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## *Leading Indicators for Oregon's Health Care Transformation*

*Quarterly data from the All-Payer, All-Claims Reporting Program*



Oregon  
**Health**  
Authority

April 30, 2015

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## Executive Summary

This is the first quarterly report on Leading Indicators for Oregon's Health System Transformation. This report examines the outcomes of transformation across the health system and multiple payers.

In the last five years, Oregon embarked on transformation of its health system to achieve the triple aim of better health, better care, and lower costs. As the state curbs the rising cost of health care, every dollar saved on unnecessary health expenses is a dollar that can be reinvested in children and families, education, creating good jobs, and building statewide prosperity. Health System Transformation has saved \$139 million in health care costs from 2013-14. Oregon created Medicaid coordinated care organizations, expanded Medicaid coverage, and opened a health insurance exchange. This year, Oregon has also spread the coordinated care model to public employee health care coverage (Public Employees Benefit Board) and will expand the model to the Oregon educators' health care coverage (Oregon Educators Benefit Board) in 2016.

Key goals of health system transformation include:

Enrollment: increasing health care coverage among Oregonians.

Utilization: the right care, in the right place, at the right time.

Spending: curbing the rising cost of health care to make health care spending more sustainable.

Highlights from this report include:

- Enrollment in health care coverage through commercial plans, Medicaid CCOs, Medicare Advantage plans, and OEGB and PEBB plans increased by 12 percent between 2013 and 2014. Today, 313,535 more individuals have coverage.
- From 2011 to 2013, we saw a 10 percent decrease in emergency department visits and a 9% increase in primary care visits, indicating great progress in getting the right care, in the right place, at the right time. Preventive care and chronic disease management can be better served through primary care than through emergency departments.
- From 2011 to 2013, spending per member per month by Medicaid CCOs and PEBB plans decreased by 5 percent and 8 percent, respectively. Spending by across other types of coverage increased.

The data from this report comes from the All-Payer, All-Claims database. Oregon is one of 11 states with an existing All-Payer, All-Claims database. The legislatively created database can help policymakers understand how well health system transformation is achieving its goals across Oregon. This database contains information about enrollment, utilization, and spending for 81% of Oregon's four million residents. Oregon's major health payers began reporting their payments made to providers to this database in 2010.

This quarterly report will continue to guide policymakers with data on leading health system indicators. This will help in understanding and guiding where we are and where we're heading as health system transformation progresses and the coordinated care model spreads across the system.

# Leading Indicators for Oregon's Health System Transformation from the All-Payer, All-Claims Reporting Program



This report is the first in a series that uses data from Oregon's All-Payer, All-Claims reporting program (APAC) to examine the outcomes associated with Oregon's health system transformation.

In the last five years, Oregon has embarked on transformation of its health care system to achieve the Triple Aim: better health, better care and lower costs. Oregon created Medicaid coordinated care organizations (CCOs), expanded Medicaid coverage and opened a health insurance exchange under the Affordable Care Act (ACA), spread the coordinated care model to coverage public employees (PEBB) and has plans to spread the model to educators (OEBC).

Among its important goals, Oregon's health system transformation is intended to:

Increase **enrollment**, ensuring more Oregonians have health care coverage.

Optimize **utilization**, ensuring Oregonians receive the right care, in the right setting, at the right time.

Contain **spending**, making health care more sustainable.

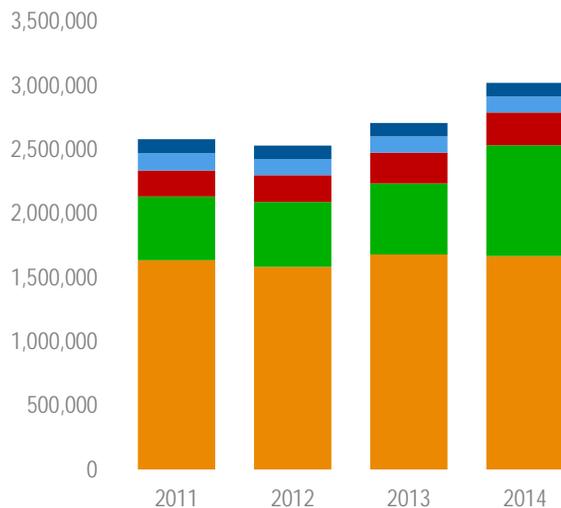
Information in this report can help policymakers understand how well health system transformation is achieving its goals.

Beginning in 2010, Oregon's major health care payers have reported payments made to health care providers to the APAC database. **With claims data from more than 3.2 million Oregonians in 2014, this database contains information about enrollment, utilization, and spending for 81% of Oregon's four million residents.**

Due to data limitations of APAC, this report excludes data for people with some types of public and commercial coverage. In addition, it excludes data for uninsured people. See Methodology for details.

## Enrollment

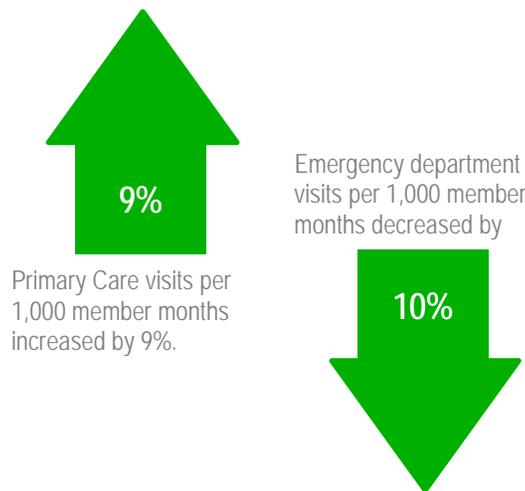
From 2013 to 2014, enrollment in **commercial**, **Medicaid CCO**, **Medicare Advantage**, **OEBC**, and **PEBB** coverage increased by 313,535 people.\*



\* Enrollment is reported as unique individuals with coverage in June of each year and excludes non-CCO Medicaid coverage.

## Utilization

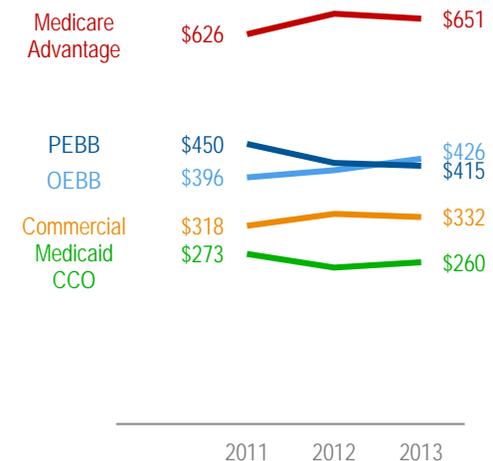
From 2011 to 2013, **primary care visits increased and emergency room visits decreased** per 1,000 member months among **Medicaid CCO** members.†



† Due to regular claims lag, data are not yet sufficiently complete to report on 2014, the first year of expanded coverage under the ACA.

## Spending

From 2011 to 2013, **Medicaid CCO** and **PEBB** spending per member per month decreased. Spending by other plans increased.‡



‡ Due to regular claims lag, data are not yet sufficiently complete to report on 2014, the first year of expanded coverage under the ACA.

See Glossary for key terms. Icons from Flaticon.com.

## Enrollment: Increasing the Number of Oregonians with Health Care Coverage



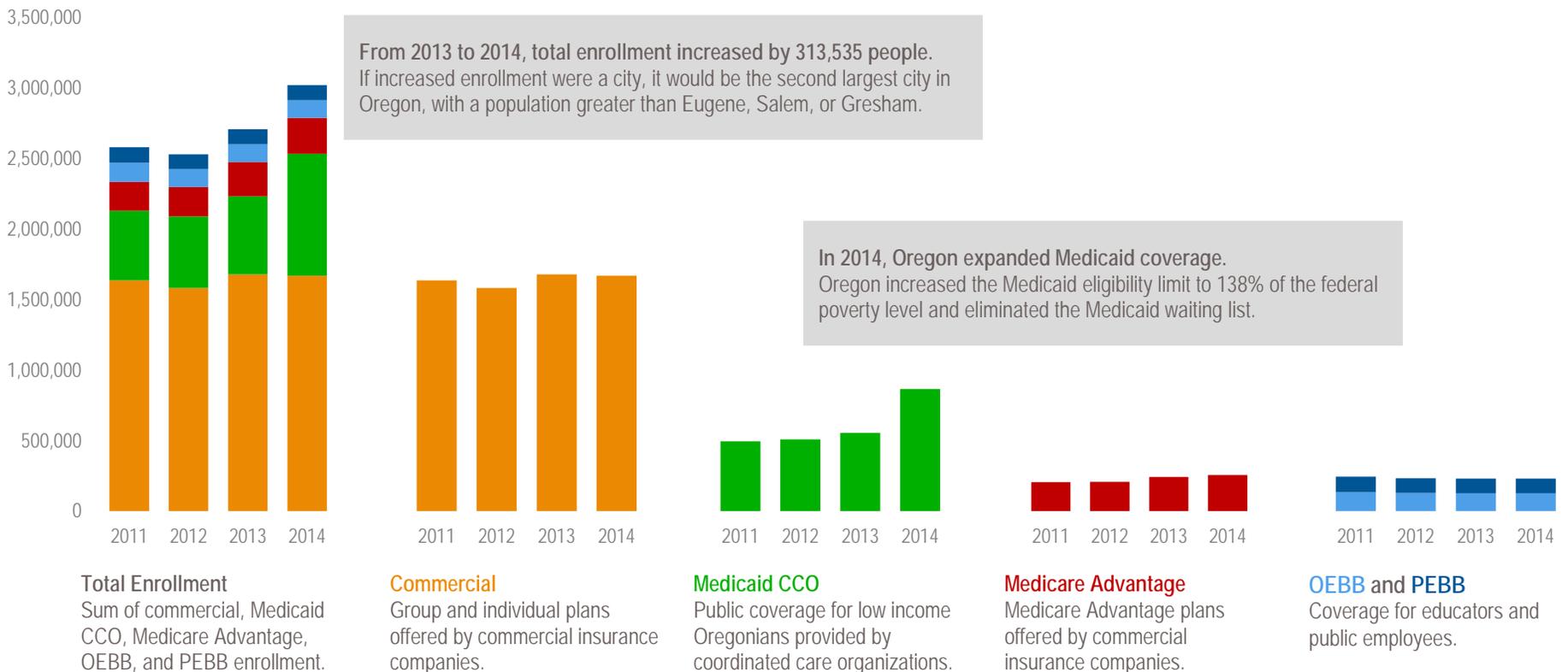
Enrollment in health care coverage increases the likelihood that a person will receive needed health care.<sup>1</sup> APAC includes data on the number of Oregonians enrolled in coverage over time, as well as:

- **Type of coverage.** Type of coverage represents who pays for care. Amounts paid for specific health care services can vary substantially across types of coverage. This report presents data on commercial, Medicaid CCO, Medicare Advantage, OEBB, and PEBB coverage.
- **Age.** Age affects health care utilization and spending. Older members tend to use more health care services than younger members.
- **Geography.** Geography can affect health care access, utilization, and spending, as proximity to health care providers can vary by county.

The graphs below capture 2014 changes in coverage due to the Affordable Care Act. Due to data limitations of APAC, they exclude Medicaid fee for service, Medicare fee for service, and some other types of public and commercial coverage. Enrollment is reported as number of unique individuals enrolled in coverage in June of each year.

**TYPE OF COVERAGE:** Total enrollment increased from 2013 to 2014, driven by increased **Medicaid CCO** enrollment.

**Commercial**, **Medicare Advantage**, and **OEBB** and **PEBB** enrollment remained largely unchanged.

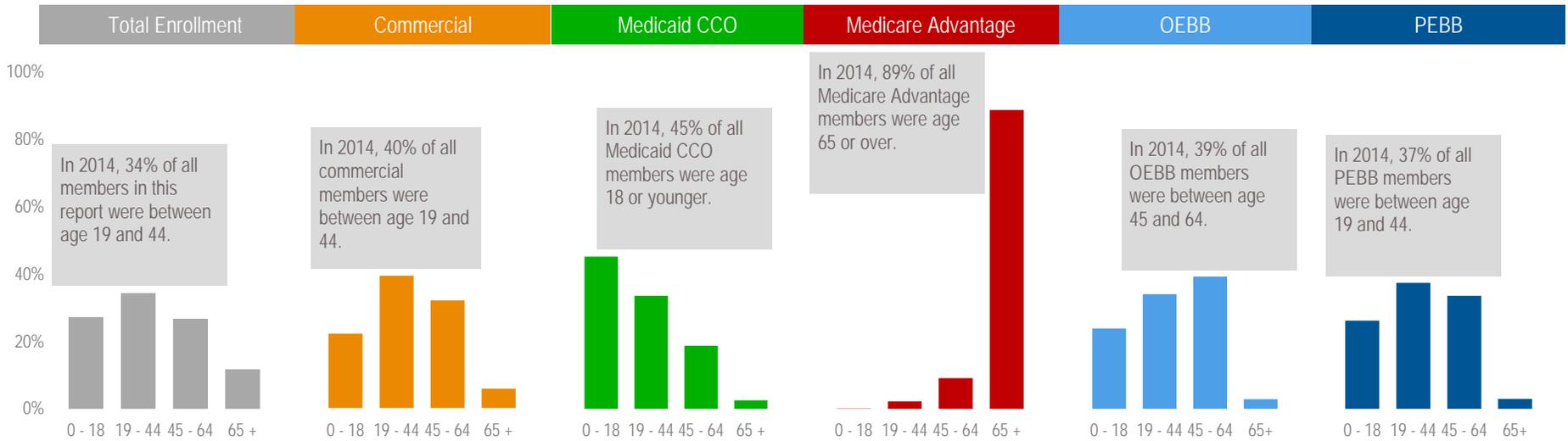


See Glossary for key terms.

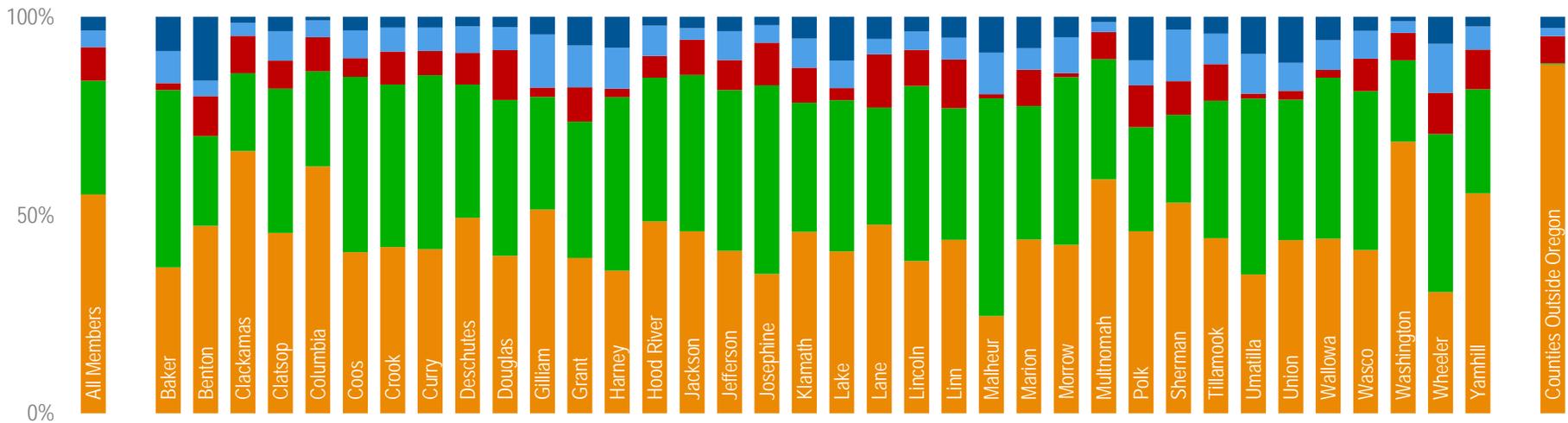
# Enrollment: Increasing the Number of Oregonians with Health Care Coverage



**AGE:** As of June 2014, 27% of members in this report were age 18 or younger. At the same point in time, 45% of **Medicaid CCO** members were age 18 or younger.



**GEOGRAPHY:** As of June 2014, 55% of all members in this report had **commercial coverage**, while 29% had **Medicaid CCO** coverage. **Medicare Advantage**, **OEBB**, and **PEBB** accounted for 9%, 4%, and 4% of all members in this report, respectively.



See Glossary for key terms.

# Spending: Making Health Care More Sustainable

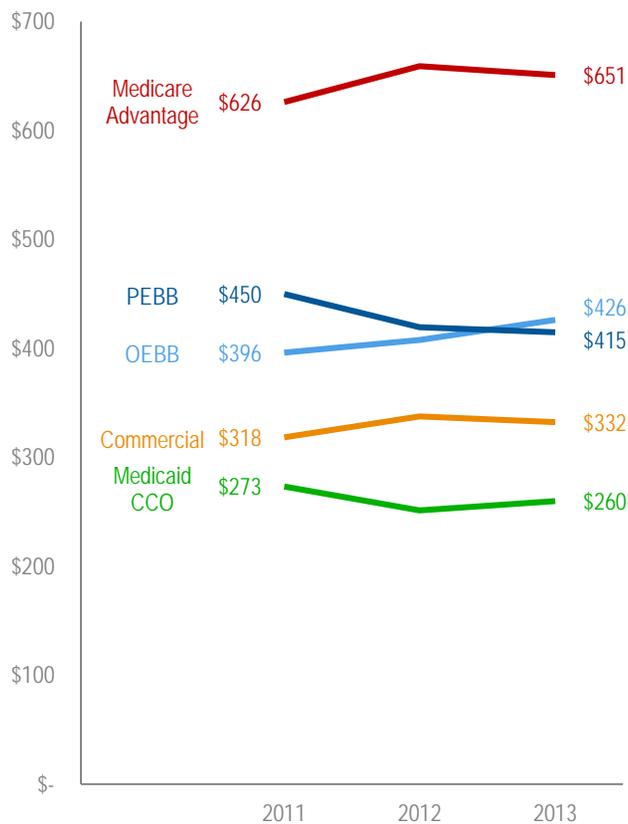


In 2012, health care spending in Oregon was estimated to be nearly \$16 billion.<sup>2</sup> Containing health care spending growth will help make increased coverage sustainable and make financial resources available for other important uses.

From 2011 to 2013, total spending per member, per month by Medicaid CCOs and Public Employees' Benefit Board plans declined. Oregon is spreading the coordinated care model to other types of coverage in order to bend the health care cost curve.

To provide a standard measure of spending across types of coverage, the graphs below show total paid per member, per month (PMPM) by payer. Total paid per member, per month is defined as: (total paid by payers + total paid by patients) / total months of enrollment in each calendar year.

From 2011 to 2013, total PMPM spending by **Medicaid CCOs** and **PEBB** plans declined.\*  
Spending by **commercial**, **Medicare Advantage**, and **OEBB** plans increased.



## Total PMPM Spending: What's Included?

**Primary Care:** Services provided during visits to a primary care provider, including preventive exams and well-baby exams.

**Emergency:** Visits to the hospital emergency department.

**Inpatient:** Care provided at a hospital or other inpatient facility where the patient stays overnight, including visits to specialists.

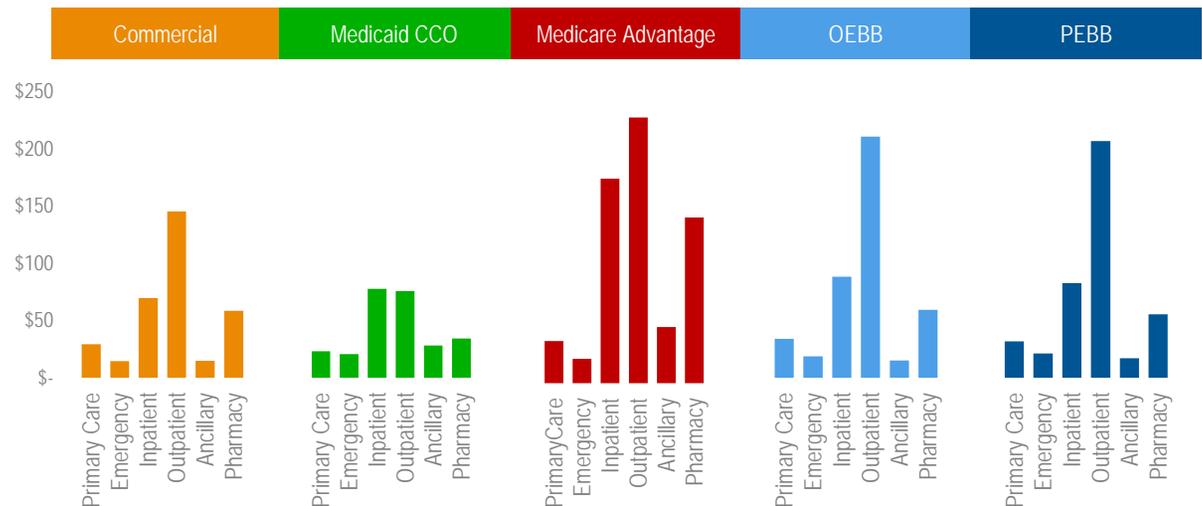
**Outpatient:** Care provided at a hospital, clinic, or other facility where the patient does not stay overnight.

**Ancillary:** Includes private duty nursing, ambulance and non-emergency transportation, dental care, durable medical equipment, and supplies.

**Pharmacy:** Prescription drugs where at least part of the cost is paid by a payer.

In 2013, outpatient services was the largest PMPM spending category for all payers except **Medicaid CCOs**.\*

Inpatient Services was the largest PMPM spending category for **Medicaid CCOs**.



\* Data for 2014 are incomplete due to regular claims lag, and are excluded from this report. These data will be "filled in" with future submissions and covered in future reports.

See Glossary for key terms.

## Utilization: Ensuring the Right Care, in the Right Setting, at the Right Time

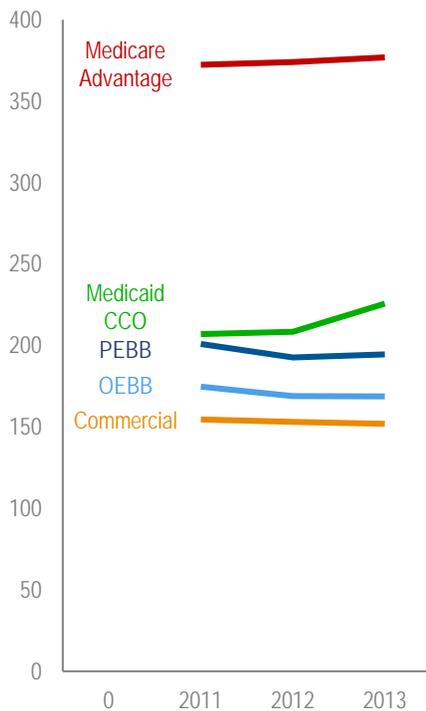


Utilization of the right care, in the right setting, at the right time can reduce the need for more costly care and reduce health care spending. For example, timely utilization of primary and preventive care can reduce emergency department visits and other more costly forms of care.<sup>3</sup>

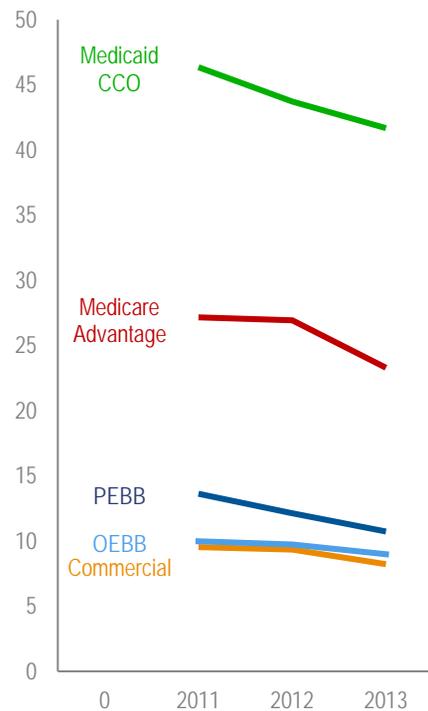
The graphs below show the number of emergency department visits, primary care visits, inpatient hospital admissions, and psychiatric hospital admissions from 2011 to 2013. These settings represent areas of focus for Oregon's health system transformation. To provide a standard measure of utilization across types of coverage, the graphs show number of visits or admissions per 1,000 total months of enrollment. The graphs have different scales because the frequency of visits or admissions per 1,000 member months varies widely across the four settings. For example, primary care visits are far more frequent than psychiatric hospital admissions per 1,000 member months. Using different scales helps clearly show changes over time.

Future reports will include indicators of whether care was provided in the appropriate setting. For example, reports may include quality measures for number of hospital admissions that could have been prevented with appropriate care in another setting.

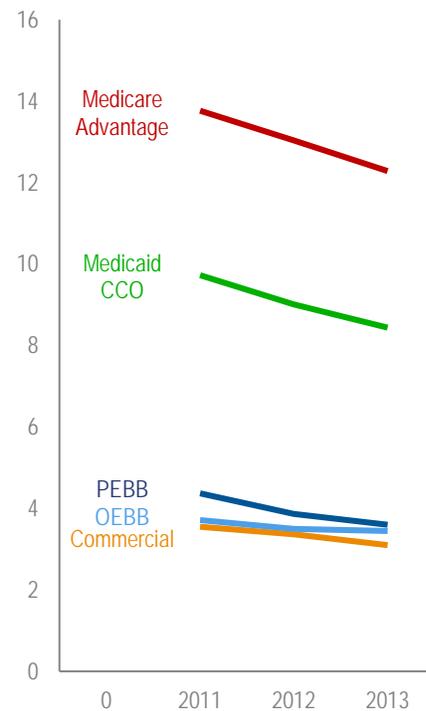
From 2011 to 2013, primary care visits per 1,000 member months increased by 9% among Medicaid CCO members.\*



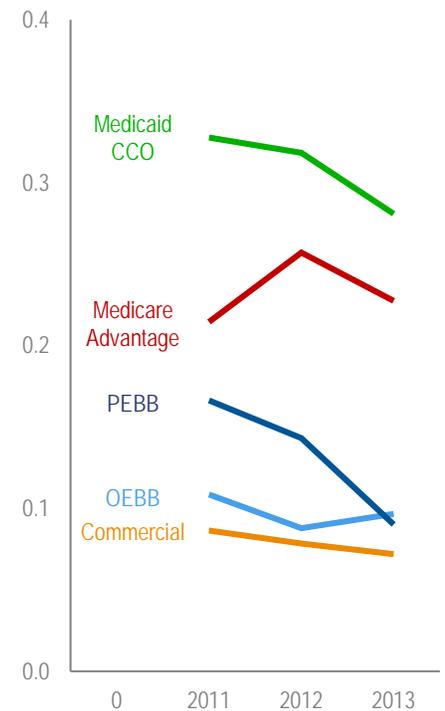
From 2011 to 2013, emergency dept. visits per 1,000 member months fell by 10% among Medicaid CCO members.\*



From 2011 to 2013, inpatient admissions per 1,000 member months fell across all payers.\*



From 2011 to 2013, psychiatric hospital admissions per 1,000 member months fell across 4 of 5 payers.\*



\* Data for 2014 are incomplete due to regular claims lag, and are excluded from this report. These data will be "filled in" with future submissions and covered in future reports.

See Glossary for key terms.

## Glossary

**Claim:** Communication from a medical provider to a payer requesting payment for services rendered by the provider. A claim includes information about the patient's diagnoses, the procedures performed by the provider, the amount the payer and patient will pay for the service under a health insurance plan, and in the case of a paid claim, the amount paid by the payer.

**Claims lag:** Delay between the time care occurs and the time the claim is processed and reported by the payer. A claim may take weeks or months to process, meaning that claims data submitted to APAC for recent calendar quarters are not yet sufficiently complete to report spending, utilization, or other metrics. Claims with a high dollar amount, such as inpatient claims, tend to take more time for providers and payers to reach agreement.

**Health care spending categories:** The following categories of health care spending are used in this report.

- **Ancillary:** Includes psychiatric hospital and residential care, private duty nursing, ambulance and non-emergency transportation, dental care, durable medical equipment, and supplies.
- **Emergency:** Visits to the hospital emergency department.
- **Inpatient:** Care provided at a hospital or other inpatient facility where the patient stays overnight.
- **Outpatient:** Care provided at a hospital, clinic, or other facility where the patient does not stay overnight, including visits to specialists.
- **Pharmacy:** Prescription drugs where at least part of the cost is paid by a payer.
- **Primary Care:** Services provided during visits to a primary care provider, including preventive physical exams and well-baby exams.

**Member months:** Total number of months within a given calendar year that the enrolled members of a health insurance plan have health coverage. For example, if one member was enrolled in a plan for all 12 months of 2013 and another member was enrolled for only 10 months, member months equal 22. To provide standard measures of utilization and spending across types of coverage or insurance plans, total spending or total utilization is often divided by member months.

**Payer:** An entity that pays doctors, hospitals, and other health care providers for care and services received by a person with health care coverage. Payers include the following types of health care coverage:

- **Commercial coverage:** Group and individual health insurance plans offered by commercial health insurance companies, as well as group health insurance plans offered by employers that self-insure (self-insured employers set aside funds to pay for health care, rather than buying group coverage from a commercial insurance company). Data for some types of commercial coverage are not included in APAC. See Methodology for details.
- **Medicaid:** Health coverage for low-income Oregonians. Medicaid coverage includes coordinated care organizations (CCOs), other Medicaid managed care organizations, and Medicaid fee for service (FFS). Medicaid is funded by a mix of state and federal resources. Since 2014, Oregonians with incomes below 138 percent of the federal poverty level have been Medicaid eligible, and the waiting list for the Medicaid has been eliminated.
- **Medicaid coordinated care organizations (CCOs):** Local organizations that deliver care and coverage for Medicaid members. They cover physical, mental, and dental health care using global budgets that grow at a fixed rate. CCOs are accountable for the health outcomes of populations they serve. As of June 15, 2014, 90 percent of Medicaid enrollees were enrolled in a CCO.
- **Medicare Advantage:** A type of Medicare health plan offered by a commercial insurance company that covers hospital, nursing facility, and home health care, as well as services and supplies. The federal Medicare program pays a fixed amount each month per enrolled member to the companies offering Medicare Advantage plans.
- **Oregon Educators Benefit Board (OEBB) and Public Employees Benefit Board (PEBB):** Boards that contract with commercial health insurance companies to provide health insurance plans for educators and public employees, and contribute the employer share of premiums for covered employees. OEBB and PEBB became part of the Oregon Health Authority in 2009.

**Per Member, Per Month (PMPM):** Spending on care for members of a health plan divided by member months. Dividing spending by member months provides a comparable measure of spending across types of coverage or health plans. For a comparable measure of utilization across types of coverage or health plans, counts of total primary care visits, emergency department admissions, or other services used are divided by thousand member months.

# Methodology

## Data Sources

Data for commercial, Medicaid CCO (with the exception of spending data), Medicare Advantage, OEGB, and PEBB coverage are from the All Payer All Claims reporting program (APAC). The following data suppliers report enrollment and paid claims to APAC.

- Commercial insurance companies: Offer group and individual health insurance plans, Medicare Advantage plans, and contract with OEGB and PEBB to offer plans for educators and public employees.
- Pharmacy benefit managers (PBMs): Work with commercial insurance companies to administer pharmacy benefits.
- Third party administrators (TPAs): Administer health insurance plans for self-insured employers (employers that set aside their own funds to pay claims, rather than buying group coverage from a commercial insurance company).
- Medicaid: The Oregon Health Authority reports data for Medicaid Coordinated Care Organizations (CCOs) and other types of Medicaid coverage to APAC.

Spending data for Medicaid CCO coverage is from the Oregon Health Authority's Decision Support Surveillance and Utilization Review System (DSSURS) data warehouse.

## Data Timeframes

Due to anticipated claims lag, spending and utilization are reported for 2011 – 2013 only. A claim can take weeks or months to process from the time a health care service occurs to the time the claim is processed and reported. As a result, claims data submitted to APAC for 2014 calendar quarters are not yet sufficiently complete to gain an accurate picture of spending and utilization in 2014. These data will be “filled in” with future submissions and covered in future reports.

Enrollment is reported for 2011 – 2014. Payers submit data on months in which each covered person is enrolled in coverage along with claims data. Unlike spending and utilization data, enrollment data is not subject to claims lag.

## What's Not Included in this Report

A September 2014 study estimated there were 3.8 million Oregonians with coverage as of June 30, 2014.<sup>4</sup> This report includes data for 3.0 million unique people with coverage in June 2014, with the caveat that a small number of people are counted more than once (see below). This means that the report includes data for 80% of Oregonians with health care coverage in June 2014. The report excludes data for people with the following types of coverage:

- Medicare fee for service (FFS): Pays claims for Medicare enrollees not enrolled in CCOs or other Medicaid managed care. Medicare FFS data are reported to APAC, but were excluded for consistency with other spending data extracted from DSSURS and reported by OHA.

- Medicare fee for service (FFS): Pays claims for Medicare enrollees not enrolled in a Medicare Advantage plan. Medicare FFS began reporting data to APAC in 2013. OHA is in the process of validating these data, and will include Medicare FFS data from APAC in future reports.
- TRICARE: Coverage for active duty military service members, National Guard and Reserve members, and their families.
- Veterans Administration: Coverage for people who served in the active military service.
- Indian Health Service: Provides federal health services to American Indians and Alaska Natives.
- The following types of commercial coverage: Accident policies, dental insurance, disability policies, hospital indemnity policies, long-term care insurance, Medicare supplemental insurance, specific disease policies, stop-loss plans, student health insurance, vision-only insurance, workers compensation, and coverage from commercial carriers and TPAs with fewer than 5,000 enrollees in Oregon.

The report also excludes data from alcohol and drug treatment claims. Federal law requires excluding data on alcohol and drug treatment that could be linked to a specific person.

In addition, the report excludes data on care and services received by people who pay out of pocket, including the uninsured. Paying out-of-pocket for health care and services does not generate claims, so spending and utilization of out-of-pocket payers cannot be reported using data from APAC.

## Enrollment

Enrollment is reported as number of unique people enrolled in each type of coverage in June of each year. The number of people enrolled in each type of coverage changes throughout the year as people lose or gain coverage, or move from one type of coverage to another. To allow for unbiased comparison of enrollment across years, enrollment is reported as number of unique people enrolled at the same time each year.

People with more than one type of coverage are counted more than once. A small number of people are enrolled in more than one type of coverage at the point in time when enrollment was counted, and are counted once for each type of coverage they were enrolled in.

- Counted more than once: People enrolled in Medicaid and Medicare Advantage, commercial coverage and Medicaid, or commercial coverage and Medicare Advantage.
- Counted once: People enrolled in one or more health insurance plans of the same coverage type (for example, two commercial plans).

## Methodology

To put increased enrollment from 2013 to 2014 in perspective, increased enrollment was compared to 2014 Certified Population Estimates for Oregon cities prepared by Portland State University's Population Research Center, accessed from [www.pdx.edu/prc/population-reports-estimates](http://www.pdx.edu/prc/population-reports-estimates).

### Spending

Total PMPM is defined as:

$$\frac{\text{total paid by payer} + \text{total paid by patients}}{\text{member months}}$$

- Paid by payer: Amount paid by payer to provider for services.
- Paid by patients: Patient's responsibility to pay for services. In some cases, patient's responsibility to pay may differ from what the patient actually paid to the provider.

Spending is reported by six service categories called Health Cost Guidelines (HCGs). HCGs are based on diagnosis codes, procedure codes, and other claims information. HCGs do not overlap: each dollar is reported in only one category. HCGs include:

- Ancillary: Includes private duty nursing, ambulance and non-emergency transportation, dental care, durable medical equipment, and supplies.
- Emergency: Visits to the hospital emergency department.
- Inpatient: Care provided at a hospital or other inpatient facility where the patient stays overnight.
- Outpatient: Care provided at a hospital, clinic, or other facility where the patient does not stay overnight.
- Pharmacy: Prescription drugs where at least part of the cost is paid by a payer.
- Primary Care: Services provided during visits to a primary care provider, including preventive physical exams and well-baby exams.

In this report, Medicaid CCO spending excludes spending on alcohol and drug treatment and skilled nursing facility (SNF) care.

*Spending* on health care differs from the *cost of providing* health care:

- Spending: Amount paid by payers and patients for health care services.
- Cost: Expense of providing health care services, including supplies, labor, and overhead.

Spending is reported in this report because it is more accurately captured in claims data.

### Utilization

To provide a standard measure of how frequently members in each type of coverage use important care and services, the report shows total visits and admissions to the following settings per 1,000 member months. 1,000 member months = total months of coverage for all members in the calendar year / 1,000.

- Emergency Visits: Visits to the hospital emergency department.
- Primary Care Visits: Visits to a primary care provider.
- Inpatient Admissions: Hospital or other inpatient facility admissions where the patient stays overnight.
- Inpatient Admissions for Mental Health Conditions: Admissions to an inpatient psychiatric hospital. Includes admissions for mood disorders, schizophrenia and other psychotic disorders, and other mental health conditions. Excludes admissions to a residential setting.

### Notes

1 Hadley, Jack. "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income." *Medical Care Research and Review* 60 (2003): 3S - 75S.

2 Oregon Health and Science University. *Sustainable Health Expenditures Workgroup: 2011 - 2013 Trends in Health Care Spending*. <http://www.oregon.gov/oha/analytics/SHEWDocs/Presentation%20-%20SHEW%20CHSE.pdf>

3 For example, see Kronman, Andrea C. et al. "Can Primary Care Visits Reduce Hospital Utilization Among Medicare Beneficiaries at the End of Life?" *Journal of General Internal Medicine* 23 (2008): 1330 - 1335.

4 Oregon Health and Science University. *Impacts of the Affordable Care Act on Health Insurance Coverage in Oregon*. <http://www.ohsu.edu/xd/research/centers-institutes/center-for-health-systems-effectiveness/current-projects/upload/Impacts-of-the-Affordable-Care-Act-on-Health-Insurance-Coverage-in-Oregon.pdf>