Oregon Health Policy Board

AGENDA

June 3, 2014
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
1:00 p.m. to 4:00 p.m.

Live web streamed at: OHPB Live Web Streaming

#	Time	Item	Presenter	Action Item
1	1:00	Welcome, call to order and roll **Action item:** • 5/6/14 Minutes	Carla McKelvey, Acting Chair	X
2	1:05	Director's Report	Suzanne Hoffman, OHA	
3	1:15	Transition Project Update	Tina Edlund, Governor's Office	
4	1:30	Presentation: Task Force on the Future of Public Health Services	Lillian Shirley, Public Health Director Tammy Baney, Deschutes County Commissioner	
5	2:15	Break		
6	2:30	Brief Policy Update	Leslie Clement, OHA	
7	2:45	Second OHPB Health System Dashboard Release	Gretchen Morley, OHA Lori Coyner, OHA Russell Voth, OHA	
8	3:45	Public Testimony	Chair	
9	4:00	Adjourn	Chair	

Next meeting:
July 1, 2014
8:30 a.m. to noon
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4

DRAFT

Oregon Health Policy Board
DRAFT Minutes
May 6, 2014
9:30-12:00 noon
Market Square Building
1515 SW 5th Avenue, 9th Floor

Item
Welcome and Call To Order Vice Chair Dr. Carla McKelvey called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present except Mike Bonetto. Leslie Clement was present from the Oregon Health Authority (OHA). **Consent Agenda:** The meeting minutes from April 1, 2014 were unanimously approved. The Workforce Committee by-law amendments were approved and can be viewed here, starting on page 5. June's meeting will be in the new location: OHSU Center for Health & Healing Floor 3; Room #4 3303 S.W. Bond Ave. Portland, OR 97239 The OHPB Meeting scheduled for September 9 will be located in Southern Oregon, further details to come.
Director's Report – Leslie Clement Leslie Clement provided an update on enrollment: 308,000 new OHP enrollees related to new ACA eligibility rules with 75,460 QHP enrollees. According to a recent market place enrollment report reflecting Cover Oregon's rankings as of May 1, compared to all states and Washington D.C., Oregon's total enrollment came in 15th out of 51, QHP enrollment 28th out of 51 and Medicaid enrollment, 5th out of 51. State based exchanges were the same for Medicaid, 5th out of 15 and QHP ranked 7th out of 15. The Cover Oregon Board made a decision to use the federal technology for the next open enrollment period which begins on November 15, 2014, with coverage effective January 1, 2015.
Status Report of Policy Board Recommendations – Leslie Clement & Kelly Ballas, OHA Leslie Clement reviewed a status report of the bodies of work listed on the work plan: Measurement Framework: • There will be a report out at the June meeting; it will be the next iteration of the multi-payer dashboard, including new data sources. APAC Technical Advisory Group: • Applications have been received and are being reviewed to select the TAG leadership.

Sustainable Health Care Expenditures (Formerly Sustained Rate of Growth):

- View the Sustainable Healthcare Expenditures Workgroup Charter here, starting on page 10.
- The Sustainable Healthcare Expenditures Workgroup Charter was approved.

Kelly Ballas reviewed the proposed charter for the Coordinated Care Model Alignment Joint Workgroup, which can be viewed here, starting on page 8.

This workgroup was formed at the request of the OHPB, to spread the coordinated care model. The administrator of PEBB, OEBB and the Director of OHA would form this work group guided by the triple aim, the coordinated care model alignment work group document and the coordinated care principles.

The Coordinated Care Model Alignment Joint Workgroup will be formed prior to the next OHPB meeting and they will return with a work plan to present to the board.

The Coordinated Care Model Alignment Joint Workgroup Charter was approved, with the discussed changes: add an alignment of metrics, have the group report to both OHPB and the exchange board and have an individual from OID within the workgroup.

OHA Internal Transformation Plan Update – Bob Dannenhoffer, Umpqua Health Alliance & Leslie Clement, OHA

Leslie Clement provided the framework for internal transformation. The OHA needs to take some of the transformation on as a state agency and took on establishing transformation plans for the agency. The OHA has adopted the Tiger Team approach (cross-functional teams) that come together to address improvement areas. Innovator agents will be leading the Tiger Teams and milestones and deliverables will be established.

Five areas for quality improvement that will be addressed:

- Statewide Behavioral Health System
- Rate Setting Policies and Procedures
- Rule Promulgation Process
- Eligibility and Enrollment
- Contract Processes

View the Transformation Plan Update here , starting on page 12.

CCOs and Early Learning Hubs – Bob Dannenhoffer, Umpqua Health Alliance, Helen Bellanca, Health Share of Oregon and Dana Hargunani, OHA

Dana Hargunani reviewed the early learning hub map, (starting on page 15).

Dr. Bellanca, Maternal Child Family Program Manager for Health Share of Oregon, reviewed how the communities and CCOs are working together. Important factors to understand are the population, data and metrics.

Better meeting the needs of families is addressed by the Universal well-being assessment for families, which is the core of Public Health, Community Programs, and Health care services.

Another way to work together most in the future is Kindergarten Readiness as one of the CCO metrics. Thinking about the role that CCOs and health care providers would play in Kindergarten readiness, the primary and secondary drivers and the factors that influence the drivers so health care providers and CCOs see their role in making sure children are ready for Kindergarten. View the CCOs and Early Learning Hubs presentation here, starting on page 16.
Workforce Committee: Demographic and geographic profile of Oregon's Population and Current Health Care Workforce – Lisa Angus and Cathryn Cushing - OHA Lisa and Cathryn reviewed findings from a work force committee report that the board requested to investigate the diversity of Oregon's health care workforce compared to the state's population. The healthcare work force committee's charge is to coordinate efforts around recruitment, education and to ensure Oregon has the workforce it needs to support transformation. The committee makes recommendations to the board, advises the board on direction to take and answers questions around the healthcare workforce. One of the deliverables is to do a demographic and geographic profile of Oregon's population based on race, ethnicity and languages spoken. View the Workforce Committee report here, starting on page 21.
Public Testimony **Ty Schwoeffermann from Urban League of Portland,** followed up on his conversation from last month regarding traditional health workers. He's had good conversations with Tina Edlund and Sean Kolmer and things are moving in a good direction. Traditional health workers being part of a pipeline strategy would solve two major issues: place-base issue and racial and ethnic diversity.
Adjourn

Next meeting:

June 3, 2014
1:00 to 5:00 p.m.

OHSU Center for Health & Healing
Floor 3; Room #4
3303 S.W. Bond Ave.
Portland, OR 97239

OREGON HEALTH POLICY BOARD

COVER OREGON IT TRANSITION PROJECT UPDATE

TINA EDLUND, TRANSITION PROJECT DIRECTOR

JUNE 3, 2014

ENROLLMENTS (AS OF MAY 27, 2014)

COVER OREGON	
Total Medical Enrollments	285,578
QHP Enrollments	83,852
OHP Enrollments	201,726
Total Dental Enrollments	16,979

OREGON HEALTH AUTHORITY	
Fast Track OHP Enrollments	137,000

TOTAL MEDICAL ENROLLMENTS	
Cover Oregon & OHA Enrollments *(incl. Fast Track)*	422,578

STATE COMPARISON (AS OF APRIL 19, 2014)

	Compared to all states and D.C.	Compared to other state-based exchanges
RAW NUMBERS		
Total Enrollment	**15th of 51**	**6th of 15**
Qualified Health Plans	28th of 51	7th of 15
Oregon Health Plan *(Medicaid)*	5th of 51	5th of 15
AS PERCENTAGE OF POPULATION		
Total Enrollment	**7th of 51**	**7th of 15**
Qualified Health Plans	36th of 51	9th of 15
Oregon Health Plan *(Medicaid)*	6th of 51	6th of 15

U.S. Dept. of Health and Human Services http://aspe.hhs.gov

TECHNOLOGY TRANSITION

Oregon is moving forward, making progress, and focused on having a working website to enroll Oregonians in health coverage beginning NOVEMBER 15, 2014

GOAL: NOVEMBER 15, 2014

- Oregonians can apply, shop and choose a private plan online all in one sitting
- Those eligible for Medicaid will have a more streamlined process
- Oregon retains control of the individual marketplace
  - Competition
  - Cost
  - Access

TO ACCOMPLISH GOAL

- Cover Oregon will use the federal technology for QHP eligibility and enrollment
- OHA will build on existing technology investment for Medicaid eligibility

ROADMAP TO NOVEMBER

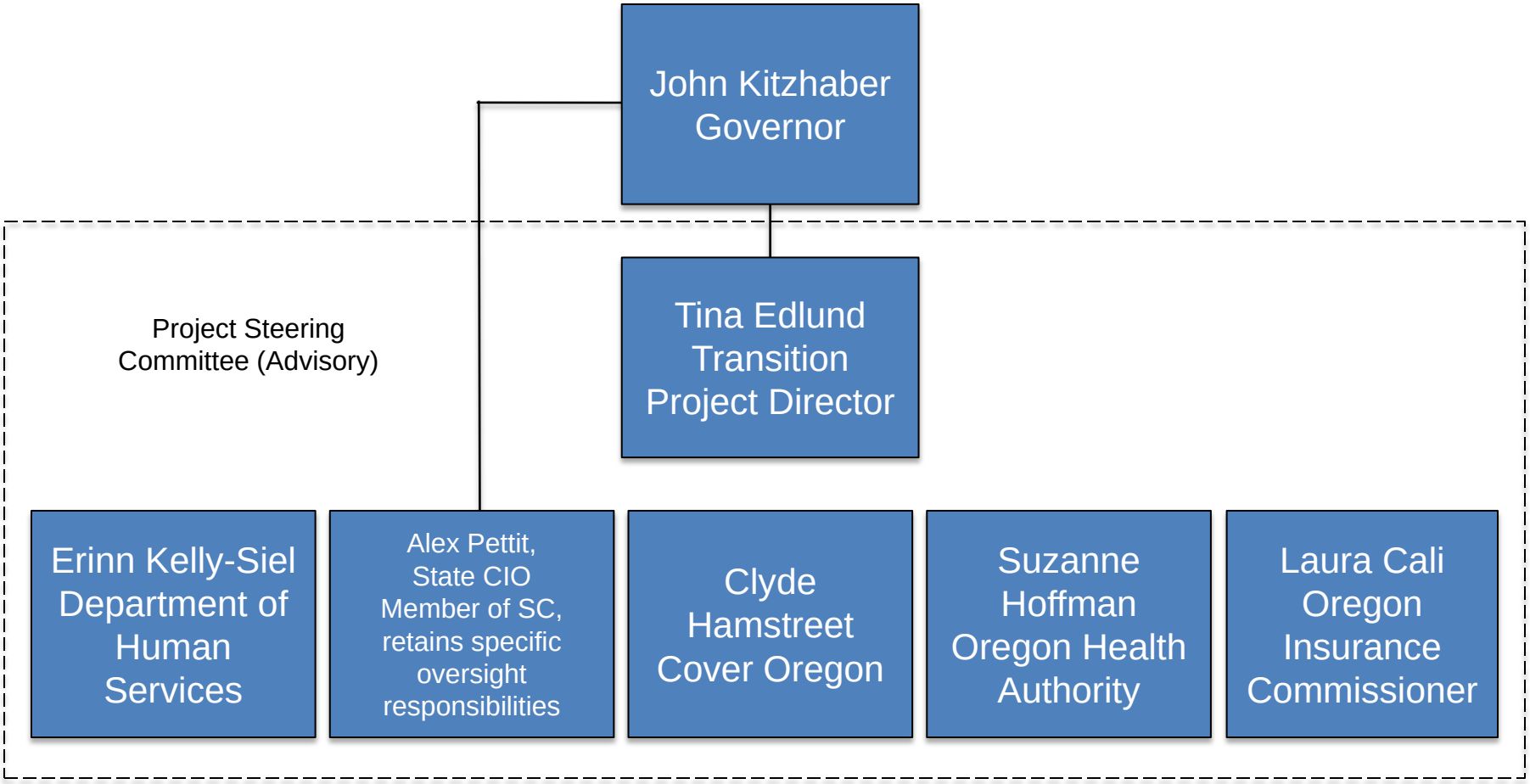
CMS: CONCEPT AGREEMENTS

- **Utilize previously approved federal resources: 90/10 IT funding**
- **Federal Responsibility (beginning Nov. 15, 2014)**
  - QHP eligibility and enrollment
  - Call Center functions for QHP customers
  - Agent/broker training and registration
- **Oregon Responsibility**
  - Rate review
  - Front-end consumer outreach and education, incl. tribal consults
  - Qualified health plan management
  - Medicaid program: determinations, notices, redeterminations, Medicaid call center, Medicaid online application and appeals

CMS: ONGOING DISCUSSIONS

- Enrollment of existing consumers from Cover Oregon into federal technology
- Distribution of shared responsibility:
  - QHP monitoring and oversight
  - Community partners/navigators

IT TRANSITION LEADERSHIP



THREE-PRONGED APPROACH

2014 Operations Project

- State retains responsibility for 2014 Operations through Dec. 31, 2014, including:
  - QHP Change in Circumstances/Life Events/New to Oregon Enrollees
  - Continued 2014 Medicaid Enrollments
  - Medicaid Redeterminations

2015 QHP Transition Project

- By Nov. 15, 2014, use federal technology for QHP eligibility and enrollment, including portal and call center
- State retains:
  - Front-end consumer outreach and education, including tribal consults
  - Certification of plans
  - Initial QHP plan management and some QHP oversight

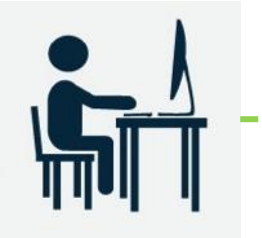
2015 MAGI Medicaid Project

- By Nov. 15, 2014, transfer Medicaid engine to OHA and connect OHA to federal technology
- OHA retains:
  - Front-end consumer outreach and education, including tribal consults
  - Medicaid portal (New) and call center
  - Medicaid determinations, enrollments, notices, redeterminations and appeals

KEY COMPONENTS FOR SUCCESS

- Co-located cross-agency Project Team with dedicated resources that reports to Governor’s office
- Operational resources at Cover Oregon, OHA, and other state agencies available to project team
- Single Systems Integrator Contract to coordinate both sets of work
- Quality Assurance and Independent Verification and Validation (IV&V) continue

SCENARIO 1: QHP ENROLLMENT



- Individual visits Oregon's public website
- Clicks "Apply Now"

- Automatically re-directed to federal portal
- Completes application

- Federal portal determines eligibility for QHP and tax credits

- QHP eligibility and shopping instructions appear online

- Individual enrolls into a plan & pays premium

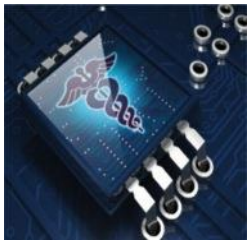
- Consumer is COVERED

SCENARIO 2: MEDICAID ENROLLMENT (DIRECT TO OHP)

- Individual visits Oregon's public website
- Clicks on "Apply for Medicaid Benefits"

- Automatically redirected to OHP application site
- Individual completes application for OHP

- Eligibility rules engine determines Medicaid eligibility



- Medicaid eligibility determination sent to MMIS for CCO assignment and further processing

- OHP welcome packet sent to consumer from MMIS

- Consumer is COVERED

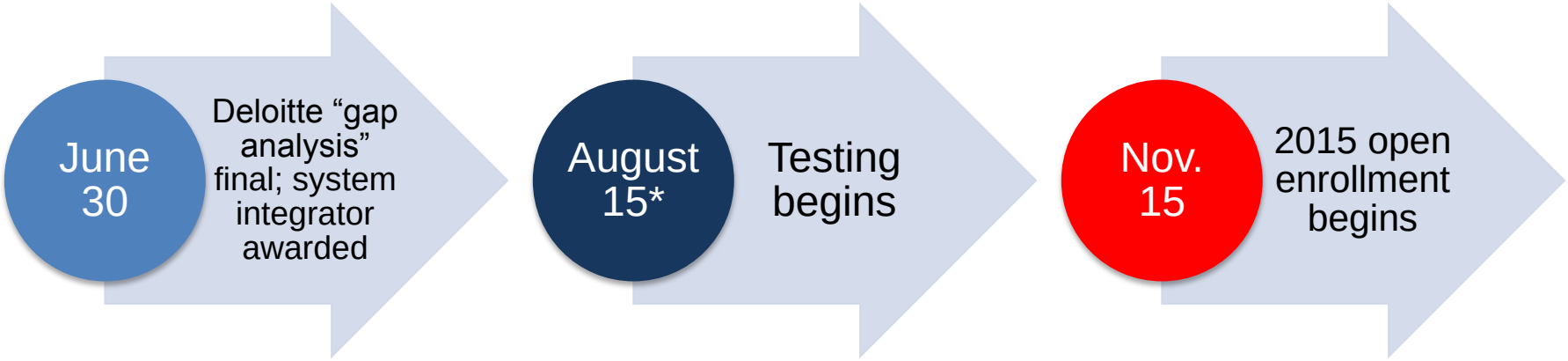
TRANSITION PROGRESS TO DATE

- Governance structure identified with single point of accountability
- Cross-agency project team and roles identified; co-located at single site
- Work plan established
- Web page established for posting of all project materials: resources.coveroregon.com/technology_transition.html
- “Gap analysis” contract in place

GAP ANALYSIS

- Deloitte conducting 45-day gap analysis to:
  - Build roadmap for business processes to transfer QHP to federal system
  - Analyze needs for moving current Medicaid eligibility technology to OHA
- Submit for quality review on June 20, sign off no later than June 30
- Notice posted May 26 for system integrator
- RFP to complete technology transition

MILESTONES TIMELINE



*Precise date to begin testing will be determined after execution of System Integrator contract

Overview of the Task Force on the Future of Public Health Services

June 3, 2014

Tammy Baney, MPH, Task Force Chair

Lillian Shirley, BSN, MPH, MPA, Public Health Division Director

Oregon Health Authority

HB 2348: Background

- Introduced in 2013; would have created eight public health regions
- Amended to become a task force studying the future of public health services in Oregon and to make recommendations for legislation.
- Report due to the Legislature Oct 1, 2014

Task Force Charge

Legislation requires the task force to focus on recommendations that:

- Create a public health system for the future
- Explore the creation of regional structures
- Enhance efficiency and effectiveness
- Allow for appropriate partnerships with regional health care service providers and community organizations
- Consider cultural and historical appropriateness
- Are supported by best practices

Task Force Membership

- Tammy Baney (Chair), Deschutes County Commissioner
- Liz Baxter (Vice Chair), Oregon Public Health Institute
- Carrie Brogoitti, Union County Public Health
- Carlos Crespo, Portland State University
- Charlie Fautin, Benton County Public Health
- Nicole Maher, Northwest Health Foundation
- John Sattenspiel, Trillium Community Health Plan CCO
- Jennifer Mead, Department of Human Services
- Gary Oxman, Multnomah County
- Alejandro Queral, United Way of the Columbia-Willamette
- Eva Rippeteau, AFSCME Council 75
- Rep. Jason Conger (R-Bend)
- Rep. Mitch Greenlick (D-Portland)
- Sen. Bill Hansell (R-Pendleton)
- Sen. Laurie Monnes Anderson (D-Gresham)

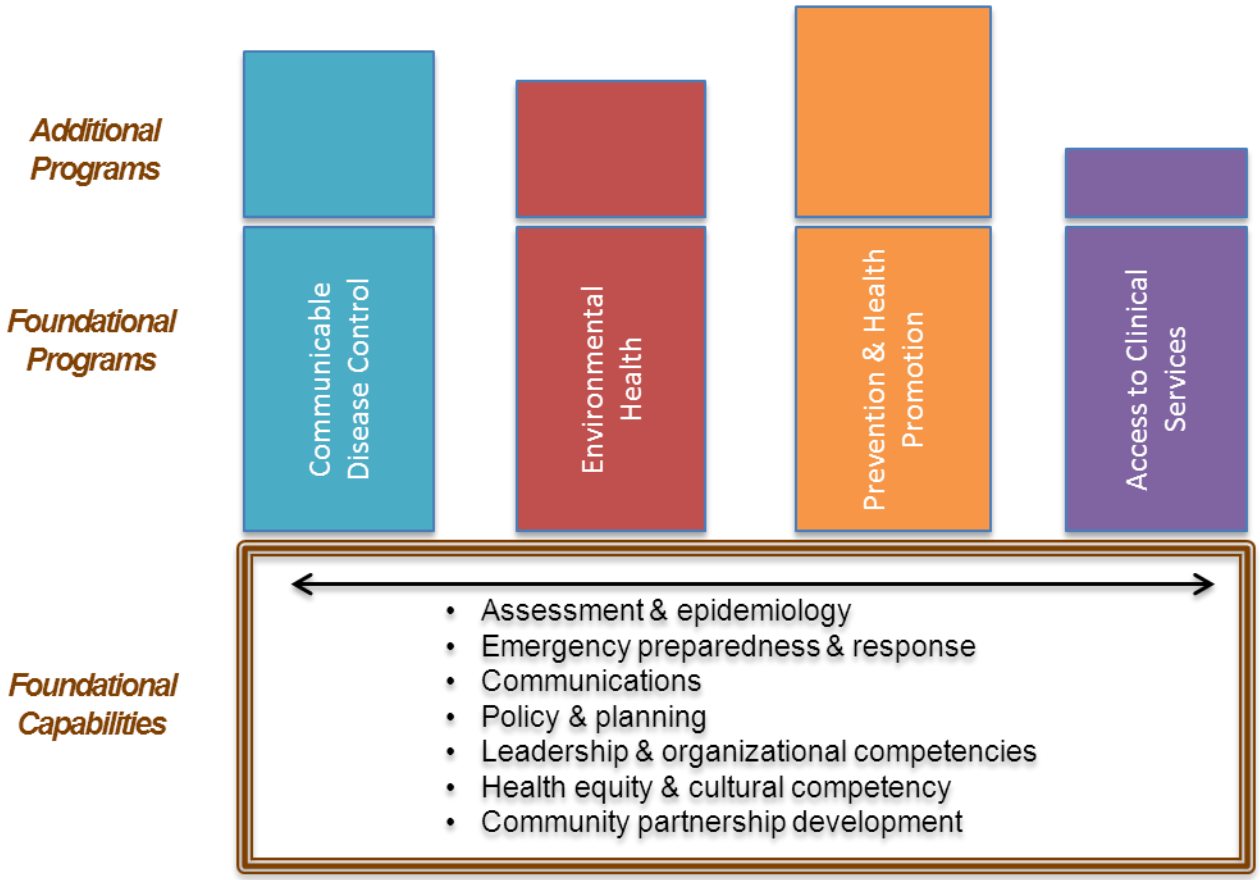
Meetings & Topics To Date

- November: Planning Meeting (Salem)
- January: Public Health 101 (Portland)
  - Role of Governmental Public Health
  - Local Public Health Overview: Roles of Counties
- February: Health System Transformation 101 (Salem)
  - Context of Health System Transformation
  - Examples of Health System Transformation Implementation
  - Overview on the Social Determinates of Health

Meetings & Topics (cont.)

- March: Public Health System Designs Part 1 (Portland)
  - Examples of how state programs are funded, structured
  - Overview of Governmental Public Health Archetypes (Pat Libby)
- April: Public Health System Designs Part 2 (Portland)
  - Examples of how local programs are funded, structured
  - Overview of Institute of Medicine (IOM) model for public health and Washington State's approach (Dave Fleming)
  - Task Force instructed staff on development of straw model, to be built on IOM and Washington State experience
- May: Working Session (Bend)
  - Overview of link between public health and early learning
  - Reviewed and edited straw model

DRAFT Conceptual Framework for Governmental Public Health Services



Updated 5/23/2014

DRAFT

Future Timeline

May	• Disucss Foundational Governmental Public Health Elements and Services
June	• Discuss Governance and Structure
July	• Assess Sustainable Funding
August	• Solicit and Incorporate Public Input
September	• Refine and finalize the model
October	• Provide report to Oregon Legislature

Questions?

Oregon Health Policy Board

Quarterly Dashboard

Presented June 3, 2014

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Background

Oregon's health system is in the midst of significant changes as it implements both state and federal reforms. Policies to expand insurance coverage, improve health, provide better care and reduce costs affect the lives of all Oregonians.

The Oregon Health Authority (OHA) presents this second edition of a dashboard to the Oregon Health Policy Board for review and feedback. OHA's intent is to provide a clear view of Oregon's health system from available data sources, including commercial insurance carriers, Medicare, Medicaid, health care providers, and population surveys. Trends will be tracked over time and new data sources will be added as they become available. By mapping the shifting terrain of Oregon's health care landscape, OHA seeks to inform the direction of policymakers, health care providers, insurers, purchasers and individuals.

The dashboard includes information on the following aspects of health and health care in Oregon:

- Health Care Cost and Utilization
- Health Insurance Coverage
- Quality of Care
- Medical Debt
- Health Status

As in the initial version of this dashboard released in March 2014, this dashboard does not yet capture many of the changes that are anticipated following Affordable Care Act insurance coverage expansions that went in to effect at the beginning of 2014. Subsequent editions of this dashboard will reflect these changes. This will allow the Oregon Health Policy Board and other stakeholders to understand how the state's health systems are changing as reforms are implemented, develop programs and policies that correspond to the changing system, and communicate effectively what changes are taking place in Oregon.

The data for the dashboard are derived from a number of sources which are described at the end of this document. OHA seeks to provide the most recent data available, which varies by source. In some instances, data included in the dashboard is incomplete due to ongoing submission or has not gone through rigorous validation. OHA will update future editions of the dashboard to reflect any more recent and validated data. In particular, OHA and the Oregon Insurance Division are forming a technical advisory group to enhance its All-Payer All-Claims database, which is the source of much of the cost and utilization data provided here. The group's work will improve the information OHA is able to provide in future dashboards.

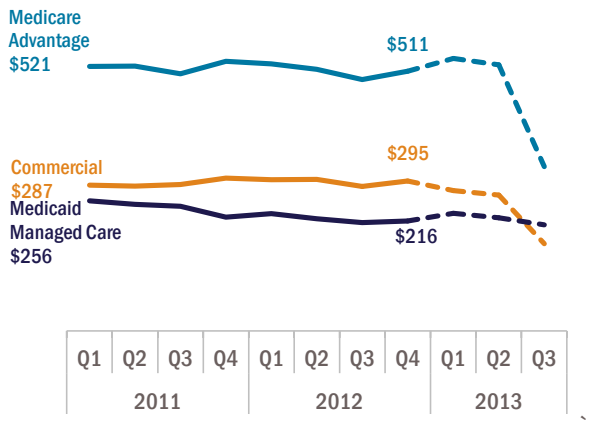
Please direct questions and comments on the OHPB Dashboard to:

Lori Coyner, Director, Office of Health Analytics - Lori.Coyner@state.or.us
Russell Voth, Manager, Health System Research and Data, Office of Health Analytics - Russell.Voth@state.or.us

Overview

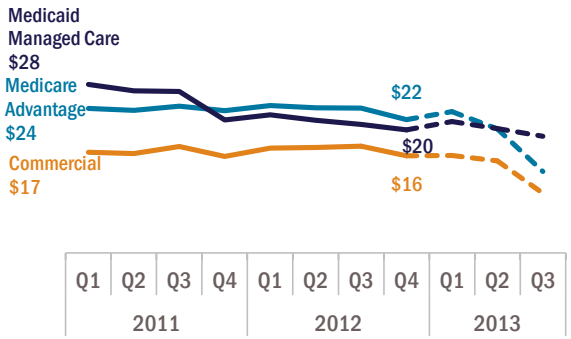
Cost & Utilization (pages 2-8)

Total* Expenditures Per Member Per Month (PMPM)

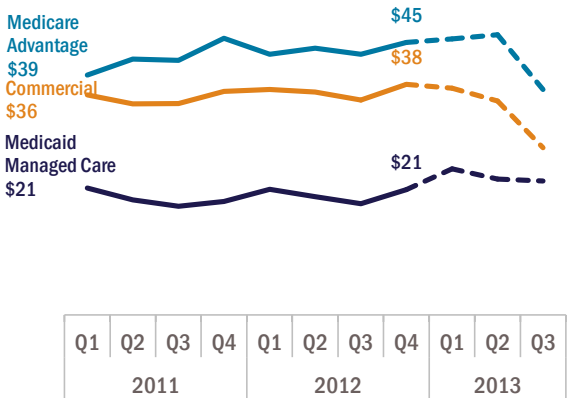


*Excludes pharmacy

Emergency Department Expenditures PMPM

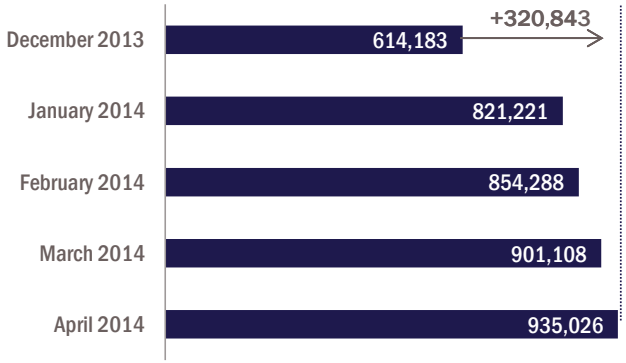


Primary Care Expenditures PMPM

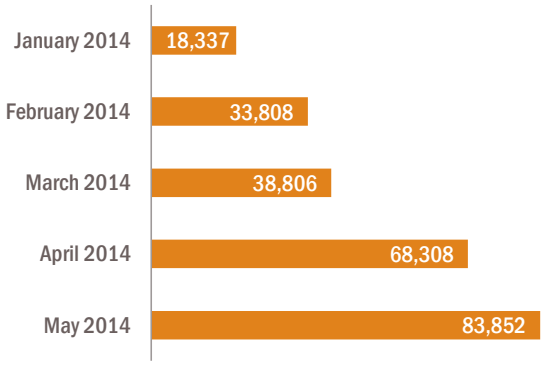


Enrollment (pages 10-12)

Oregon Health Plan

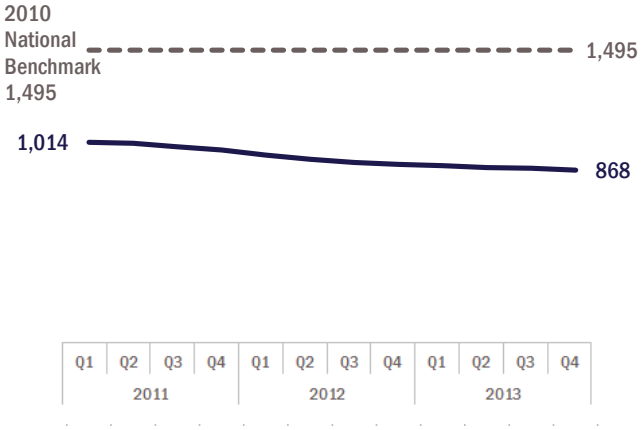


Cover Oregon Qualified Health Plans



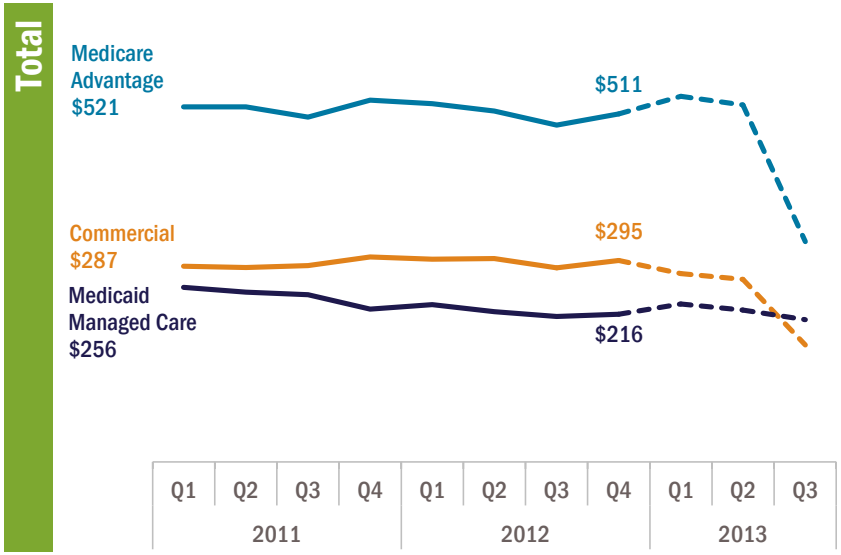
Quality (page 13)

Total PQI Admissions*



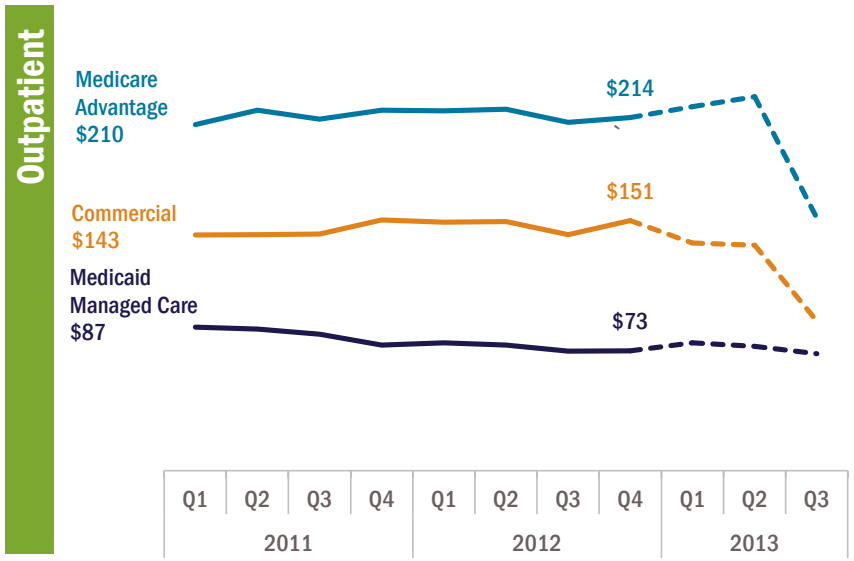
*Prevention Quality Indicator
Four-quarter moving average per 100,000 person years

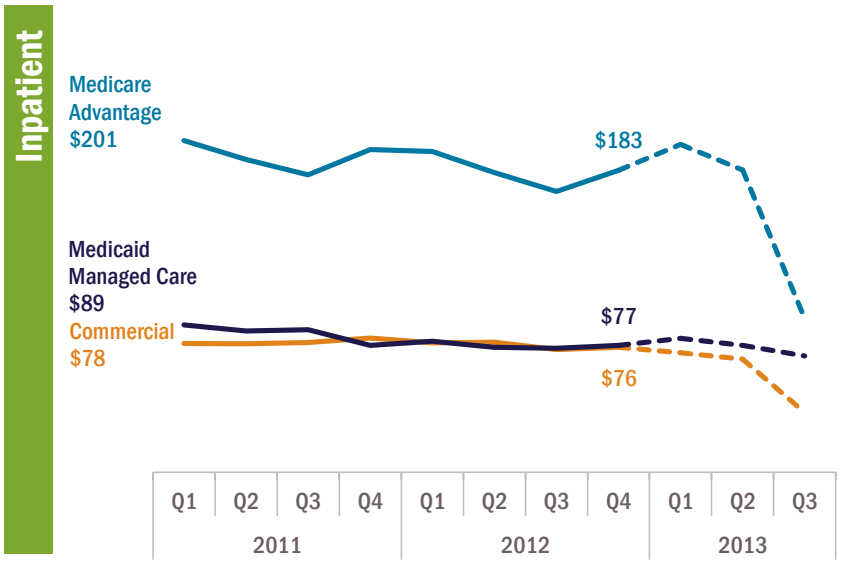
Cost: Expenditures Per Member Per Month



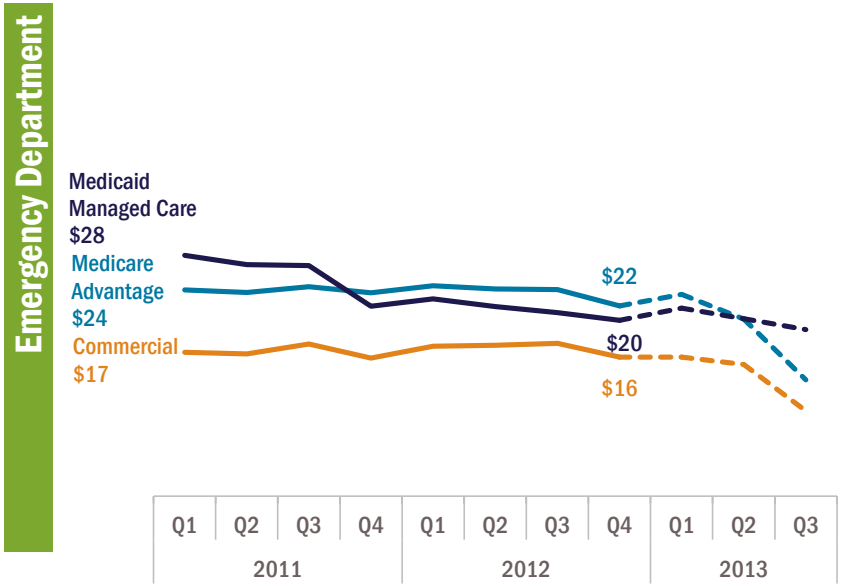
This section presents total allowed amounts per member per month by commercial, Medicare Advantage and Medicaid managed care. Cost data are compiled according to Milliman's Health Cost Guidelines grouper. For more details on groupings, see data notes page at the end of the dashboard. Dashed lines indicate where data are partially incomplete due to a delay between the time that a health care service occurs and when a claim for the service is processed and reported by the payer.

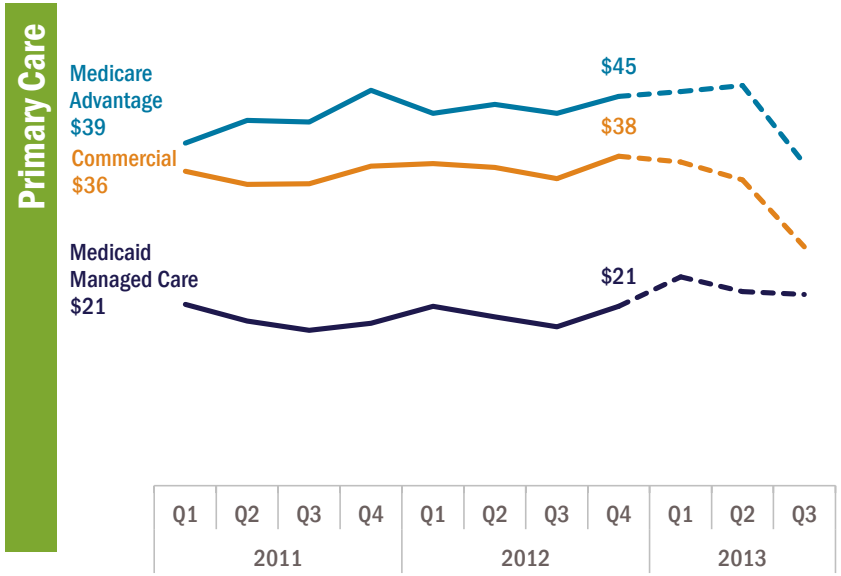
Certain expenditures such as capitated or lump-sum payments are not reflected in these charts because they are not reported in claims data. In addition, pharmacy is excluded from all lines of business and Medicaid expenditures that are not covered under managed care are also not included. Examples include expenditures for skilled nursing facilities, and non-emergent medical transportation.





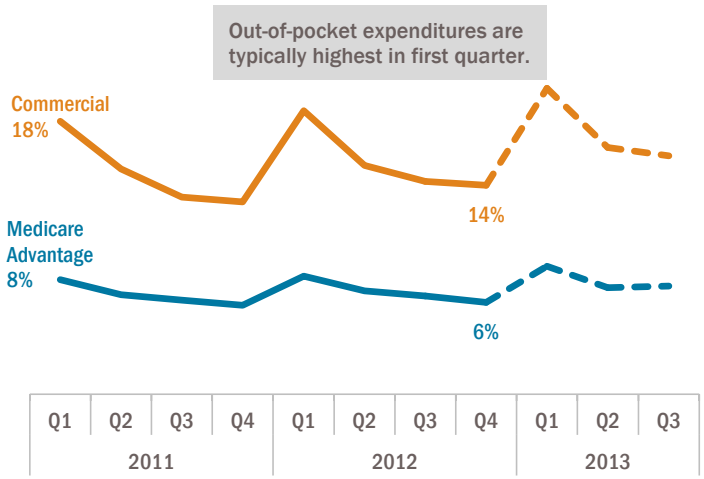
Cost & Utilization: Expenditures Per Member Per Month





Cost and Utilization: Consumer Out-of-Pocket Expenditures

Consumer Out-of-Pocket Share of Total Expenditures



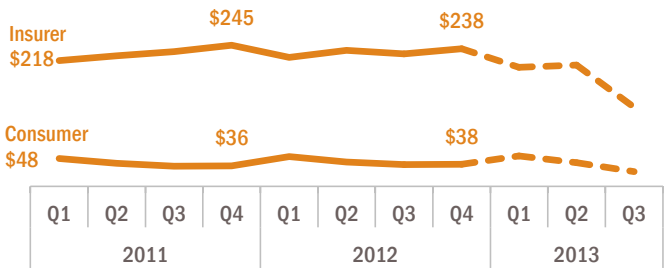
Consumers' out-of-pocket expenditures include copayments, coinsurance, and deductibles. These expenditures are larger early in the calendar year due to annual deductible requirements.

PMPMs in this section consist of insurer paid amounts and patient paid amounts, in contrast with PMPMs on page 3 which are based on allowed amounts.

Dashed lines indicate where data are partially incomplete. All data in this section are sourced from the All Payer All Claims Database.

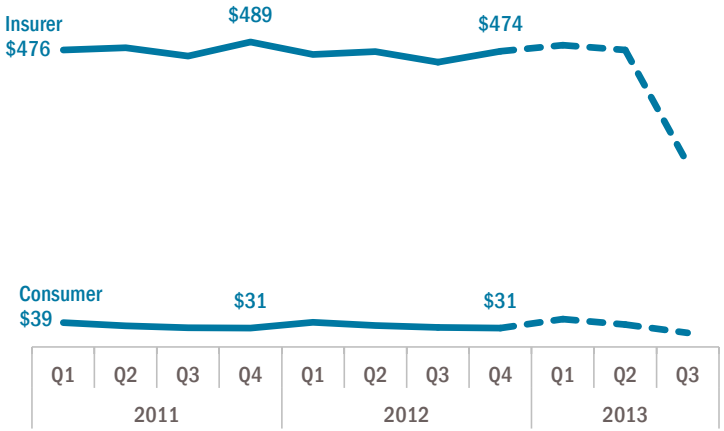
Commercial

Total PMPM
Insurer Covered and Consumer Out-of-Pocket Expenditures



Medicare Advantage

Total PMPM
Insurer Covered and Consumer Out-of-Pocket Expenditures

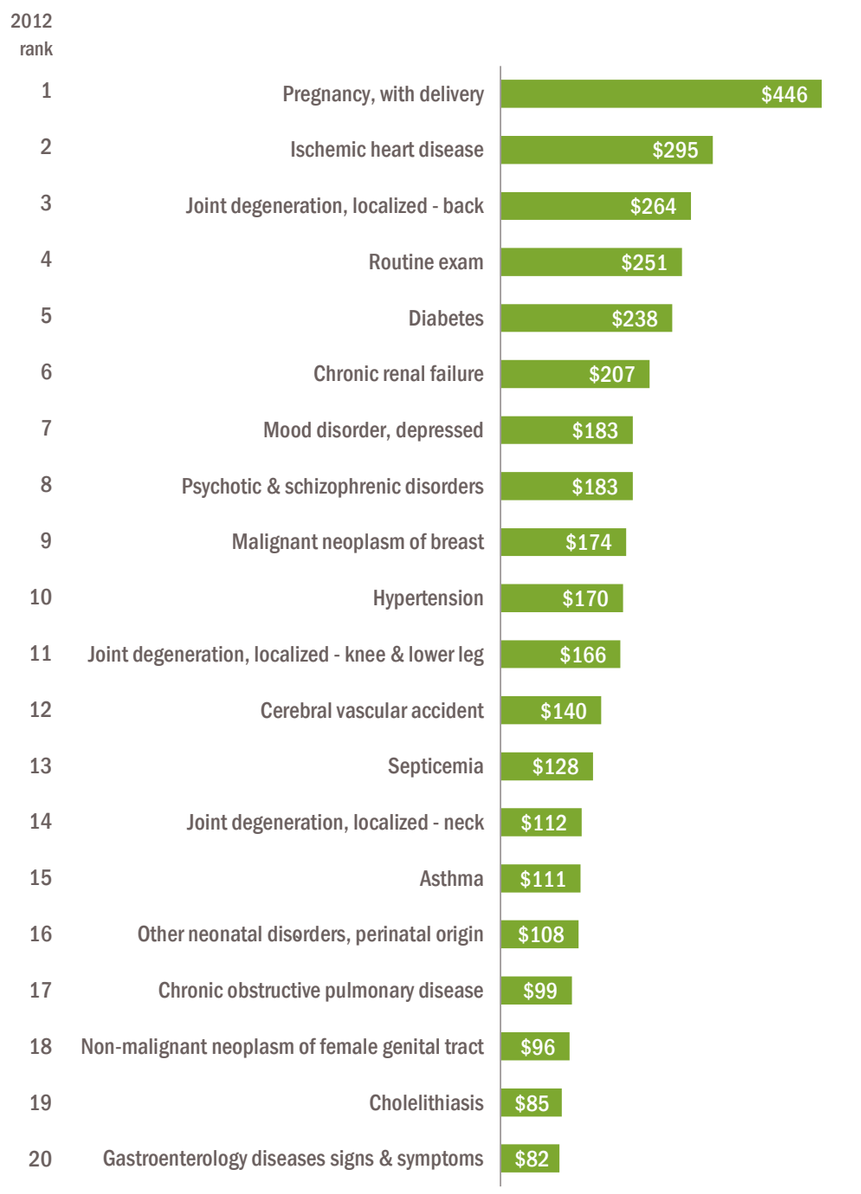


Cost: Top Health Care Treatment Episodes

- Episode Treatment Groups identify unique episodes of care. An episode of care combines all clinically related services for one patient and a discrete diagnostic condition.
- Together, the top 20 episodes from 2012 account for about 35% of total claim costs.
- All data in this section are sourced from the All Payer All Claims Database.

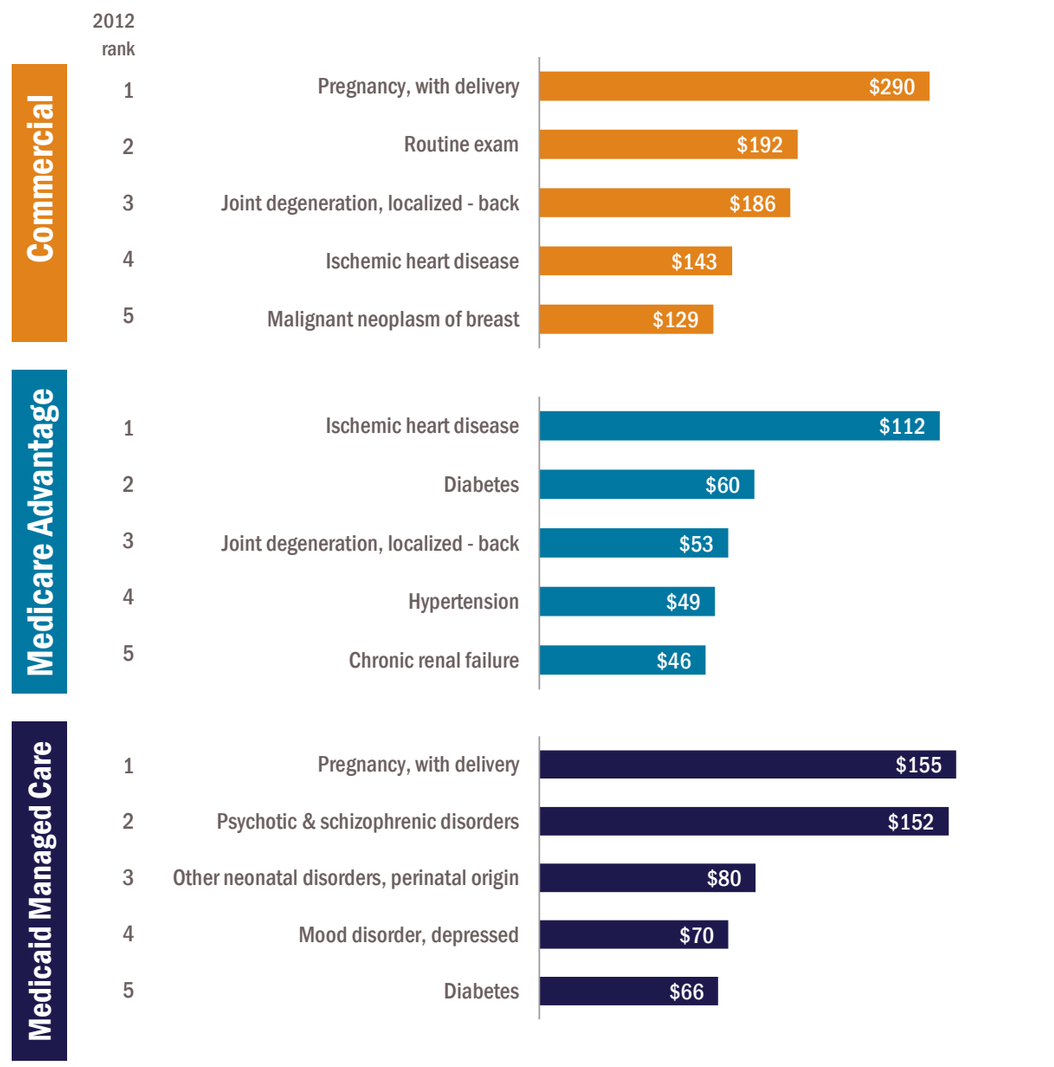
Top 20 Episodes by Total Expenditures - Statewide 2012

Dollars in millions



Top 5 Episodes by Total Expenditures - Lines of Business 2012

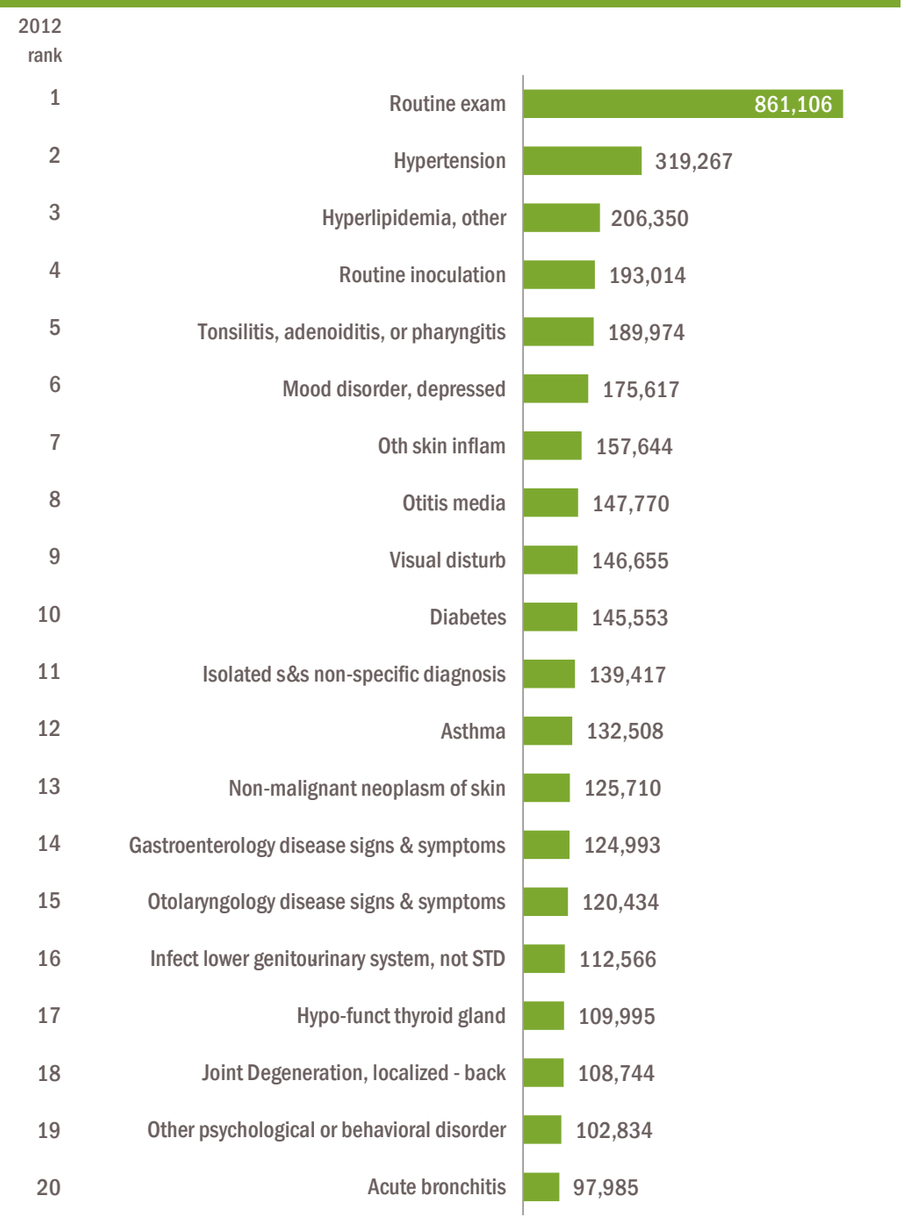
Dollars in millions



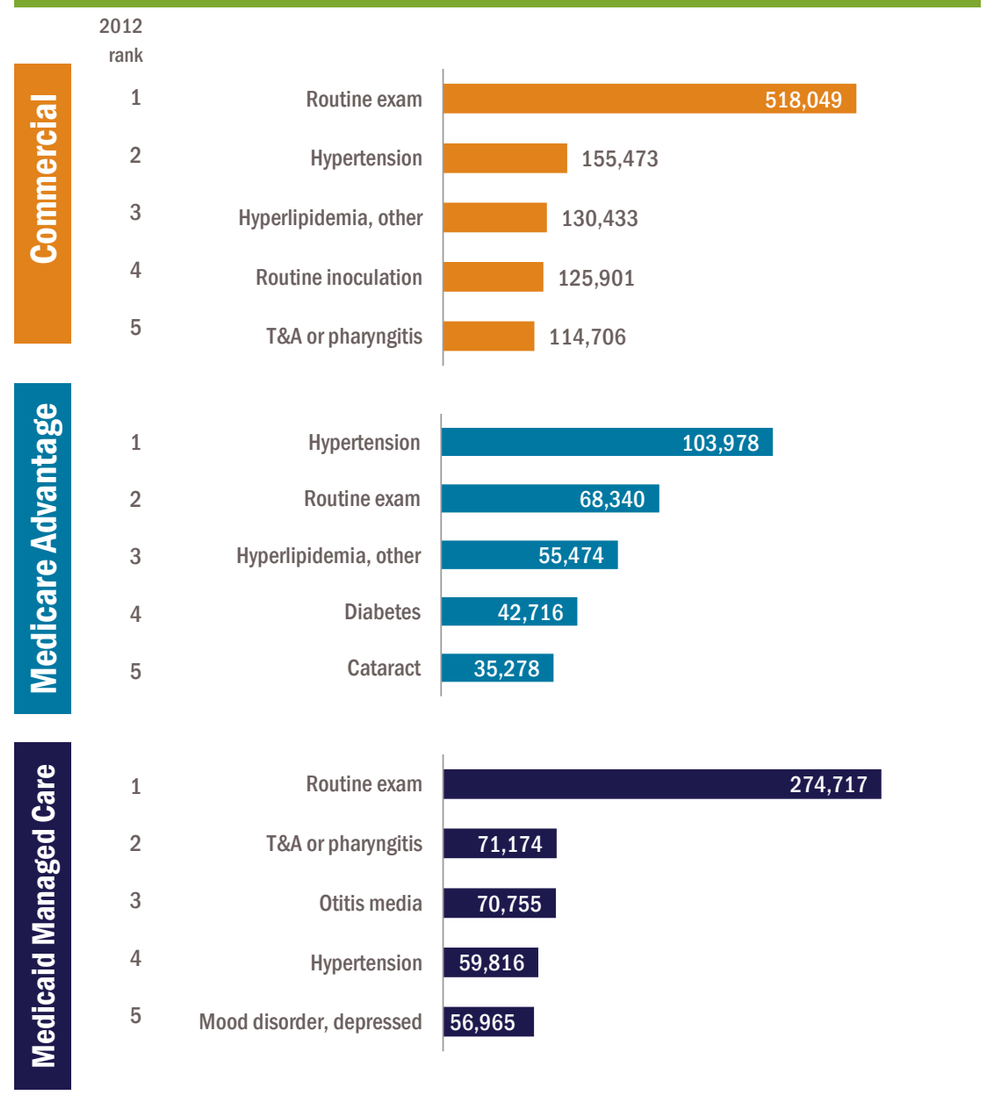
Utilization: Top Health Care Treatment Episodes

- Episode Treatment Groups identify unique episodes of care. An episode of care combines all clinically related services for one patient and a discrete diagnostic condition.
- All data in this section are sourced from the All Payer All Claims Database.

Top 20 Episodes by Number of Episodes - Statewide 2012



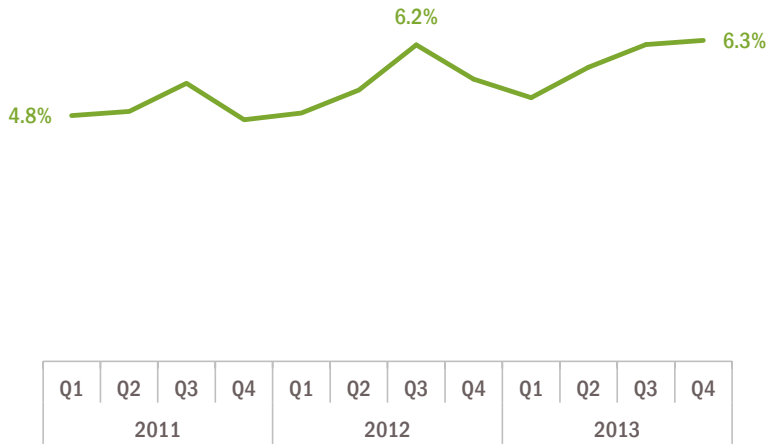
Top 5 Episodes by Number of Episodes - Lines of Business 2012



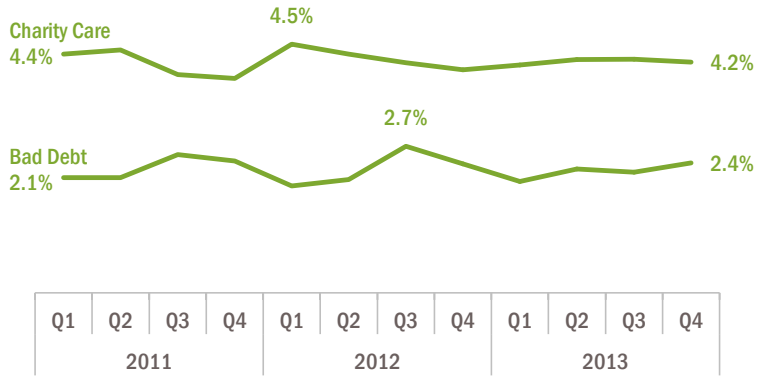
Cost & Utilization: Uninsured and Uncompensated Hospital Utilization

While hospital care for the uninsured has remained relatively stable over the last several years, that trend may change as more Oregonians are covered through the Affordable Care Act insurance coverage expansions. Uninsured hospital discharges are sourced from Oregon's hospital discharge database. Hospital uncompensated care is sourced from Databank.

Uninsured Hospital Discharges
as a percentage of total hospital discharges



Hospital Uncompensated Care
as a percentage of hospital gross charges

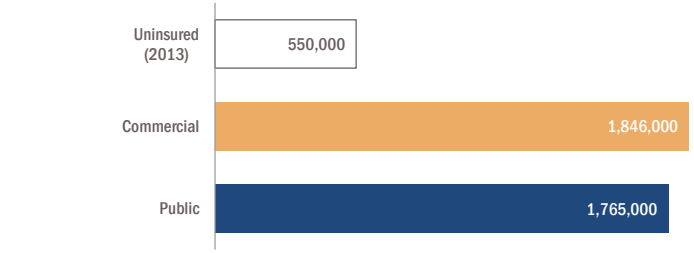


Enrollment: Health Insurance Coverage

Overview

Insurance Coverage

Some Oregonians have more than one form of coverage.



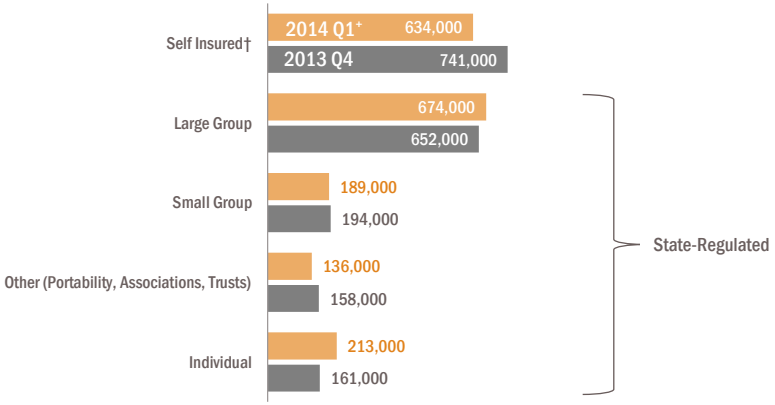
With the ACA coverage expansion, an increasing share of Oregonians receives public health insurance under Medicaid.

Between December 2013 and April 2014 Medicaid enrollment increased by roughly 50% percent.

Commercial health insurance enrollment is sourced from quarterly enrollment reports submitted to DCBS (Department of Consumer and Business Services). These data are preliminary as of 5/30/2014.

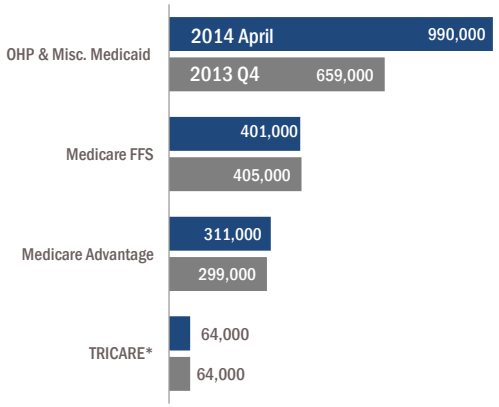
Medicaid enrollment comes from OHA and includes those recieving full and partial benefits, Medicare from Center for Medicare and Medicaid Services and TRICARE from DCBS.

Commercial Insurance

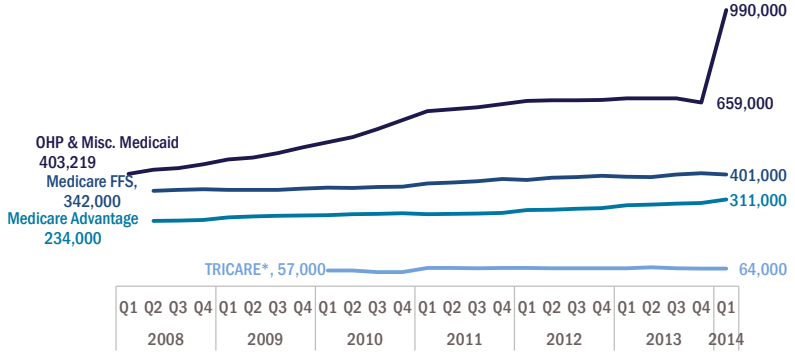


** 2014:Q1 DCBS data are preliminary*
† Only a portion of self-insured plans report enrollment data

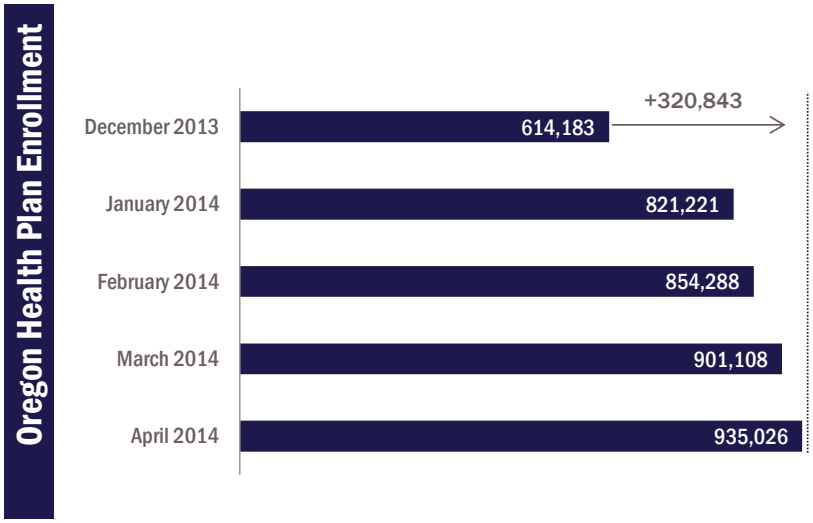
Public Insurance



** TRICARE data are reported quarterly by DCBS and is preliminary for 2014:Q1*



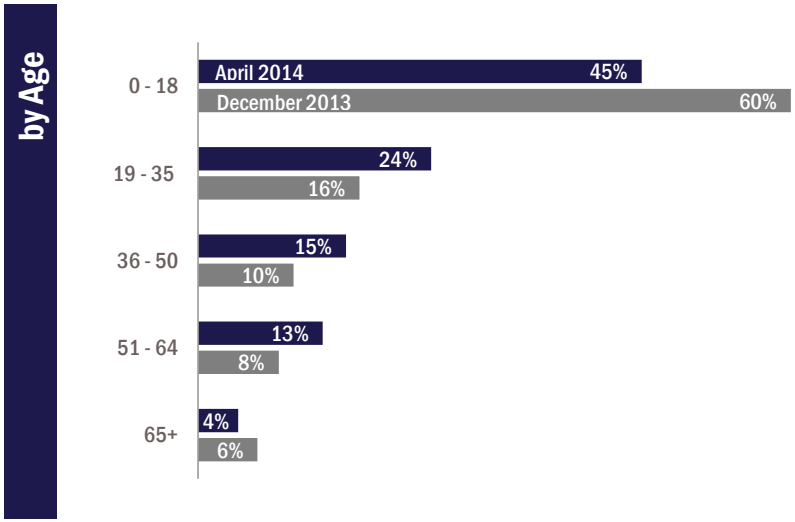
Enrollment: Oregon Health Plan before and after ACA Expansion

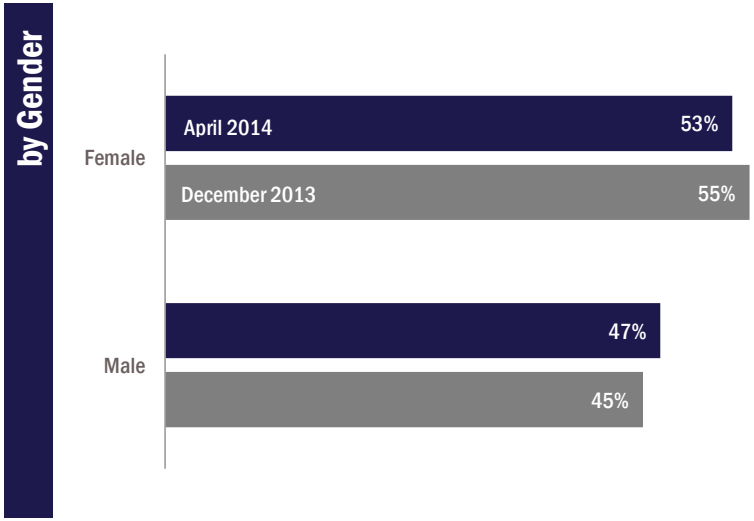


The ACA expanded access to health insurance in part by extending non-elderly adults' eligibility for Medicaid. The chart at left demonstrates the growth in enrollment in Medicaid managed care and Fee For Service programs over the last five months.

Note: the enrollment numbers on this page vary from those on the previous page, as the numbers reported here include only OHP enrollees eligible for full benefits.

The bottom two charts compare the characteristics of OHP enrollment in December 2013 prior to expansion and April 2014, the most recent month for which data is available. The expansion led to an increase in participation among adults, whereas previously OHP enrollees were mostly children. Post-expansion enrollment is also slightly more evenly split between women and men.



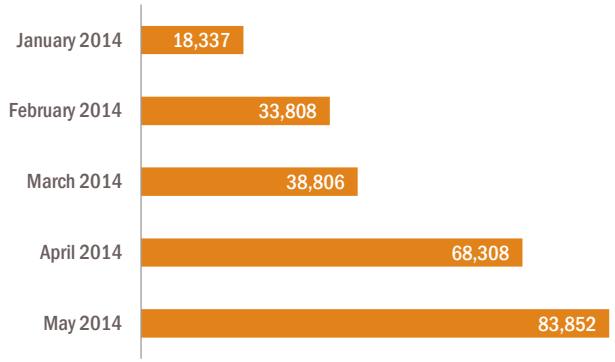


Enrollment: Qualified Health Plans through Cover Oregon

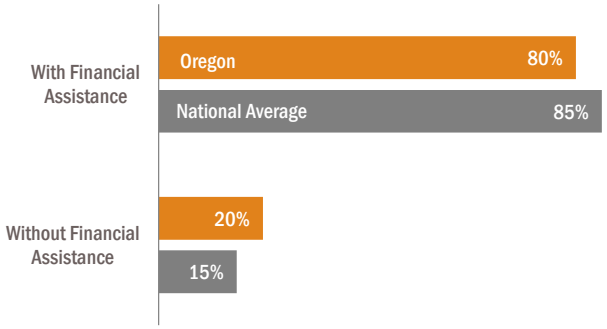
The ACA expanded access to health insurance in part through the establishment of Cover Oregon. Oregonians who have purchased individual insurance through Cover Oregon have characteristics largely similar to their national counterparts. A slightly smaller share of enrollees receives financial assistance in Oregon than they do nationwide; a slightly larger share are female; and a somewhat greater share of enrollees select the gold, silver and bronze tiers of coverage in Oregon.

Enrollment data for January through April come from monthly Health Insurance Marketplace Summary Reports distributed by the Department of Health and Human Services (HHS). The categorical data is taken from the May 1, 2014 Summary Report. The May enrollment total is taken from the Cover Oregon website.

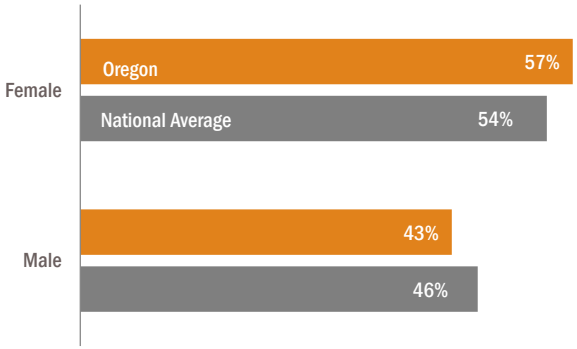
Enrollment Over Time



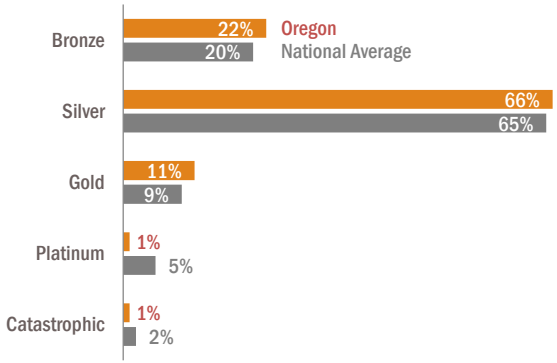
by Finanacial Assistance



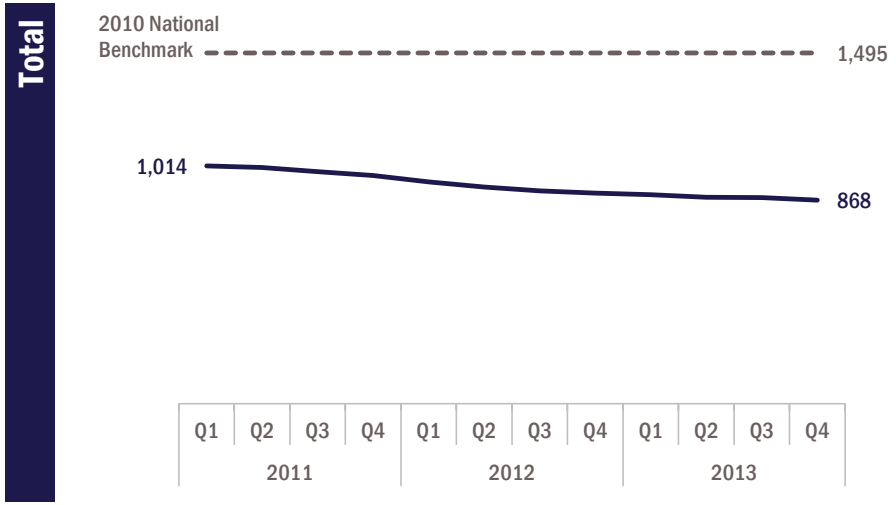
by Gender



by Metal Tier

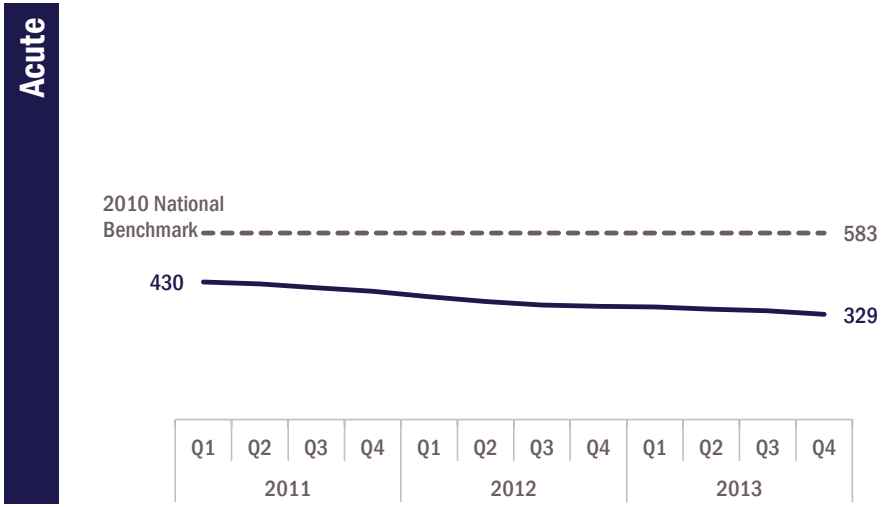


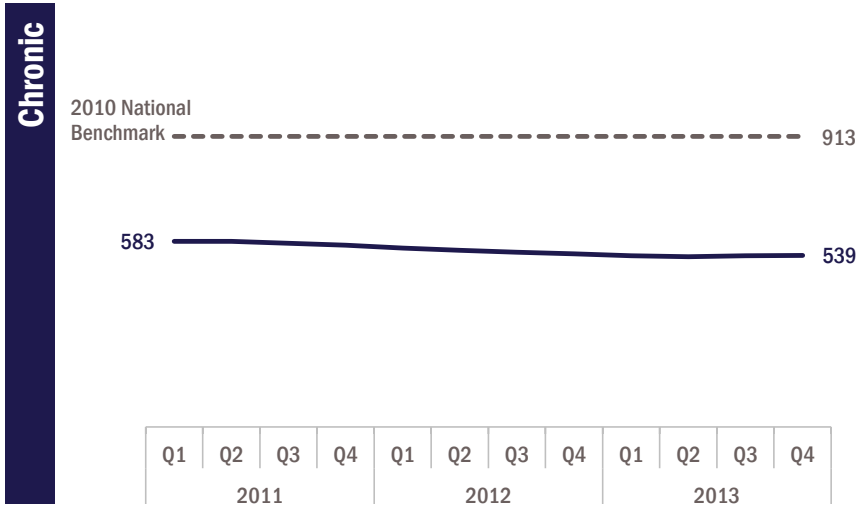
Quality: Prevention Quality Indicator (PQI) Admissions (Four-quarter moving average, per 100,000 person years)



The Prevention Quality Indicators (PQIs) presented in this section are federally-specified measures used to identify hospitalizations that could likely have been avoided through early intervention and outpatient care. These PQIs include hospitalizations of all Oregon residents in Oregon hospitals. As uninsured individuals gain coverage and easier access to outpatient care, these hospitalizations may decline. In interpreting the graphs, a lower rate is better.

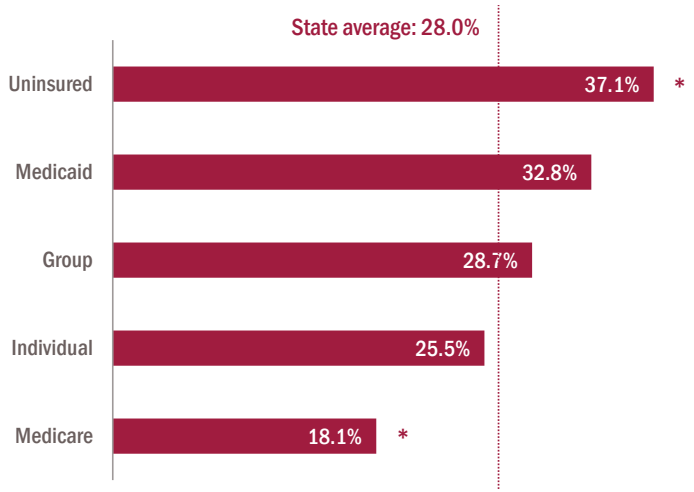
For future dashboards, quality metrics will be informed by work underway to identify a core set of quality metircs across Cover Oregon, Oregon Educators Benefit Board, Public Employees Benefit Board, and the CCOs.





Medical Debt: Currently paying off medical bills

by Insurance Status

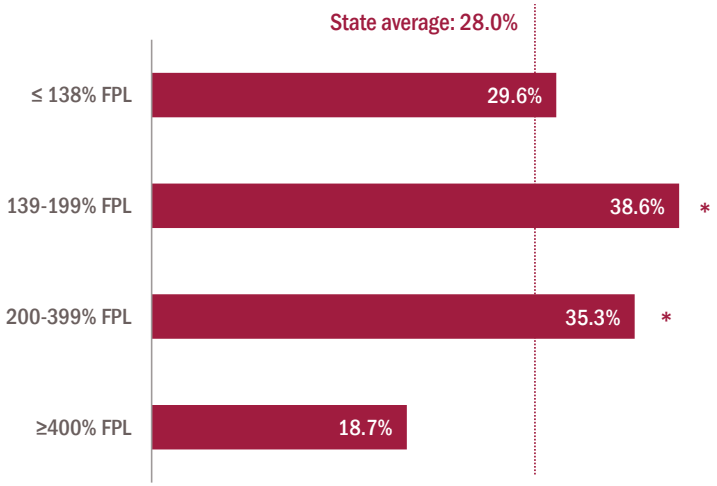


The data on this page are from the Oregon Health Insurance Survey (OHIS), a representative survey of Oregonians coverage status and other insurance-related issues. As part of the study, respondents were asked if they were in the process of paying off any medical bills at the time of the interview.

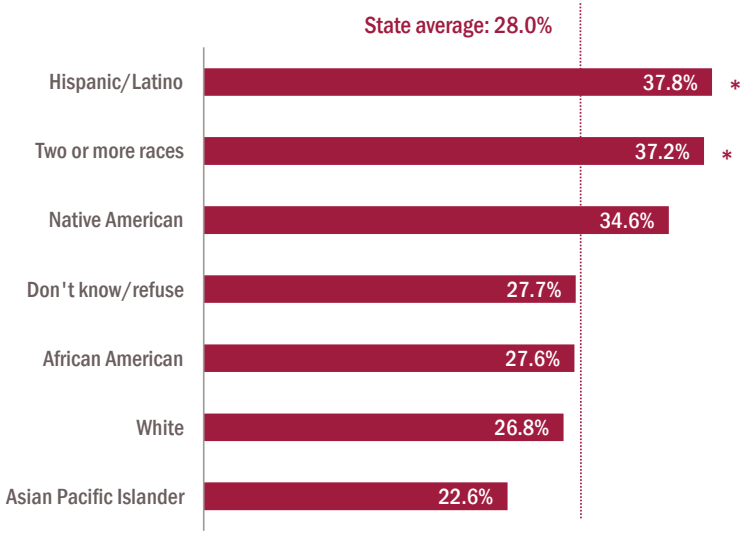
In interpreting the graphs, a lower rate is better. The overall share reporting yes to this question was not significantly different between 2011 and 2013, the two years the survey has been fielded.

* Asterisks indicates that the rate for the specific group is significantly different from the state average.

by Poverty Status

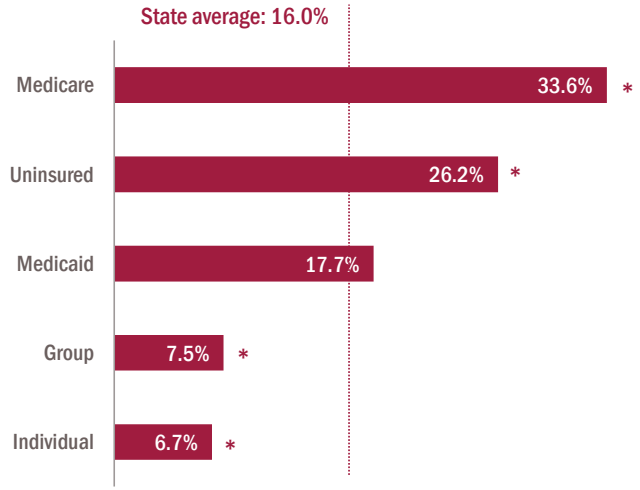


by Race/Ethnicity



Health Status: Percent poor/fair health

by Insurance Status

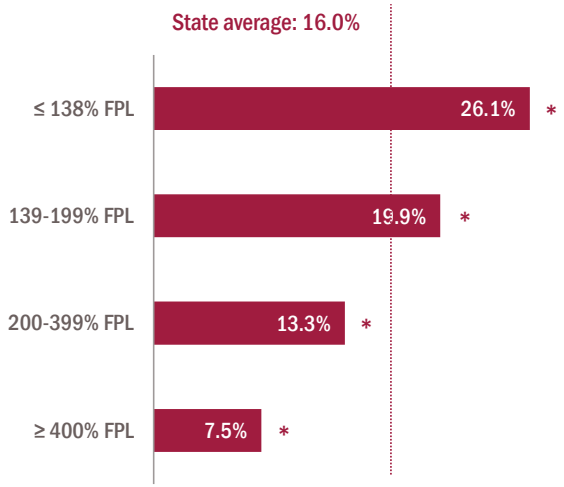


The data on this page are also from the Oregon Health Insurance Survey (OHIS). As part of the study, respondents were asked to characterize their general health as excellent, very good, good, fair, or poor.

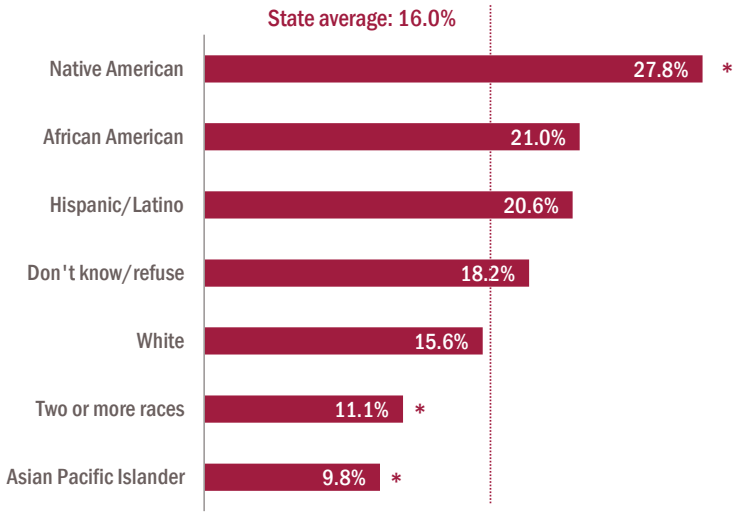
The graphs show the share reporting either far or poor health, so a lower rate is better. The overall percent was not significantly different between 2011 and 2013, the two years the survey has been fielded.

* Asterisks indicates that the rate for the specific group is significantly different from the state average.

by Poverty Status



by Race/Ethnicity



Data Notes

Cost & Utilization by types of care (pages 3-4)

Data for the most recent three quarters are partially incomplete due to claims data lag. Claims data lag occurs due to a delay between the time that a health care service occurs and when a claim for the service is processed and reported by the payer.

Alcohol and drug abuse treatment claims are not included in the data for the dashboard.

Per member per month (PMPM) expenditures are calculated using the allowed amount to best capture total claim expenditures—amounts paid by the insurer plus consumer out-of-pocket costs.

For reporting cost and utilization, claims are classified into six mutually exclusive categories using Milliman's Health Cost Guidelines (HCG) grouper: inpatient, emergency, outpatient, primary care, pharmacy, and ancillary.

Separately billed inpatient and outpatient physician fees are included in the four categories above.

Ancillary services include durable medical equipment, therapeutics, certain forms of custodial care, institutional and residential care, and other categories (such as dental, non-emergency transportation, and ambulance). Ancillary utilization includes visits and procedures.

Primary care includes home and office visits, well-baby exams, physical exams, and preventive care. The Office of Health Analytics is using this as a preliminary measurement of primary care utilization and cost while continuing to work with stakeholders on identifying the appropriate claims to include when measuring primary care. Primary care PMPM expenditures include outpatient facility claims and professional claims.

Total PMPM expenditures are calculated from the sum of allowed amounts from inpatient, emergency, outpatient, primary care, and ancillary services claims. Pharmacy expenditures are not included in total PMPMs.

Cost & Utilization: Consumer Out-of-Pocket Expenditures (page 5)

Data for the most recent three quarters are partially incomplete due to data lag. Claims data lag occurs due to a delay between the time that a health care service occurs and when a claim for the service is processed and reported by the payer.

Insurer covered expenditures represent insurer paid amounts. Consumer out-of-pocket share includes copayments, coinsurance, and deductibles. For some claims, insurer payments and out-of-pocket share may not account for all expenditures as coordination of benefits and other risk-sharing arrangements are not fully captured in APAC.

Cost & Utilization: Top Health Care Treatment Episodes (pages 6-7)

Episode Treatment Groups (ETGs) are derived from a disease classification methodology that identifies distinct episodes of care. A patient's episode of care consists of all clinically related services for a discrete diagnostic condition. The ETGs can track an episode of care across medical treatment settings (inpatient, emergency, outpatient, ancillary, or pharmacy). ETGs in APAC are grouped according to OptumInsight's methodology. For more information, see http://www.optuminsight.com/transparency/etg-links/learn-about-etgs/.

Episodes by Number of Episodes is calculated annually using a prorated measurement that allows episodes spanning more than one year to be allocated between those years. For example, if 75% of an episode's allowed expenditures occurred in 2011 and 25% occurred in 2012, then 2011 is assigned 0.75 episodes and 2012 is assigned 0.25 episodes. A complete episode for a chronic condition such as diabetes is considered to be one year's worth of care related to the condition.

Episodes by Total Expenditures are ranked according to the total annual allowed amount for each ETG.

Cost & Utilization: Uninsured and Uncompensated Hospital Utilization (page 8)

Dashboard data represent uninsured and total discharges at Oregon acute care hospitals by Oregon residents. Uninsured discharges are defined as self pay and charity care discharges. Total discharges include all Oregon residents regardless of their form or lack of health insurance.

Charity care is the total amount of health care services, based on full, established charges, provided to patients who are determined by the hospital to be unable to pay for the cost of health care services.

Bad debt is the unpaid obligation for care, based on full, established charges, for which the hospital expected payment but is unable to collect.

Charity care and bad debt are expressed as a percentage of hospitals' total charges.

Enrollment: Health Insurance Coverage (page 9)

Not all self-insured entities are required to report to DCBS, which may result in the self-insured coverage being under-represented. In addition, some Oregonians have more than one form of coverage. In such cases, these individuals will be reported separately by each form of coverage. For example, an individual with both Medicare and Medicaid coverage would be counted twice in the Public category. Consequently, these numbers are not directly comparable to the number of unique individuals who receive coverage in each category, and the numbers cannot be summed to the total population in Oregon.

A number of changes were made to the reporting requirements between 2013:Q4 and 2014:Q1. These include separate categories for enrollments that occurred through and outside of the exchange, primarily for individual and small group plans, and the disaggregation of other categories. For the current dashboard, the 2014:Q1 data has been reconfigured to be comparable to the 2013:Q1 data.

Enrollment: Cover Oregon (page 11)

Demographic information and plan choices are based on percentages generated by a special-purpose QHP enrollment file applied to a non-duplicative count of QHP enrollments for the reporting period. The most recent Health Insurance Marketplace Summary Enrollment reports are available at: http://aspe.hhs.gov/health/reports/2012/ACA-Research/index.cfm

Current Cover Oregon enrollment information is available at: http://resources.coveroregon.com/Enrollment-update.html

Quality (page 12)

Prevention Quality Indicators (PQIs) have been determined by the Agency for Healthcare Research and Quality (AHRQ) as measures of potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs). For more information see: http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx

Chronic PQIs include diabetes short-term complications, diabetes long-term complications, chronic obstructive pulmonary disease (COPD) or asthma in older adults, hypertension, congestive heart failure, angina without procedure, uncontrolled diabetes, asthma in younger adults and rate of lower-extremity amputation among patients with diabetes.

Acute PQIs include dehydration, bacterial pneumonia, and urinary tract infections.

Information on the national benchmarks is available here:
http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/Version_45_Benchmark_Tables_PQI.pdf

Debt and Health Status

The statistical significance of the differences was determined by comparing the 90 percent confidence intervals around the point estimates.

The reported race and ethnicity categories are mutually exclusive. Responses from individuals who identified themselves as either Hispanic or Latino are reported solely in the 'Hispanic/Latino' category. All other categories (i.e., white, African-American, etc.) do not include individuals who identified themselves as either Hispanic or Latino.

Sources

All Payer All Claims Database

The 2009 Oregon State Legislature passed HB 2009, which created the All Payer All Claims Reporting Program (APAC) to measure the quality, quantity, and value of health care in Oregon. The Oregon Health Authority contracts with Milliman, Inc. to collect data on all paid claims from commercial health plans, licensed third party administrators, pharmacy benefit managers, and the Oregon Health Plan.

At this time, APAC excludes certain lines of business that are not required to report, such as carriers with less than 5,000 covered lives; Medicare Fee-For-Service; TRICARE; uninsured and self-pay; and stand-alone vision and dental coverage. Additionally, data from Kaiser Health Plan of the Northwest also is missing from APAC at this time.

This quarter's version of the dashboard includes APAC data for commercial and Medicare Advantage claims. OHA is working to validate state Medicaid data with Milliman's proprietary HCG grouper for inclusion in future dashboards. OHA also is working with the Centers for Medicare and Medicaid Services to collect Medicare Fee-For-Service data for APAC.

Inpatient Hospital Discharge Database

The inpatient hospital discharge database is updated quarterly with information on discharges from Oregon acute care hospitals. Data elements include length of stay, discharge date, discharge status, payer, and procedure and diagnosis codes.

Databank

OHA receives utilization and financial data from each of Oregon's hospitals at the end of each quarter from the Oregon Databank program, a state-mandated hospital reporting program administered by Apprise Health Insights.

Department of Business and Consumer Services Quarterly Enrollment Reports

All licensed carriers, third party administrators and special districts report total enrollment on a quarterly basis to the Department of Consumer and Business Services (DCBS). Data are available via the DCBS Report Catalogue: http://www.oregon.gov/DCBS/insurance/insurers/other/Pages/quarterly-enrollment-reports.aspx

Medicare Data

Medicare Advantage and Fee For Service enrollment comes from the Medicare Advantage State/County Penetration File from the federal Center for Medicare and Medicaid Services: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration.html

Oregon Health Insurance Survey

The Oregon Health Authority and OHPR conducted this large-scale health and health insurance survey of Oregonians in the first quarter of 2011 and again in early 2013. Information gathered from the survey is helping the state understand the health care needs and concerns as we move through state and federal health reform. For more information see: http://www.oregon.gov/oha/OHPR/RSCH/pages/insurance_data.aspx#Survey_Reports_and_Data

Oregon Hospital Financial Performance

2006-2012 Trends

May 2014

Background

Oregon's hospitals continue to face significant changes in the health care market place. The 2007-2009 recession and subsequent economic recovery have impacted hospitals' financial wellbeing. Oregon's Health System Transformation and the federal Patient Protection and Affordable Care Act are changing the financing, delivery and availability of health care in numerous ways that impact hospitals and health systems.

In order to understand and respond to the impact of these changes on Oregon hospitals' financial performance and wellbeing, the Oregon Health Authority (OHA) collects audited financial data from each of Oregon's acute care hospitals. This report presents summary information based on this audited financial data. By mapping the shifting terrain of Oregon's health care landscape, OHA seeks to inform the direction of policymakers, health care providers, insurers, purchasers and individuals.

Additional information on the data presented in this report can be found at
http://www.oregon.gov/oha/OHPR/RSCH/Pages/Hospital_Reporting.aspx#AUDITED_FINANCIALS_&_FR-3

Please direct questions and comments to:
Russell Voth, Manager, Health System Research and Data, Office of Health Analytics - Russell.Voth[at]state.or.us

Definitions of Hospital Types: DRG, Type A and Type B

Diagnosis Related Group (DRG) - Since 1984, hospitals have been reimbursed for care provided to Medicare patients under the Inpatient Prospective Payment System (IPPS). Under the IPPS system, hospitals receive a fixed payment for each patient based on the DRG to which the patient is assigned. The Centers for Medicare and Medicaid Services (CMS) publishes a standard rate for each DRG every year in the Federal Register, but actual reimbursements are hospital-specific with multiple adjustment factors. DRG payments generally are not affected by the costs actually incurred by an individual patient during his or her hospital stay.

Type A – Rural hospitals that have 50 beds or fewer and are greater than 30 miles from another acute inpatient facility. Although these types of facilities make up roughly twenty percent of Oregon hospitals, they account for less than five percent of Oregon's staffed hospital beds.

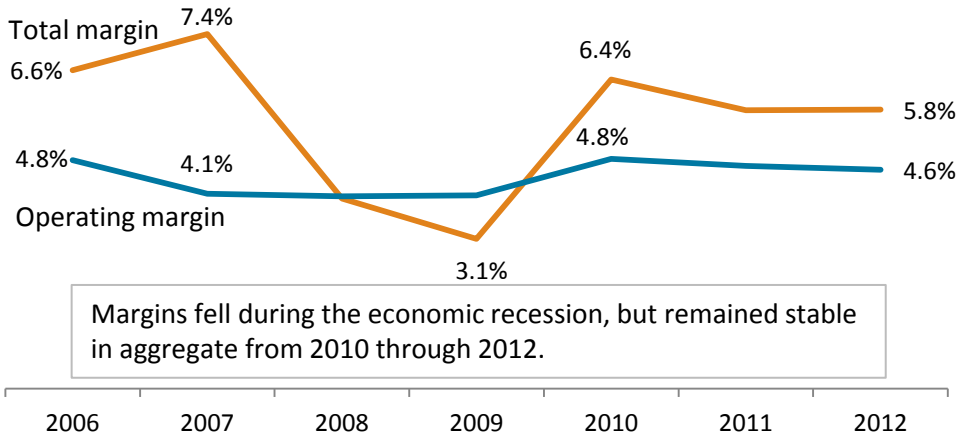
Type B - Rural hospitals with 50 or fewer beds and located less than 30 miles from another acute inpatient care facility. These types of facilities make up approximately thirty-five percent of Oregon hospitals, but account for less than 10 percent of Oregon's staffed hospital beds.

Hospital Financial Performance Metric Definitions

Gross Hospital Patient Revenue	A calculation of the total revenue that would be generated by patient care activities if the hospital received payments equal to its retail rates or "charges" for all services provided. Typically, these retail rates are higher than what is actually paid by public and private insurers.
Net Patient Revenue	The amount of revenue received (or expected to be received) from all payers for patient services. Net patient revenue is gross patient revenue minus discounts provided to payers, charity care, and bad debt.
Other Operating Revenue	Revenue received from hospital operations that are not patient care. Examples include revenue from the operation of gift shops, cafeterias, or parking structures.
Total Operating Revenue	The sum of net patient revenue and other operating revenue.
Total Operating Expense	All expenses associated with the operating the hospital, such as salaries, employee benefits, purchased services, supplies, professional fees, and insurance.
Operating Income	The operating profit or loss, calculated as total operating revenue minus total operating expense.
Operating Margin	Operating margin is calculated as operating income divided by total operating revenue. If total operating revenue exceeds operating costs, the ratio will be positive and the hospital is operating at a profit. If operating revenue is less than operating expenses, the hospital is operating at a loss and will have a negative operating margin.
Net Nonoperating Revenue (Expense)	Revenues or expenses that are peripheral transactions outside of a hospital's daily activities, such as investments and tax revenues.
Net Income	Total profit or loss, including operating revenues and expenses *as well as* nonoperating gains and losses.
Total Margin	Total margin is calculated as net income divided by total revenue. It measures the overall financial performance of the hospital.
Charity Care	The total amount of health care services, based on full, established charges, provided to patients who are determined by the hospital to be unable to pay for the cost of health care services.
Bad Debt	The unpaid obligation for care, based on a hospital's full, established charges, for which the hospital expected payment but is unable to collect.
Uncompensated Care	The sum of charity care and bad debt charges. It measures the total amount of care hospitals provide without receiving payment.

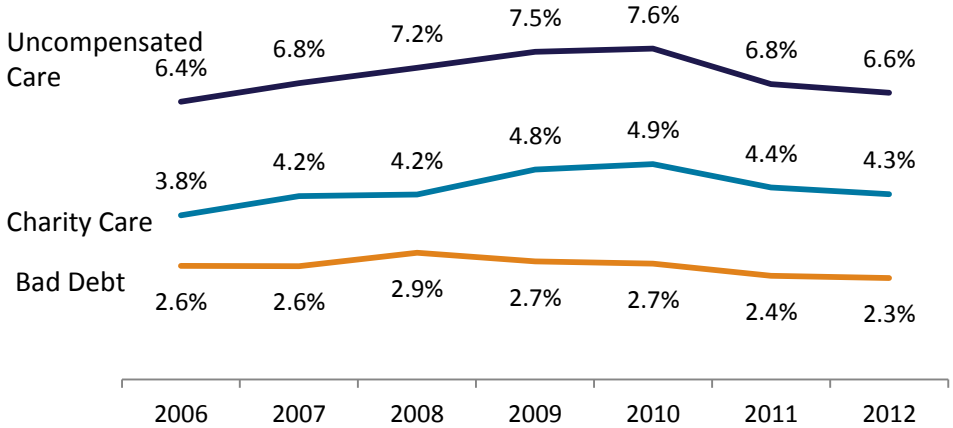
Aggregate Hospital Financial Performance Metrics, All Oregon Hospitals, 2006-2012

Total & Operating Margins

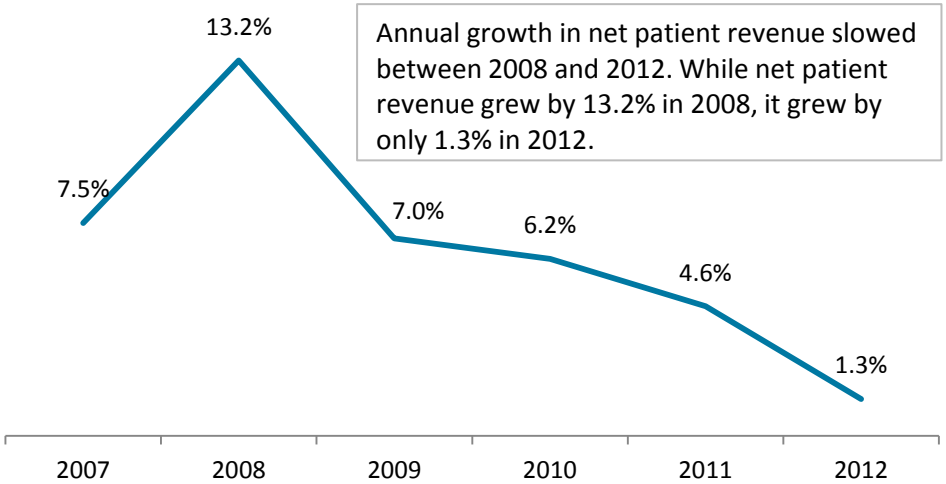


Margins fell during the economic recession, but remained stable in aggregate from 2010 through 2012.

Uncompensated Care as a Percentage of Gross Patient Revenue

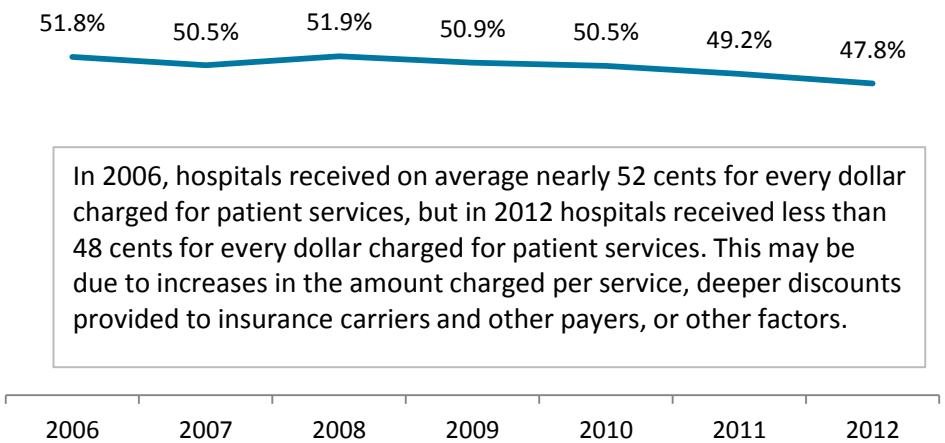


Year-Over-Year Change in Net Patient Revenue



Annual growth in net patient revenue slowed between 2008 and 2012. While net patient revenue grew by 13.2% in 2008, it grew by only 1.3% in 2012.

Ratio of Net Patient Revenue to Gross Patient Revenue



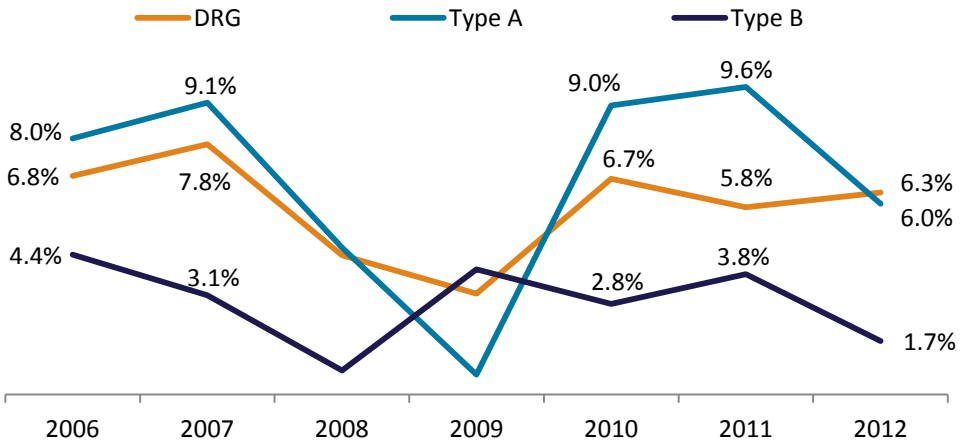
In 2006, hospitals received on average nearly 52 cents for every dollar charged for patient services, but in 2012 hospitals received less than 48 cents for every dollar charged for patient services. This may be due to increases in the amount charged per service, deeper discounts provided to insurance carriers and other payers, or other factors.

Aggregate Hospital Financial Performance Metrics, All Oregon Hospitals, 2006-2012

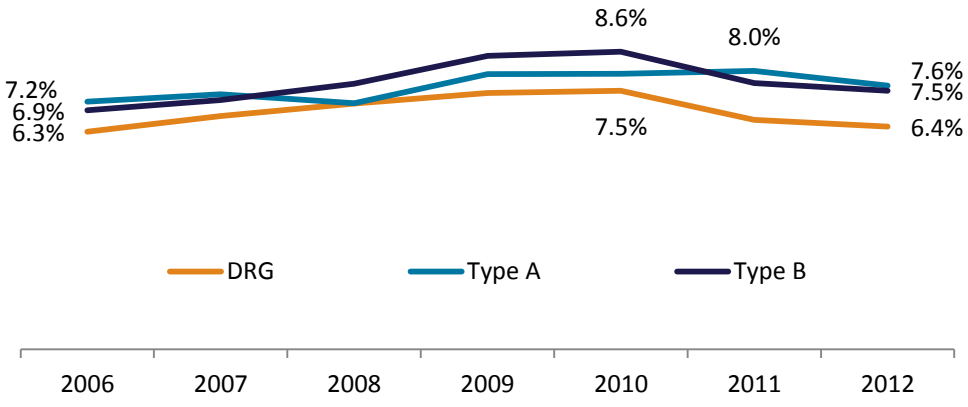
	2006	2007	2008	2009	2010	2011	2012
Gross Hospital Patient Revenue	$ 11,652,465,588	$ 12,849,046,426	$ 14,159,692,399	$ 15,445,678,250	$ 16,558,164,876	$ 17,747,229,150	$ 18,531,515,349
Net Patient Revenue	$ 6,040,773,023	$ 6,494,056,877	$ 7,352,973,375	$ 7,864,459,859	$ 8,354,853,888	$ 8,736,334,904	$ 8,850,136,990
Other Operating Revenue	$ 266,583,650	$ 278,460,202	$ 318,866,906	$ 319,833,357	$ 330,231,450	$ 327,818,086	$ 390,115,042
Total Operating Revenue	$ 6,307,356,673	$ 6,772,517,079	$ 7,671,840,281	$ 8,184,293,216	$ 9,147,339,947	$ 9,539,406,535	$ 9,768,168,591
Total Operating Expense	$ 6,007,298,324	$ 6,490,626,399	$ 7,364,672,186	$ 7,855,281,552	$ 8,710,106,534	$ 9,097,464,440	$ 9,323,406,793
Operating Income	$ 300,058,527	$ 274,596,186	$ 307,168,095	$ 329,011,664	$ 437,283,410	$ 441,942,095	$ 444,761,798
Operating Margin	4.8%	4.1%	4.0%	4.0%	4.8%	4.6%	4.6%
Net Nonoperating Revenue (Expense)	$ 126,031,581	$ 242,746,327	$ (3,738,756)	$ (76,114,581)	$ 164,135,788	$ 117,614,118	$ 130,034,419
Net Income	$ 426,089,850	$ 517,342,522	$ 303,429,339	$ 252,897,083	$ 598,643,327	$ 559,556,213	$ 574,796,216
Total Margin	6.6%	7.4%	4.0%	3.1%	6.4%	5.8%	5.8%
Charity Care	$ 439,597,986	$ 540,839,877	$ 601,534,473	$ 744,536,727	$ 819,117,853	$ 782,268,632	$ 788,054,146
Bad Debt	$ 304,077,809	$ 333,836,856	$ 411,772,908	$ 418,657,322	$ 439,892,784	$ 422,243,829	$ 431,981,115
Total Uncompensated Care	$ 743,675,795	$ 874,676,733	$ 1,013,307,381	$ 1,163,194,049	$ 1,259,010,637	$ 1,204,512,461	$ 1,220,035,260

Hospital Financial Performance Metrics, All Oregon Hospitals by Type, 2006-2012

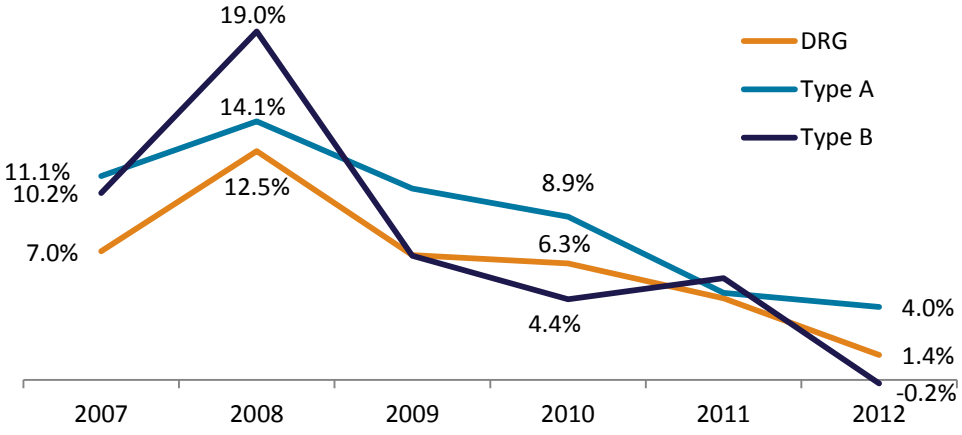
Total Margins



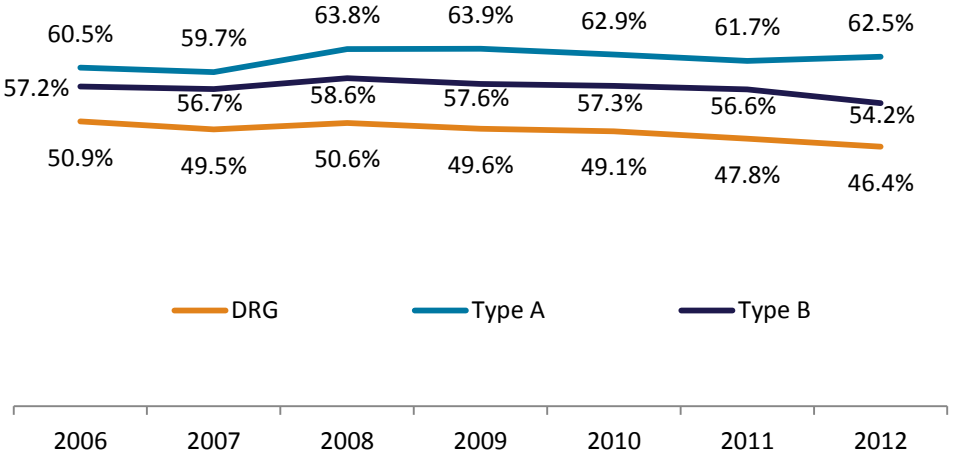
Uncompensated Care as a Percentage of Gross Patient Revenue



Year-Over-Year Change in Net Patient Revenue



Ratio of Net Patient Revenue to Gross Patient Revenue



DRG Hospital Financial Performance Metrics, All Oregon DRG Hospitals, 2006-2012

	2006	2007	2008	2009	2010	2011	2012
Gross Hospital Patient Revenue	$ 10,108,044,934	$ 11,127,490,405	$ 12,219,594,724	$ 13,328,962,109	$ 14,303,095,662	$ 15,341,261,526	$ 16,032,241,325
Net Patient Revenue	$ 5,143,309,894	$ 5,502,971,460	$ 6,188,380,727	$ 6,608,914,876	$ 7,027,601,413	$ 7,338,863,778	$ 7,437,965,572
Other Operating Revenue	$ 238,361,811	$ 249,793,544	$ 281,899,186	$ 286,994,218	$ 293,250,962	$ 272,751,211	$ 333,824,188
Total Operating Revenue	$ 5,381,671,705	$ 5,752,765,004	$ 6,470,279,913	$ 6,895,909,094	$ 7,783,325,865	$ 8,101,010,551	$ 8,299,706,320
Total Operating Expense	$ 5,107,445,815	$ 5,489,582,475	$ 6,187,168,716	$ 6,608,482,504	$ 7,387,924,097	$ 7,706,184,399	$ 7,889,104,618
Operating Income	$ 274,225,860	$ 255,891,036	$ 283,111,197	$ 287,426,590	$ 395,401,766	$ 394,826,152	$ 410,601,701
Operating Margin	5.1%	4.4%	4.4%	4.2%	5.1%	4.9%	4.9%
Net Nonoperating Revenue (Expense)	$ 99,921,546	$ 209,520,364	$ (2,245,251)	$ (72,622,688)	$ 140,025,360	$ 83,113,250	$ 120,098,130
Net Income	$ 374,147,168	$ 465,411,407	$ 280,865,946	$ 214,803,902	$ 532,968,598	$ 477,939,402	$ 530,699,832
Total Margin	6.8%	7.8%	4.3%	3.1%	6.7%	5.8%	6.3%
Charity Care	$ 389,035,830	$ 482,312,734	$ 527,860,908	$ 639,383,675	$ 712,211,565	$ 681,045,516	$ 684,072,706
Bad Debt	$ 246,931,040	$ 267,568,195	$ 339,544,540	$ 347,425,282	$ 356,972,202	$ 335,929,665	$ 348,086,941
Total Uncompensated Care	$ 635,966,870	$ 749,880,929	$ 867,405,448	$ 986,808,957	$ 1,069,183,767	$ 1,016,975,181	$ 1,032,159,647

Type A Hospital Financial Performance Metrics, All Oregon DRG Hospitals, 2006-2012

	2006	2007	2008	2009	2010	2011	2012
Gross Hospital Patient Revenue	$ 436,134,639	$ 490,791,431	$ 523,769,889	$ 577,890,789	$ 639,412,766	$ 682,375,871	$ 700,667,373
Net Patient Revenue	$ 263,917,444	$ 293,179,896	$ 334,420,525	$ 369,250,796	$ 402,056,579	$ 421,113,075	$ 437,786,772
Other Operating Revenue	$ 10,134,370	$ 10,299,254	$ 14,809,722	$ 9,128,436	$ 8,862,567	$ 7,419,334	$ 9,812,834
Total Operating Revenue	$ 274,051,814	$ 303,479,150	$ 349,230,247	$ 378,379,232	$ 411,005,146	$ 427,406,651	$ 447,599,605
Total Operating Expense	$ 263,964,519	$ 291,932,420	$ 337,764,329	$ 366,092,034	$ 388,628,857	$ 407,435,832	$ 426,895,313
Operating Income	$ 10,087,503	$ 11,546,730	$ 11,465,918	$ 12,287,198	$ 22,376,289	$ 19,970,819	$ 20,704,293
Operating Margin	3.7%	3.8%	3.3%	3.2%	5.4%	4.7%	4.6%
Net Nonoperating Revenue (Expense)	$ 12,833,459	$ 17,715,726	$ 4,770,177	$ (10,009,254)	$ 16,135,676	$ 23,292,353	$ 6,316,886
Net Income	$ 22,920,941	$ 29,262,455	$ 16,236,095	$ 2,277,944	$ 38,511,965	$ 43,263,172	$ 27,021,178
Total Margin	8.0%	9.1%	4.6%	0.6%	9.0%	9.6%	6.0%
Charity Care	$ 14,508,365	$ 16,475,049	$ 19,315,955	$ 23,561,010	$ 26,254,991	$ 30,811,331	$ 29,910,672
Bad Debt	$ 16,692,514	$ 19,700,919	$ 17,917,187	$ 22,385,639	$ 24,645,900	$ 24,084,640	$ 23,500,611
Total Uncompensated Care	$ 31,200,879	$ 36,175,968	$ 37,233,142	$ 45,946,649	$ 50,900,891	$ 54,895,971	$ 53,411,282

Type B Hospital Financial Performance Metrics, All Oregon DRG Hospitals, 2006-2012

	2006	2007	2008	2009	2010	2011	2012
Gross Hospital Patient Revenue	$ 1,108,286,015	$ 1,230,764,590	$ 1,416,327,786	$ 1,538,825,352	$ 1,615,656,448	$ 1,723,591,753	$ 1,798,606,651
Net Patient Revenue	$ 633,545,685	$ 697,905,521	$ 830,172,123	$ 886,294,187	$ 925,195,896	$ 976,358,051	$ 974,384,646
Other Operating Revenue	$ 18,087,469	$ 18,367,404	$ 22,157,998	$ 23,710,703	$ 28,117,921	$ 47,647,541	$ 46,478,020
Total Operating Revenue	$ 651,633,154	$ 716,272,925	$ 852,330,121	$ 910,004,890	$ 953,008,936	$ 1,010,989,333	$ 1,020,862,666
Total Operating Expense	$ 635,887,990	$ 709,111,504	$ 839,739,141	$ 880,707,014	$ 933,553,580	$ 983,844,209	$ 1,007,406,862
Operating Income	$ 15,745,164	$ 7,158,420	$ 12,590,980	$ 29,297,876	$ 19,505,355	$ 27,145,124	$ 13,455,804
Operating Margin	2.4%	1.0%	1.5%	3.2%	2.0%	2.7%	1.3%
Net Nonoperating Revenue (Expense)	$ 13,276,576	$ 15,510,237	$ (6,263,682)	$ 6,517,361	$ 7,974,752	$ 11,208,515	$ 3,619,403
Net Income	$ 29,021,741	$ 22,668,660	$ 6,327,298	$ 35,815,237	$ 27,162,764	$ 38,353,639	$ 17,075,206
Total Margin	4.4%	3.1%	0.7%	3.9%	2.8%	3.8%	1.7%
Charity Care	$ 36,053,791	$ 42,052,094	$ 54,357,610	$ 81,592,042	$ 80,651,297	$ 70,411,785	$ 74,070,768
Bad Debt	$ 40,454,255	$ 46,567,742	$ 54,311,181	$ 48,846,401	$ 58,274,682	$ 62,229,524	$ 60,393,563
Total Uncompensated Care	$ 76,508,046	$ 88,619,836	$ 108,668,791	$ 130,438,443	$ 138,925,979	$ 132,641,309	$ 134,464,331