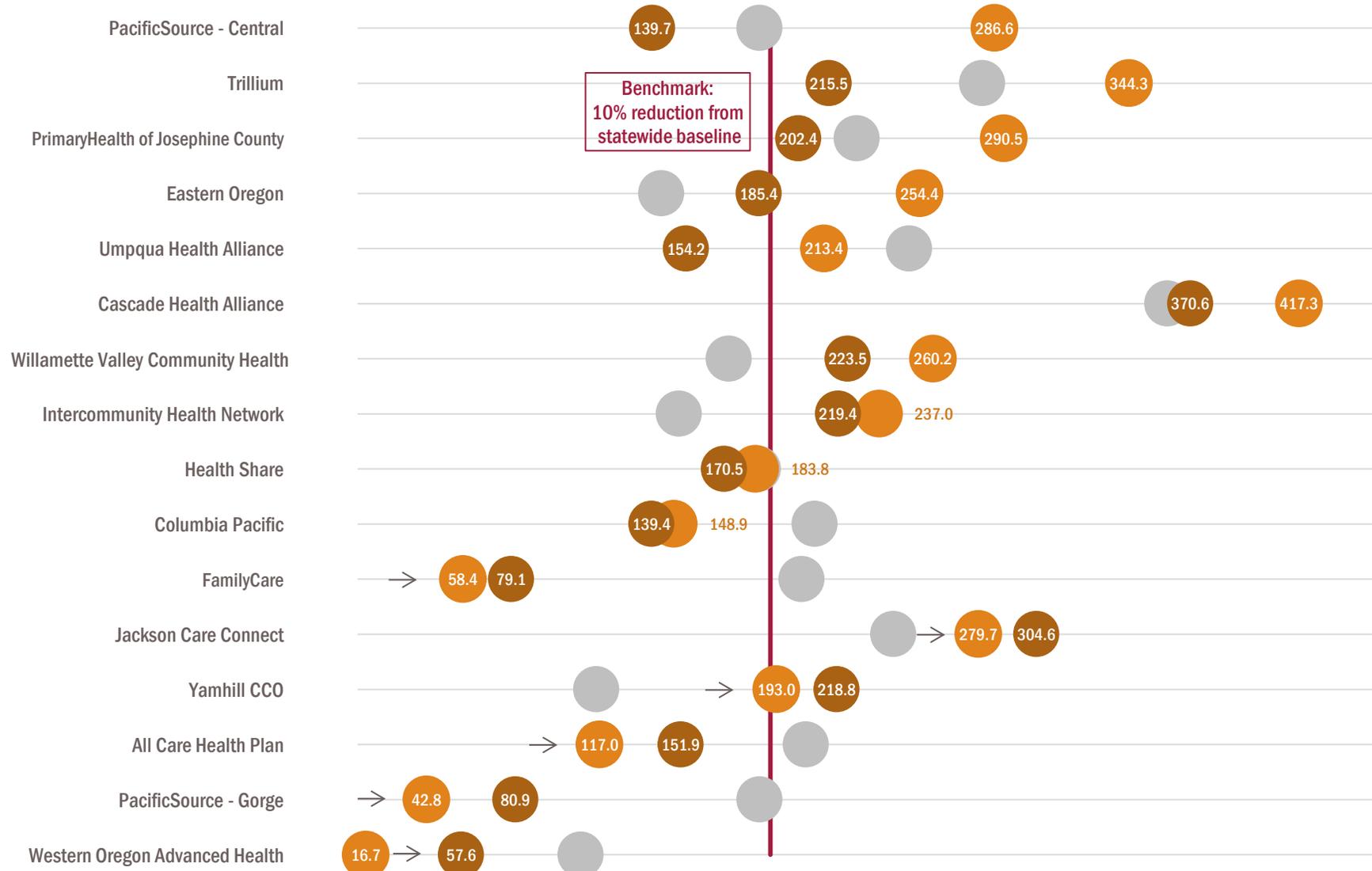
# DIABETES SHORT-TERM COMPLICATION ADMISSION RATE (PQI 01)

The number of CCOs that have met the benchmark increased between 2013 & June 2014.

(Lower scores are better). Rates are per 100,000 member years

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.





# CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI 5)

## Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate

**Measure description:** Rate of adult patients (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma. Rates are reported per 100,000 member years. A lower score is better.

PQIs (prevention quality indicators) come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

**Purpose:** Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce health care costs.

### July 2013 - June 2014 data (n= 3,835,271 member months)

Statewide, this measure continued to improve with a decrease of 48 percent between 2011 and June 2014.

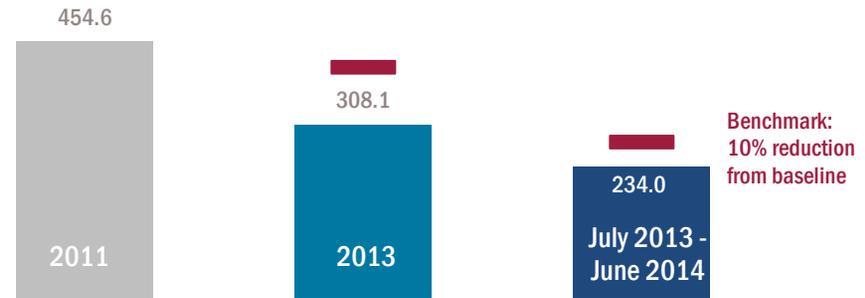
All of the expansion population is included in the PQI measures, and the denominator has increased by 44 percent. While the number of numerator events has increased, the influx of new members in the denominator has increased at a faster pace, resulting in a continued drop in the PQI rates (lower is better).

## Statewide, hospital admission rates for adults with COPD or asthma continue to fall.

(Lower scores are better)

Data source: Administrative (billing) claims

2014 benchmark source: OHA consensus, based on prior performance trend

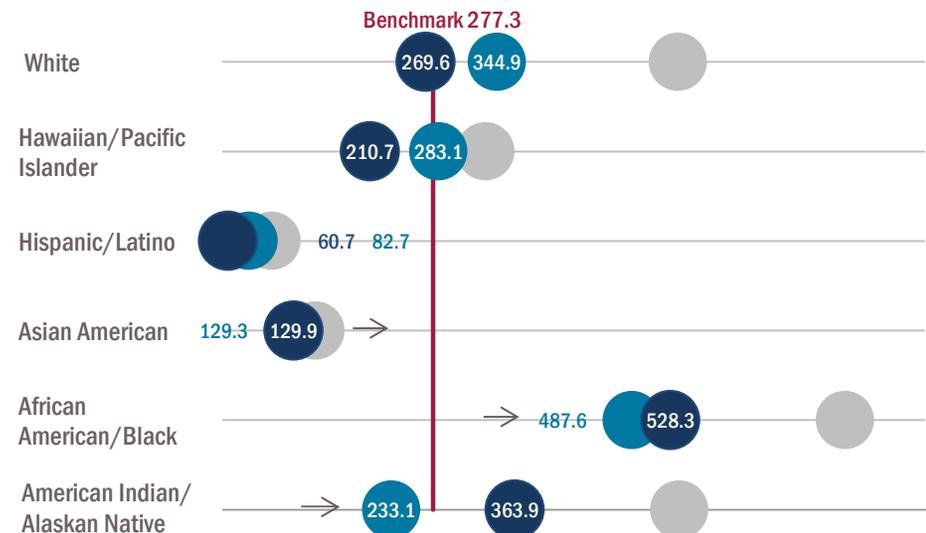


## Admission rates for adults with COPD were mixed across racial/ethnic groups between 2013 and June 2014.

(Lower scores are better)

Gray dots represent 2011.

Data missing for 8.7% of respondents. Each race category excludes Hispanic/Latino.





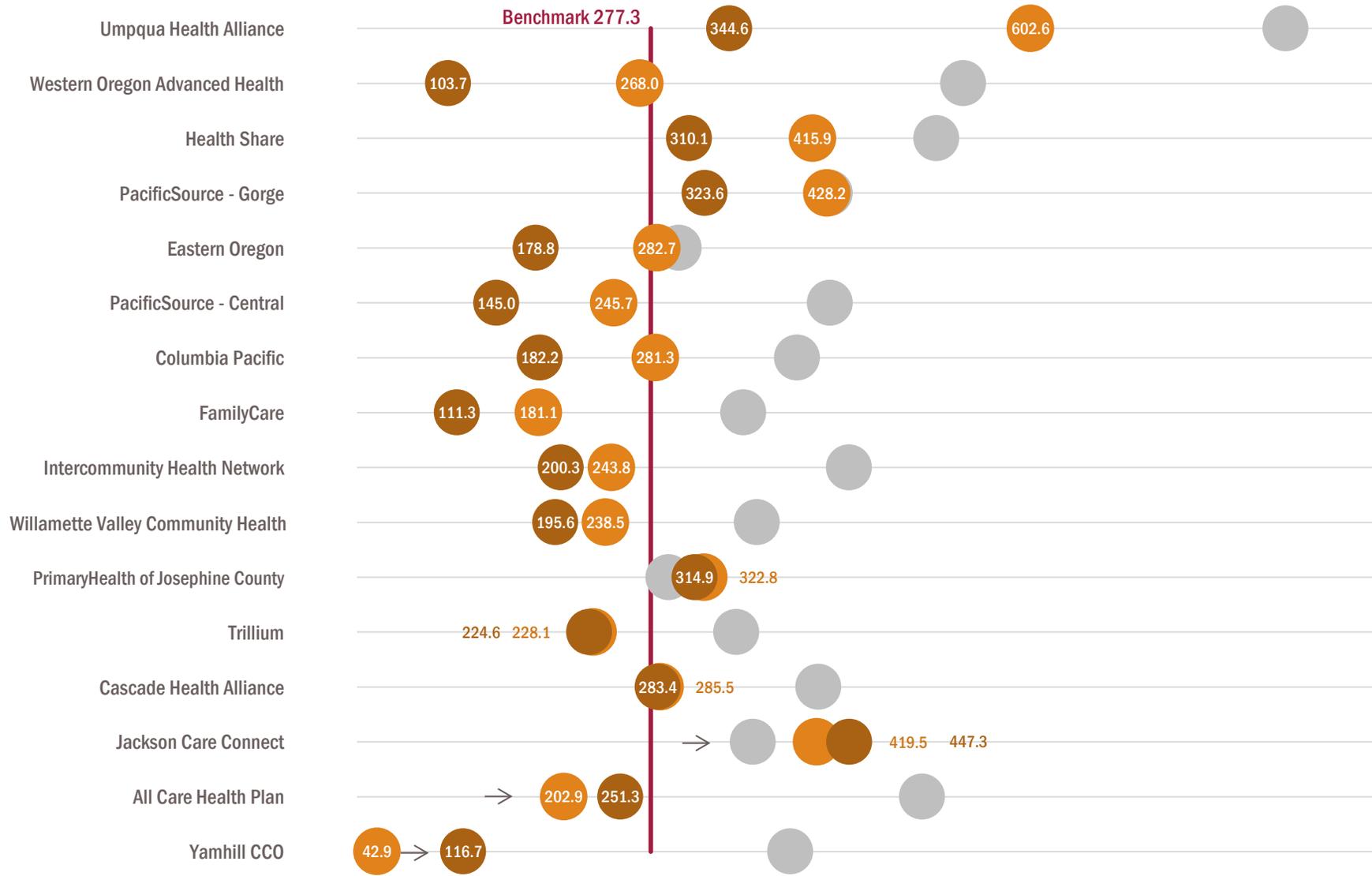
# CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI 5)

Overall, CCOs continued to showed improvement between 2013 & June 2014.

(Lower scores are better). Rates are per 100,000 member years

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators





# CONGESTIVE HEART FAILURE ADMISSION RATE (PQI 8)

## Congestive heart failure admission rate

**Measure description:** Rate of adult patients (ages 18 and older) who had a hospital stay because of congestive heart failure. Rates are reported per 100,000 member years. A lower score is better.

PQIs (prevention quality indicators) come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

**Purpose:** Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce health care costs.

### July 2013 - June 2014 data (n=3,835,271 member months)

Statewide, this measure continued to improve with a decrease of 34 percent between 2011 and June 2014.

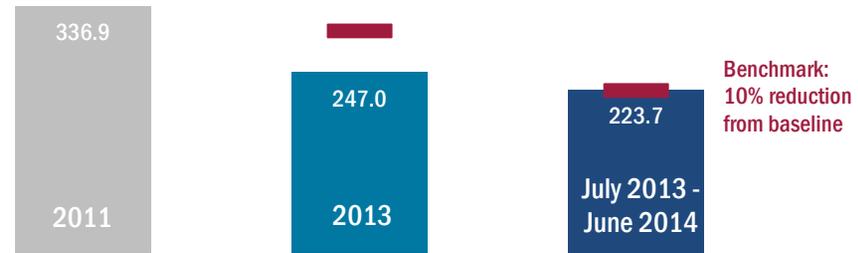
All of the expansion population is included in the PQI measures, and the denominator has increased by 44 percent. While the number of numerator events has increased, the influx of new members in the denominator has increased at a faster pace, resulting in a continued drop in the PQI rates (lower is better).

## Statewide, congestive heart failure admission rates continue to decline.

(Lower scores are better)

Data source: Administrative (billing) claims

2014 benchmark source: OHA consensus, based on prior performance trend

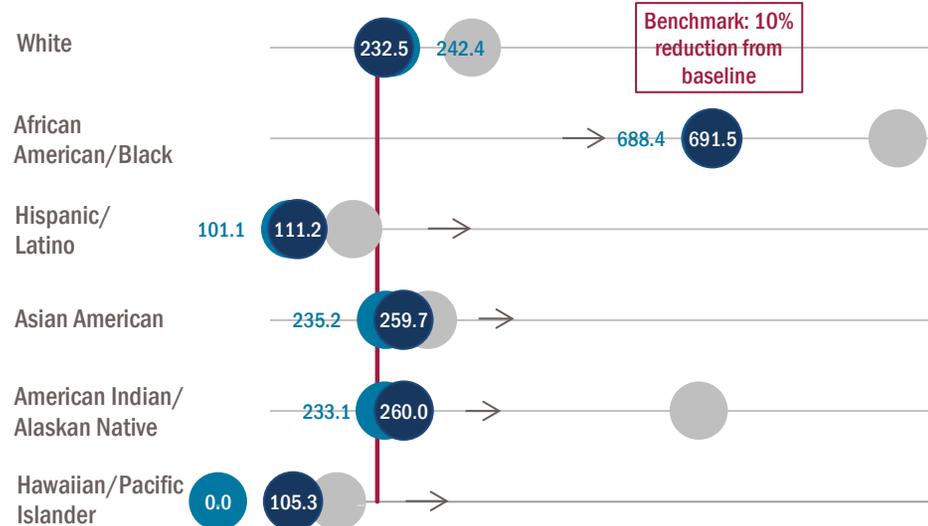


## Admission rates have increased for all racial/ethnic groups except whites between 2013 and June 2014.

(Lower scores are better)

Gray dots represent 2011.

Data missing for 8.7% of respondents. Each race category excludes Hispanic/Latino.





# CONGESTIVE HEART FAILURE ADMISSION RATE (PQI 8)

## CCOs with the highest admission rates in 2013 have improved the most as of June 2014.

(Lower scores are better). Rates are per 100,000 member years.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.





# ADULT ASTHMA ADMISSION RATE (PQI 15)

## Adult (ages 18-39) asthma admission rate

**Measure description:** Rate of adult patients (ages 18-39) who had a hospital stay because of asthma. Rates are reported per 100,000 member years. A lower score is better. PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

**Purpose:** Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospitalization. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce health care costs

**July 2013 - June 2014 data** (n= 3,835,271 member months)

Statewide, this measure continued to improve with a decrease of 39 percent between 2011 and June 2014.

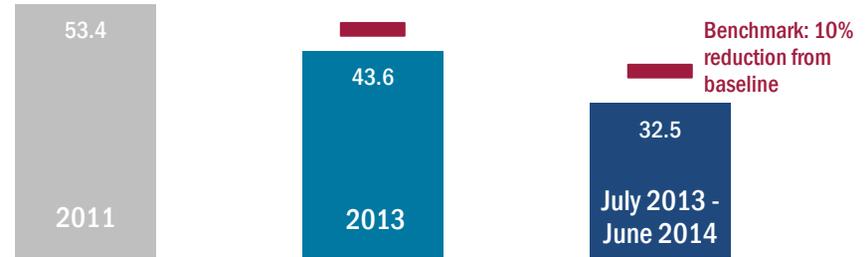
All of the expansion population is included in the PQI measures, and the denominator has increased by 44 percent. While the number of numerator events has increased, the influx of new members in the denominator has increased at a faster pace, resulting in a continued drop in the PQI rates (lower is better).

## Statewide, hospital admission rates for adult asthma continue to decline.

(Lower scores are better)

Data source: Administrative (billing) claims

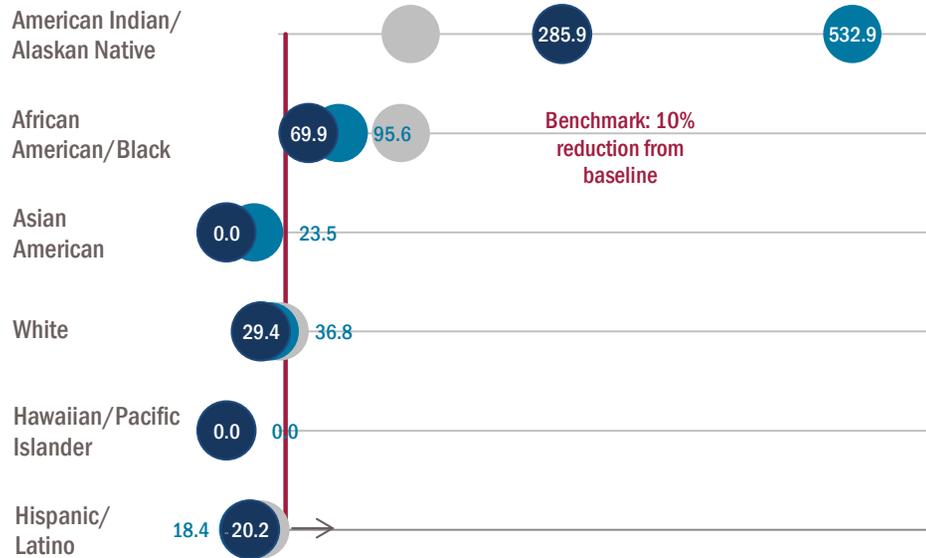
2014 benchmark source: OHA consensus, based on prior year trend



## Although American Indian/Alaskan Natives experienced the greatest improvement between 2013 & June 2014, they still have the highest adult asthma admission rate.

(Lower scores are better). Gray dots represent 2011.

Data missing for 8.7% of respondents. Each race category missing Hispanic/Latino.





# ADULT ASTHMA ADMISSION RATE (PQI 15)

Twelve of 16 CCOs improved adult asthma admission rates between 2013 & June 2014.

(Lower scores are better). Rates are per 100,000 member years.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.





# TOBACCO USE PREVALENCE

## Tobacco use prevalence

**Measure description:** Percentage of adult Medicaid members (ages 18 and older) who currently smoke cigarettes or use other tobacco products

**Purpose:** Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

### 2013 data (n=4,812)

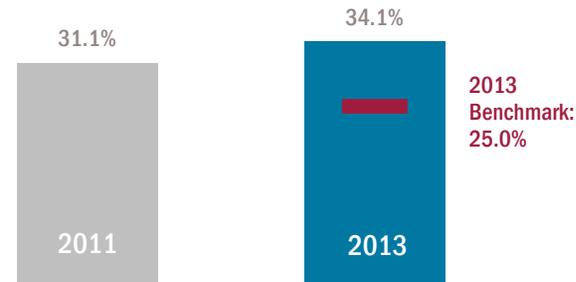
Tobacco use among adult Medicaid members increased from 2011 to 2013. In 2013, 34.1 percent of Medicaid members reported tobacco use which is higher than the tobacco use rate of the general population (16.3 percent in 2010).

## Statewide, tobacco use increased in the Medicaid population since 2011.

(Lower scores are better)

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)

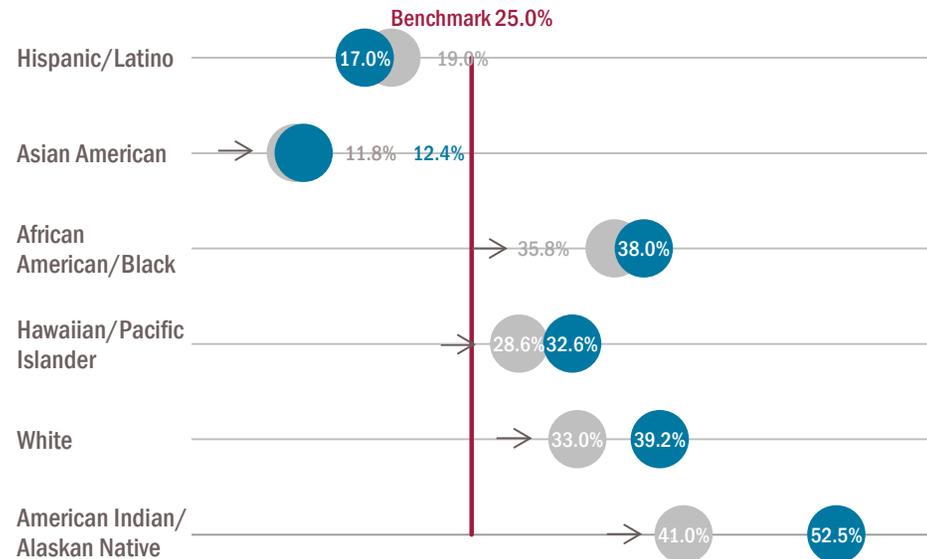
2014 benchmark source: Oregon's 1115 demonstration waiver goals



## Tobacco use increased for all racial/ethnic groups except Hispanic/Latino between 2011 and 2013.

(Lower scores are better).

Each race category excludes Hispanic/Latino.





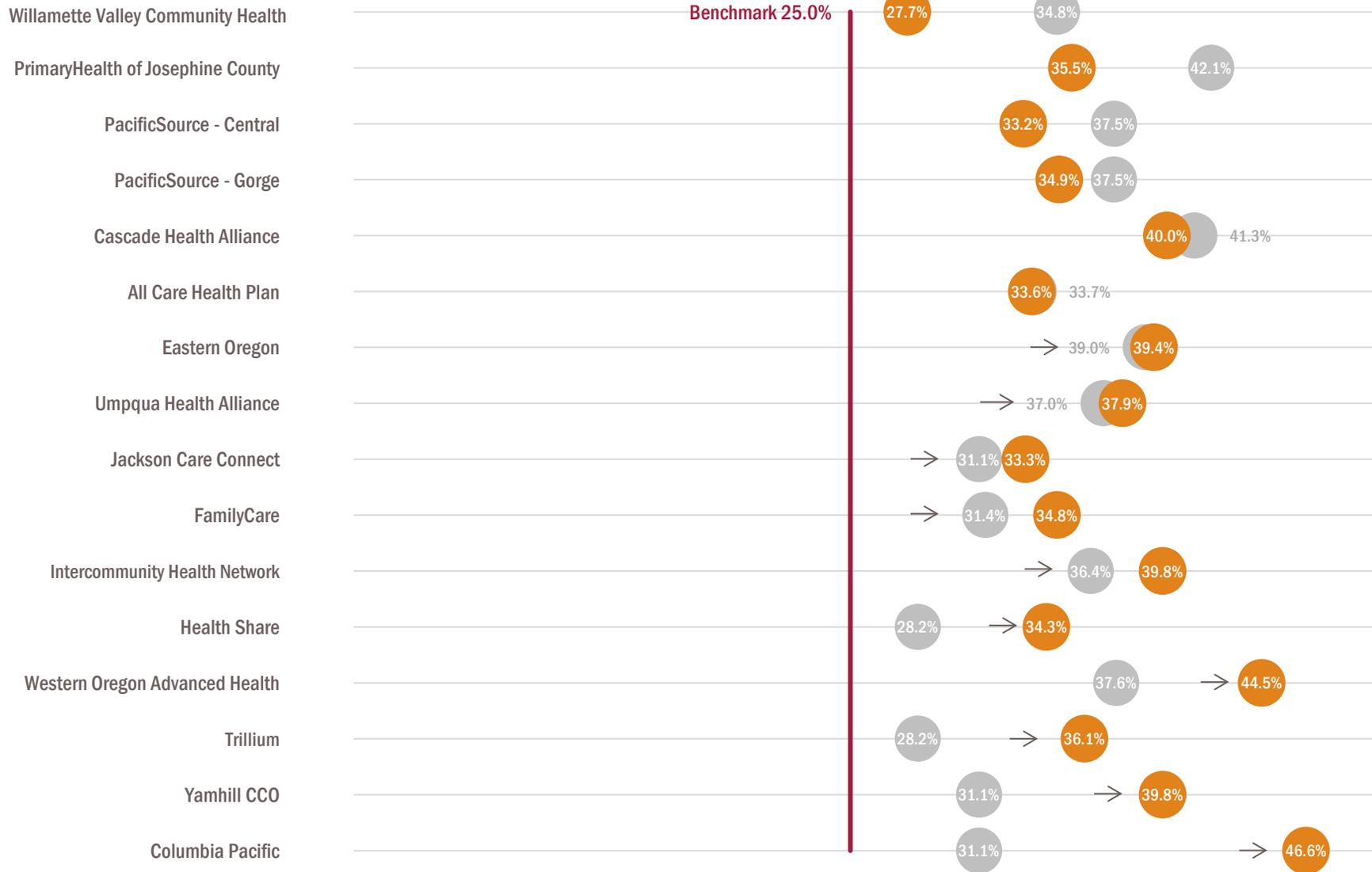
# TOBACCO USE PREVALENCE

While tobacco use decreased in six CCOs between 2011 and 2013, tobacco use increased in ten CCOs.

(Lower scores are better)

2011 baselines are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.



# NEW ACA POPULATION

## Overview

With the Affordable Care Act (ACA) coverage expansion, an increasing number of Oregonians receive health insurance through the Oregon Health Plan (Medicaid). More than 380,000 Oregonians gained coverage in 2014, meaning approximately 990,000 Oregonians are enrolled today. This increase has changed the demographic composition of the Medicaid population in Oregon.

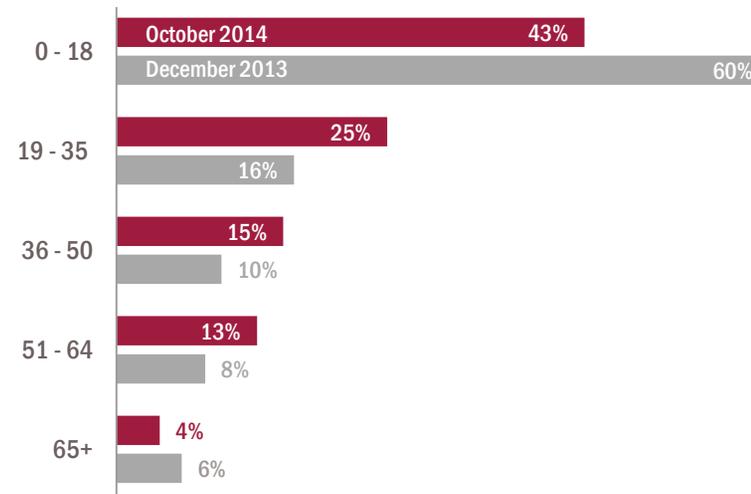
This section of the report highlights those changes. This section of the report also provides more detailed information on three utilization measures, since the ACA expansion: emergency department utilization, avoidable emergency department utilization, and outpatient utilization. Data are presented for January 1, 2014 – June 30, 2014, and are broken out by three groups of members.

**"Pre-2014"** members are clients whose enrollment in a CCO began prior to 2014.

**"New"** members are clients who were newly enrolled in a CCO in 2014 and were not enrolled before that point.

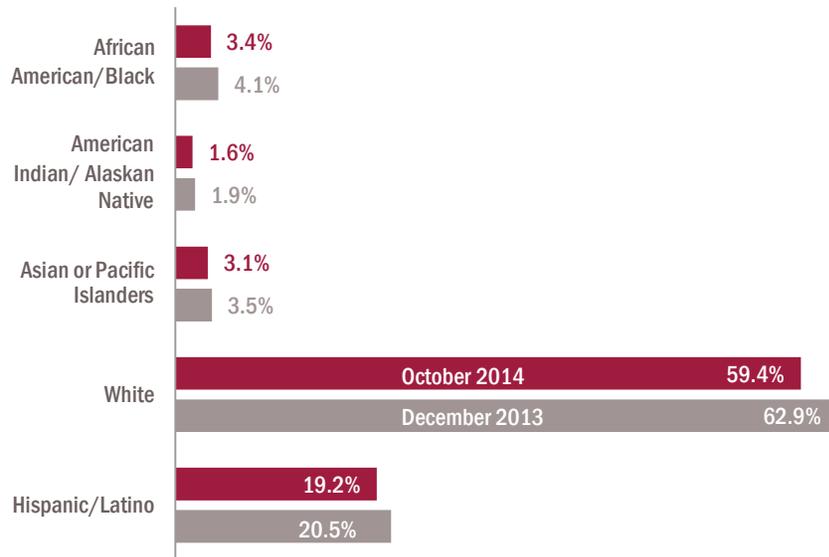
**"Returning"** members are clients who were not enrolled in the Oregon Health Plan during calendar during 2013, but were at sometime prior to 2013.

The proportion of members ages 19-35 enrolled in Medicaid has increased more than other age groups between December 2013 and **October 2014**



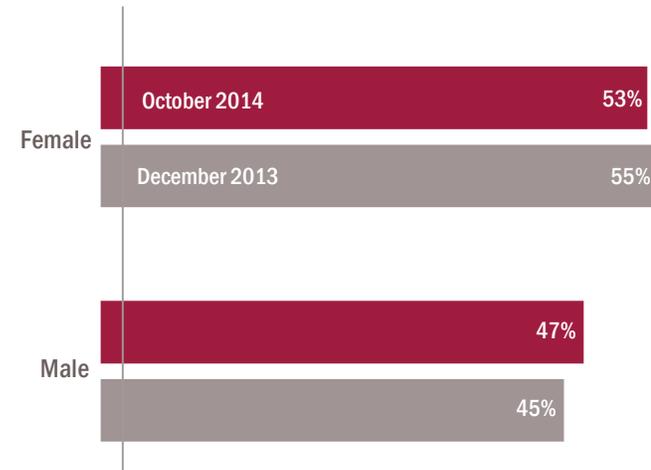
# NEW ACA POPULATION

Despite the influx of new member, the racial/ethnic makeup of Medicaid enrollees has not changed much between December 2013 and **October 2014**.



(Data missing for 7% of respondents in 2014)

The proportion of males enrolled in Medicaid has increased between December 2013 and **October 2014**.



# NEW ACA POPULATION - AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

## Avoidable emergency department utilization with new ACA population.

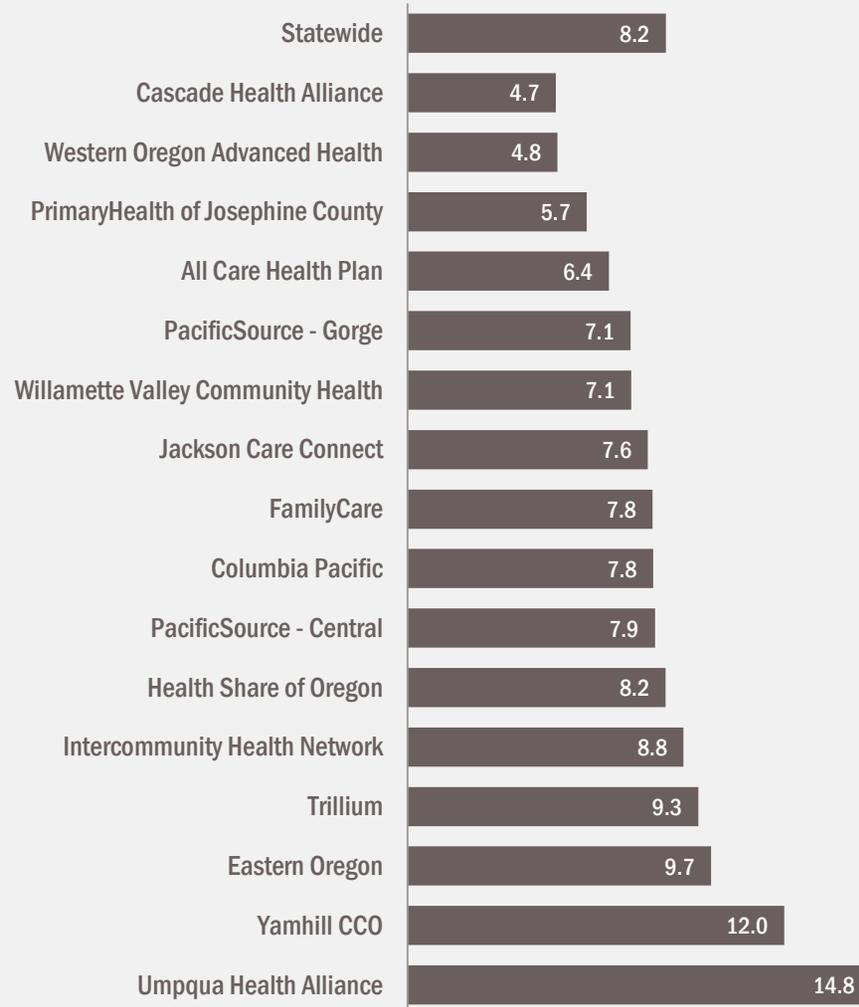
**Measure description:** Rate of patient visits to an emergency department for conditions that could have been more appropriately managed by or referred to a primary care provider in an office or clinic setting. Rates are derived from the ambulatory care: emergency department utilization measure and are reported per 1,000 member months. A lower number suggests more appropriate emergency department utilization.

### January - June 2014 data (n= 5,924,279 member months)

This graph shows avoidable emergency department visit rates for all CCO members between January 1, 2014 and June 30, 2014. The observed rate of 8.2 is below the 2013 rate of 8.6 (see page 8) despite the large influx of new Medicaid members.

## Avoidable emergency department utilization since January 1, 2014.

Lower is better.  
Rates are reported per 1,000 member months  
Data source: Administrative (billing) claims



# NEW ACA POPULATION - AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

## Avoidable emergency department utilization with new ACA population, by member type.

January - June 2014 data (n= 5,924,279 member months)

New ACA members enrolled in a CCO in 2014 but with no prior Oregon Health Plan enrollment (blue bars) have fewer avoidable emergency department visits than other members (4.7 versus 9.0 and 8.3). Existing members enrolled in a CCO in 2013 and 2014 had the highest rate of avoidable emergency department visits for the first six months of 2014.

"Pre-2014" members are clients whose enrollment in a CCO began prior to 2014.

"New" members are clients who were newly enrolled in a CCO in 2014 and were not enrolled before that point.

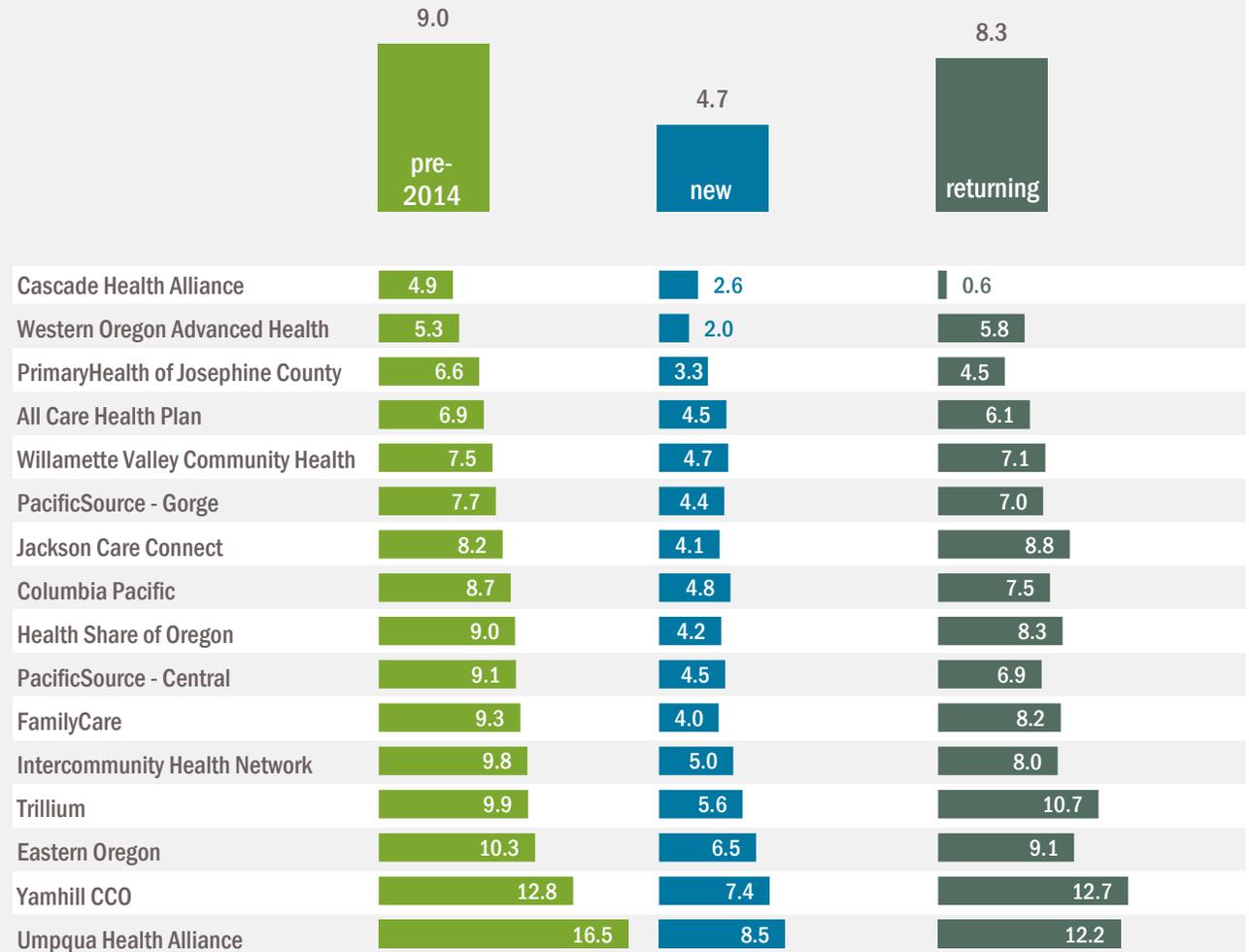
"Returning" members are clients who were not enrolled in the Oregon Health Plan during calendar during 2013, but were at sometime prior to 2013.

Statewide, new ACA members have lower rates of avoidable emergency department utilization than other members.

Lower is better.

Rates are reported per 1,000 member months

Data source: Administrative (billing) claims



# NEW ACA POPULATION - EMERGENCY DEPARTMENT UTILIZATION

## Emergency department utilization with new ACA population

**Measure description:** Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of this care.

**January - June 2014 data** (n= 5,924,279 member months)

This graph shows emergency department visit rates for all CCO members between January 1, 2014 and June 30, 2014. The rate of 49.1 per 1,000 member months below the 2013 rate of 50.5 (see page 10) despite the influx of new Medicaid members.

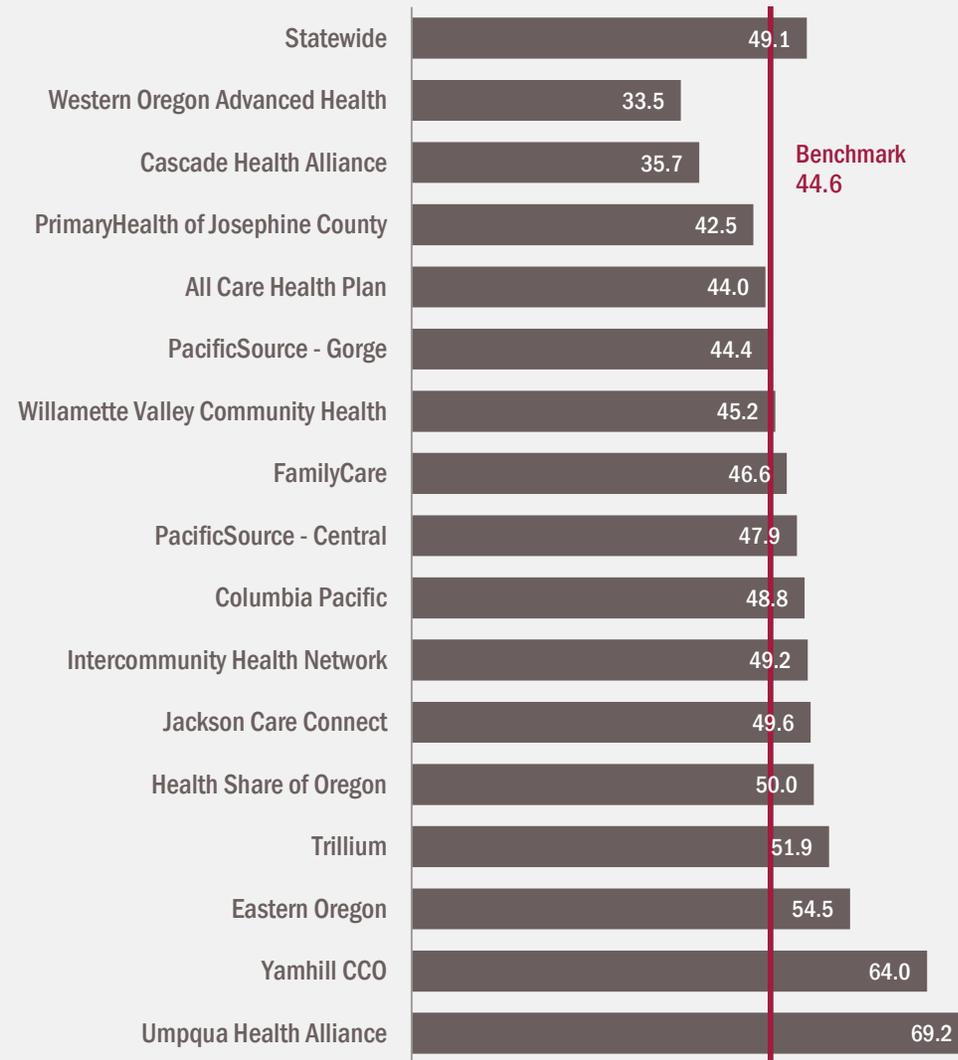
## Emergency department utilization since January 1, 2014

Lower is better.

Rates are reported per 1,000 member months

Data source: Administrative (billing) claims

2014 benchmark source: 2013 National Medicaid 90th percentile



# NEW ACA POPULATION - EMERGENCY DEPARTMENT UTILIZATION

## Emergency department utilization since January 1, 2014, by member type.

January - June 2014 data (n= 5,924,279 member months)

New ACA members enrolled in a CCO in 2014 but never enrolled in the Oregon Health Plan prior (blue bars) used the emergency department less frequently than members who have prior enrollment experience (34.4 versus 51.0 and 59.7). Members returning to Medicaid in 2014 had the highest rate of emergency department visit use (59.7).

"Pre-2014" members are clients whose enrollment in a CCO began prior to 2014.

"New" members are clients who were newly enrolled in a CCO in 2014 and were not enrolled before that point.

"Returning" members are clients who were not enrolled in the Oregon Health Plan during calendar during 2013, but were at sometime prior to 2013.

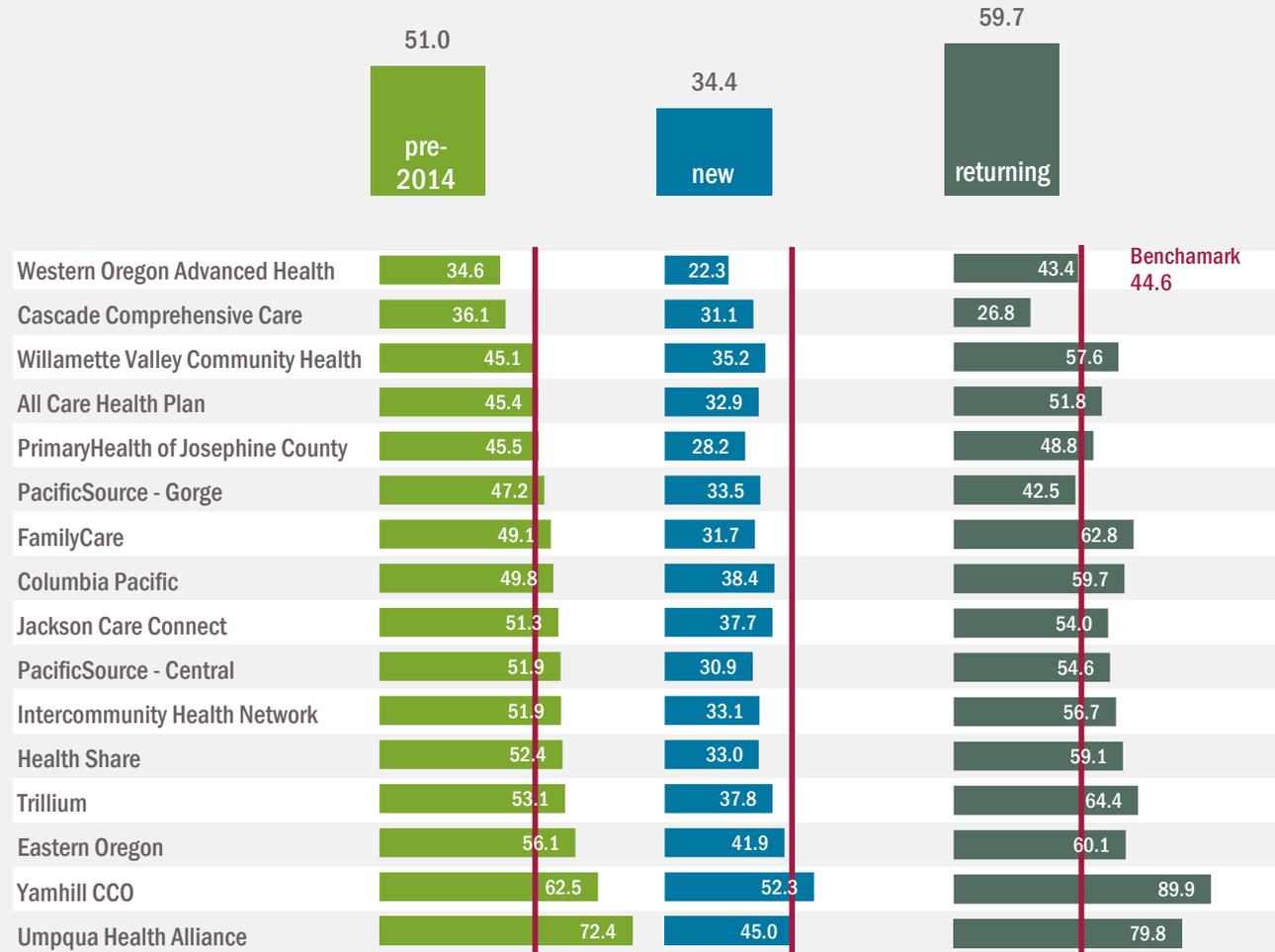
## Statewide, new ACA members use emergency rooms less frequently than other members.

Lower is better.

Rates are reported per 1,000 member months

Data source: Administrative (billing) claims

2014 benchmark source: 2013 National Medicaid 90th percentile



# NEW ACA POPULATION - OUTPATIENT UTILIZATION

## Outpatient utilization with new ACA population

**Measure description:** Rate of outpatient services, such as office visits, home visits, nursing home care, urgent care and counseling or screening services. Rates are reported per 1,000 member months.

### January - June 2014 data

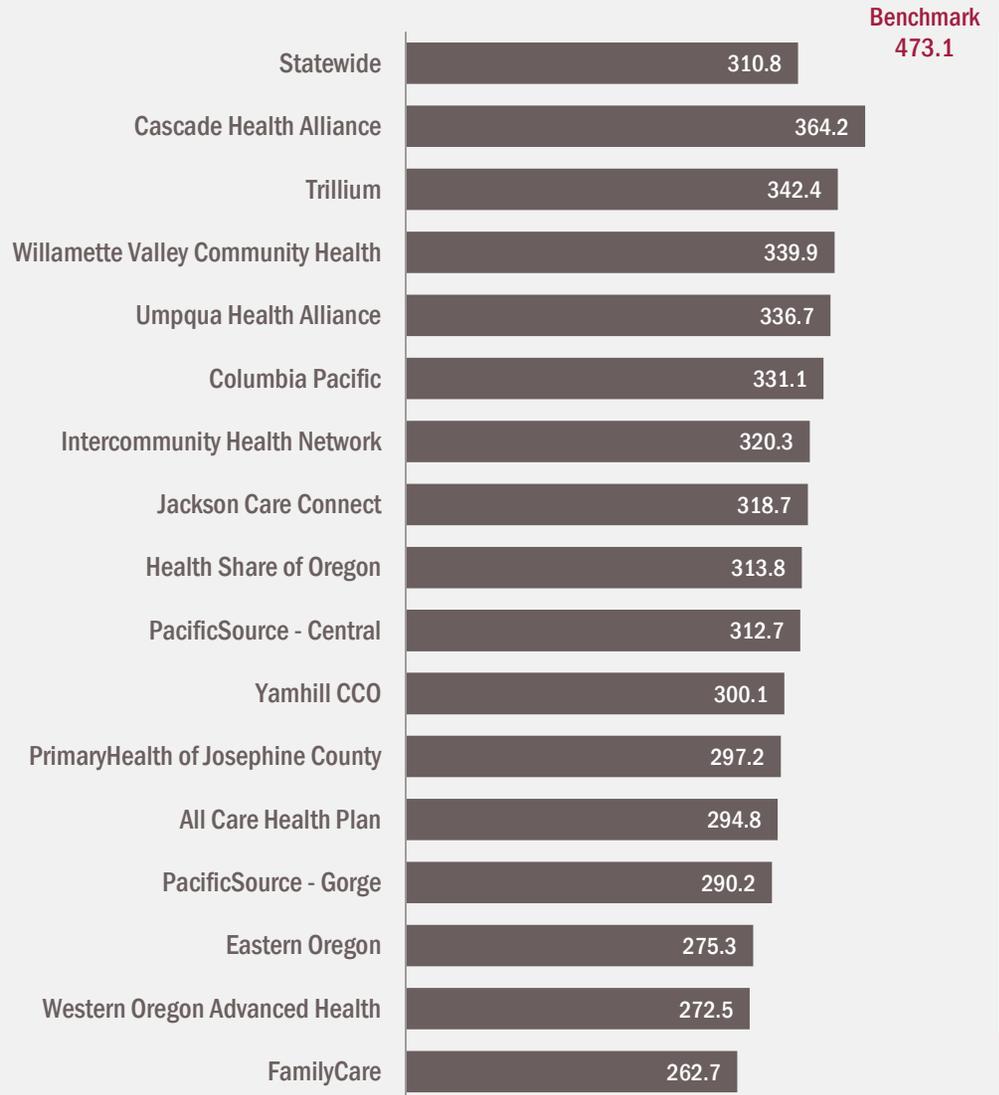
(n= 5,924,279 member months)

This graph shows outpatient utilization rates for all CCO members between January 1, 2014 and June 30, 2014.

## Ambulatory outpatient utilization since January 1, 2014

Data source: Administrative (billing) claims

Benchmark source: 2013 national Medicaid 90th percentile



# NEW ACA POPULATION - OUTPATIENT UTILIZATION

## Outpatient utilization with new ACA population, by member type.

January - June 2014 data (n= 5,924,279 member months)

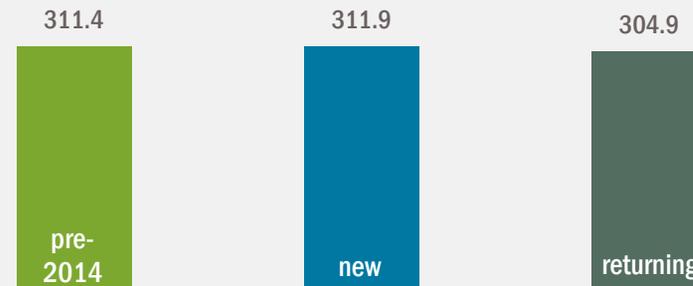
Member enrolled returning to Medicaid in 2014 used outpatient services slightly less frequently than existing members and new members with no prior enrollment experience.

"Pre-2014" members are clients whose enrollment in a CCO began prior to 2014.

"New" members are clients who were newly enrolled in a CCO in 2014 and were not enrolled before that point.

"Returning" members are clients who were not enrolled in the Oregon Health Plan during calendar during 2013, but were at sometime prior to 2013.

Statewide, new ACA expansion members receive care in an outpatient setting more frequently than other members.



CCO	pre-2014	new	returning
Cascade Health Alliance	356.8	588.9	369.2
Trillium	350.3	324.9	319.1
Umpqua Health Alliance	340.9	335.8	313.2
Willamette Valley Community Health	333.6	375.5	345.2
Intercommunity Health Network	326.4	308.2	299.7
Columbia Pacific	321.0	344.9	367.1
Jackson Care Connect	319.2	325.7	302.4
Health Share of Oregon	315.9	309.6	303.0
PacificSource - Central	312.0	310.1	321.7
PrimaryHealth of Josephine County	302.6	297.1	267.7
All Care Health Plan	294.5	310.1	275.2
Yamhill CCO	287.9	344.5	320.2
PacificSource - Gorge	286.1	302.1	297.7
Western Oregon Advanced Health	269.1	287.4	269.5
Eastern Oregon	266.8	303.8	297.4
FamilyCare	256.3	270.2	275.1

# FINANCIAL DATA

## Overview

This section of the report contains cost and utilization data for Medicaid spanning calendar years 2011 – 2013, as well as data through the second quarter of 2014. OHA uses Milliman’s MedInsight Health Cost Guidelines (HCG) Grouper software to classify claims. Cost and utilization data reported here are comparable to reports produced from Oregon’s All-Payer All-Claims database for commercial and Medicare populations.

This report does not include data on services that have occurred but have not yet been recorded or encountered. Data may be incomplete due to lags in submitting data to OHA. Future reports will be updated as more complete data are submitted.

# FINANCIAL DATA: INPATIENT COSTS

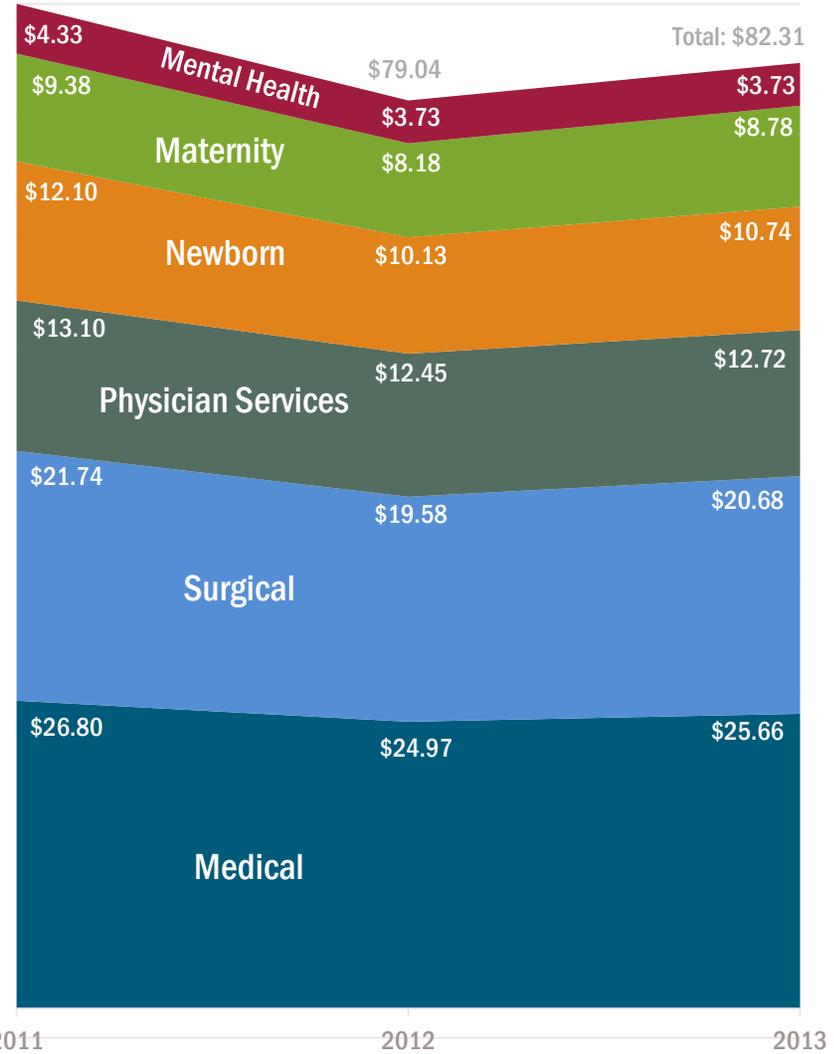
## Hospital Inpatient Care

As the Medicaid population increased from 2011 with the creation of CCOs and new Oregon Health Plan members who were able to access health care through the Affordable Care Act this year, per member per month costs have decreased 5.7 percent for inpatient hospital services since 2011, the baseline year. This indicates utilization did not increase as more members enrolled in Medicaid and the inpatient dollars were spread to a larger population. The greatest cost declines were in mental health inpatient and maternity categories, dropping 12.7 percent and 11.1 percent from 2011 respectively.

Overall, inpatient costs have decreased since 2011.

Figures are U.S. dollars per member, per month

Total: \$87.45



# FINANCIAL DATA: INPATIENT COSTS

## Inpatient: Maternal Utilization

**Measure description:** Newborns that are born without complications compared to newborns with complications, and total C-section deliveries compared to normal deliveries. Fewer resources are needed for well and normal newborn deliveries at both the time of the delivery and for follow-up care.

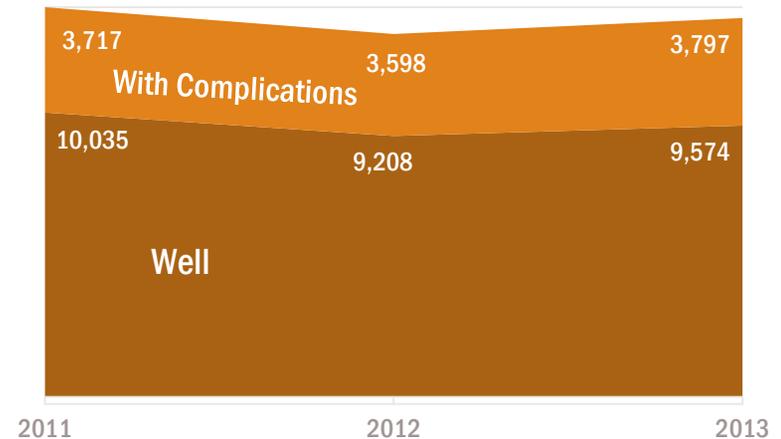
**Purpose:** There are higher cost implications for newborn deliveries with medical complications and also via C-section. There will always be a certain number of births that occur with complications and also by C-section, however, reducing inappropriate or avoidable occurrences will result in better health outcomes as well as decreased costs.

**2013 data** (n= 13,371 births, 14,332 deliveries)

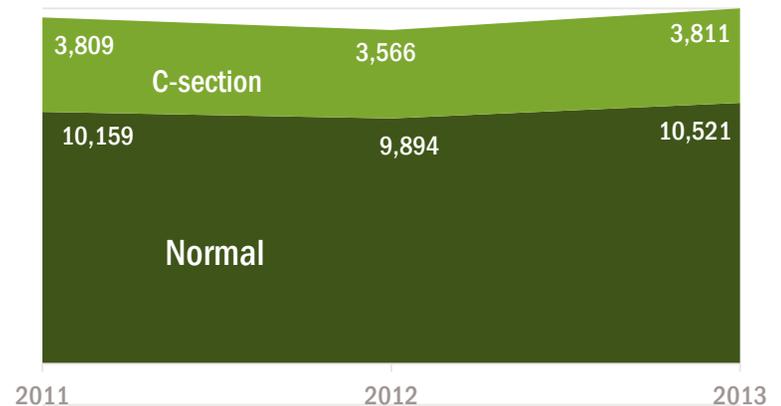
The ratio of newborn births with complications has increased 1.4 percent from 2011 to 2013, a slight upward trend. There are a wide range of situations or conditions that can contribute to complications at birth though higher complications are linked to poorer health of the mother. See page 48-49 for data on low birth weight.

C-sections as a percentage of total deliveries remained steady at around 27 percent all three years, showing that the implementation of CCOs has not had an impact on this measure as of 2013.

As a percent of total births, newborn complications are trending up slightly.



The percent of deliveries by C-section remains steady.



# FINANCIAL DATA: INPATIENT COSTS

## Inpatient: Maternal Costs

**Measure description:** The average cost of births with complications compared to those without complications and the cost of a C-section compared to a normal delivery. The total cost of the service is divided by the total number of the services performed to get the cost per birth.

**Purpose:** The financial impact of a birth with complications can be considerable. Reducing complications wherever possible, through prenatal evaluations or other initiatives, can lower overall spending for CCOs. C-sections are also more costly than normal deliveries, though are influenced by physician practice patterns and patient preference, which can make C-section rates more difficult for CCOs to influence. Q2 2014 (n= \$11,454 with complications, \$1,799 well, \$6,570 C-section, \$4,100 normal).

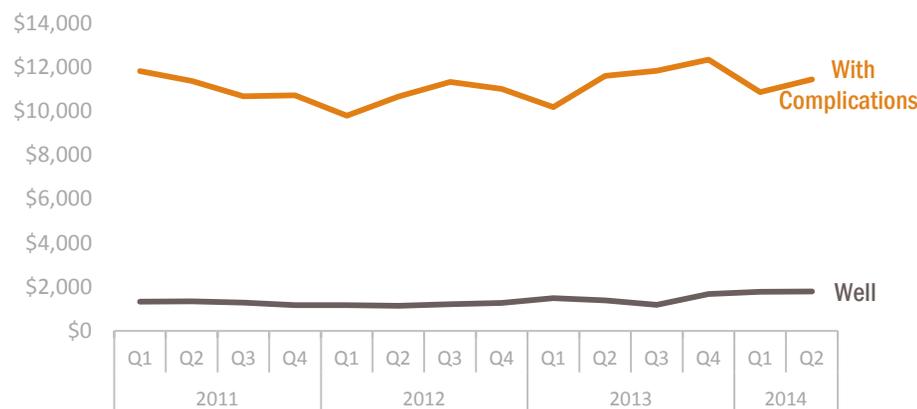
**Updated data** (n= 13,371 births, 14,332 deliveries; Q2 2014 n= \$11,454 with complications, \$1,799 well, \$6,570 C-section, \$4,100 normal)

Cost per case for newborns with complications ranged between 6 to 9 times higher than those that were well each quarter. For the second quarter 2014 the cost per case for newborns with complications was \$11,454 and historically there have been about 3,800 cases, which comes to a potential annual total of approximately \$43 million. The well cases, babies born without complications, at \$1,799 would come to \$7 million for a difference of \$36 million.

C-sections cost almost twice as much per case as a normal delivery (\$6,570 compared to \$4,100).

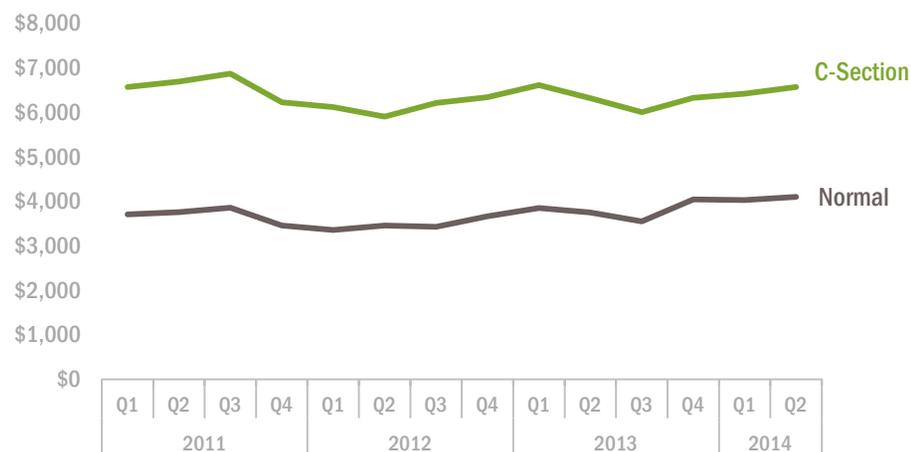
Newborn costs per case for those with complications are much higher than those who are well.

Figures in U.S dollars



C-Section cost per case is higher than costs for normal deliveries.

Figures in U.S. dollars



# FINANCIAL DATA: OUTPATIENT COSTS

## Outpatient Costs

**Measure description:** Per member, per month (PMPM) cost of outpatient services. Costs are calculated by dividing the total claims paid by the total member months and are categorized by major services.

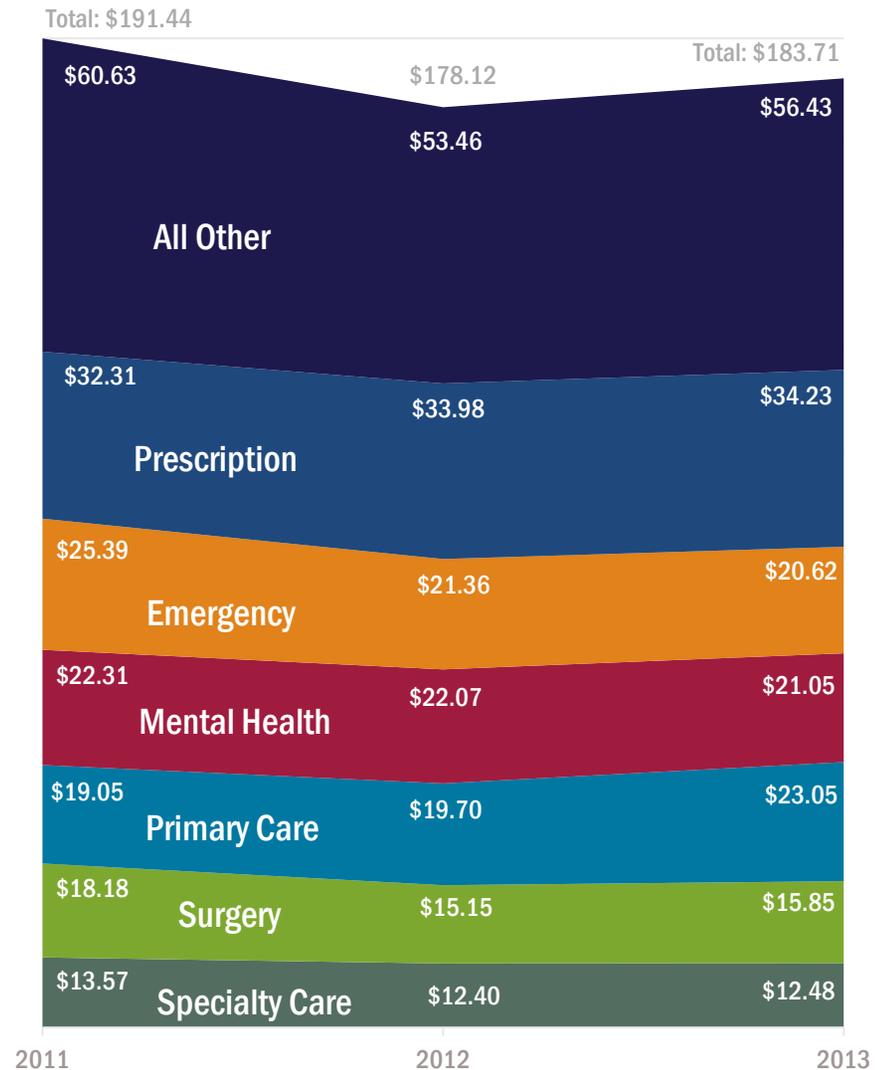
**Purpose:** Different outpatient interventions require different levels of resource use and utilization changes within these services are also expected over time with the coordinated care model.

**2013** (n= \$183.71)

As overall outpatient per member, per month costs have decreased since 2011, two sub categories have increased: primary care and prescription drugs. With the inception of CCOs, a key focus has been to increase resources at the primary care level to ensure that patients are accessing care and treatment plans are initiated in a way that is effective for the patient.

Overall, outpatient costs have also decreased since 2011.

Figures are U.S. dollars, per member per month.



# FINANCIAL DATA: OUTPATIENT COSTS

## Primary Care and Emergency Department Costs

**Measure description:** Per member, per month cost of primary care services combined with primary care utilization. Costs are calculated by dividing the total claims paid by the total member months and utilization by dividing total primary care visits annually by 1,000 members.

Per member, per month costs of emergency services are calculated as total costs divided by member months.

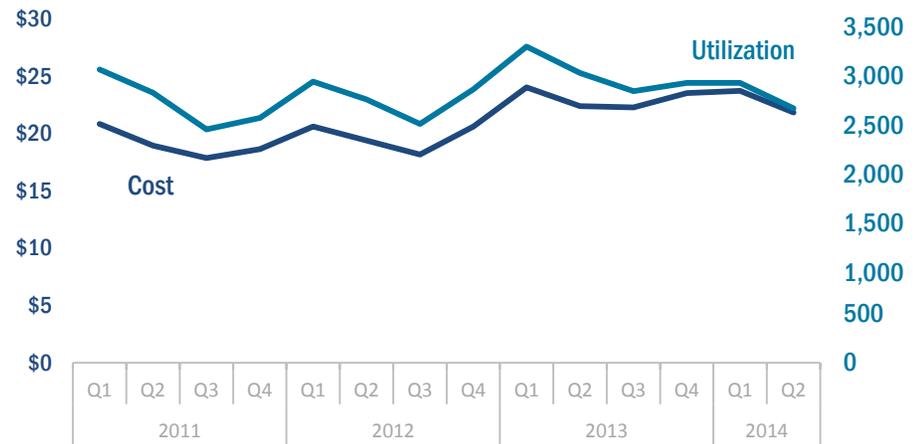
**Purpose:** Primary care and emergency department visits may be influenced by the coordinated care model with the focus on patient centered primary care enrollment.Q2

### 2014

Primary care costs and utilization have similar trends: first quarter costs and utilization are considerably higher than the previous fourth quarter. This is consistent for periods prior to CCOs and ACA expansion. Emergency department costs have decreased from 2011 by 20 percent in the second quarter of 2014. See pages 10-11 and 75-76 for additional data on emergency department utilization.

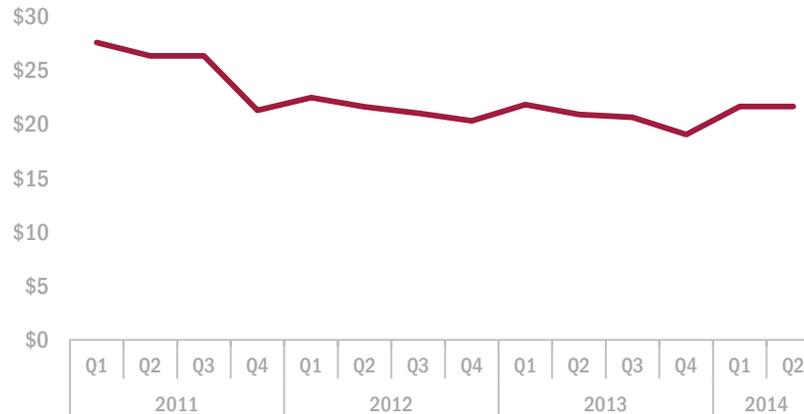
## Primary Care Cost and Utilization have similar trends.

Costs shown are U.S. dollars, per member per month; Utilization is annualized/1000 members



## Meanwhile, Emergency Department costs have declined, with no noticable increase due to the ACA expansion population.

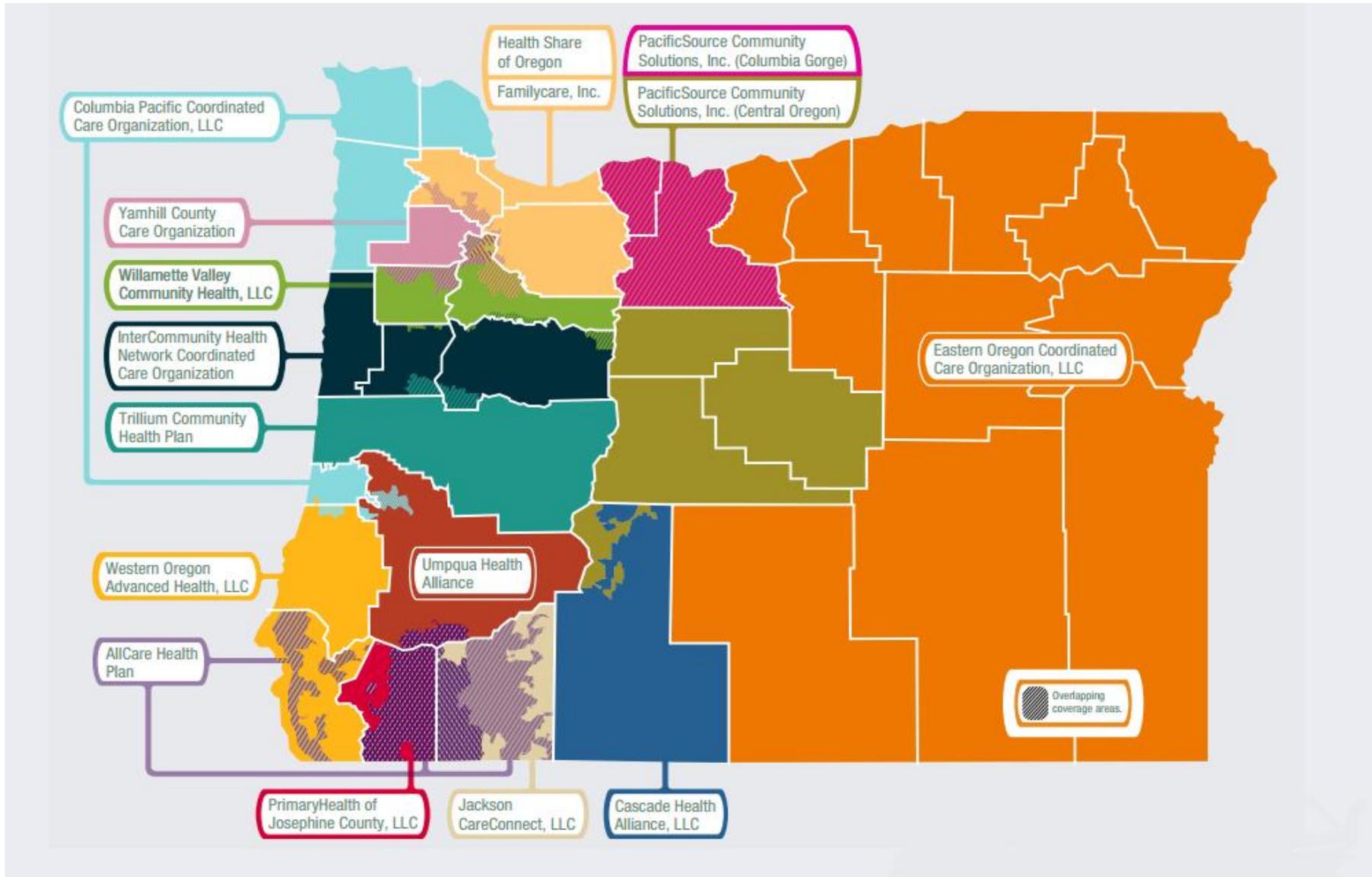
Figures in U.S. dollars, per member per month



## Coordinated Care Organization Service Areas

CCO Name	Service Area by County
AllCare Health Plan	Curry, Josephine, Jackson, Douglas (partial)
Cascade Health Alliance	Klamath County (partial)
Columbia Pacific CCO	Clatsop, Columbia, Coos (partial), Douglas (partial), Tillamook
Eastern Oregon CCO	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler
FamilyCare	Clackamas, Marion (partial), Multnomah, Washington
Health Share of Oregon	Clackamas, Multnomah, Washington
Intercommunity Health Network	Benton, Lincoln, Linn
Jackson Care Connect	Jackson
PacificSource Community Solutions - Central Oregon	Crook, Deschutes, Jefferson, Klamath (partial)
PacificSource Community Solutions - Gorge	Hood River, Wasco
PrimaryHealth of Josephine County	Douglas (partial), Jackson (partial), Josephine
Trillium Community Health Plan	Lane
Umpqua Health Alliance	Douglas (most)
Western Oregon Advanced Health	Coos, Curry
Willamette Valley Community Health	Marion, Polk (most)
Yamhill CCO	Clackamas (partial), Marion (partial), Polk (partial), Yamhill

# Coordinated Care Organization Service Areas



## OHA Contacts and Online Information

**For questions about performance metrics, contact:**

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**For questions about financial metrics, contact:**

Jeff Fritsche  
Finance Director  
Oregon Health Authority  
Email: jeffrey.p.fritsche@state.or.us

**For more information about technical specifications for measures, visit:**

<http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>

**For more information about coordinated care organizations, visit:**

<http://www.health.oregon.gov>

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