

Oregon Metrics and Scoring Committee

AGENDA

October 16, 2012

8:30 a.m. to 11:30 a.m.

Phone Meeting

Public Listen-Only Conference Line: Dial: 1-877-581-9247; participant code: 604851

#	Time	Item	Presenter	Action Item
1	8:30	Welcome and agenda review	Bob Dannenhoffer	
2	8:40	Consent agenda: October 10 th minutes	Bob Dannenhoffer	X
3	8:45	Review final incentive measure set with modifications	Bob Dannenhoffer Michael Bailit	
4	9:15	Discuss recommendations for performance and improvement targets	Michael Bailit	
5	10:30	Review questions to inform quality pool operation	Michael Bailit	
6	11:15	Next steps and wrap up	Bob Dannenhoffer	

Next Meeting:

October 22nd

1:00 pm – 4:00 pm

Clackamas Community College
29353 SW Town Center Loop E
Wilsonville, OR 97070

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Oregon Metrics and Scoring Committee

Minutes

October 10, 2012

Sheraton Airport Hotel

Cascade Rooms A & B

Portland, OR 97220

8:00 – 1:30 p.m.

Item
<p>Welcome</p> <p>Committee members present: Gloria Coronado, Robert Dannenhoffer, R.J. Gillespie, Phil Greenhill, Bob Joondeph, David Labby, Jeff Luck, Jeanine Rodriguez. Excused: Maggie Bennington-Davis.</p> <p>Consultants present (by phone): Michael Bailit, Kate Bazinsky (Bailit Health Purchasing).</p> <p>OHA Staff: Tina Edlund, Chief of Policy; Carole Romm, Accountability and Quality; Sarah Bartelmann, Project Manager; Ari Ettinger, Assistant to the Health Policy Board; Kelly Ballas, Chief Financial Officer, Melissa Hanks, OHA.</p>
<p>Consent Agenda</p> <p>The Committee approved the September 25th minutes.</p>
<p>Review requirements for incentive measures / Continue discussion on candidate measures</p> <p>Michael Bailit provided a refresher on the requirements for incentive measures and the Committee's charge, and an overview of the current measures under consideration ("candidate measures") by domain. The handout "Requirements for Incentive Measures" can be found in the meeting materials online at: http://www.oregon.gov/oha/Documents/MetricsScoringCommitteeMaterials121010.pdf.</p> <p>The Committee then discussed the pending candidate measures and came to agreement on the following set of 15 incentive measures:</p> <ol style="list-style-type: none">1. CAHPs Composite (7Qs)2. Rate of PCPCH enrollment3. ED Utilization (HEDIS)4. Initiation and Engagement of Alcohol and Drug Treatment5. Follow-up after hospitalization for mental illness6. Composite measure: mental health and physical health assessment for children in DHS custody7. Screening for clinical depression and follow-up plan8. Reducing elective delivery before 39 weeks9. Prenatal care initiated in the first trimester10. Developmental screening by 36 months (hybrid)11. Colorectal Cancer Screening (hybrid)12. Alcohol and Drug misuse, screening, brief intervention and referral for treatment (SBIRT)13. Optimal Diabetes Care (D3)14. Controlling Hypertension15. Adolescent Well-Care visits

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Select EHR/Meaningful Use measures

Michael Bailit presented a set of EHR and Meaningful use candidate measures for the Committee's consideration. The Committee selected a composite consisting of three EHR measures:

- Eligible Professional Meaningful Use Core Measure #2: Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period).
- Eligible Professional Meaningful Use Core Measure #4: Generate and transmit permissible prescriptions electronically (eRx) (>40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology).
- Eligible Professional Meaningful Use Core Measure #5: Active Medication List: >80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

OHA staff will connect with CMS for more information on benchmarks for this measure and bring the information back to the next Committee meeting.

Write-In Candidate Measures

Several organizations responded to the Committee's invitation at the September 25th meeting to propose additional measures for consideration. Proposed measures include:

- Pharmacotherapy management of COPD exacerbation
- Use of spirometry testing in the assessment and diagnosis of COPD
- Asthma medication management
- Asthma planned care visits, smoking cessation, flu shots, urgent care visits, and ER visits.
- Number of enrollees on anti-psychotic medications receiving an annual PCP visit
- Antidepressant medication management:
 - Follow up care for children newly prescribed ADHD
 - % of members diagnosed with a new episode of major depression and treated with antidepressant medication and who remained on treatment.
- Immunizations

The Committee agreed that these are important measures to include in the overall measurement framework for CCOs, but that they would not be added to the set of incentive measures. The Committee recommended that these measures be considered in future discussions on the overall measure framework.

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Status check regarding measure distribution across required domains

The Committee agreed that the set of 16 measures covers all required domains.

Review availability of baseline/benchmark data for proposed measures

Michael Bailit provided an overview of improvement and performance targets and asked the Committee to consider appropriate methods for determining targets for each incentive measure. The Committee agreed that it is appropriate to treat measures differently and use varying methodologies to come up with improvement and performance targets. One option considered was the Minnesota Quality Improvement Payment system. Additional details about the MN methodology are available online at: <http://www.health.state.mn.us/healthreform/measurement/QIPReport051012final.pdf>

The Committee considered improvement and performance targets for each of the incentive measures and requested that Michael Bailit and OHA staff construct recommended methodologies for improvement and performance targets for each incentive measure before the next meeting. Existing baseline and benchmark data on candidate measures can be found in the meeting materials available online at: <http://www.oregon.gov/oha/Documents/MetricsScoringCommitteeMaterials121010.pdf>.

Review of incentive program framework

Tina Edlund gave a high-level overview of the incentive program framework and CMS' and the Governor's expectations. The quality pool will have to operate within the parameters in the waiver, and:

- Oregon has committed to keeping Medicaid expenditures below trend on a pmpm basis—the agreement translates to 4.4% from this year to next - the Quality Pool must exist under this ceiling.
- The entire pool is at risk and will be paid out each year.

Robert Dannenhoffer proposed designating half the available funds for trend increases CCOs cannot control and the other half for bonuses. All CCOs would see some increase in funds, although the amount would depend on performance on the incentive measures.

OHA will work with CMS to design how the quality pool works and ensure that the proposed structure complies with rules for federal financial participation. OHA in consultation with Michael Bailit will design the structure of the quality pool and bring an outline back to the Committee for comment.

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Next steps and wrap up

Michael Bailit and OHA will bring updated numerator and denominator statements, details on data sources, and methodology for all incentive measures to the next meeting.

Michael Bailit and OHA will send out suggestions for improvement and performance target methodology for the Committee's consideration on Friday, October 12th.

OHA will provide a document or graphic that lays out the measurement and incentive payment timelines for the next meeting.

Public Testimony

The Committee heard public testimony from Andy Smith, Oregon Association of Community Mental Health Programs. Andy asked that the Committee consider two additional measures: tobacco use, particularly for people with mental health and/or substance abuse issues, and addressing behavioral health through the EHR measures.

Adjourn

Next Meetings:

October 16th – 8:30 a.m. – 11:30 a.m.
By phone.

October 22nd – 1 p.m. – 4 p.m.
Clackamas Community College
29353 SW Town Center Loop E
Wilsonville, OR97070

Final Incentive Measures with Modifications

October 16, 2012

	Measure	Brief Description	Notes
1	Substance abuse – SBIRT	% of members 18+ with routine visit in the measurement year screened for substance abuse and referred as necessary	OHA will also track this measure for members ages 12+
2	Initiation and engagement of alcohol and other drug dependence treatment	% of adolescent and adult members with a new episode of alcohol or other drug dependence who received treatment	
3	Adolescent well care visits	Members who were 12-21 years of age and had at least one comprehensive wellcare visit with a primary care practitioner or an OB/GYN practitioner during the measurement year	
4	Follow-up after hospitalization for mental illness	% of members with follow-up visit within 7 days after hospitalization	HEDIS measure that will be used has broad definitions for provider type.
5	Mental health and physical health assessment for children in DHS custody	% of children who receive a mental health assessment and physical health assessment within 60 days of DHS custody date.	
6	Patient-Centered Primary Care Home enrollment	% of patients enrolled in tier 1, 2, or 3 patient-centered primary care home	
7	Total emergency department utilization	Total number of visits to the ED during the measurement year per 1,000 Member Months	OHA will use HEDIS specifications for this measure.
8	Screening for clinical depression and follow up plan	% of members 18+ screened for clinical depression using a standardized tool and follow-up plan documented	
9	Controlling high blood pressure	% of patients 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year	

Metrics and Scoring Committee: Final incentive measures with modifications

	Measure	Brief Description	Notes
10	Elective delivery before 39 weeks	Patients with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed	
11	Prenatal care	% of deliveries that received a prenatal care visit as a member of the health plan in the first trimester or within 6 weeks of enrollment in the health plan	
12	Developmental screening by 36 months	The % of children with documentation that they were screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding their first, second or third birthday.	
13	Colorectal cancer screening	% of individuals 50-75 years of age who had appropriate screening for colorectal cancer.	
14	Optimal diabetes use (D3)	Patients meeting all three goals: BL less than 140/90 LDL less than 100 mg/dl A1c is less than 8%	
15	CAHPS Composite (access and satisfaction)	5 Questions from the CAHPS 4.0 H Adult Questionnaire: <ul style="list-style-type: none"> • In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect? • In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers? • In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan? • In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you 	

	Measure	Brief Description	Notes
		<p>needed?</p> <ul style="list-style-type: none"> • In the last 12 months, how often did your health plan’s customer service give you the information or help you needed? <p>2 Questions from the CAHPs 4.0 H Child Questionnaire:</p> <ul style="list-style-type: none"> • In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, developmental or behavioral problem? • In the last six months how often was it easy to get this treatment or counseling for your child? 	
16	EHR Composite	<ol style="list-style-type: none"> 1. Eligible Professional Meaningful Use Core Measure #2: Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period.) 2. Eligible Professional Meaningful Use Core Measure #4: Generate and transmit permissible prescriptions electronically (eRx) (>40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.) 3. Eligible Professional Meaningful Use Core Measure #5: Active Medication List: >80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data 	

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Metric and Scoring Committee
Suggested Methodology for Defining Improvement and Performance Targets
 October 16, 2012

Final Measure Set	Improvement Target	Performance Target	Notes
CAHPS composite (7 questions)	MN method with 3% floor; <i>or</i> Tiered approach that requires the lower performers to improve at a greater rate compared to the higher performers: 50 th -74 th percentile: 3% ¹ 25 th -49 th percentile: 4% 0-24 th percentile: 5%	75 th percentile	
Rate of PCPCH enrollment	HOLD pending additional information regarding baseline data	.8 or above	3% increase on this measure will probably be very easy to attain relative to some of the other measures. As of the last day of the measurement period, by percent of enrollees in each level Number of enrollees in tier 3 x3 Number of enrollees in tier 2 x2 Number of enrollees in tier 1 x1 Sum and divide by Denominator- number of enrollees times three

¹ These percentages are shown for demonstration only. The increases should be defined after OHA calculates CCO-specific rates using predecessor organization data, assess the extent of the variation and determines the size of the increase that would be necessary for statistical significance by CCO.

Metrics and Scoring Committee: Suggested methodology for targets

Final Measure Set	Improvement Target	Performance Target	Notes
ED Utilization	MN method with 3% floor; <i>or</i> Tiered approach that requires the lower performers to improve at a greater rate compared to the higher performers: 50 th -74 th percentile: 3% 25 th -49 th percentile: 4% 0-24 th percentile: 5% Baseline feasible, but not currently available.	90 th percentile (using most recent NCQA Quality Compass data at the time that the targets are communicated to the CCOs) 2011 Medicaid Benchmark: 44.40% (OHA recommends 75 th percentile)	
Initiation and engagement of alcohol and drug treatment	MN method with 3% floor <i>or</i> Tiered approach that requires the lower performers to improve at a greater rate compared to the higher performers: Averaged 50 th -74 th percentile: 3% Averaged 25 th -49 th percentile: 4% Averaged 0-24 th percentile: 5% Initiation baseline: 28% Engagement baseline: 13% Average: 20.5%	Average of the 90 th percentiles for the two rates (engagement and initiation) (using most recent NCQA Quality Compass data at the time that the targets are conveyed to the CCOs) 2011 Medicaid Initiation 75 th percentile: 48.84% 2011 Medicaid Engagement 75 th percentile: 20.52% Average: 34.68%	Create a composite of the two rates: Average the baselines and the benchmarks

Metrics and Scoring Committee: Suggested methodology for targets

Final Measure Set	Improvement Target	Performance Target	Notes
<p>Follow-up after hospitalization for mental illness</p>	<p>MN method with 3% floor; <i>or</i> Tiered approach that requires the lower performers to improve at a greater rate compared to the higher performers: 50th-74th percentile: 3% 25th-49th percentile: 4% 0-24th percentile: 5%</p> <p>Baseline: 52%</p>	<p>90th percentile plus the “delta” between the old and new baseline</p> <p>2012 Medicaid (w/o change in provider type) 90th percentile: 68%</p>	<p>Calculate the baseline without the added provider types – then compare the difference between 52% and NCQA-defined measure result. Take the difference and add it to the 2012 HEDIS benchmarks to have new quartiles to measure against.</p>
<p>Mental health and physical health assessment for children in DHS custody (bundled measure)</p>	<p>MN method with 3% floor; <i>or</i> Tiered approach using CCO data. Look at performance across CCOs and based on the distribution apply a tiered-based approach for CCOs that don’t meet the performance target.</p> <p>Baseline for MH: 58% Baseline for PH: feasible but not currently available Baseline for bundle: feasible but not currently available</p>	<p>90% or above (state goal)</p>	<p>Goal should be 100%, but CMS and hospitals let permit exclusion of 10% of records for “other issues”, so set performance target at 90%.</p>

Metrics and Scoring Committee: Suggested methodology for targets

Final Measure Set	Improvement Target	Performance Target	Notes
Screening for clinical depression and follow-up plan	No improvement target for year one	90% or above 2010 PQRI Experience Rpt Average Performance Rate per Eligible Professional: 2010: 84.2%	A number of medical home initiatives include depression screening in their registry data set -look to see what they are reporting for rates of depression screening.
Reducing elective delivery before 39 weeks	MN method with 1% floor; <i>or</i> Tiered approach using CCO data. Look at performance across CCOs and based on the distribution apply a tiered-based approach for CCOs that don't meet the performance target. Baseline feasible but not yet available.	5% or below	5% rate of elective early term delivery would be reasonable as a national quality benchmark. March of Dimes (OR) agrees this is a reasonable benchmark. ¹
Prenatal care initiated in the first trimester	MN method with 3% floor; <i>or</i> Tiered approach that requires the lower performers to improve at a greater rate compared to the higher performers 75 th -89 percentile: 3% 50 th -74 th percentile: 4% 0-49 th percentile: 5% Baseline: 30.4% (admin data)	90 th percentile (OHA recommends 75 th percentile) 2012 Medicaid benchmark data 75 th percentile: 89%	

Metrics and Scoring Committee: Suggested methodology for targets

Final Measure Set	Improvement Target	Performance Target	Notes
Developmental screening by 36 months (hybrid or claims-based data)	5% over baseline or Tiered approach using CCO data. Look at performance across CCOs and based on the distribution apply a tiered-based approach for CCOs that don't meet the performance target. above 75% (but less than 50%): improve 3% 50 th -74 th percentile: 4% 25 th -49 th percentile: 5% 0 th -24 th percentile: 6% Baseline: 14.6% using admin data only	50%	
Colorectal cancer screening (hybrid)	MN method with 3% floor; or Tiered approach that requires the lower performers to improve at a greater rate compared to the higher performers 50 th -74 th percentile: 3% 25 th -49 th percentile: 4% 0-24 th percentile: 5% Baseline: 30.5% using admin data only	75 th percentile plus the "delta" between the old and new baseline 2012 Commercial Benchmark unadjusted 75 th percentile: 65.76%	Look at the difference between Medicaid and commercial rates across all common measures to assess the average percentage point difference, and then adjust the NCQA commercial colorectal cancer benchmark appropriately.

Metrics and Scoring Committee: Suggested methodology for targets

Final Measure Set	Improvement Target	Performance Target	Notes
Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT)	No improvement target	20%	Assume baseline is zero.
Optimal diabetes care (D3) (bundle measure)	No improvement target	20% Mean for D5 in MN in 2009 was 28% for total population.	
Controlling hypertension	No improvement target	75 th percentile 2012 Medicaid Benchmark 75 th percentile: 60%	
Adolescent well-care visits	MN method with 3% floor <i>or</i> Tiered approach that requires the lower performers to improve at a greater rate compared to the higher performers 50 th -74 th percentile: 3% 25 th -49 th percentile: 4% 0-24 th percentile: 5% Baseline: 26.3%	90 th percentile (OHA recommends 75 th percentile) 2011 Medicaid Benchmark 75 th percentile: 56.9%	
EHR composite (3 questions)	HOLD pending potential baseline data from CMS	HOLD pending potential baseline data from CMS	

Suggested consideration: if baseline is below 25% in absolute terms the overall increase required is greater.

Review Questions to Inform Quality Incentive Pool Operation Agenda Item #5

Oregon Metrics and Scoring Committee
Michael Bailit
October 16, 2012

bailit
health
PURCHASING

Meeting Agenda Item #5

#5 Structural Elements of
the Incentive Pool

#5 Algorithm Design

#6 Wrap-Up

Structural Elements of the Incentive Pool

OHA is responsible for determining the structure of the incentive pool, but would appreciate comments from the Committee.

- Specifically, OHA is interested in getting comments on the following questions:
 - What should be the size of the incentive pool?
 - How should the incentive pool be divided among the CCOs?
 - How should the amount of incentive funds that are potentially available to the CCOs be determined?
 - What should be the timing of the distribution of funds?

How should the incentive pool be divided among the CCOs?

- A. All of the CCOs compete for the dollars across the entire incentive pool.
 - The dollars are distributed to the CCOs on the basis of performance with the highest PMPM amounts going to the highest performers. CCOs don't prospectively know the amount they might earn.
- B. Each CCO has a defined amount of dollars from the incentive pool for which it is eligible in any particular year.
 - CCOs know at least the minimum amount they might earn.

What happens to incentive funds not earned by CCOs?

If each CCO has a maximum amount of dollars from the incentive pool for which it is eligible in any particular year, then what happens to the incentive pool funds that are not earned by CCOs?

- A. They “revert back” to the state and are treated as savings to state taxpayers and CMS.
- B. They are distributed to the highest performing CCOs as additional Quality Pool payments.
- C. They are rolled over into the next year’s Quality Pool.

How should the amount of funds that are available to the CCOs be determined?

- A. The amount of potential funding should be determined based on the number of member months for the incentive period.
- B. The amount of potential funding should be determined based on the number of individuals enrolled for the entire incentive period.
- C. The amount of potential funding should be determined based on the amount of expenditures made by the CCO during the incentive period.

What should be the timing of the distribution of funds?

- A. The funds are distributed on an annual basis. The incentive period runs for one year; there is an additional three-month period to account for the lag in claims data, with the incentive payments being made shortly thereafter.
- B. The funds are distributed on both an annual and quarterly basis, depending upon the measure. For both annual and quarterly performance assessments, there is an additional three-month period to account for the lag in claims data, with the incentive payments being made shortly thereafter.

Algorithm Design

OHA is responsible for determining the algorithm that will be used to distribute the funds, but would appreciate comments from the Committee. Specifically, OHA is interested in getting comments on the following design elements:

- Should each CCO be assessed on both a performance target and an improvement target?
- Should performance against the performance target be valued the same as performance improvement?
- Should all performance measures be considered to represent equivalent value?
- Should CCOs be required to achieve a minimum score in order to receive a quality pool distribution?
- Should CCOs only be rewarded through the algorithm, or should they also be penalized?

Meeting Agenda Item #5

#5 Structural Elements of
the Incentive Pool

#5 Algorithm Design

#6 Wrap- Up

Should each CCO be assessed on both a performance target and an improvement target?

OHA Proposal:

- CCOs will be assessed against a performance target. If the CCO meets the performance target, it gets full credit for the measure.
- If the CCO does not meet the performance target for a given measure, it is assessed against an improvement standard.

Should performance against target be valued the same as performance improvement?

OHA Proposal:

- The value assigned to meeting a performance target is the same as for demonstrating improvement

Should all performance measures be considered to represent equivalent value?

Proposed Options:

- Each measure is treated as of equivalent value.

or

- Measures are assigned varying weights to reflect their relative value.

Should CCOs be required to achieve a minimum score in order to receive a quality pool distribution?

Proposed Options:

- Yes. Only those CCOs with a qualifying score can receive any distribution.

or

- No. All CCOs can receive a distribution so long as they report required information/reports.

or

- No. All CCOs can receive a distribution if performance on specific measures warrants it regardless of overall performance.

Should CCOs only be rewarded through the algorithm, or should they also be penalized?

Proposed Options:

- CCOs are only rewarded for attaining targets or improving performance.
- *or*
- CCOs are rewarded for attaining targets or improving performance, but also penalized:
 - when performance does not meet minimum expectations for all measures;
- *or*
 - when performance does not meet minimum expectations for certain measures that represent basic performance expectations;
- *and/or*
 - when performance significantly declines over the prior period.

Meeting Agenda Item #5

#5 Structural Elements of
the Incentive Pool

#5 Algorithm Design

#6 Wrap- Up

Wrap-Up

- Next Steps
- Next Meeting:
 - October 22nd
 - 1:00 pm – 4:00 pm
 - Clackamas Community College
 - 29353 SW Town Center Loop E
 - Wilsonville



October 10, 2012

Dear Members of the CCO Metrics and Scoring Committee,

The Oregon Foundation for Reproductive Health (OFRH) is a statewide nonprofit advocacy and policy organization whose mission is to improve access to comprehensive reproductive health care, including preventing unintended pregnancies and planning healthy families.

We are writing to provide testimony regarding the selection of Incentive Measures for CCOs. We provided testimony multiple times to previous committees regarding the selection of Core Metrics for CCOs, and we are very pleased that one of the Core Metrics is “Effective contraception use among women who do not desire pregnancy”.

We understand that there is some overlap of Core Metrics and Incentive Measures for CCOs. **We urge you to consider adding “Effective contraception use among women who do not desire pregnancy” as an Incentive Measure.**

Your previous meeting materials indicate that one Quality Improvement Focus Area is “Improving perinatal and maternity care”. This makes a great deal of sense, because maternity care is a major category of health care spending. In the current matrix of proposed measures, you list four in the category of maternity care: Prenatal care (% of deliveries that received a prenatal care visit in the first trimester or within 6 weeks of enrollment), postpartum care (% of deliveries that had a postpartum visit at 3-8 weeks), C-section rate and elective delivery before 39 weeks.

While those are all worthy candidates for measures, consider the fact that in Oregon in 2010, there were about 46,000 deliveries. Of those, about 46% were the result of unintended pregnancies, based on state PRAMS data, a survey of women postpartum. While some of those unintended pregnancies were wanted, most of them (37%) were either unwanted or occurred sooner than desired by the women. The average cost for prenatal care and hospital delivery (uncomplicated) is about \$7600 (AHRQ data from 2004). That means that for the 17,020 births in Oregon that were unwanted or too soon, we accrued at least \$129,352,000 in prenatal and birth costs alone for pregnancies that weren’t desired in the first place. In 2010, 53% of deliveries in Oregon were paid for by Medicaid.

Instead of addressing the enormous costs of maternity care just by targeting late-in-the game measures like elective inductions and C-sections, why not focus on reducing the rate of unintended pregnancies as well? In that way, you increase quality, save costs at a much higher rate, and you help women achieve their *own* goals for their desired number of children and the spacing of their children.

Your first proposed incentive measure selection criterion is that measures should be “representative of the array of services provided and beneficiaries served by the CCOs”. Another criterion is to “exclude measures that would be expected to be heavily influenced by patient case mix”. While nearly all hospitals in Oregon provide maternity care, a dwindling number of primary care practices offer prenatal care. However, every adult primary care practice sees adult women of reproductive potential. If you include maternity measures AND a measure such as “Effective contraception use among women who

don't desire pregnancy", you will better represent the array of beneficiaries served by CCOs and reach ALL primary care practices, regardless of whether they offer prenatal care services. Women are fertile for about 35 years of their lives, but most women only spend about 4 years pregnant or postpartum. If you really want to address reproductive health quality and cost, you MUST look beyond the period of pregnancy care and address the many years of reproductive potential when women are trying to avoid pregnancy.

Thank you so much for your consideration of our concerns, and for all your work on behalf of Oregonians. If you have any questions about this testimony, feel free to contact us.

Best regards,

Oregon Foundation for Reproductive Health

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