



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:

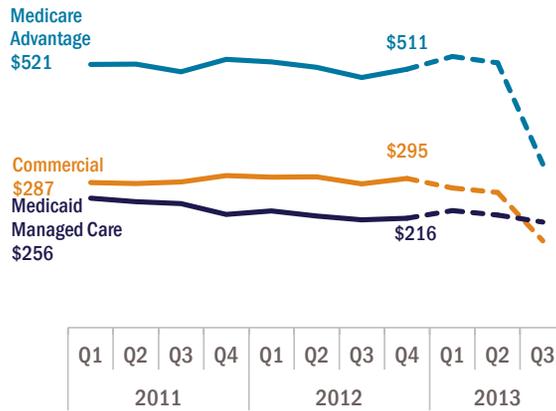
Lori Coyner, Director, Office of Health Analytics - Lori.Coyner@state.or.us

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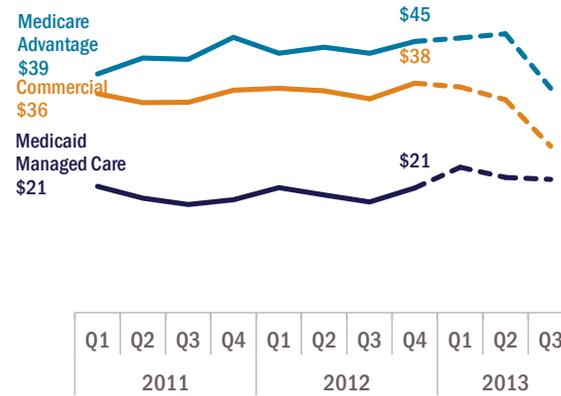
Overview

Cost & Utilization (pages 2-8)

Total* Expenditures Per Member Per Month (PMPM) Emergency Department Expenditures PMPM



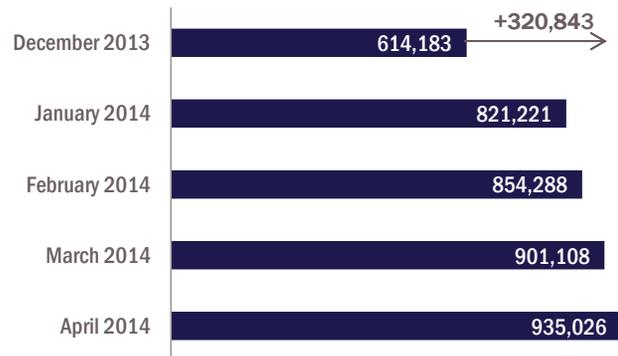
Primary Care Expenditures PMPM



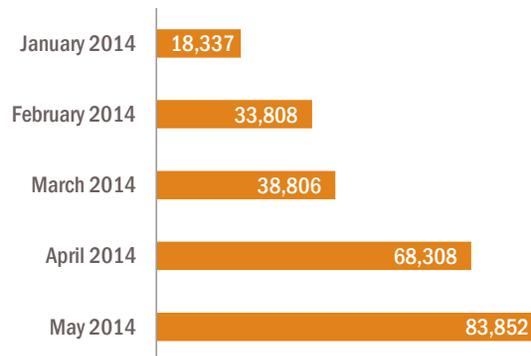
*Excludes pharmacy

Enrollment (pages 10-12)

Oregon Health Plan

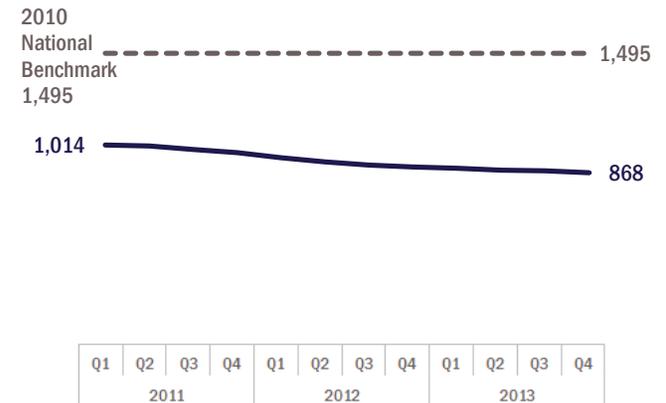


Cover Oregon Qualified Health Plans



Quality (page 13)

Total PQI Admissions*



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

Cost: Expenditures Per Member Per Month

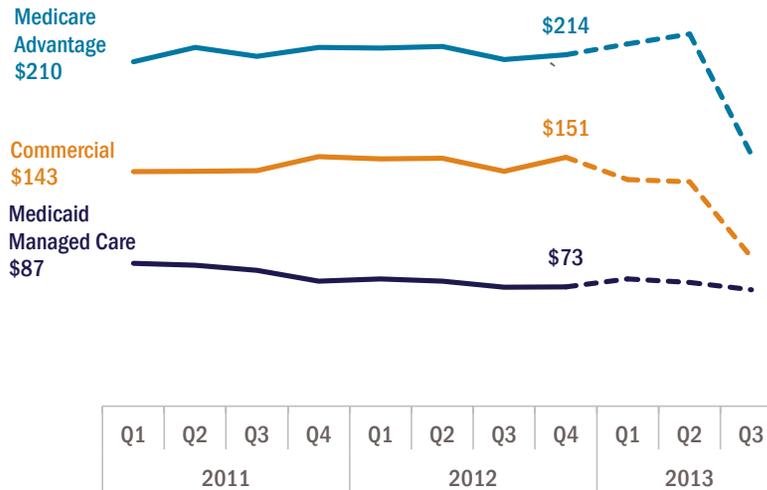
Total



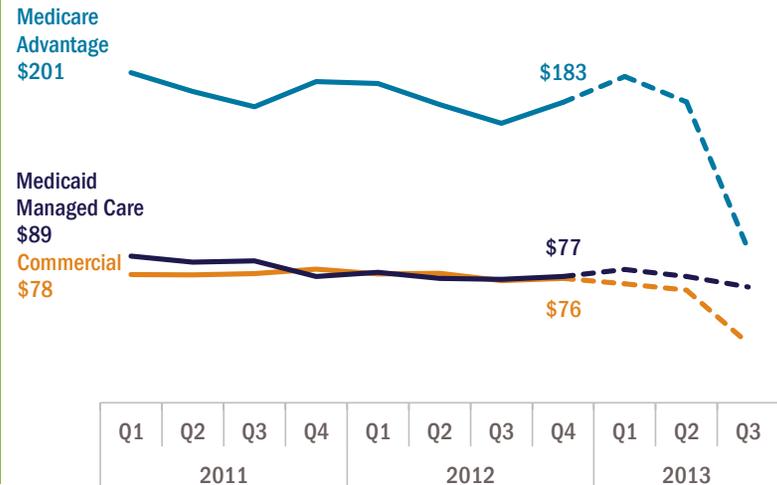
This section presents total allowed amounts per member per month by commercial, Medicare Advantage and Medicaid managed care. Cost data are compiled according to Milliman's Health Cost Guidelines grouper. For more details on groupings, see data notes page at the end of the dashboard. Dashed lines indicate 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.

Outpatient

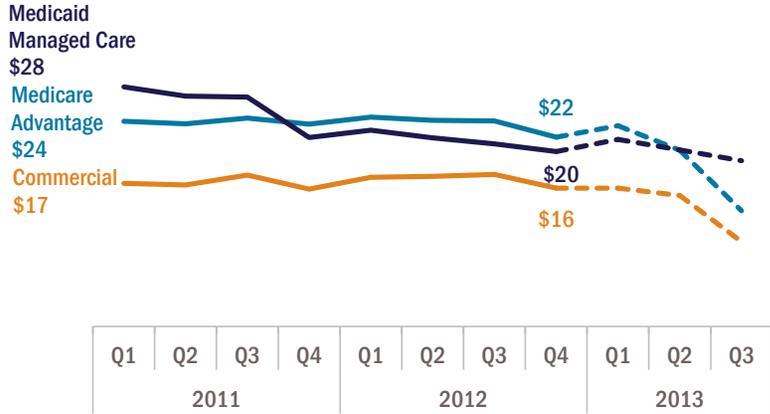


Inpatient



Cost & Utilization: Expenditures Per Member Per Month

Emergency Department

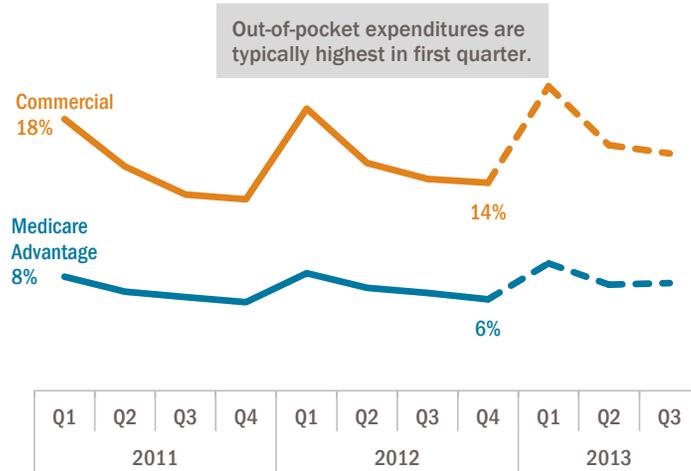


Primary Care



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

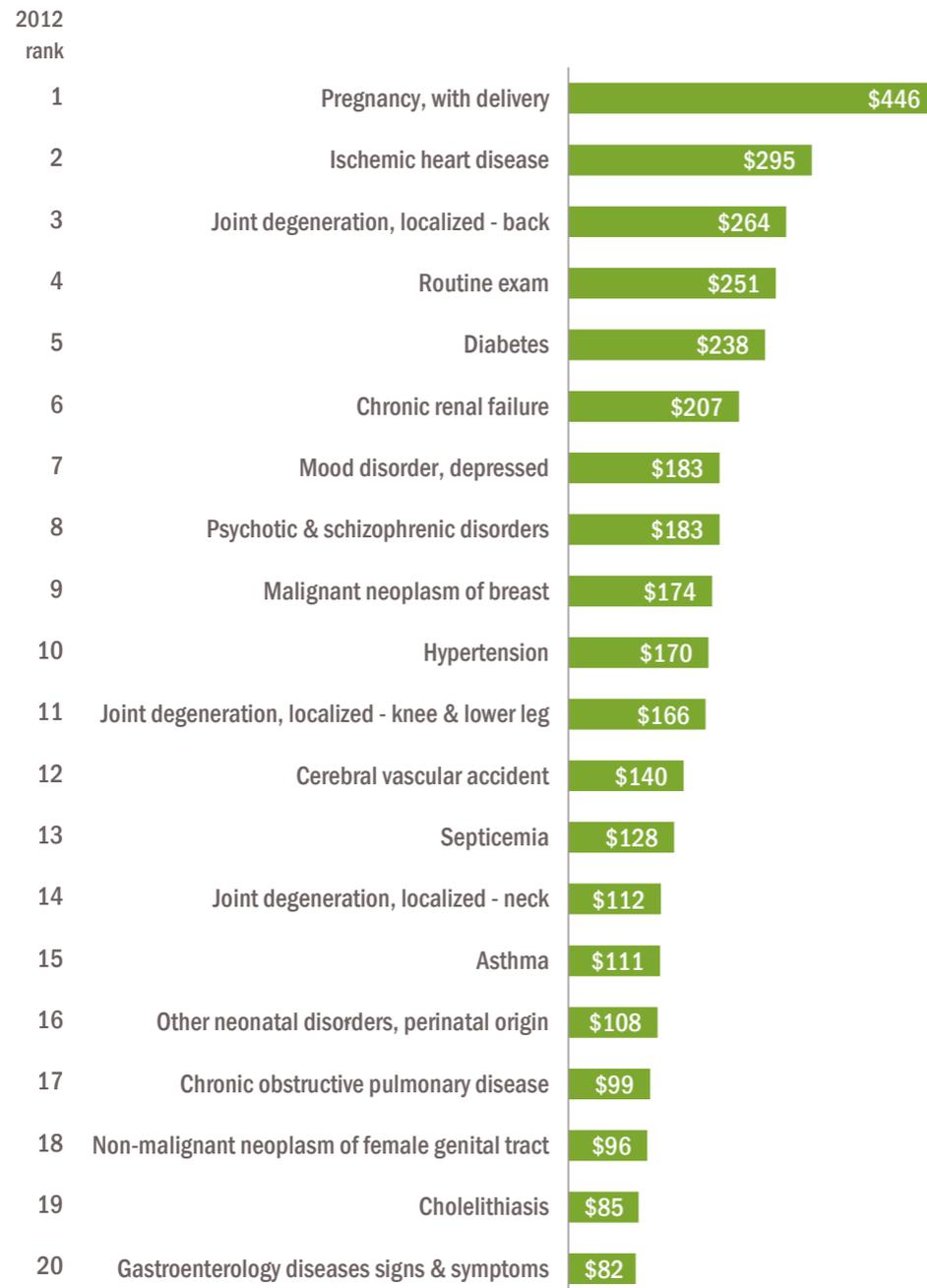
Total PMPM Insurer Covered and Consumer Out-of-Pocket Expenditures



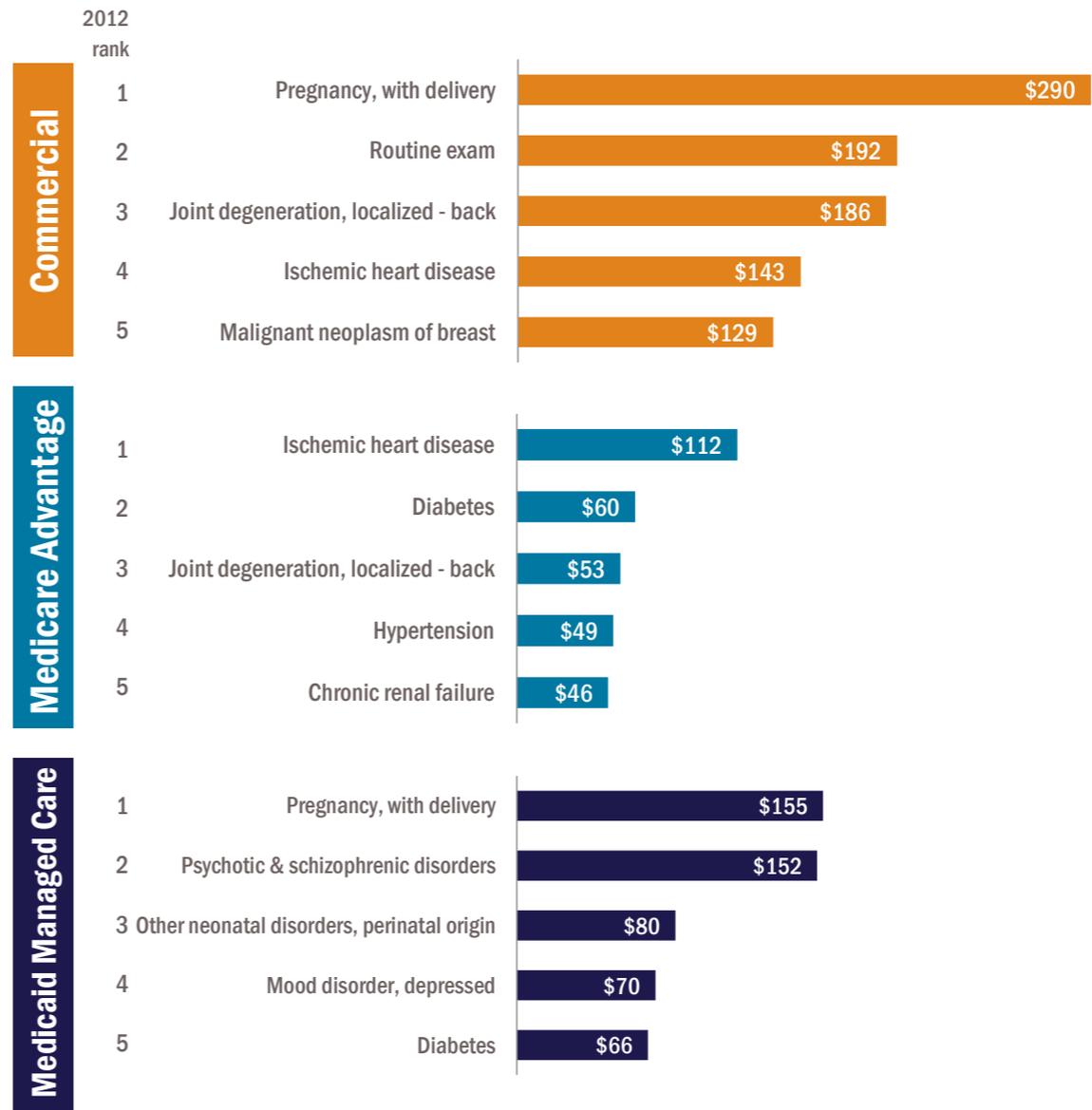
Cost: Top Health Care Treatment Episodes

- 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



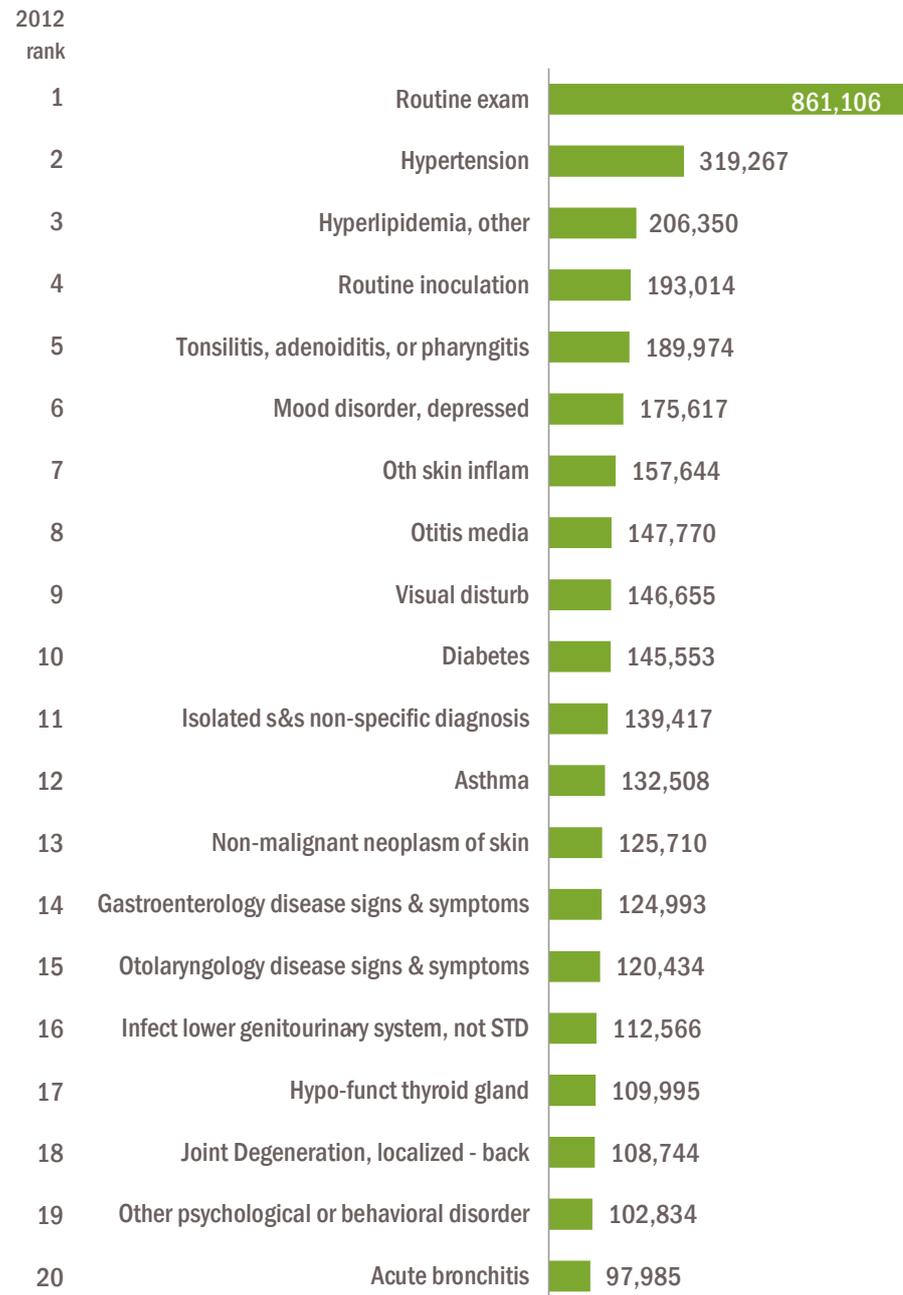
Top 5 Episodes by Total Expenditures - Lines of Business 2012 Dollars in millions



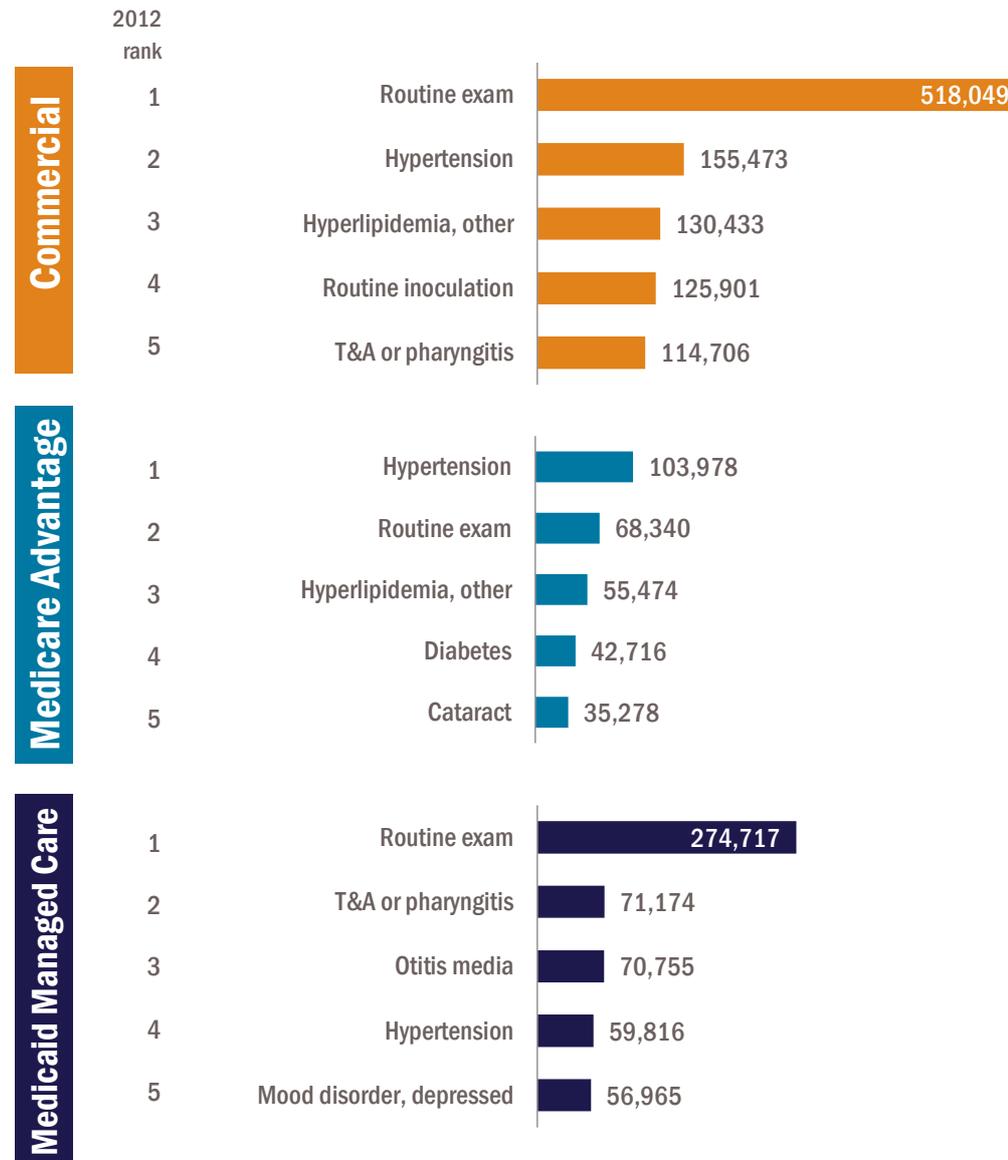
Utilization: Top Health Care Treatment Episodes

- 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



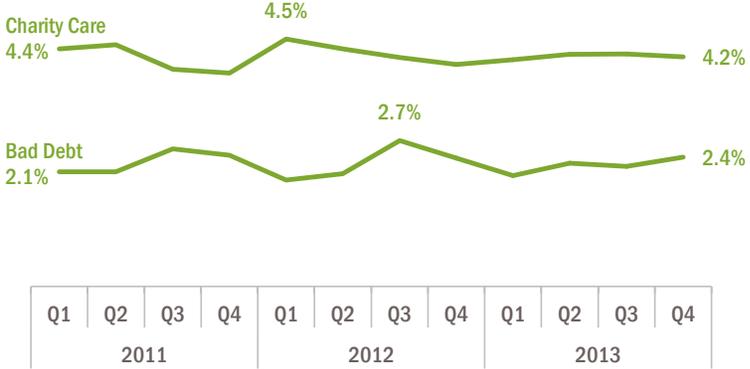
Cost & Utilization: Uninsured and Uncompensated Hospital Utilization

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

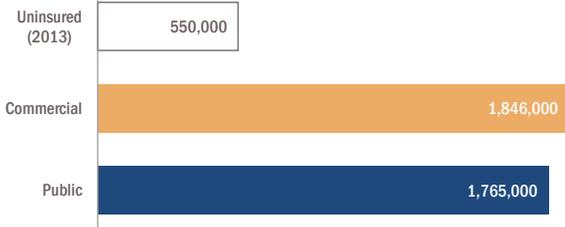


Enrollment: Health Insurance Coverage

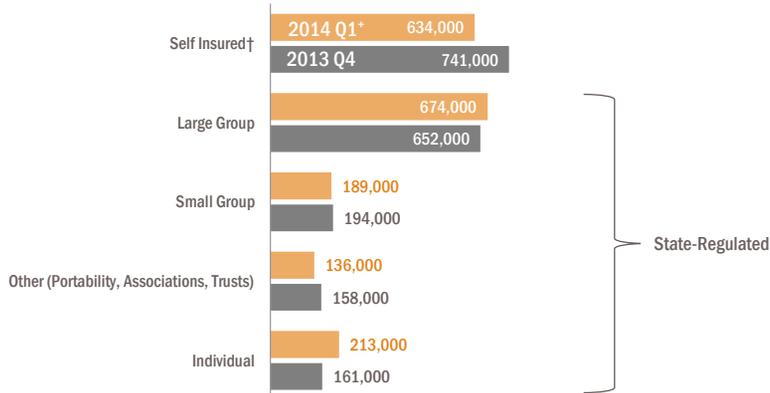
Overview

Insurance Coverage

Some Oregonians have more than one form of coverage.



Commercial Insurance



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

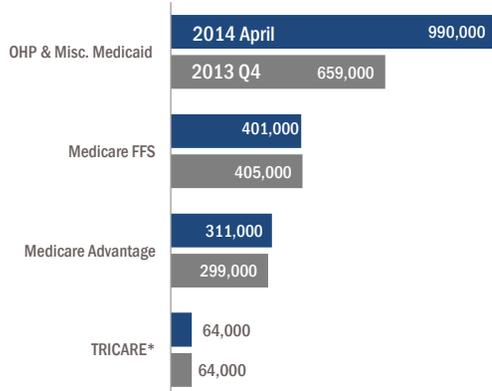
With the ACA coverage expansion, an increasing share of Oregonians receives public health insurance under Medicaid.

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

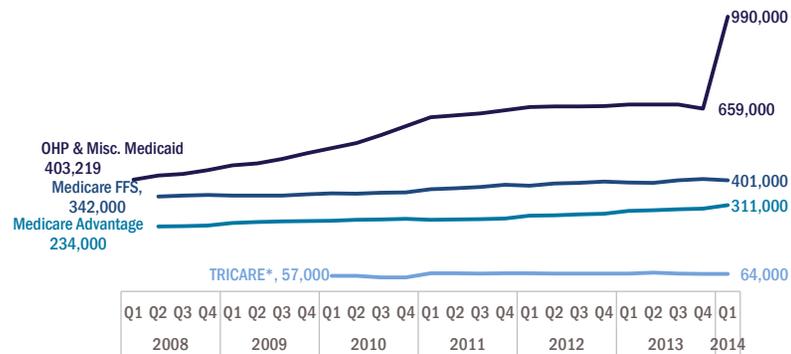
Commercial health insurance enrollment is sourced from quarterly enrollment reports submitted to DCBS (Department of Consumer and Business Services). These data are preliminary as of 5/30/2014.

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

Public Insurance

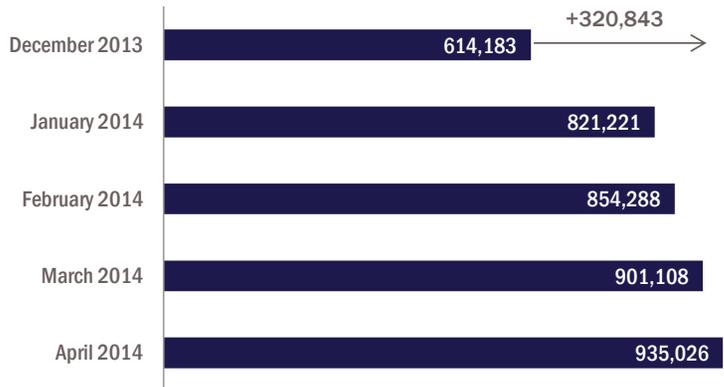


* TRICARE data are reported quarterly by DCBS and is preliminary for 2014:Q1



Enrollment: Oregon Health Plan before and after ACA Expansion

Oregon Health Plan Enrollment

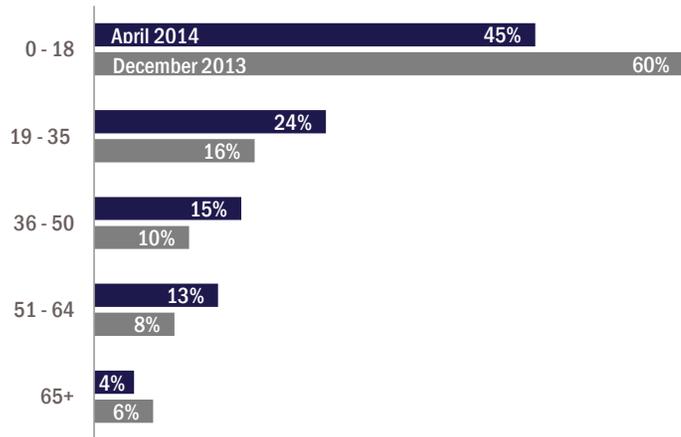


The ACA expanded access to health insurance in part by extending non-elderly adults' eligibility for Medicaid. The chart at left demonstrates the growth in enrollment in Medicaid managed care and Fee For Service programs over the last five months.

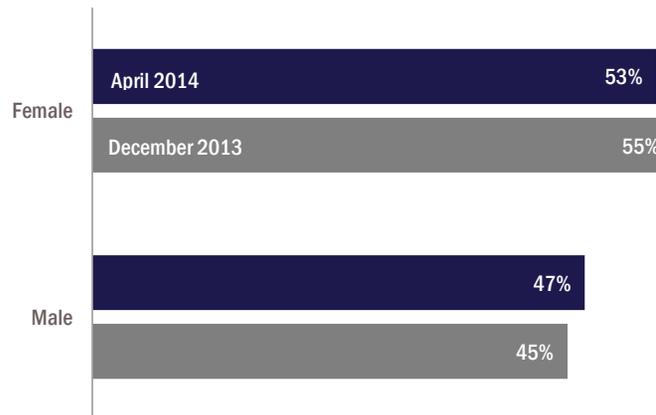
Note: the enrollment numbers on this page vary from those on the previous page, as the numbers reported here include only OHP enrollees eligible for full benefits.

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.

by Age



by Gender

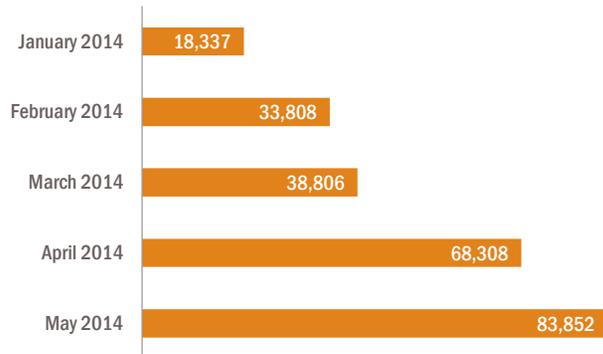


Enrollment: Qualified Health Plans through Cover Oregon

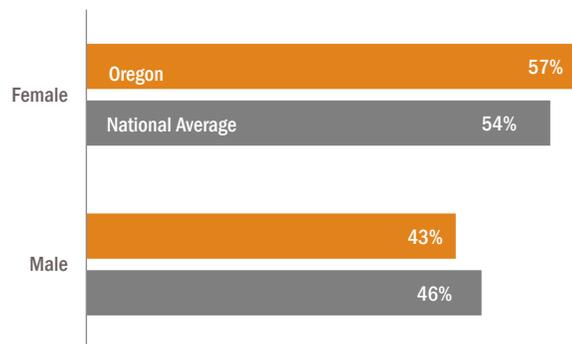
The ACA expanded access to health insurance in part through the establishment of Cover Oregon. Oregonians who have purchased individual insurance through Cover Oregon have characteristics largely similar to their national counterparts. A slightly smaller share of enrollees receives financial assistance 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.

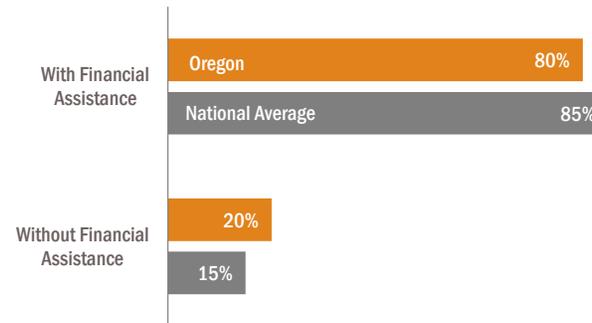
Enrollment Over Time



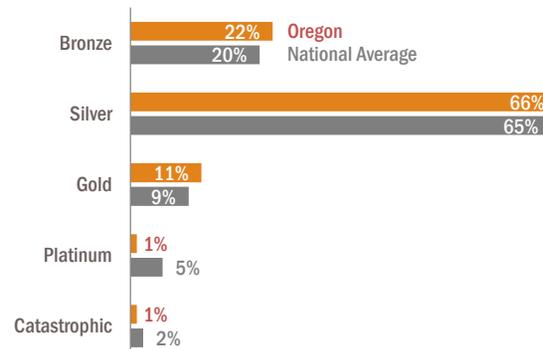
by Gender



by Financial Assistance



by Metal Tier



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

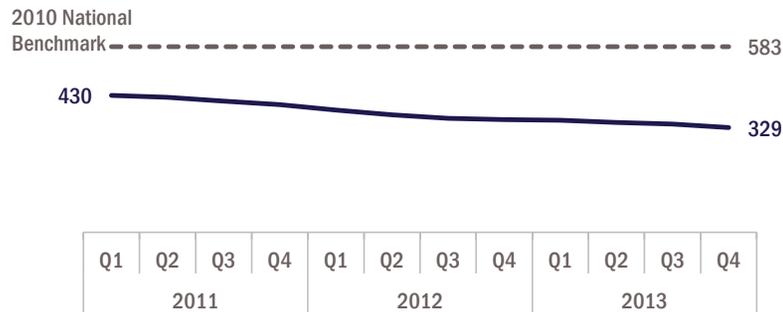
Total



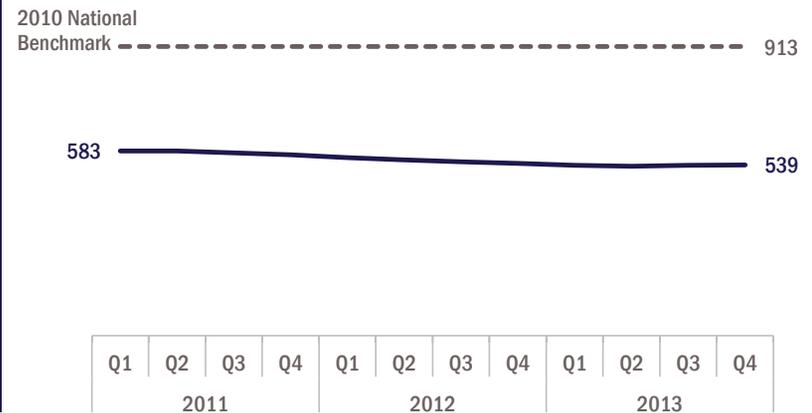
The Prevention Quality Indicators (PQIs) presented in this section are federally-specified measures used to identify hospitalizations that could likely have been avoided through early intervention and outpatient care. These PQIs include hospitalizations of all Oregon residents in Oregon hospitals. As 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 metrics across Cover Oregon, Oregon Educators Benefit Board, Public Employees Benefit Board, and the CCOs.

Acute

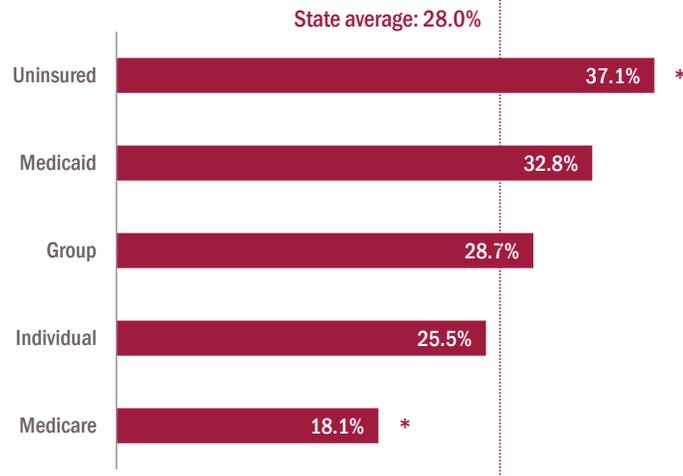


Chronic



Medical Debt: Currently paying off medical bills

by Insurance Status

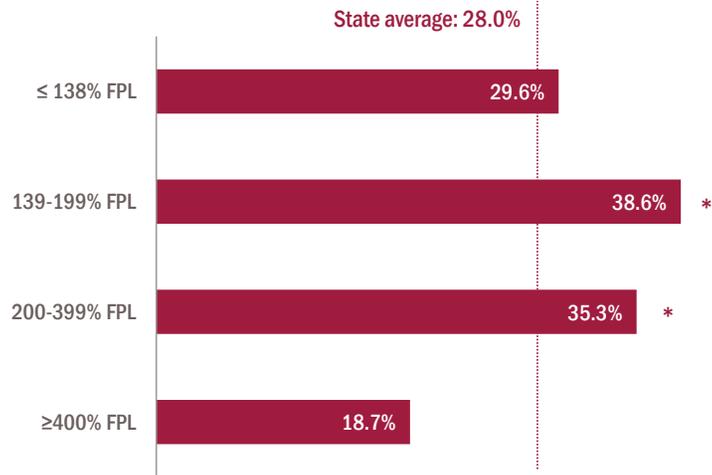


The data on this page are from the Oregon Health Insurance Survey (OHIS), a representative survey of Oregonians coverage status and other insurance-related issues. As part of the study, respondents were asked if they were in the process of paying off any medical bills at the time of the interview.

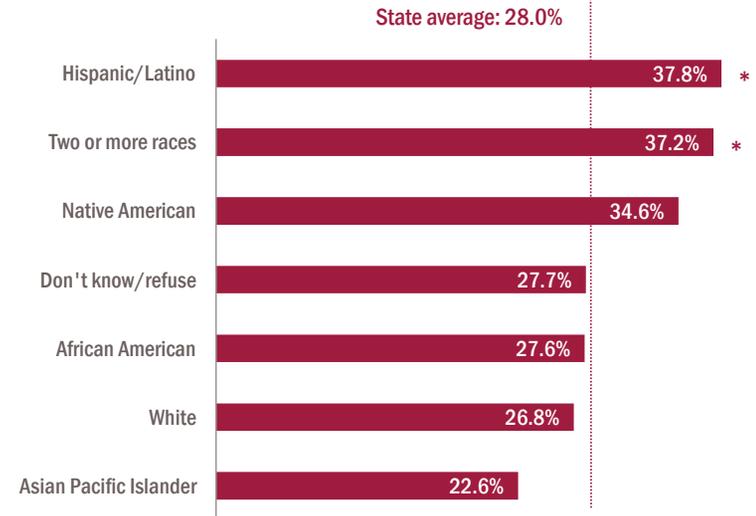
In interpreting the graphs, a lower rate is better. The overall share reporting yes to this question was not significantly different between 2011 and 2013, the two years the survey has been fielded.

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

by Poverty Status

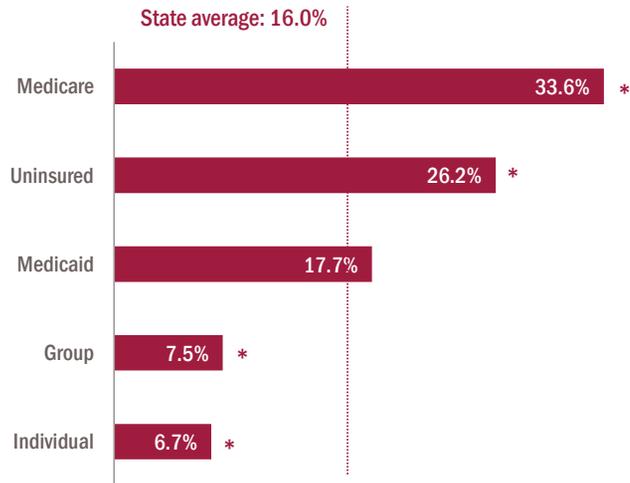


by Race/Ethnicity



Health Status: Percent poor/fair health

by Insurance Status

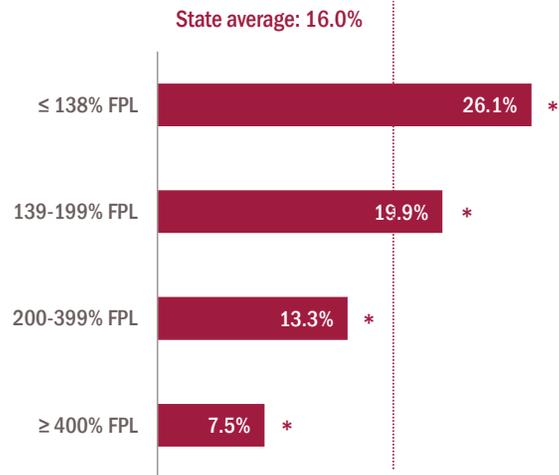


The data on this page are also from the Oregon Health Insurance Survey (OHIS). As part of the study, respondents were asked to characterize their general health as excellent, very good, good, fair, or poor.

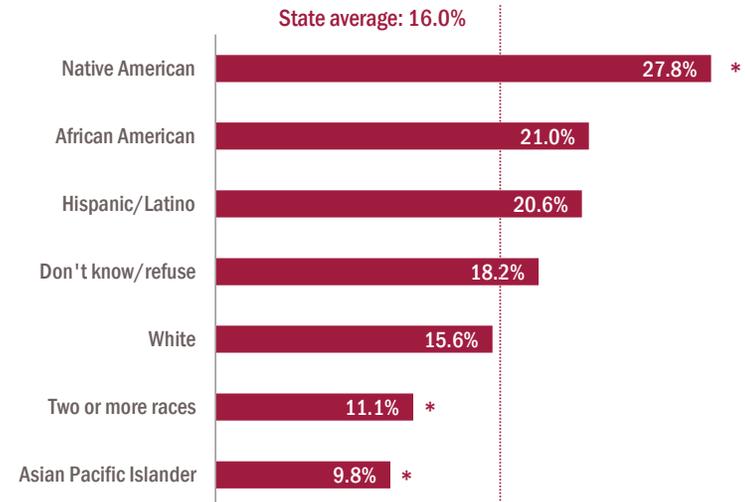
The graphs show the share reporting either far or poor health, so a lower rate is better. The overall percent was not significantly different between 2011 and 2013, the two years the survey has been fielded.

* 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/pgi_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