Oregon Health Policy Board

Initial Quarterly Dashboard

Oregon Health Authority

Presented March 4, 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 initial 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 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
- Access to Care
- Quality of Care

Much of the data in this initial dashboard does not yet capture changes that are anticipated following Affordable Care Act insurance coverage expansions that went in to effect at the beginning of 2014, but 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 been checked to confirm accuracy. 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:

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Cost and Utilization

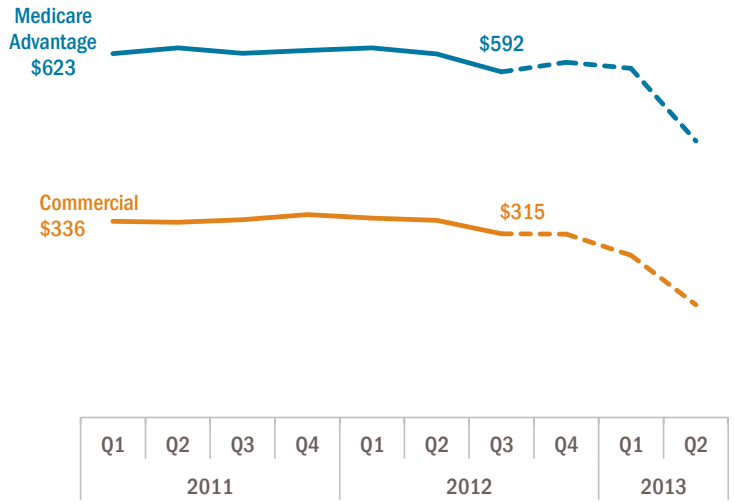
Overview

This section presents the rates of health care utilization and total allowed amounts per member per month by commercial and Medicare Advantage. Medicare Fee-For-Service and Medicaid data will be included in future dashboards.

All data in cost and utilization section of this dashboard are from the All Payer All Claims Database, with the exception of OHA Medicaid inpatient data, which comes from Oregon's Health System Transformation Quarterly Progress Report.

Cost and utilization data are compiled according to Milliman's Health Cost Guidelines grouper. For more details on groupings, see data notes page at end of dashboard. Dashed lines indicate where data are partially incomplete (usually the most recent three quarters).

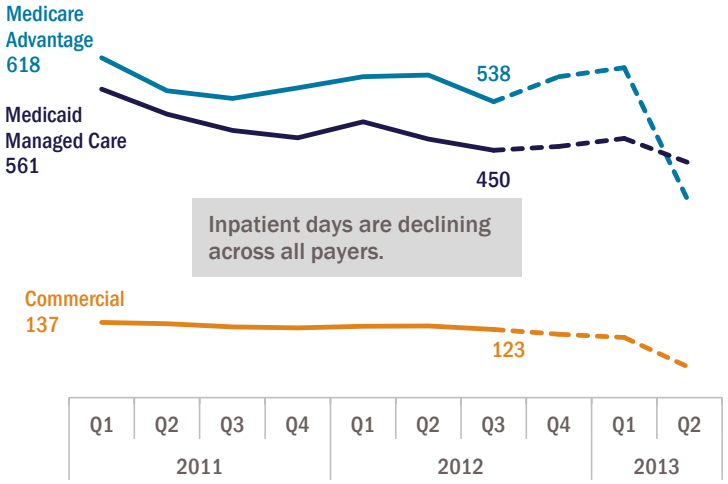
Total Expenditures Per Member Per Month



Hospital Inpatient

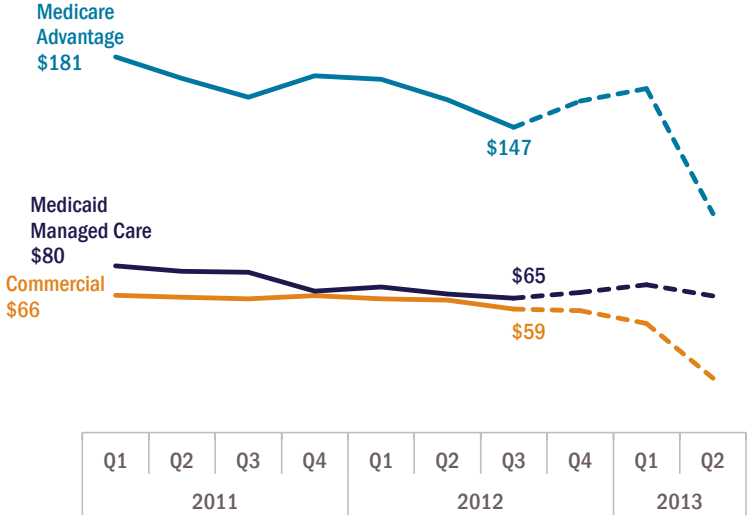
Hospital Inpatient Days

Annualized / 1,000 members



Inpatient days are declining across all payers.

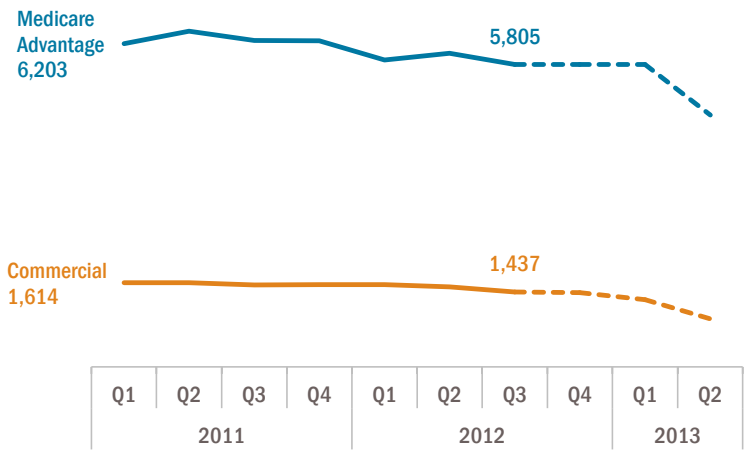
Hospital Inpatient Expenditures Per Member Per Month



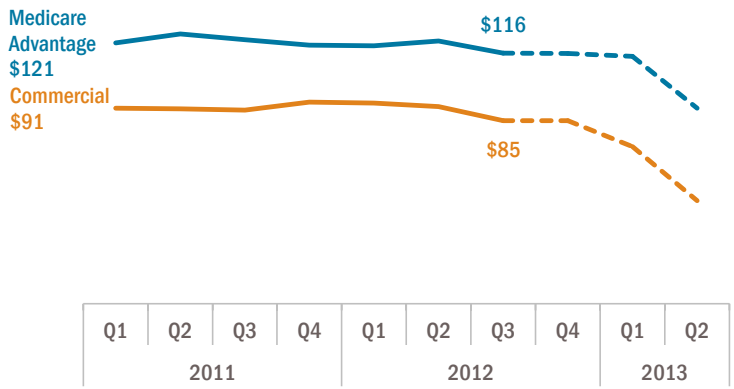
Cost and Utilization, cont.

Outpatient

Visits
Annualized / 1,000 members

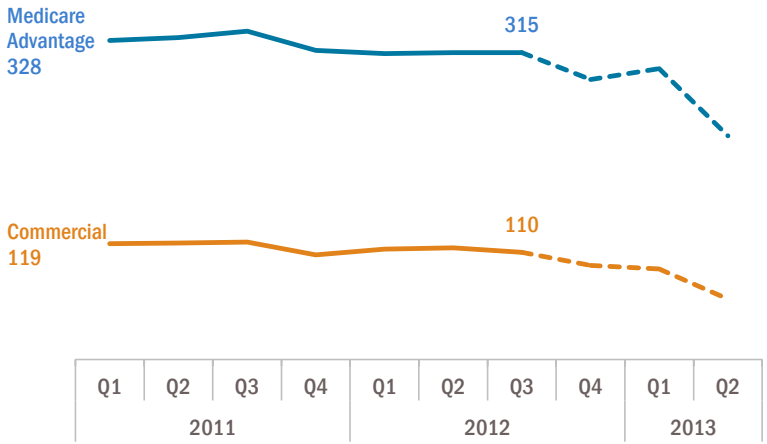


Expenditures Per Member Per Month

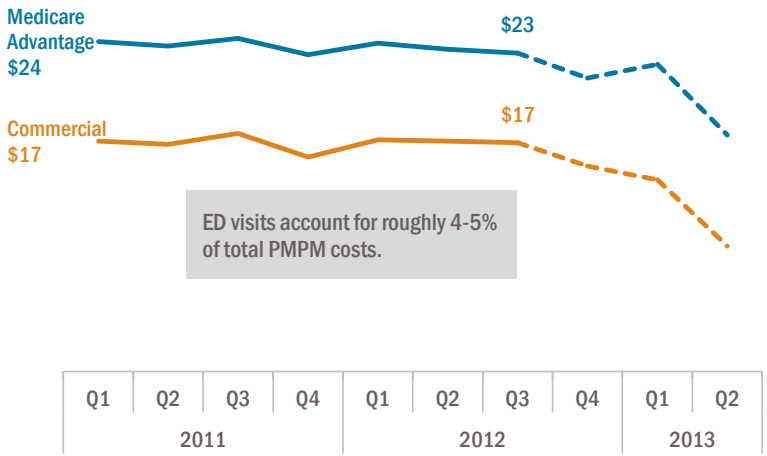


Emergency Department

Visits
Annualized / 1,000 members



Expenditures Per Member Per Month

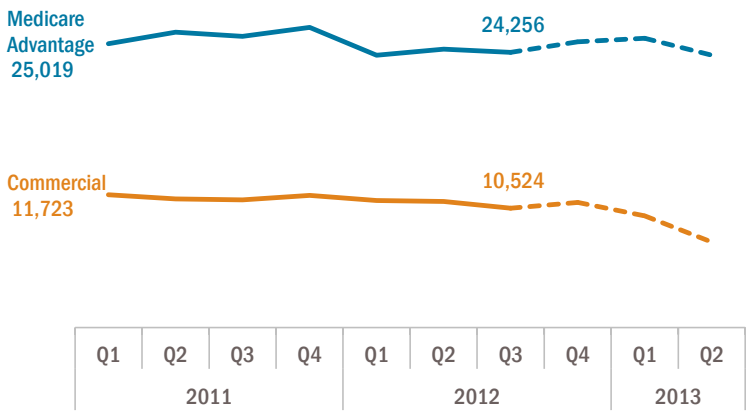


ED visits account for roughly 4-5% of total PMPM costs.

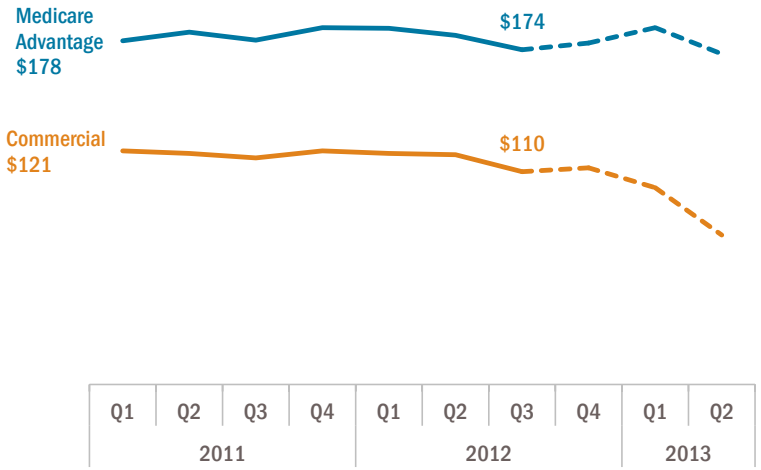
Cost and Utilization, cont.

Professional

Procedures & Visits
Annualized / 1,000 members

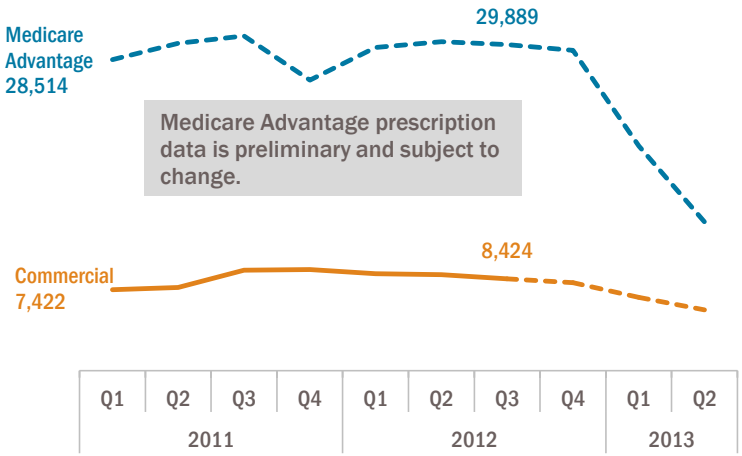


Expenditures Per Member Per Month

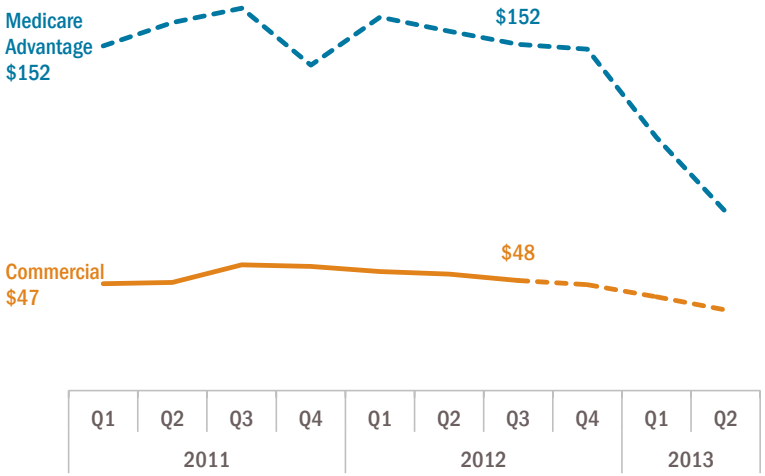


Pharmacy

Prescriptions
Annualized / 1,000 members



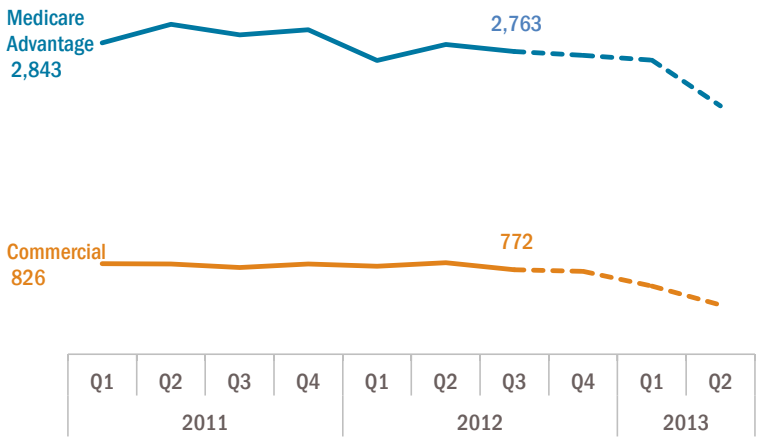
Expenditures Per Member Per Month



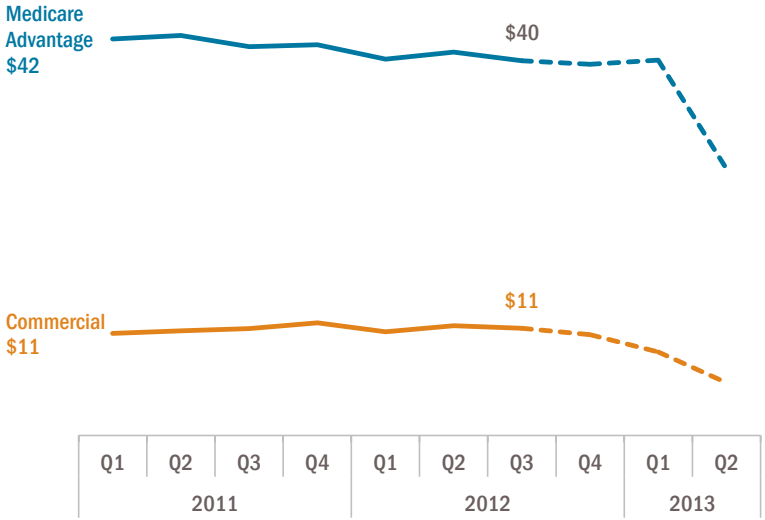
Cost and Utilization, cont.

Ancillary Services*

Procedures & Visits
Annualized / 1,000 members



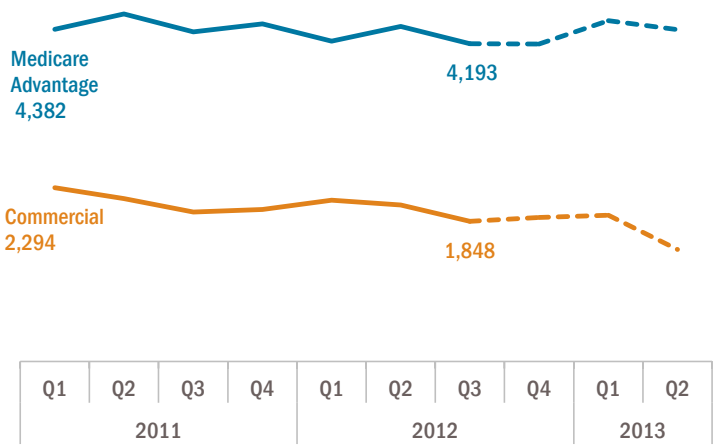
Expenditures Per Member Per Month



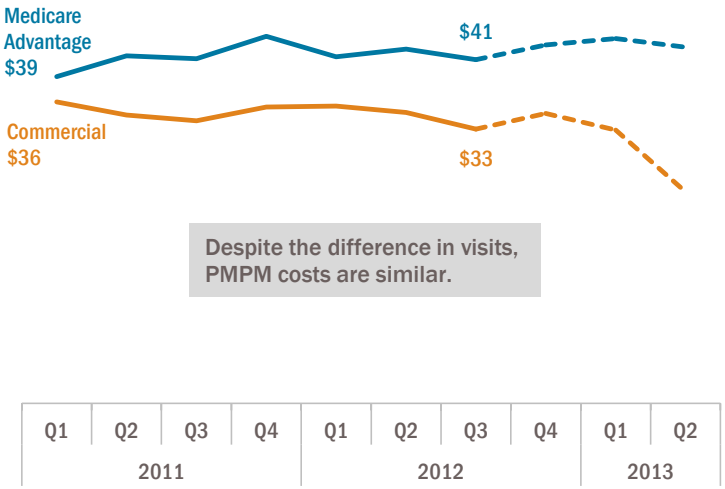
* Ancillary Services include durable medical equipment, therapeutics, and certain forms of custodial care

Primary Care*

Visits
Annualized / 1,000 members



Expenditures Per Member Per Month



Despite the difference in visits, PMPM costs are similar.

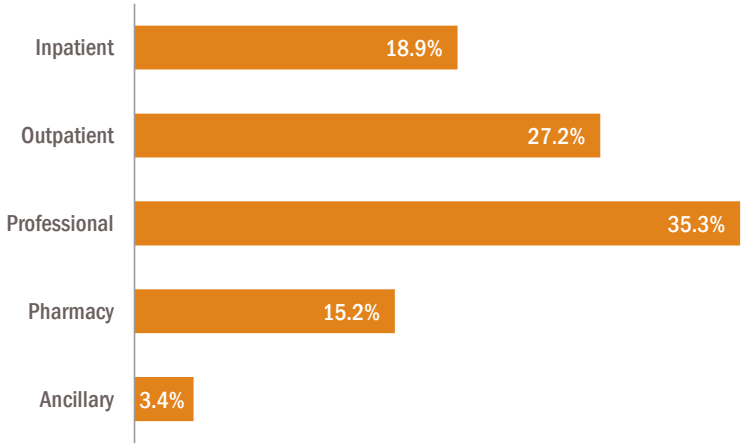
* see data notes page for Primary Care definition

Cost and Utilization: Expenditures Across Types of Care

The type of care Oregonians receive varies by population. Commercially insured Oregonians tend to be younger and healthier th an Oregonians with Medicare Advantage coverage. Medicare Advantage members receive more of their care in an inpatient setting and rely more heavily on ph armaceuticals while the commercially insured receive more of their care in an outpatient setting and rely more heavily on professional services. In addition, Medi care Advantage members receive a greater share of their care in the form of ancillary services, which includes durable medical equipment, therapeutics and certain for ms of custodial care.

Commercial

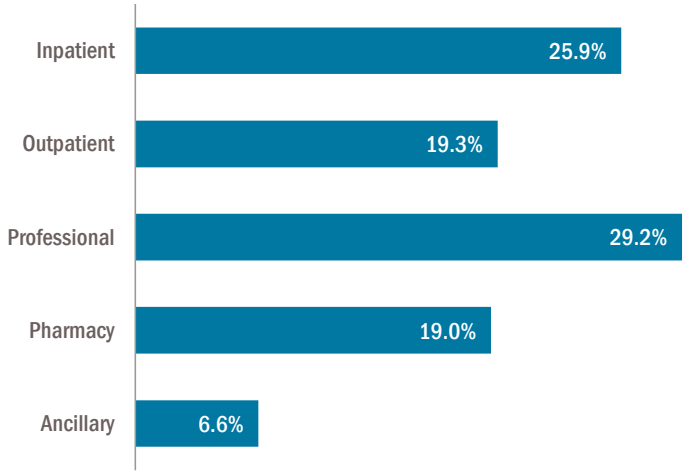
Total Expenditures by Health Cost Group in 2012



ED and Primary Care are included in Outpatient and Professional. ED accounts for 5.0% of total expenditures, Primary Care for 10.6%.

Medicare Advantage

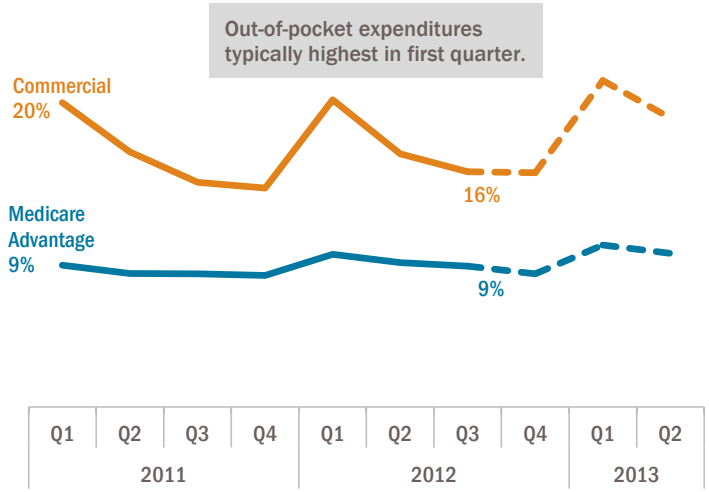
Total Expenditures by Health Cost Group in 2012



ED and Primary Care are included in Outpatient and Professional. ED accounts for 3.7% of total expenditures, Primary Care for 6.9%.

Cost and Utilization: Consumer Out-of-Pocket Expenditures

Consumer's Out-of-Pocket Share of Total Expenditures



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

In general, consumers pay the lowest share for inpatient services (4-7% of total inpatient expenditures).

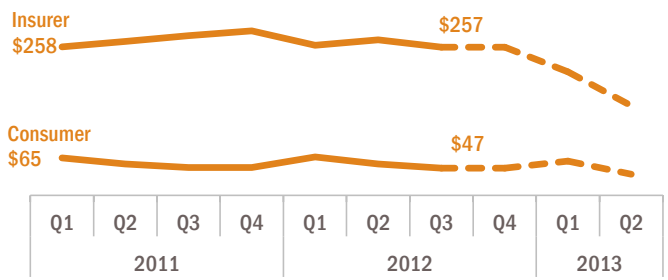
For commercial consumers, the highest share of expenditures is for ancillary services (20-30% of total ancillary expenditures) and ED visits (20-26% of total ED expenditures).

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

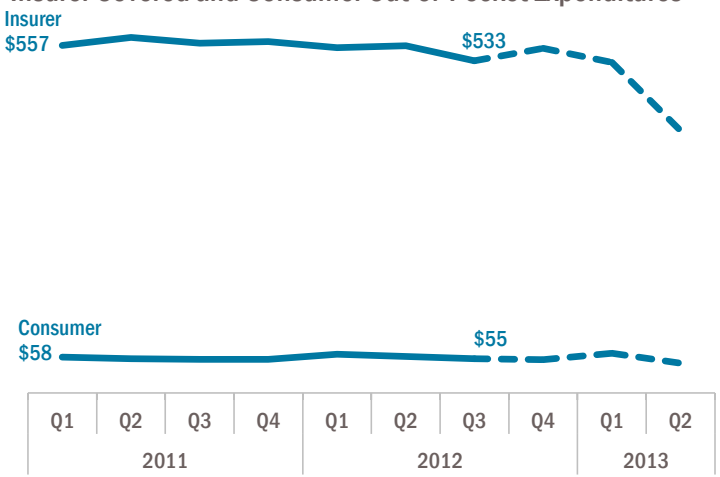
Insurer Covered and Consumer Out-of-Pocket Expenditures



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.
- Arrows indicate movement in rank from 2011 to 2012.

Commercial

Top 20 Episodes by Total Expenditures, 2012
Dollars in millions

2011 rank		2012 rank		Dollars
1		1	Pregnancy w delivery	$283
3	↑	2	Routine exam	$190
2	↓	3	Joint degeneration, localized - back	$183
4		4	Ischemic heart disease	$144
5		5	Malignant neoplasm of breast	$128
6		6	Chronic renal failure	$123
7		7	Joint degeneration, localized - knee & lower leg	$112
8		8	Diabetes	$108
9		9	Mood disorder, depressed	$106
10		10	Hypertension	$91
12	↑	11	Joint degeneration, localized - neck	$87
11	↓	12	Non-malignant neoplasm of female genital tract	$84
13		13	Joint derangement - knee & lower leg	$69
14		14	Cholelithiasis	$62
18	↑	15	Non-malignant neoplasm of intestines & abdomen	$60
15	↓	16	Isolated signs, symptoms & non-specific diagnoses	$60
16	↓	17	Gastroenterology disease signs & symptoms	$60
17	↓	18	Chronic sinusitis	$59
22	↑	19	Inflammatory bowel disease	$59
19	↓	20	Asthma	$57

Medicare Advantage

Top 20 Episodes by Total Expenditures, 2012
Dollars in millions

2011 rank		2012 rank		Dollars
1		1	Ischemic heart disease	$111
2		2	Diabetes	$60
3		3	Joint degeneration, localized - back	$53
4		4	Hypertension	$48
5		5	Chronic renal failure	$46
6		6	Cerebral vascular accident	$45
10	↑	7	Septicemia	$44
7	↓	8	Joint degrangement - knee & lower leg	$42
8	↓	9	Chronic obstructive pulmonary disease	$40
9	↓	10	Cataract	$37
11		11	Congestive heart failure	$33
12		12	Closed fracture or dislocation - thigh, hip & pelvis	$31
15	↑	13	Malignant neoplasm of breast	$27
13	↓	14	Bacterial lung infection	$23
17	↑	15	Malignant neoplasm of skin, major	$23
16		16	Malignant neoplasm of pulmonary system	$21
21	↑	17	Routine exam	$20
20	↑	18	Joint degeneration, localized - thigh, hip & pelvis	$19
18	↑	19	Malignant neoplasm of prostate	$19
23	↑	20	Other metabolic disorders	$18

Utilization: Top Health Care Treatment Episodes

- Episode Treatment Groupers identify unique episodes of care. An episode of care consists of all clinically related services for one patient and a discrete diagnostic condition.
- Arrows indicate movement in rank from 2011 to 2012.
- All data in this section are sourced from the All Payer All Claims Database.

Commercial

Top 20 Episodes by Number of Episodes, 2012

2011 rank		2012 rank		
1		1	Routine exam	514,884
2		2	Hypertension	152,833
4	↑	3	Hyperlipidemia, other	131,251
6	↑	4	Routine inoculation	116,756
3	↓	5	Tonsillitis, adenoiditis or pharyngitis	113,368
7	↑	6	Mood disorder, depressed	97,228
5	↓	7	Other inflammation of skin	95,453
8		8	Non-malignant neoplasm of skin	90,113
9		9	Isolated signs, symptoms & non-specific diagnoses	85,560
11	↑	10	Visual disturbances	79,073
10	↓	11	Otitis media	72,482
16	↑	12	Asthma	67,284
14	↑	13	Gastroenterology diseases signs & symptoms	66,865
13	↓	14	Diabetes	65,049
18	↑	15	Hypo-functioning thyroid gland	61,462
19	↑	16	Other neuropsychological or behavioral disorders	59,478
17		17	Otolaryngology diseases signs & symptoms	59,002
15	↓	18	Acute bronchitis	55,822
20	↑	19	Conditions associated with menstruation	55,731
21	↑	20	Chronic sinusitis	55,664

Routine inoculation had the largest increase (17%) in episodes between 2011 and 2012.

Medicare Advantage

Top 20 Episodes by Number of Episodes, 2012

2011 rank		2012 rank		
1		1	Hypertension	104,811
2		2	Routine exam	68,547
3		3	Hyperlipidemia, other	57,941
4		4	Diabetes	44,657
5		5	Cataract	35,176
7	↑	6	Hypo-functioning thyroid gland	28,693
6	↓	7	Ischemic heart disease	27,303
8		8	Non-malignant neoplasm of skin	27,202
9		9	Joint degeneration, localized -back	25,024
10		10	Other skin inflammation	23,603
11		11	Infection of lower genitourinary system, not STD	21,606
12		12	Glaucoma	20,069
14	↑	13	Fungal skin infection	19,242
15	↑	14	Mood disorder, depressed	18,998
18	↑	15	Other metabolic disorders	16,654
16		16	Malignant neoplasm of skin, major	16,435
27	↑	17	Routine inoculation	15,610
20	↑	18	Joint degeneration, localized -knee & lower leg	15,430
17	↓	19	Inflammatory eye disease	14,806
22	↑	20	Chronic obstructive pulmonary disease	14,091

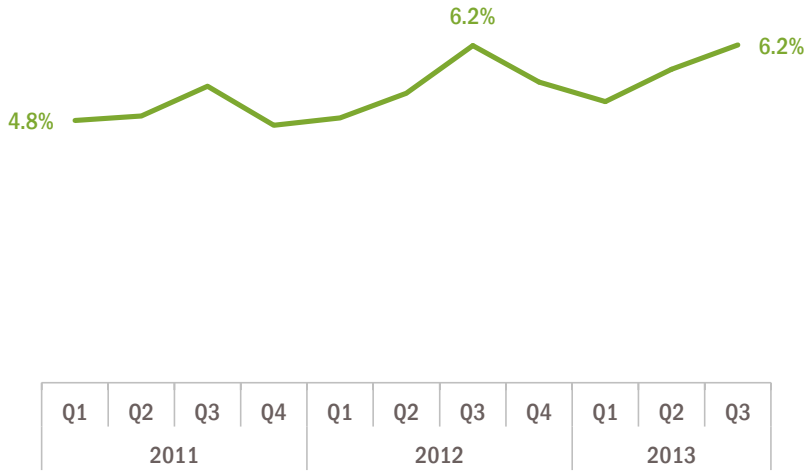
Routine inoculation had the largest increase (29%) in episodes between 2011 and 2012.

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

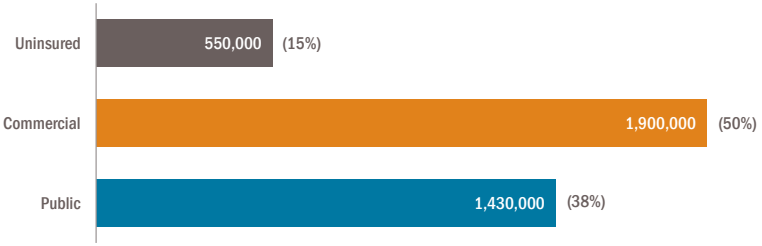
as a percentage of hospital gross charges

Enrollment: Health Insurance Coverage

Overview

Insurance Coverage and Percent of Oregon Population, 2013

Some Oregonians have more than one form of coverage. Percentages do not add to 100.



Roughly half of Oregonians receive commercial health insurance, and a growing portion receive public health insurance such as Medicaid or Medicare.

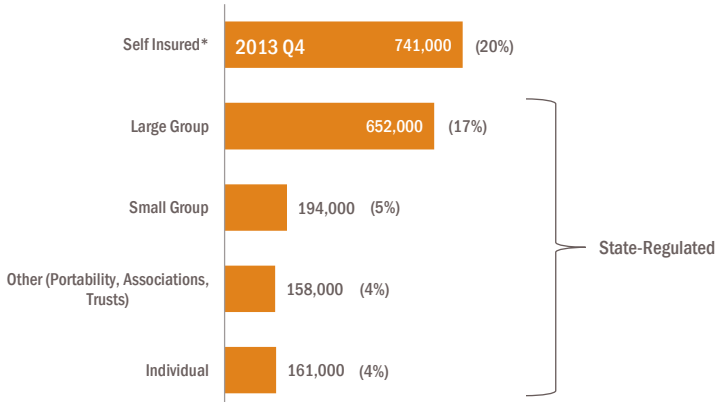
Roughly 30% of Oregonians receive large group, small group, individual or other forms of coverage that are regulated by the Department of Consumer and Business Services (DCBS) and approximately 13% of Oregonians receive coverage that is subject to DCBS's rate review process.

Between December 2013 and January 2014 Medicaid enrollment increased by over 30% percent, largely the result of Fast Track enrollment efforts.

Commercial health insurance enrollment is sourced from quarterly enrollment reports submitted to DCBS.

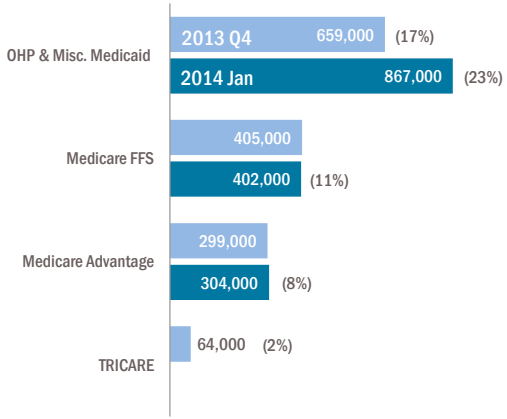
Medicaid enrollment comes from OHA, Medicare from Center for Medicare and Medicaid Services and TRICARE from DCBS.

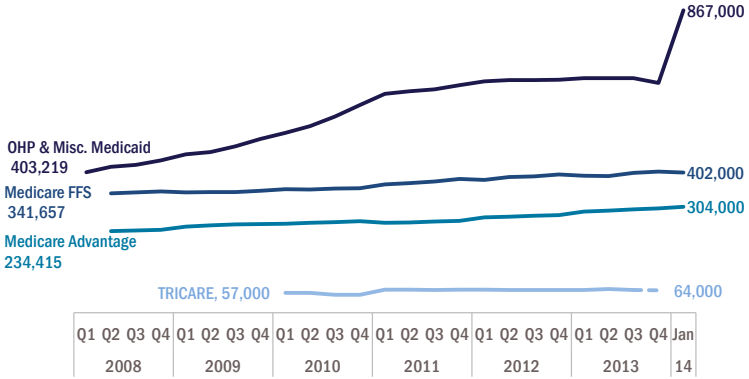
Commercial Insurance



Only a portion of Self-Insured plans report enrollment data

Public Insurance

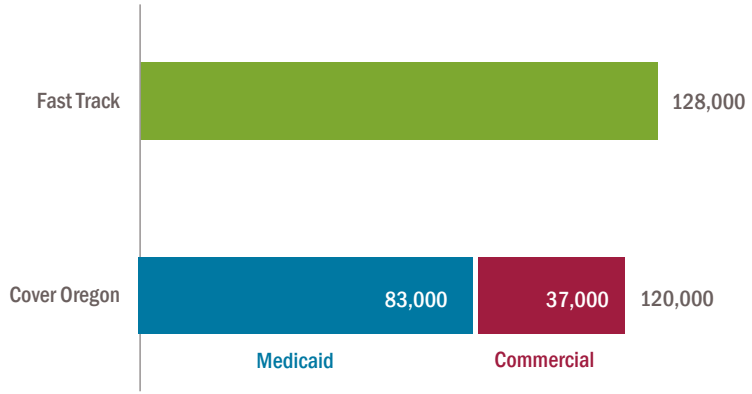




Enrollment: ACA Expansion

Overview

Medicaid Fast Track and Cover Oregon Enrollment
week of 2/24/2014



The ACA expanded access to health insurance by creating the Cover Oregon insurance marketplace, providing subsidies for commercial coverage in Qualified Health Plans and expanding non-elderly adults' eligibility for Medicaid.

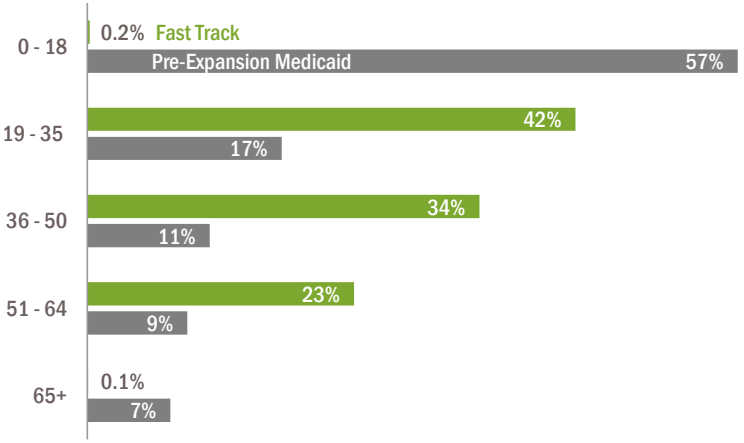
The Medicaid expansion was facilitated by Fast Track enrollment efforts, which were authorized through a CMS waiver to reduce administrative barriers and streamline the enrollment process by using existing program application data primarily through the Supplemental Nutrition Assistance Program (SNAP) to confirm Medicaid eligibility.

The bottom two charts compare the characteristics of Medicaid members who were enrolled prior to Fast Track enrollment with the new Medicaid members who enrolled through the Fast Track outreach program. The new enrollees consist almost entirely of non-elderly adults, while traditionally Medicaid enrollees were mostly children. The new enrollees are also evenly split between women and men whereas traditionally Medicaid enrolled more women than men.

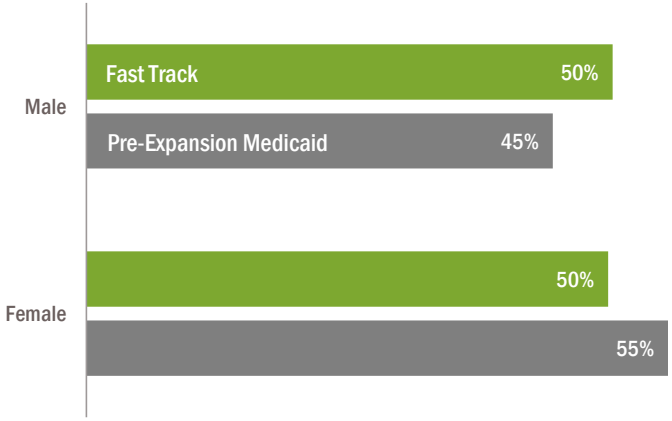
Fast track enrollment data is from OHA. Cover Oregon provided their enrollment statistics.

OHP Fast Track

Fast Track Compared to Medicaid before ACA Expansion by Age, week of 2/24/2014



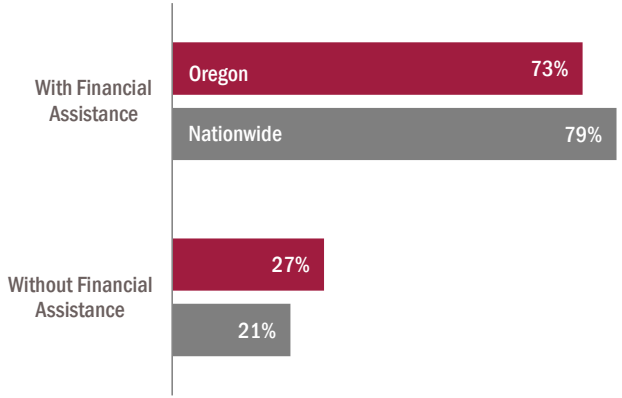
Fast Track Compared to Medicaid before ACA Expansion by Gender, week of 2/24/2014



Enrollment: Qualified Health Plans through Cover Oregon

Cover Oregon Marketplace Enrollment & National Average

By Financial Assistance Status
as of 2/1/2014

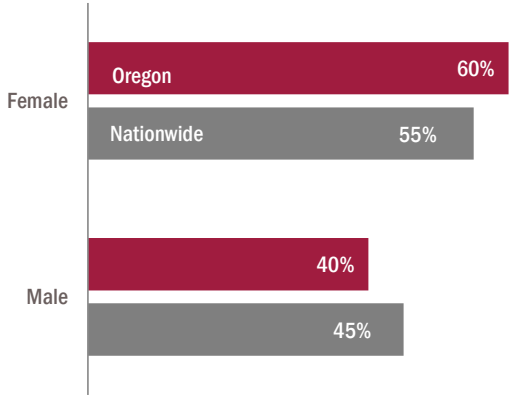


Oregonians who have purchased individual insurance through Cover Oregon have similar characteristics to the national average.

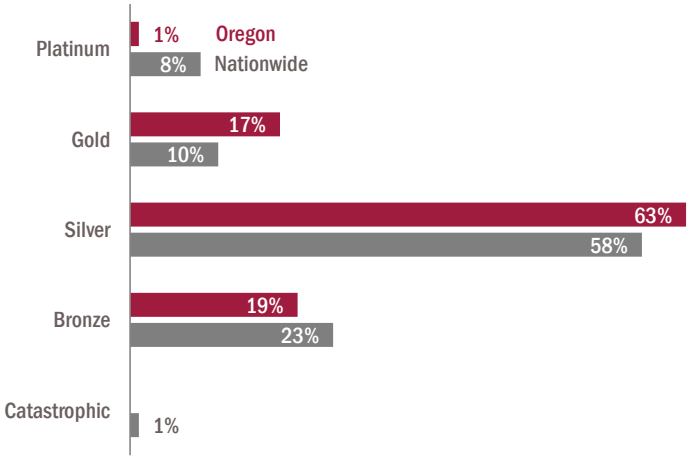
In Oregon, a slightly smaller share of enrollees receive financial assistance than they do nationwide; a slightly larger share are female; and a somewhat greater share of enrollees select the gold and silver tiers of coverage.

This data is sourced from the February 12, 2014 Issue Brief distributed by the federal Department of Health and Human Services, which reports total health insurance marketplace enrollment from October 1, 2013 to February 1, 2014.

By Gender
as of 2/1/2014



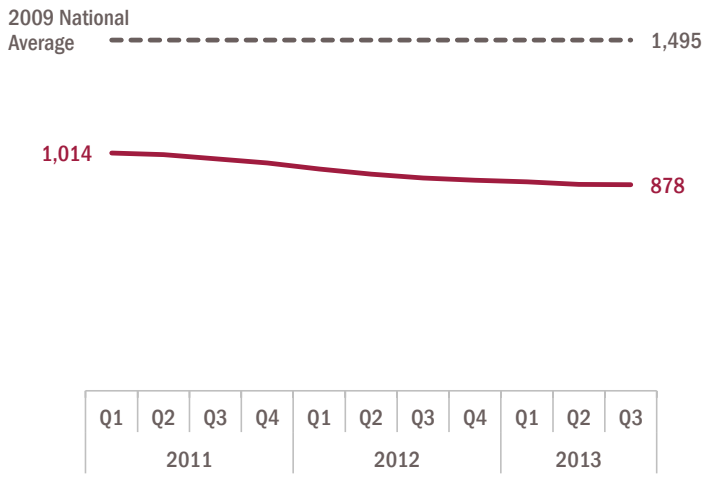
By Metal Tier (Actuarial Value of Coverage)
as of 2/1/2014



Composite Measures

Total Prevention Quality Indicator (PQI) Admissions

Four-quarter moving average per 100,000 person years

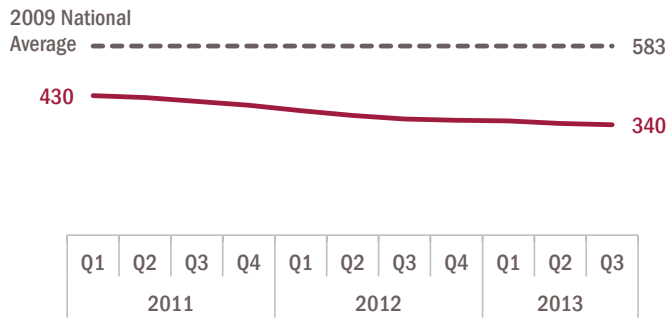


The Prevention Quality Indicators (PQIs) presented in this section are federally-specified measures used to identify hospitalizations that could likely have been avoided through early intervention and outpatient care. The four condition-specific measures on the following page align with the four PQIs also reported for the Medicaid Coordinated Care Organizations (CCOs). 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.

The dashboard's quality metrics will be educated 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.

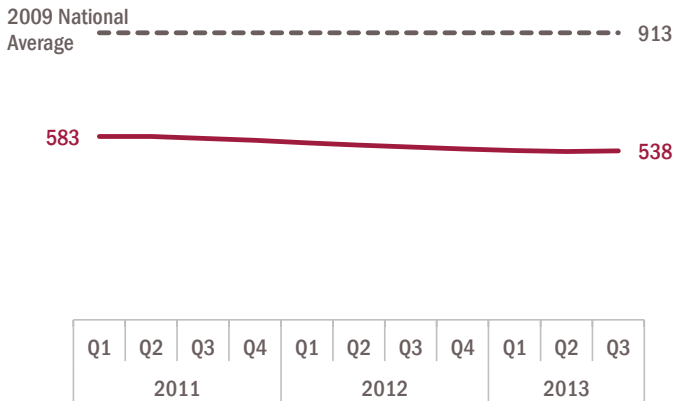
Acute PQI Admissions

Four-quarter moving average per 100,000 person years



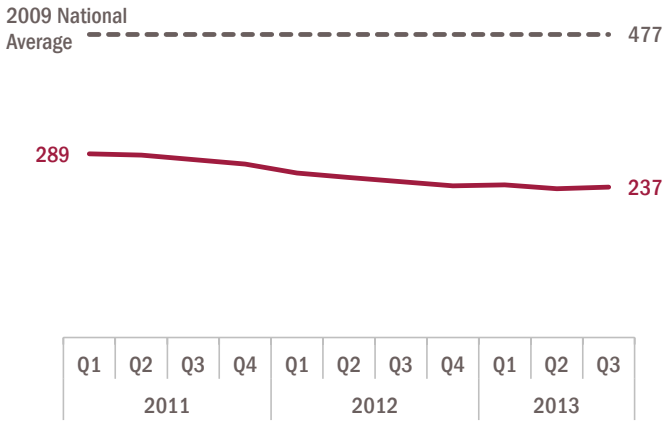
Chronic PQI Admissions

Four-quarter moving average per 100,000 person years



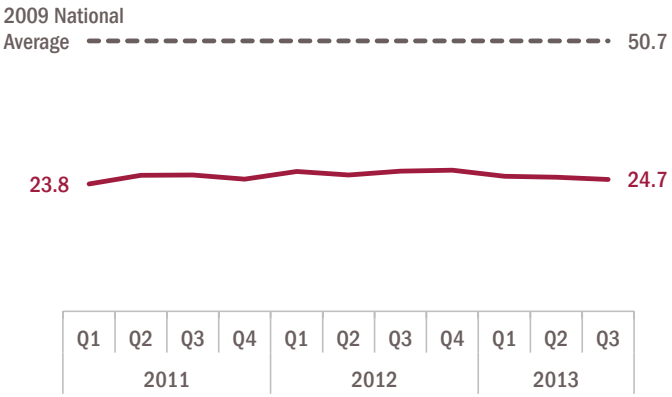
Individual PQIs

Chronic Obstructive Pulmonary Disease Admissions
Four-quarter moving average per 100,000 person years



Congestive Heart Failure Admission
Four-quarter moving average per 100,000 person years

Adult Asthma Admissions
Four-quarter moving average per 100,000 person years

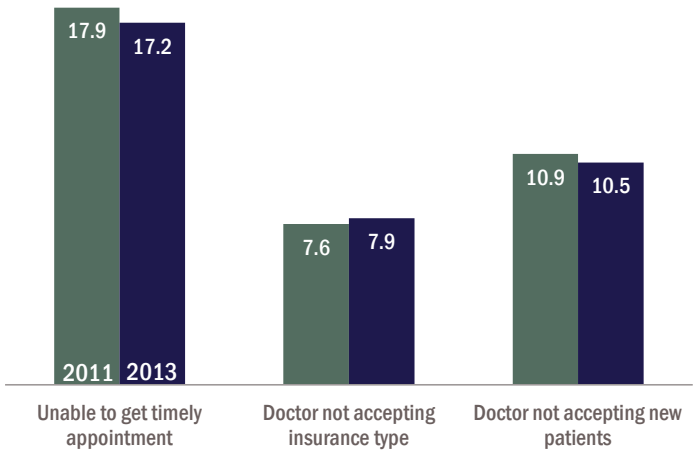


Diabetes Short Term Complications Admissions
Four-quarter moving average per 100,000 person years

Access

Overview

OHIS Health Care Access Measures

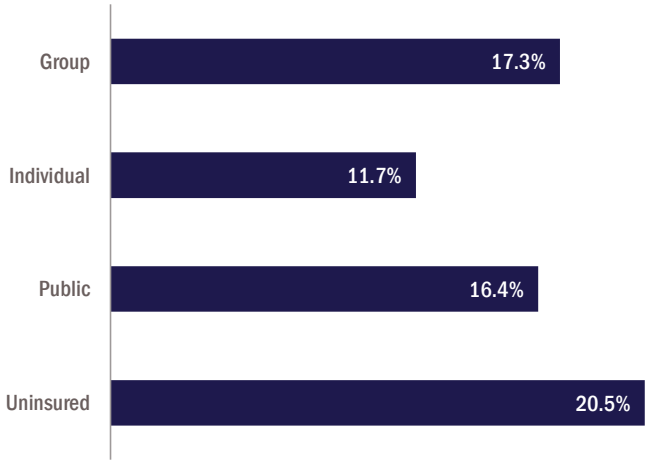


The data in the Access section are from the Oregon Health Insurance Survey (OHIS). OHIS did not show statistically significant changes in the 2011 and 2013 responses to questions about health care access.

However, differences do exist among the responses of Oregonians with different types of coverage or no coverage at all. These differences are described in the following boxes. In all instances, a smaller response rate or smaller bar demonstrates better access to care.

Making an appointment

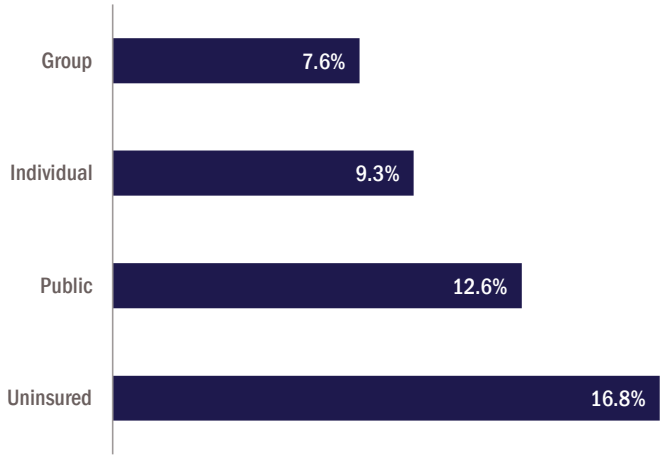
Unable to get timely appointment



Oregonians with individual coverage reported fewer problems with being able to see a doctor as soon as thought necessary, in comparison to other insurance types. This may be a sign of better access for this group or that they have different expectations. OHIS did not find significant differences among uninsured, public, and group-insured Oregonians.

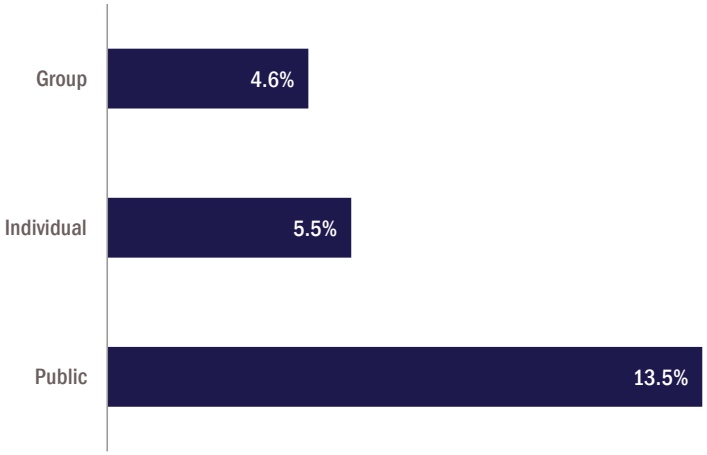
Finding a Doctor

Doctor not accepting new patients



Uninsured Oregonians were more likely to be told by a doctor's office or clinic that they are not accepting new patients. OHIS did not find significant differences among public, group or individually-insured Oregonians.

Doctor not accepting patients with insurance type



Oregonians with public insurance (primarily consisting of Medicaid and Medicare) were more likely to have been told that doctor's office or clinic is not accepting their insurance type. OHIS did not find significant differences between group and individually-insured Oregonians. Uninsured respondents are not asked this question.

Data Notes

Cost & Utilization by types of care (pages 2-6)

Data for the most recent quarters (typically the most recent three quarters) is partially incomplete due to claims data lag. Claims data lag occurs due to a delay between the time that a health care claims occurs and when it is reported and processed by the insurance carrier.

Skilled nursing facility claims and alcohol and drug abuse treatment claims are not included in the data for the dashboard.

Utilization rates per thousand members is annualized by multiplying monthly rates by 12.

Per member per month (PMPM) expenditures are calculated using allowed amount to capture total claim expenditures—insurer amount and consumer out-of-pocket spending.

For reporting cost and utilization, claims are classified into 5 categories using Milliman's Health Cost Guidelines (HCG) grouper: inpatient, outpatient, professional, pharmacy, and ancillary. Additional breakouts of emergency department and primary care also are provided.

Hospital inpatient PMPM and outpatient PMPM expenditures represent facility claims only. Separately billed inpatient and outpatient physician fees are included in the professional category.

Outpatient data include emergency department and primary care claims.

Professional utilization includes visits (office visits and exams) and procedures (surgeries, deliveries, anesthesia, imaging, and others).

Professional data include emergency department and primary care claims.

Medicare Advantage pharmacy data are preliminary pending ongoing work on the integration of Medicare Prescription Drug Plans (Part D) into APAC.

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

Emergency department PMPM expenditures include hospital facility claims and professional claims.

Primary care visits include home and office visits, well-baby exams, and physical exams. Primary care PMPM expenditures include claims for primary care visits as well as preventive procedures. 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 the sum of hospital inpatient, outpatient, professional, pharmacy, and ancillary services claims. (Emergency department and primary care claims are included in outpatient and professional.)

Cost & Utilization: Consumer Out-of-Pocket Expenditures (page 7)

Data for the most recent quarters (typically the most recent three quarters) is partially incomplete due to data lag. Claims data lag occurs due to a delay between the time that a health care claims occurs and when it is reported and processed by the insurance carrier.

Insurer covered expenditures represent insurer paid amounts. Out-of-pocket share includes copayments, coinsurance, and deductibles. For some claims, insurer share 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 8-9)

Episode Treatment Groups (ETGs) are a basic illness classification methodology that identify unique 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, outpatient, professional, 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 episodes prorated allowed—a 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 credited with 0.75 episodes and 2012 with 0.25 episodes. An 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 of expenditures on each ETG.

Cost & Utilization: Uninsured and Uncompensated Hospital Utilization (page 10)

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 11)

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.

Percentages are based on estimated total non-group quarters population from the 2011 American Community Survey.

Enrollment: ACA Expansion (page 12)

Fast Track enrollment distributions by age and gender are based on actual enrollments and Fast Track consent letters awaiting enrollment.

Enrollment: Cover Oregon (page 13)

Cover Oregon enrollment data distributions are estimates based on analysis of enrollment files sent to issuers through December 31, 2013, for those individuals for whom this data was available. For more information see the "Health Insurance Marketplace: February Enrollment Report for the period October 1, 2013–February 1, 2014," available from the Department of Health and Human Services here:
http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf

Quality (page 14-15)

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.

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 convert state Medicaid data into Milliman groupers 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://www4.cbs.state.or.us/ex/imd/reports/rpt/index.cfm?ProgID=UM8902

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