Oregon's Health System Transformation

2014 Final Report

Oregon Health Authority

MEASUREMENT PERIOD
Calendar Year 2014
Version 1.4

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EXECUTIVE SUMMARY

Incentives for better services

This report lays out the progress of Oregon's coordinated care organizations (CCOs) on quality measures in 2014. This is the sixth such report since coordinated care organizations were launched in 2012. In addition, this is the second report to show a full calendar year of data, as well as results from the second year of Oregon's pay for performance program.

New to this report are results from the three clinical quality measures. The three clinical quality measures include control of diabetes, control of high blood pressure, and depression screenings. CCOs are beginning to build their capacity to report on these measures from electronic health records and the 2014 results are promising.

Under Oregon's pay for performance program, the Oregon Health Authority held back 3 percent of the monthly payments to CCOs, which were put into a common "quality pool." To earn their full incentive payment, CCOs had to meet benchmarks or improvement targets on at least 12 of the 17 incentive measures and have at least 60 percent of their members enrolled in a patient-centered primary care home.

All CCOs showed improvements in some number of measures and 13 out of 16 CCOs earned 100 percent of their quality pool payments in 2014.

Overall, and for the second straight calendar year, the coordinated care model continues to show improvements in a number of areas of care, even with the inclusion of the more than 434,000 additional Oregonians who have enrolled in the Oregon Health Plan since Jan. 1, 2014. New rules took effect Jan. 1, 2014, opening the Oregon Health Plan to more low-income adults as allowed under the Affordable Care Act (ACA). Today, approximately 1.1 million Oregonians are enrolled in OHP.

With the significant increase in new Oregon Health Plan members since January 1, 2014, this report includes a special section on these 2014 enrollees. This section highlights emergency department use by those who newly enrolled in 2014 compared to those who were enrolled in the Oregon Health Plan prior to January 1, 2014, and compared to those who had been enrolled in the Oregon Health Plan in recent years. Statewide, newly enrolled members with no prior Medicaid experience use emergency rooms less frequently than other members with prior Medicaid experience. Newly enrolled members with no prior Medicaid experience also have fewer avoidable emergency room visits than other members.

Other improvements include continued reductions in emergency department visits and hospital readmissions, increases in developmental screening, and increases in screening for alcohol and other substance use."

These improvements are attributable to positive changes toward better care coordination and integration of services. For example, to increase developmental screening rates, many CCOs implemented a number of best practices such as provider training, alternate payment methodologies, policy or clinical guideline changes and working with early learning hubs to promote screenings within the community.

EXECUTIVE SUMMARY

The coordinated care model continues to show large improvements in the following areas for the state's Oregon Health Plan members:

- **Decreased emergency department visits.** Emergency department (ED) visit rates for people served by CCOs have decreased 22 percent since 2011 baseline data. While some of the improvements seen may be due to national trends, CCOs have implemented a number of best practices for reducing emergency department utilization rates, such as the use of emergency department navigators. One such program now includes referrals to a patient-centered primary care home for members who do not have a primary care provider, as well as referrals to dental services, drug and alcohol services, and intensive management for members that have had three or more ED visits in the previous six months.

- **Decreased hospital admissions for short-term complications from diabetes.** The rate of adult members (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease dropped by 26.9 percent since 2011 baseline data.

  Decreased rate of hospital admissions for chronic obstructive pulmonary disease. The rate of adult members (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma decreased by 60 percent since 2011 baseline data.

- **Patient-centered primary care home (PCPCH) enrollment continues to increase.** Coordinated care organizations continue to increase the proportion of members enrolled in a patient-centered primary care home – indicating continued momentum even with the new members added since January 1, 2014. PCPCH enrollment has increased 56 percent since 2011. Additionally, primary care costs continue to increase, which means more health care services are happening within primary care rather than other settings such as emergency departments.

- **Strong improvement to the Screening, Brief Intervention, and Referral to Treatment (SBIRT) measure.** This measures the percentage of adult patients (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse. Two coordinated care organization have exceeded the benchmark, a great accomplishment given the statewide baseline of almost zero. Initiation of alcohol and drug treatment has also increased. However, engagement of treatment has held steady, indicating room for improvement.

Other measures in this report that highlight room for improvement include cervical cancer and chlamydia screenings for women. The reduction in these screening rates may be due to changes in national guidelines reported in 2012, which recommended women wait three to five years between Pap tests and not have their first Pap test until age 21.

Finally, financial data indicate coordinated care organizations are continuing to hold down costs. Oregon is staying within the budget that meets its commitment to the Centers for Medicare and Medicaid Services to reduce the growth in spending by 2 percentage points per member, per year.

Oregon is continuing its efforts to transform the health delivery system. By measuring our progress, sharing it publicly and learning from our successes and challenges, we can see clearly where we started, where we are, and where we need to go next.

2014 CCO PERFORMANCE AND QUALITY POOL DISTRIBUTION

2014 Quality Pool

The Oregon Health Authority has established the quality pool -- Oregon's incentive payments to coordinated care organizations. Each CCO is being paid for reaching benchmarks or making improvements on incentive measures. This is the second time Oregon has paid CCOs for better care, rather than just the volume of services delivered.

The 2014 quality pool is $128 million. This represents 3 percent of the total amount all CCOs were paid in 2014. The quality pool is divided among all CCOs, based on their size (number of members) and their performance on the 17 incentive metrics, which are denoted with a $ icon throughout this report.

Quality Pool: Phase One Distribution

CCOs could earn 100 percent of their quality pool in the first phase of distribution by:

- Meeting the benchmark or improvement target on 12 of 16 measures; and
- Meeting the benchmark or improvement target for the electronic health record adoption measure (as one of the 12 measures above); and
- Scoring at least 0.6 (60 percent) on the PCPCH enrollment measure.

CCOs must meet all three of these conditions to earn 100 percent of their quality pool.

Challenge Pool: Phase Two Distribution

The challenge pool includes funds remaining after quality pool funds are distributed in phase one. The 2014 challenge pool is $5.2 million. Challenge pool funds were distributed to CCOs that met the benchmark or improvement target on four measures:

* Alcohol and drug misuse (SBIRT);
* Diabetes HbA1c poor control;
* Depression screening and follow-up plan;
* PCPCH enrollment.

Through the challenge pool, some CCOs earned more than 100 percent of their maximum quality pool funds. The next pages show the percentage and dollar amounts earned by each CCO.

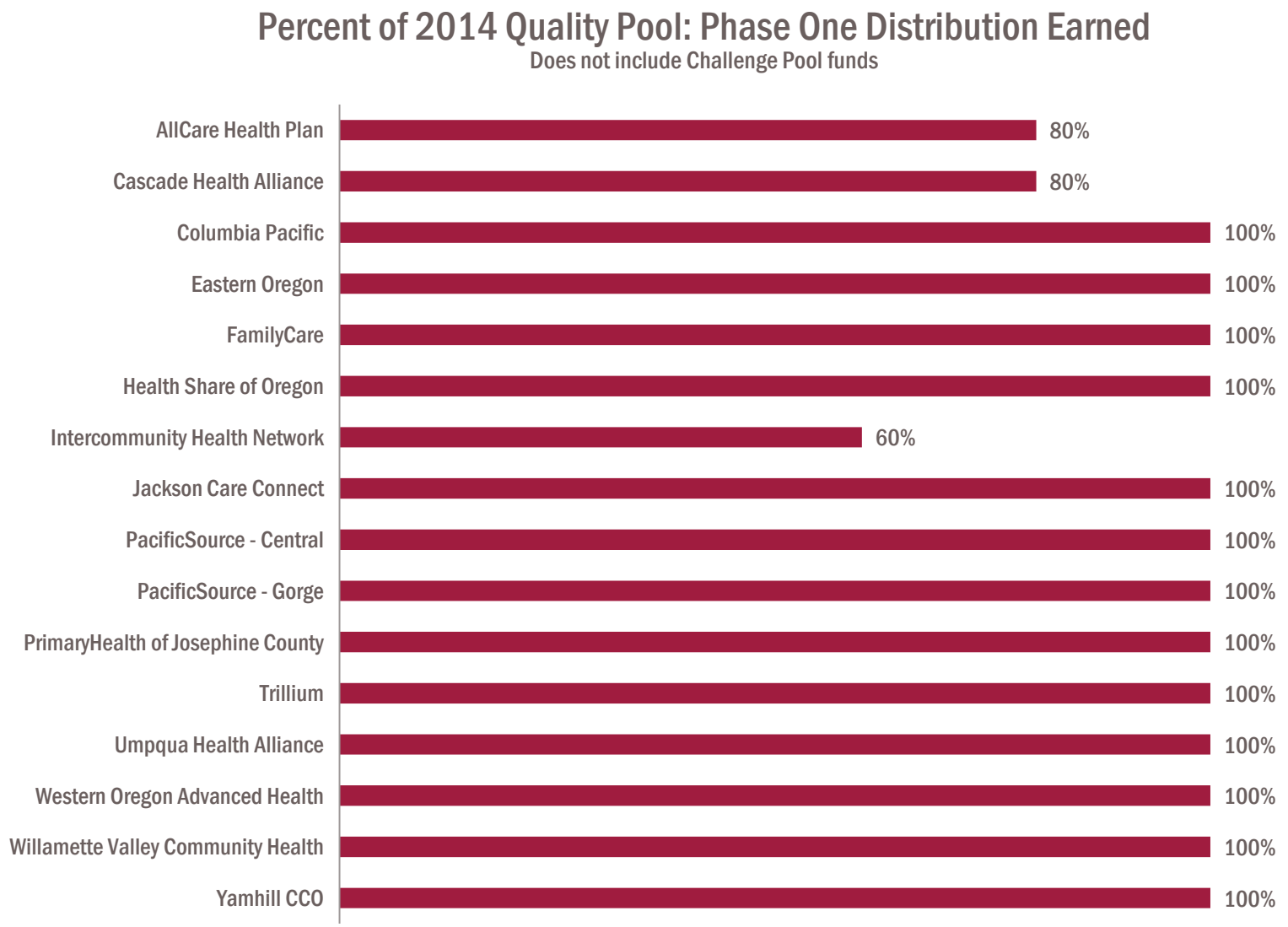
2014 CCO PERFORMANCE AND QUALITY POOL DISTRIBUTION

Coordinated Care Organization	Number of measures met*	Percent of quality pool funds earned†	Total dollar amount earned	CCO enrollment°	Which challenge pools measures were met
AllCare Health Plan	11.7	83 %	$ 6,170,421	47,178	Diabetes, PCPCH, SBIRT
Cascade Health Alliance	11.7	84 %	$ 1,423,801	15,636	Depression, Diabetes, PCPCH
Columbia Pacific	13.9	104 %	$ 4,247,607	25,530	Depression, Diabetes, PCPCH, SBIRT
Eastern Oregon	12.6	103 %	$ 6,847,819	44,801	Diabetes, PCPCH, SBIRT
FamilyCare	13.8	105 %	$ 17,157,018	110,324	Depression, Diabetes, PCPCH, SBIRT
Health Share of Oregon	16.8	105 %	$ 34,592,657	225,068	Depression, Diabetes, PCPCH, SBIRT
Intercommunity Health Network	9.9	62 %	$ 5,310,493	52,742	Diabetes, PCPCH
Jackson Care Connect	13.8	103 %	$ 4,704,838	27,828	Diabetes, PCPCH, SBIRT
PacificSource - Central Oregon	12.9	104 %	$ 8,177,907	50,875	Depression, Diabetes, PCPCH
PacificSource - Gorge	13.0	105 %	$ 1,872,161	12,244	Depression, Diabetes, PCPCH, SBIRT
PrimaryHealth of Josephine County	16.0	105 %	$ 1,601,588	10,565	Depression, Diabetes, PCPCH, SBIRT
Trillium	13.6	103 %	$ 12,658,814	72,187	Diabetes, PCPCH, SBIRT
Umpqua Health Alliance	12.9	104 %	$ 4,491,875	25,195	Depression, Diabetes, PCPCH, SBIRT
Western Oregon Advanced Health	12.8	103 %	$ 3,449,486	19,614	Diabetes, PCPCH, SBIRT
Willamette Valley Community Health	14.9	104 %	$ 12,802,864	93,357	Diabetes, PCPCH, SBIRT
Yamhill CCO	12.7	105 %	$ 2,981,967	20,753	Depression, Diabetes, PCPCH, SBIRT

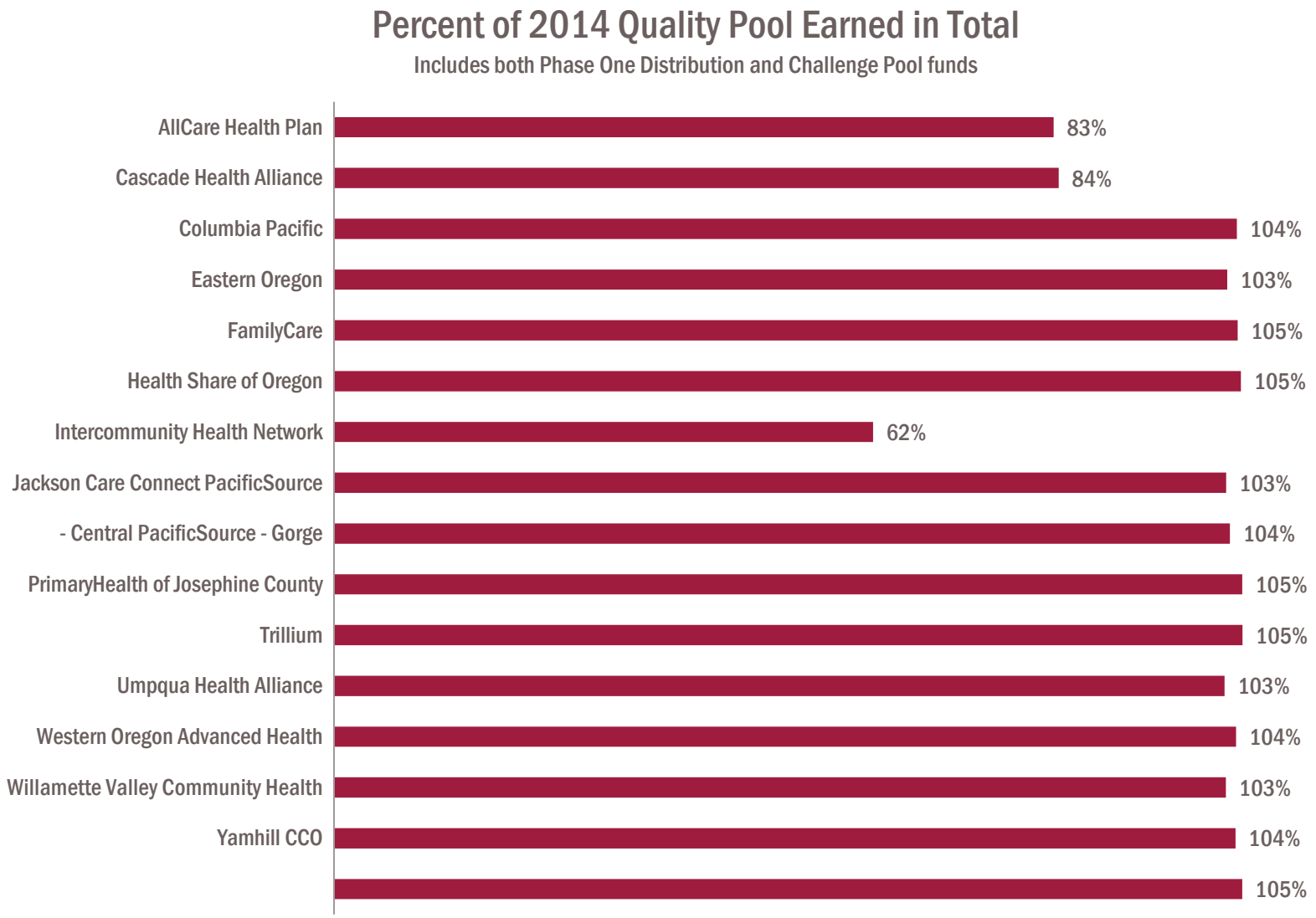
*Out of 17 total CCO incentive measures.
† Includes both phase one distribution and challenge pool.
°CCO enrollment as of December 2014.

The 2014 quality pool distribution methodology is published online at: www.oregon.gov/oha/analytics/CCOData/2014 Reference Instructions.pdf

2014 CCO PERFORMANCE AND QUALITY POOL DISTRIBUTION



2014 CCO PERFORMANCE AND QUALITY POOL DISTRIBUTION



2014 CCO PERFORMANCE AND QUALITY POOL DISTRIBUTION

2014 Incentive Measures

The 17 incentive measures were chosen in an open and public process by the Metrics and Scoring Committee and approved by the Centers for Medicare and Medicaid Services (CMS) as part of Oregon's 1115 demonstration waiver. Challenge pool measures are marked with an asterisk below:

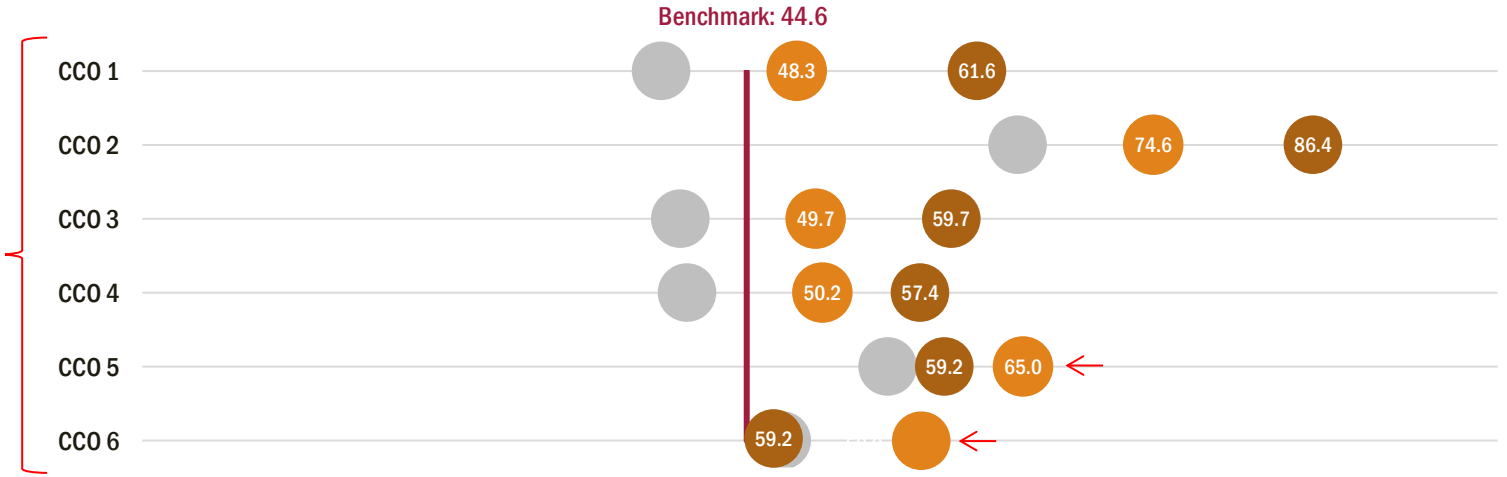
- Access to care (CAHPS)
- Adolescent well-care visits
- Alcohol and other substance misuse screening (SBIRT)*
- Ambulatory care: emergency department utilization
- Colorectal cancer screening
- Controlling hypertension
- Depression screening and follow-up plan*
- Developmental screenings in the first 36 months of life
- Diabetes HbA1c poor control*
- Early elective delivery
- Electronic health record (EHR) adoption
- Follow-up after hospitalization for mental illness
- Follow-up for children prescribed ADHD medication (initiation phase)
- Mental and physical health assessments for children in DHS custody
- Patient-centered primary care home (PCPCH) enrollment
- Prenatal and postpartum care: timeliness of prenatal care
- Satisfaction with care (CAHPS)

Additional information about these measures can be found online at www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx.
Information about the Metrics and Scoring Committee can be found online at www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx

HOW TO READ THESE GRAPHS

[Descriptive title] between 2013 & 2014.

Categories are sorted by amount of change between 2013 and 2014. That is, the CCOs with the most improvement in 2014 are listed first.



Arrows highlight negative change* (away from the benchmark).
**Changes between years have not been measured for statistical significance.*

Icons

To help readers identify which metrics belong in which measure set, each metric is accompanied by up to three icons that denote the measure set:

This icon indicates the measure is one of the 17 CCO incentive metrics. CCOs receive quality pool funding based on their performance on these measures.

This icon indicates the measure is one of the 33 state performance metrics (also known as quality and access metrics). OHA is accountable to the Center for Medicare and Medicaid Services (CMS) for statewide performance on these metrics.

This icon indicates the measure is one of the core performance metrics. There are no financial incentives or penalties for performance on these measures.

ACCESS TO CARE (CAHPS)

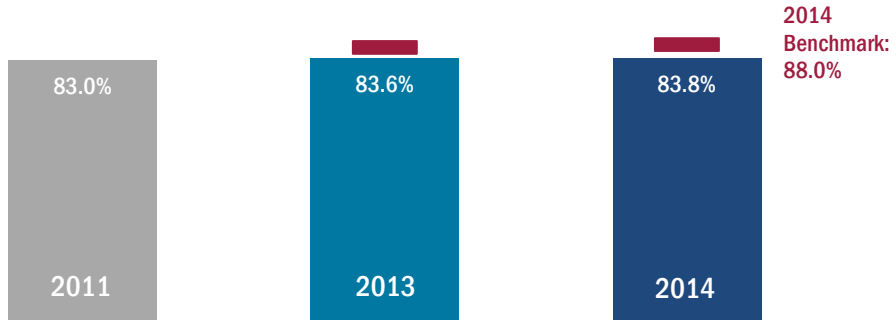
Access to care (CAHPS)

Measure description: Percentage of members (adults and children) who thought they received appointments and care when they needed them.

Purpose: Improving access to timely care and information helps increase the quality of care and reduce costs. Measuring access to care is also an important part of identifying disparities in health care and barriers to quality care, including a shortage of providers, lack of transportation, or long waits to get an appointment.

Statewide, members overall reported their access to care improved slightly in 2014.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: average of the 2013 national Medicaid 75th percentiles for adults and children

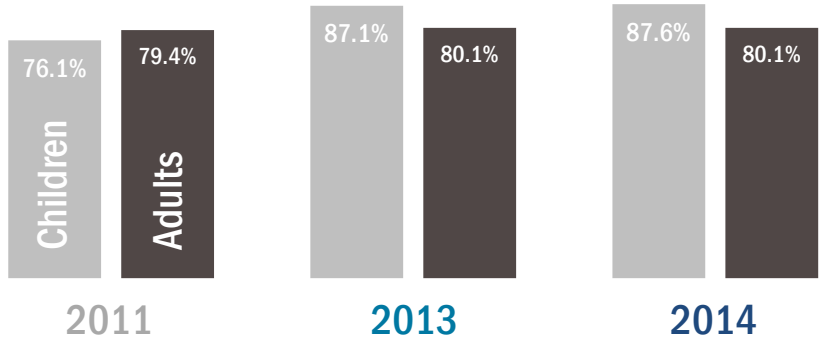


2014 data

Statewide, the percentage of individuals reporting they were able to access care quickly when they needed it remained steady. Parents report their children have greater access to care than adults report they do across all racial and ethnic groups. Performance among CCOs was fairly consistent, ranging from a low of 79.3 percent to a high of 90.0 percent. Half of CCOs improved their performance in 2014, four CCOs met their improvement target, and one CCO met the benchmark.

Access to care statewide results: children versus adults.

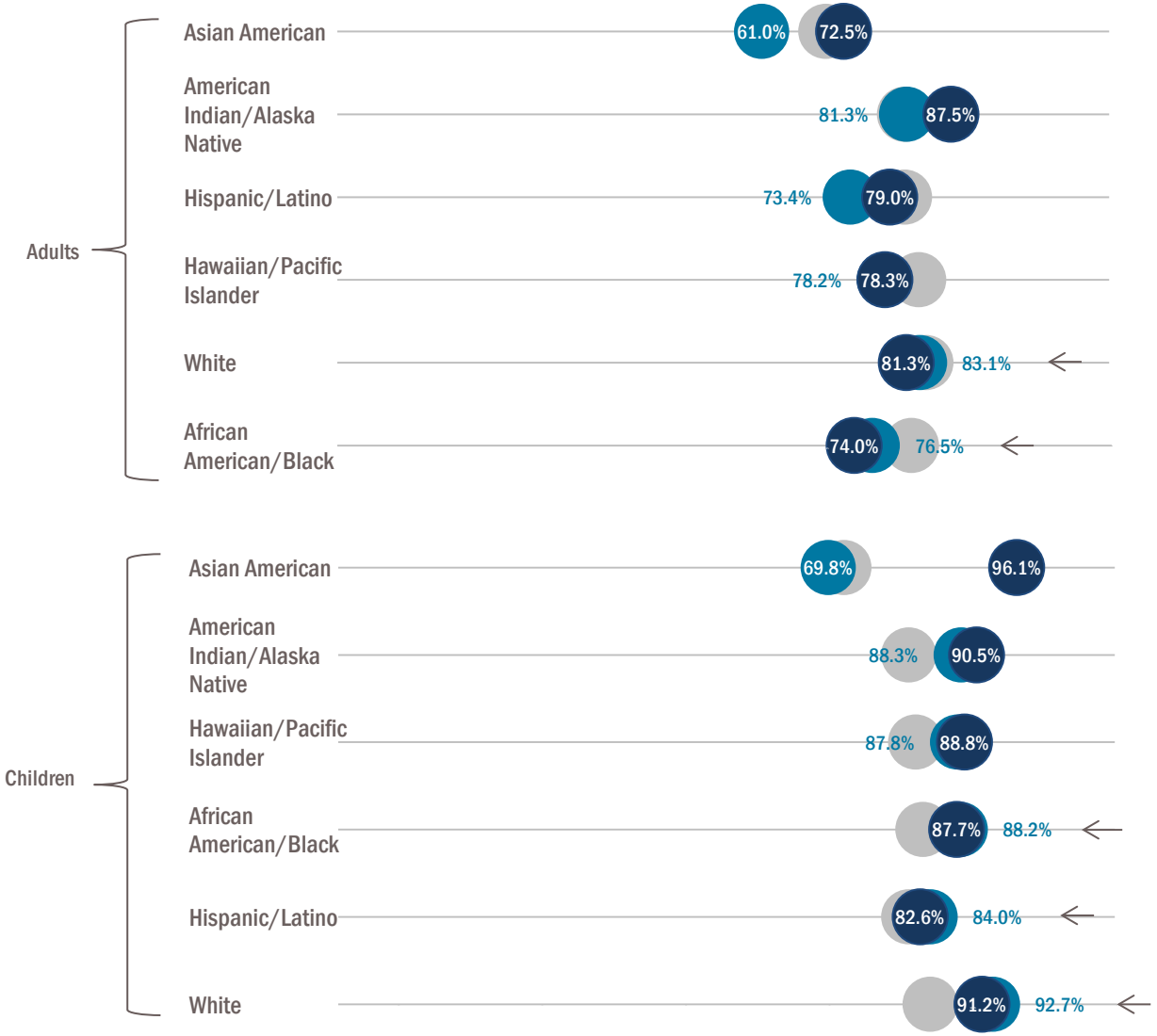
Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)



ACCESS TO CARE (CAHPS)

Asian American members reported the greatest improvement in access to care between 2013 and 2014.

Gray dots represent 2011.
Data missing for 9.2% of adults and 8.5% of children. Each race category excludes Hispanic/Latino.



ACCESS TO CARE (CAHPS)

Members in half of 16 CCOs reported improved access to care between 2013 and 2014.

Bolded names met benchmark or improvement target.
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

ADOLESCENT WELL-CARE VISITS

Adolescent well-care visits

Measure description: Percentage of adolescents and young adults (ages 12-21) who had at least one well-care visit during the year.

Purpose: Youth who can easily access preventive health services are more likely to be healthy and able to reach milestones such as high school graduation and entry into the work force, higher education, or military service.

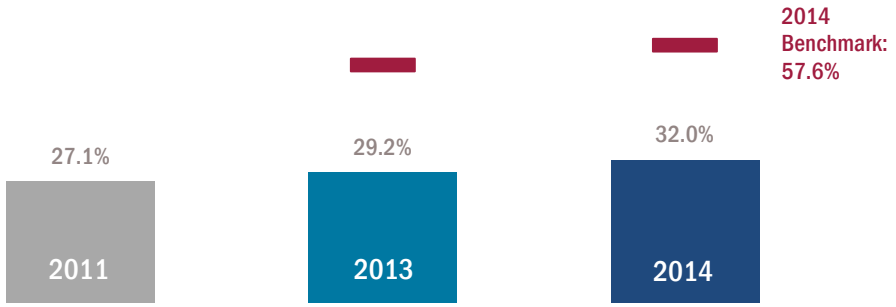
2014 data (n=121,714)

Statewide results continued to improve from 2013 to 2014, reaching 32.0 percent, but remained well below the benchmark. Well-care visits increased for all races and ethnicities, and 13 of 16 CCOs improved performance on this measure in 2014. However, only five CCOs achieved their improvement target or benchmark. There remains much room for improvement on this measure.

Barriers to improvement may include providers performing (and billing for) acute care visits and sports physical exams when a patient would benefit from comprehensive well care, cultural shifts, changes in recommendations for clinical care, and concerns about confidentiality of sensitive services. In addition, visits occurring in school-based health clinics may not be captured in the data.

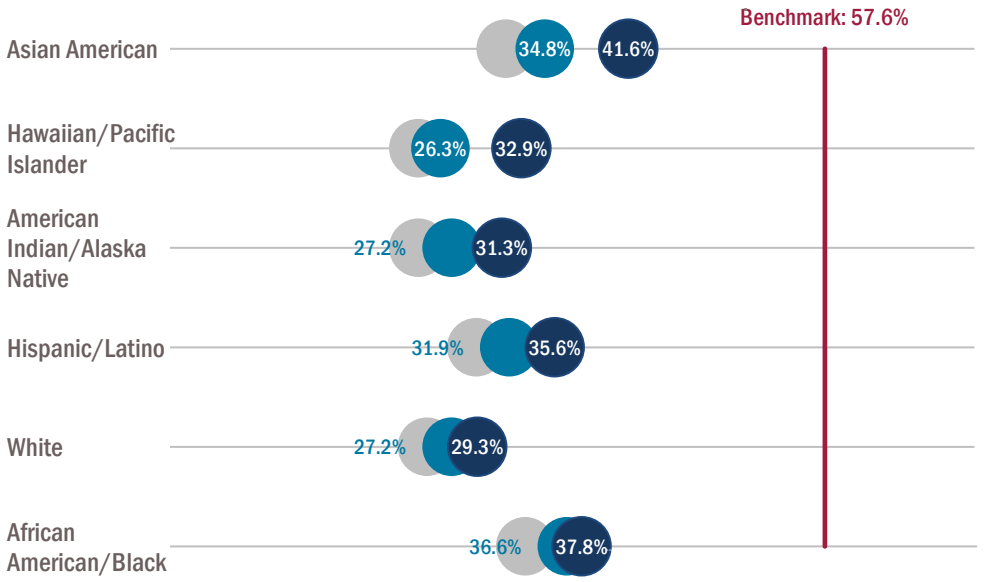
Statewide, the percentage of adolescents receiving a well-care visit increased slightly in 2014.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 75th percentile (administrative data only)



Adolescent well-care visits increased across all races and ethnicities between 2013 and 2014.

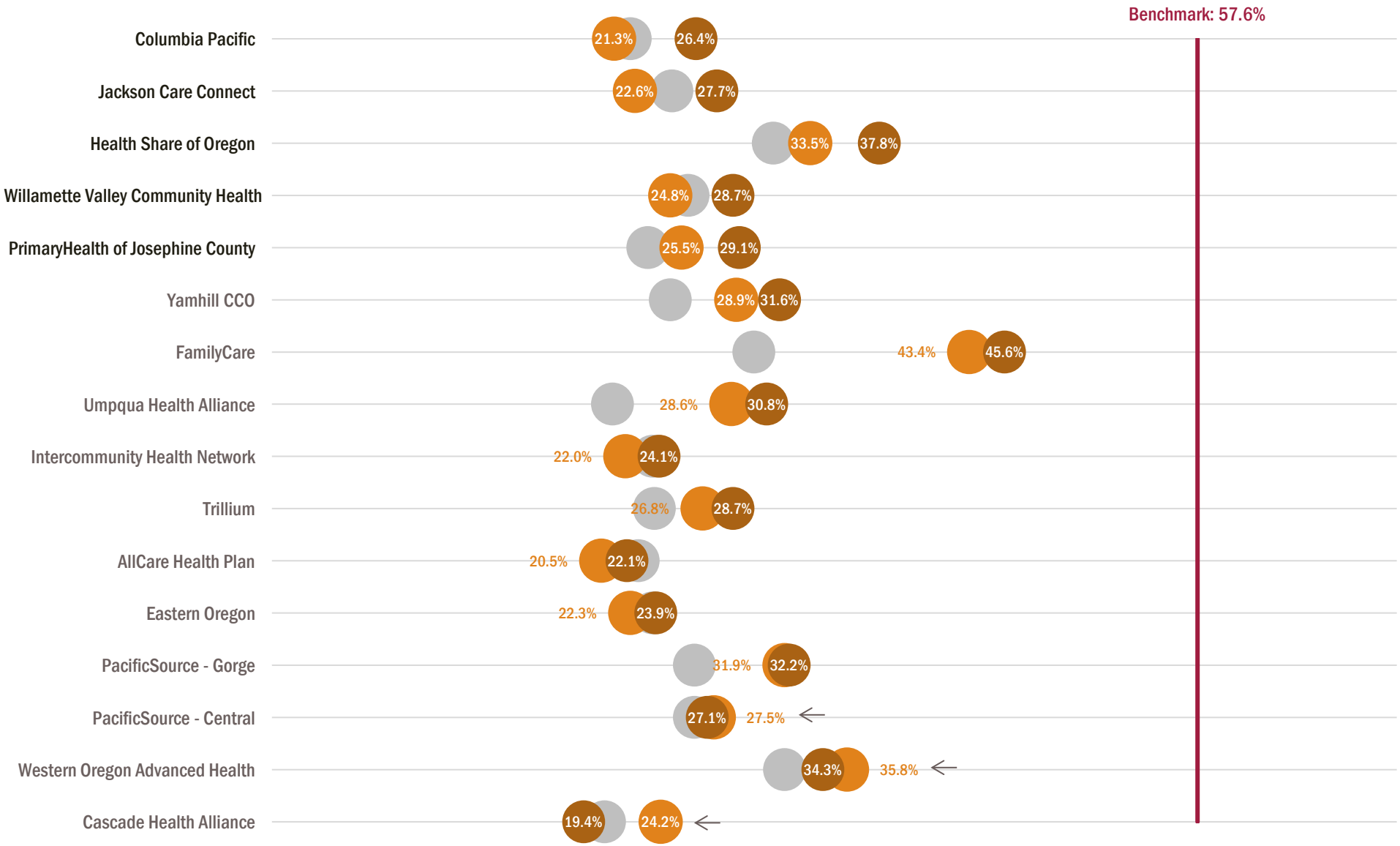
Gray dots represent 2011. Data missing for 8.5% of respondents. Each race category excludes Hispanic/Latino.



ADOLESCENT WELL-CARE VISITS

Thirteen of 16 CCOs increased adolescent well-care visits between 2013 and 2014, although none reached the benchmark.

Bolded names met benchmark or improvement target.
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT)

Screening for alcohol or other substance misuse (SBIRT)

Measure description: The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of adult members (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse.

Purpose: By offering a simple but effective screening for alcohol or drug abuse during an office visit, providers can help patients get the care and information they need to stay healthy. If risky drinking or drug use is detected, a brief intervention, and in some cases referral to additional treatment, helps the patient recover more quickly and avoid serious health problems.

2014 data (n=374,481)

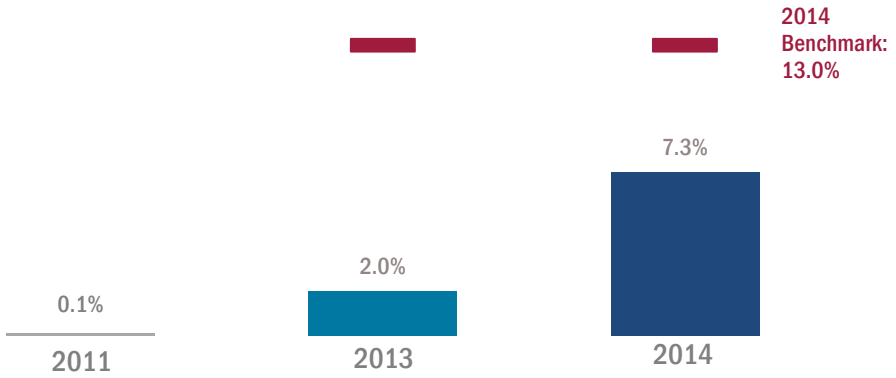
Performance on screening and brief intervention for alcohol or other substance misuse (SBIRT) increased greatly from 2013 to 2014. Statewide, performance improved from 2.0 percent to 7.3 percent, still well below the benchmark of 13.0 percent.

Screening for alcohol or other substance misuse increased across all races and ethnicities. The African American population saw the greatest increase, from 1.7 percent in 2013 to 7.2 percent in 2014. Fifteen CCOs improved their performance in 2014 and 13 met their improvement target or benchmark.

Beginning in 2015, adolescents will be included in this measure.

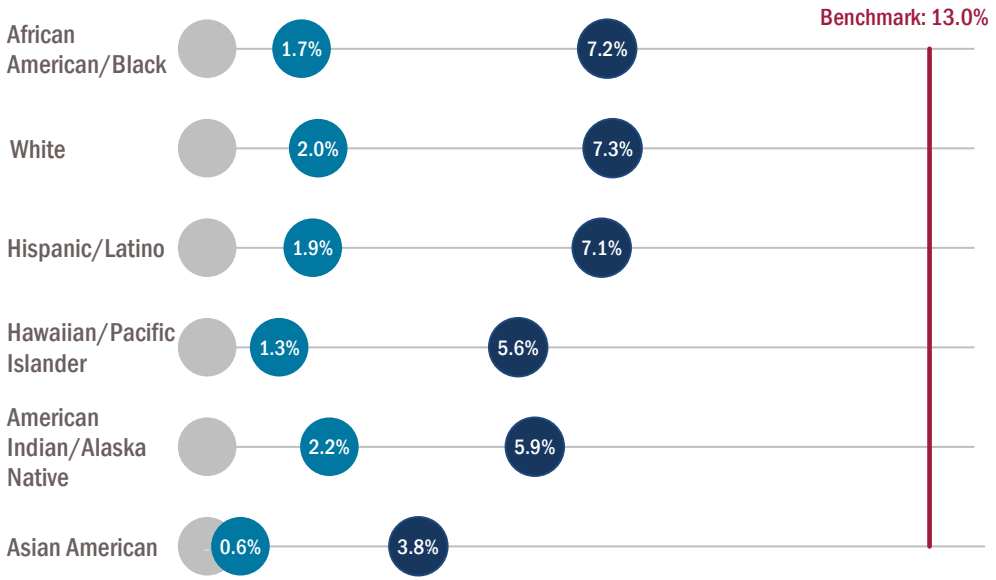
Statewide, screening for alcohol or other substance misuse increased substantially in 2014.

Data source: Administrative (billing) claims
2014 benchmark source: Metrics and Scoring Committee consensus



SBIRT increased across all races and ethnicities between 2013 and 2014.

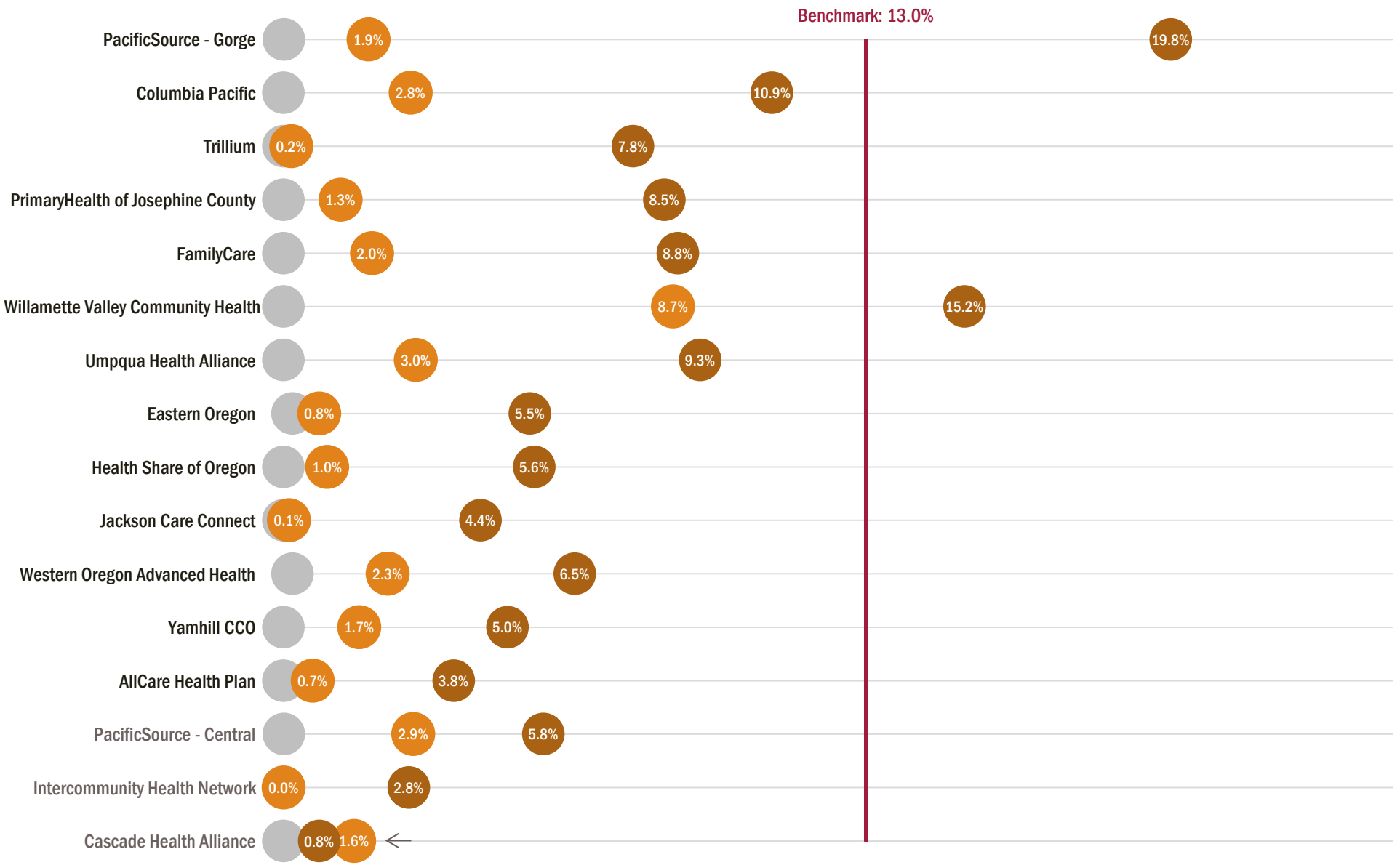
Gray dots represent 2011. Data missing for 10.3% of respondents. Each race category excludes Hispanic/Latino.



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT)

CCOs improved markedly on SBIRT between 2013 and 2014, and two achieved the benchmark.

Bolded names met benchmark or improvement target.
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



ALL-CAUSE READMISSION

All-cause readmission

Measure description: Percentage of adult members (ages 18 and older) who had a hospital stay and were readmitted for any reason within 30 days of discharge. A lower score for this measure is better.

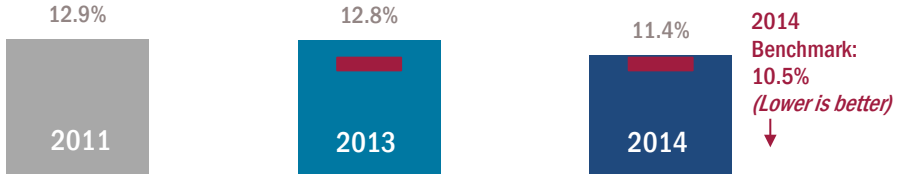
Purpose: Some patients who leave the hospital end up being admitted again shortly thereafter. Often, these costly and burdensome "readmissions" are avoidable. Reducing the preventable problems that send patients back to the hospital is the best way to keep patients at home and healthy.

2014 data (n=26,433)

Statewide, all-cause readmissions declined from 2013 to 2014, reaching 11.4 percent and approaching the benchmark of 10.5 percent. Lower is better for this measure. Readmissions improved in 13 of 16 CCOs and for all races and ethnicities except Hawaiian / Pacific Islander.

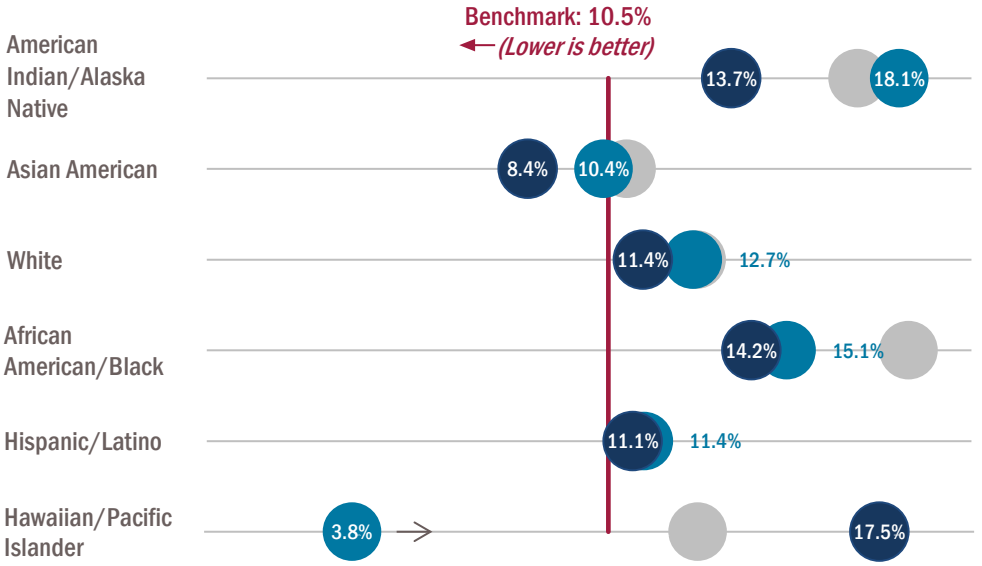
Statewide, all-cause readmissions improved in 2014.

Data source: Administrative (billing) claims
2014 benchmark source: Average of 2012 Commercial and Medicare 75th percentiles



Readmissions improved for all races and ethnicities except Hawaiian/ Pacific Islander between 2013 and 2014.

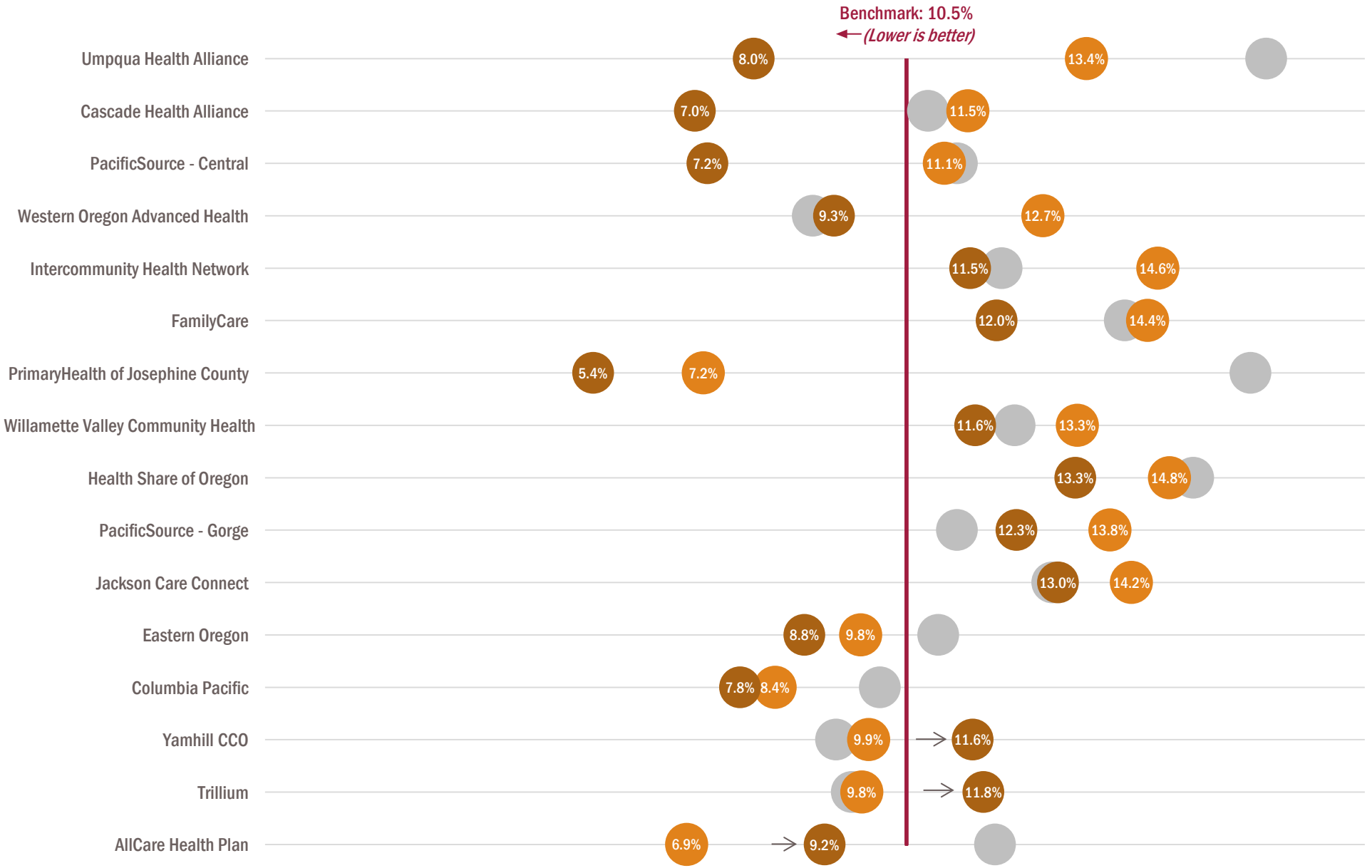
Gray dots represent 2011. Data missing for 6.6% of respondents. Each race category excludes Hispanic/Latino. 2011 and 2013 data have been updated and may differ from earlier reports.



ALL-CAUSE READMISSION

Thirteen of 16 CCOs reduced all-cause readmissions between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined. 2011 and 2013 data have been updated and may differ from earlier reports.



AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Ambulatory care: emergency department utilization

Measure description: Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of this care.

Purpose: Emergency departments are sometimes used for problems that could have been treated at a doctor's office or urgent care clinic. Reducing inappropriate emergency department use can help to save costs and improve the health care experience for patients.

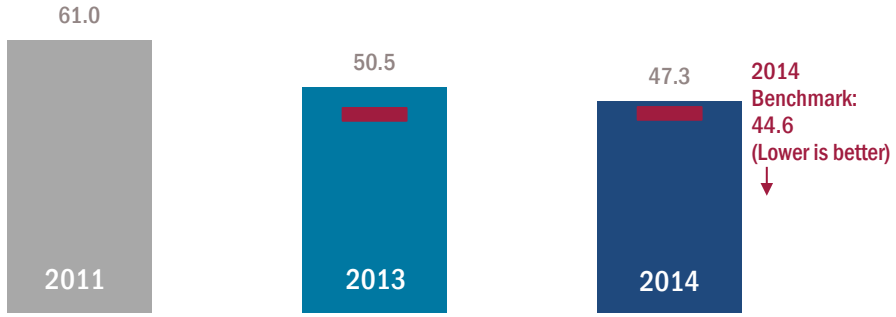
2014 data (n=9,707,039 member months)

Emergency department utilization continues to decline overall. In 2014, statewide emergency department utilization was 47.3 per 1,000 member months, approaching the benchmark of 44.6. Lower is better for this measure. There is wide variation in utilization by race and ethnicity: emergency department utilization is lowest for the Asian American population at 20.7 per 1,000 member months and highest for the African American/Black population at 66.6 per 1,000 member months. Twelve CCOs improved their performance from 2013 to 2014 and 14 met their improvement target or benchmark.

The continued reduction in emergency department visits is exciting news. Despite a 60 percent increase in enrollment from the Medicaid expansion, new members are not using the emergency department at high rates (see pages 103-104 for more information about emergency department visits and Medicaid membership).

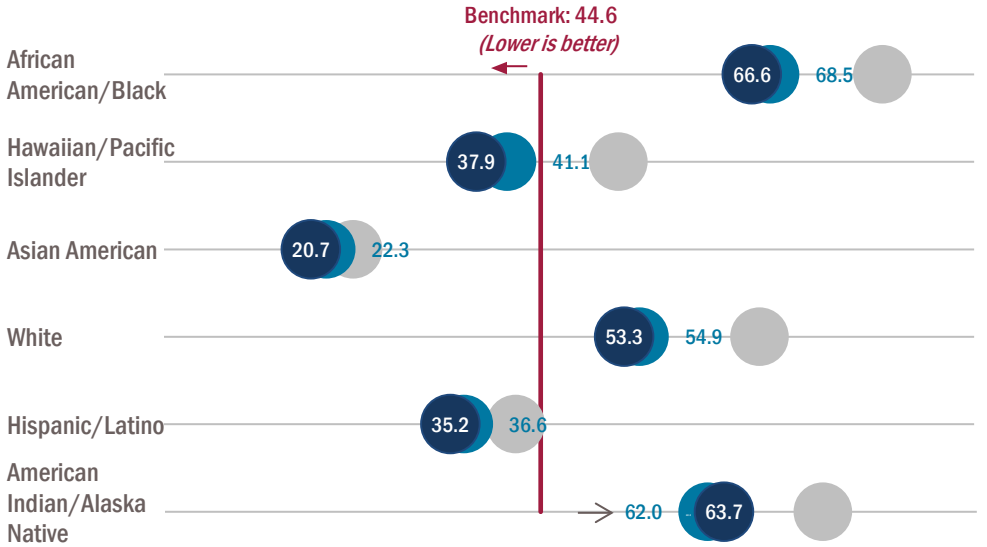
Statewide, emergency department utilization continued to decline.

Per 1,000 member months
Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 90th percentile



Emergency department utilization decreased for all races and ethnicities except American Indian/Alaska Native between 2013 and 2014.

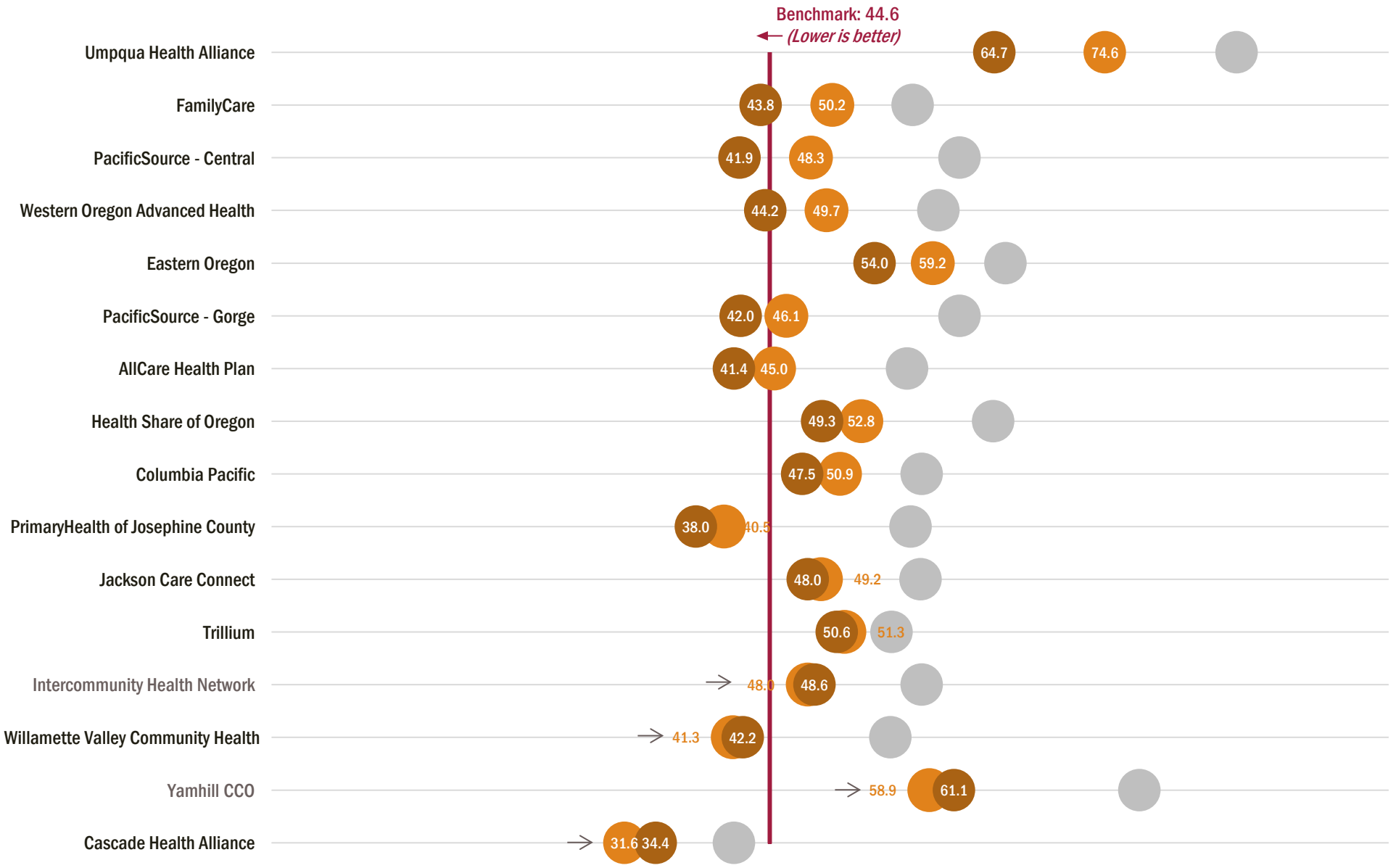
Gray dots represent 2011. Data missing for 10.9% of respondents. Each race category excludes Hispanic/Latino.



AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Twelve of 16 CCOs reduced emergency department utilization between 2013 and 2014.

Per 1,000 member months
Bolded names met benchmark or improvement target.
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization

Measure description: Rate of patient visits to an emergency department for conditions that could have been more appropriately managed by or referred to a primary care provider in an office or clinic setting.

Rates are derived from the ambulatory care: emergency department utilization measure and are reported per 1,000 member months. A lower number suggests more appropriate emergency department utilization.

Purpose: Many patients use emergency departments for conditions that could be treated, or prevented, in a different care setting. Reducing avoidable emergency department utilization is an opportunity to improve care coordination, address high utilization, and explore innovative programs such as health navigators.

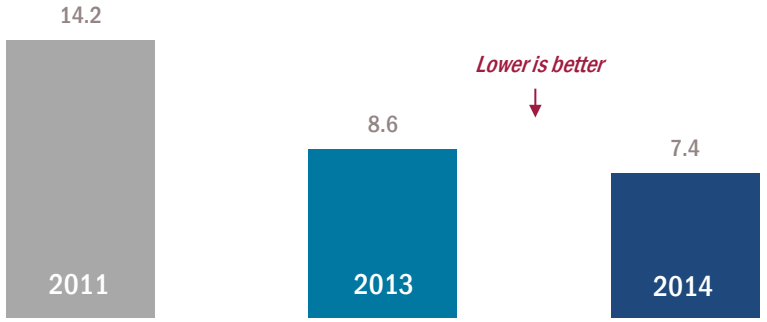
2014 data (n=9,707,039 member months)

Avoidable emergency department visits improved markedly between 2011 and 2014 with an almost 50 percent reduction. Despite a 60 percent increase in enrollment from the Medicaid expansion in 2014, new members are not using the emergency department at high rates for conditions that could be treated in a primary care setting (see pages 105-106 for more information about avoidable emergency department visits and Medicaid membership).

Avoidable emergency department visits improved across all racial and ethnic populations and 15 of 16 CCOs, reflecting the statewide focus on providing the right care, in the right setting, at the right time.

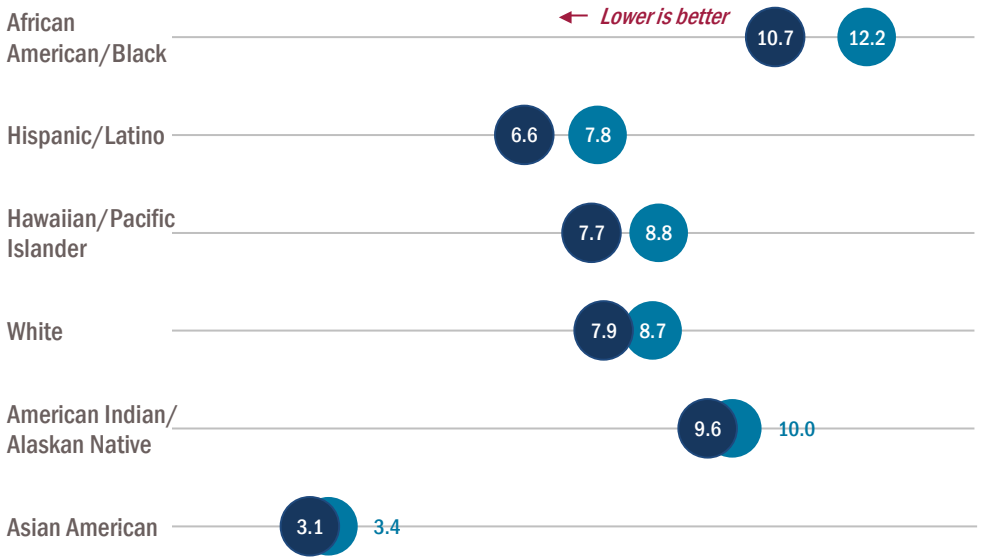
Statewide, avoidable emergency department utilization declined by almost half since 2011.

Per 1,000 member months
Data source: Administrative (billing) claims



Avoidable emergency department utilization rates improved for everybody between 2013 and 2014.

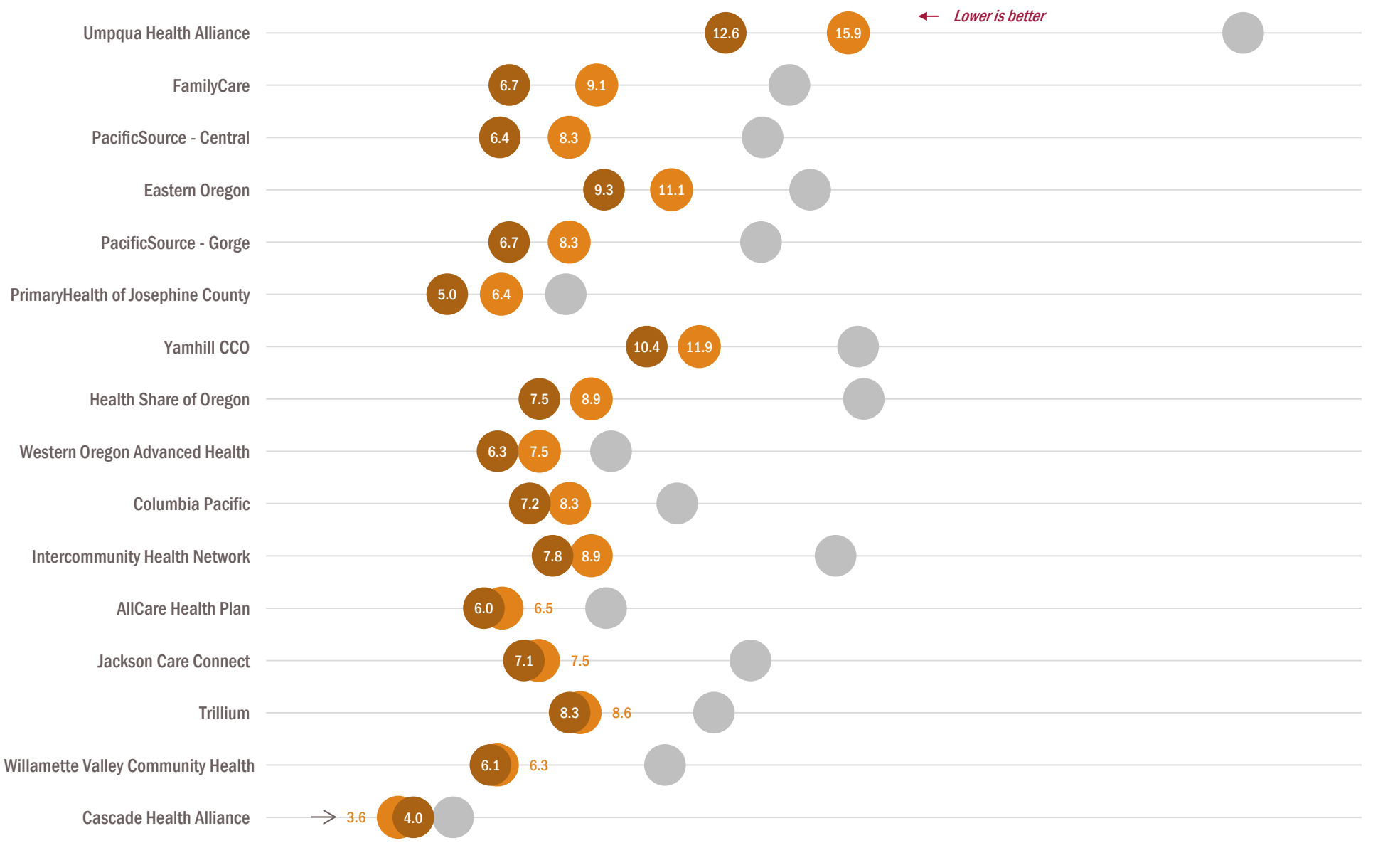
Data missing for 10.9% of respondents. Each race category excludes Hispanic/Latino.



AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization improved in 15 of 16 CCOs between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



AMBULATORY CARE: OUTPATIENT UTILIZATION

Ambulatory care: outpatient utilization

Measure description: Rate of outpatient services, such as office visits, home visits, nursing home care, urgent care and counseling or screening services. Rates are reported per 1,000 member months.

Purpose: Promoting the use of outpatient settings such as a doctor's office or urgent care clinic is part of Oregon's goal of making sure patients are getting the right care in the right places and at the right times. Increasing the use of outpatient care helps improve health and lower costs by promoting prevention and keeping down rates of unnecessary emergency department use.

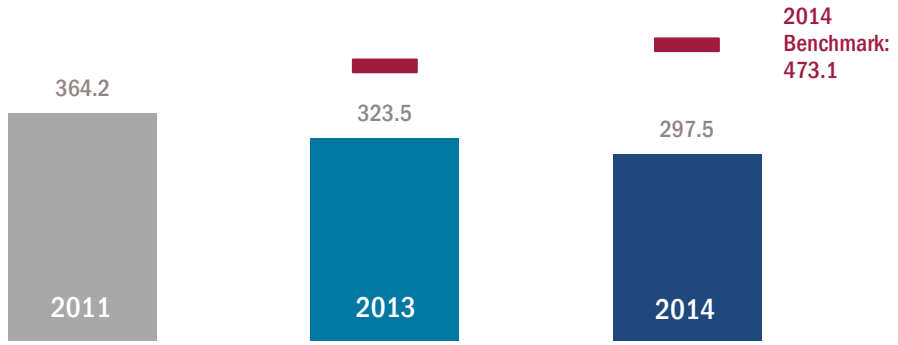
2014 data (n=9,707,039 member months)

There has been a consistent downward trend since 2011 in the rate of outpatient visits. Outpatient visits have declined for all races and ethnicities and have either declined or remained steady across all CCOs.

The denominator (member months) increased by nearly 50 percent in 2014 due to the ACA expansion. The addition of this new population could be affecting access to care, causing a reduction in outpatient utilization.

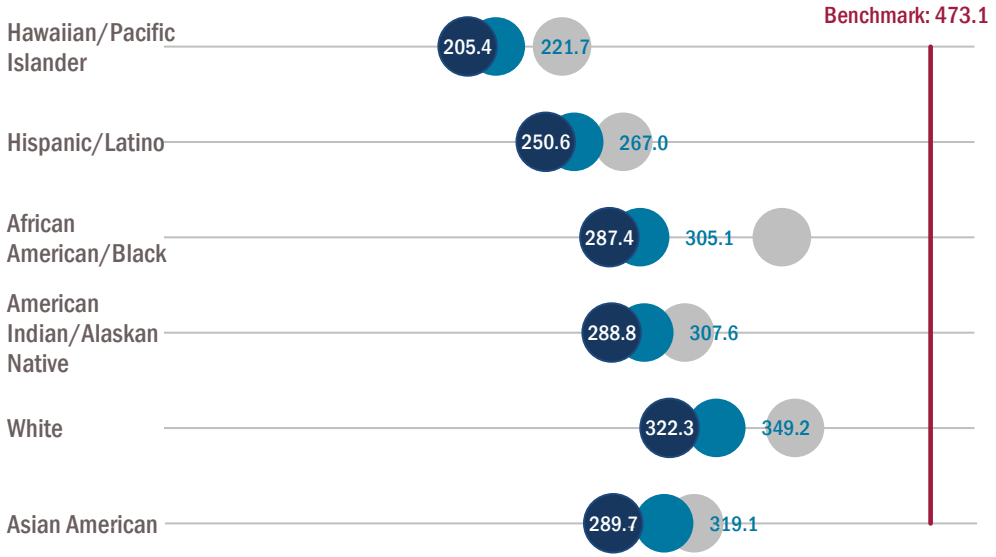
Statewide, outpatient ambulatory care rates declined each year.

Per 1,000 member months
Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 90th percentile



Outpatient visits declined for all races and ethnicities between 2013 and 2014.

Gray dots represent 2011. Data missing for 10.9% of respondents. Each race category excludes Hispanic/Latino.

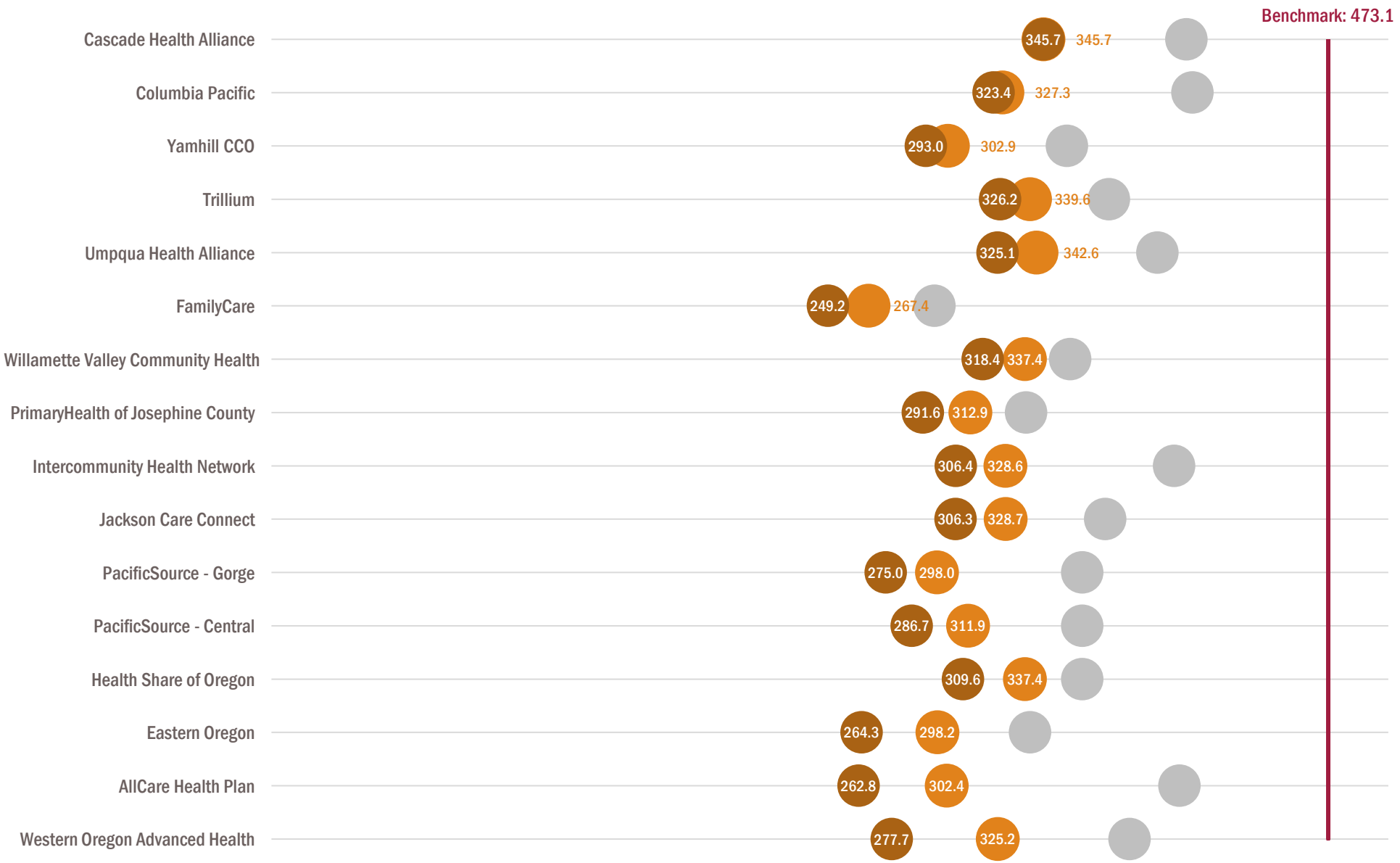


AMBULATORY CARE: OUTPATIENT UTILIZATION

Outpatient ambulatory care rates declined at a slower rate between 2013 and 2014 than in previous years.

Per 1,000 member months

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Appropriate testing for children with pharyngitis

Measure description: Percentage of children with a sore throat (pharyngitis) who were given a strep test before getting an antibiotic.

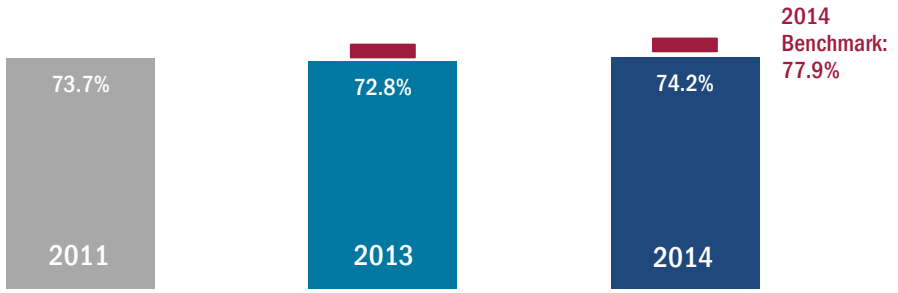
Purpose: A strep test helps determine whether or not a child will benefit from antibiotics for a sore throat (pharyngitis). This test can help reduce the overuse of antibiotics, which can improve care quality and ensure that antibiotics continue to work when they are needed.

2014 data (n=7,975)

After decreasing between 2011 and 2013, statewide results improved in 2014. However, results statewide and for all races and ethnicities remain below the national benchmark. CCO performance was mixed, with nine of 16 CCOs showing improvement between 2013 and 2014. Six of 16 CCOs met the benchmark.

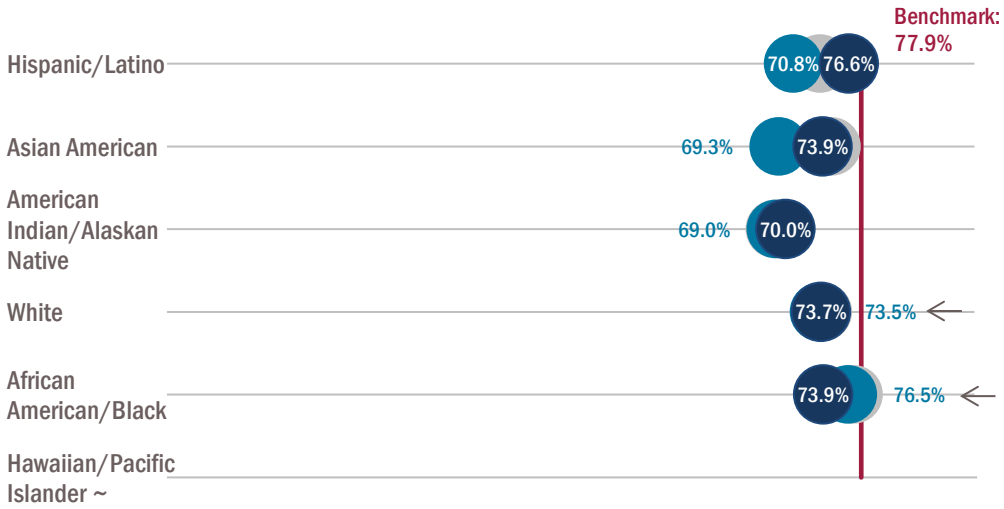
Statewide, appropriate testing for pharyngitis improved in 2014.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 75th percentile



Hispanic/Latino members experienced the greatest improvement in appropriate pharyngitis testing between 2013 and 2014.

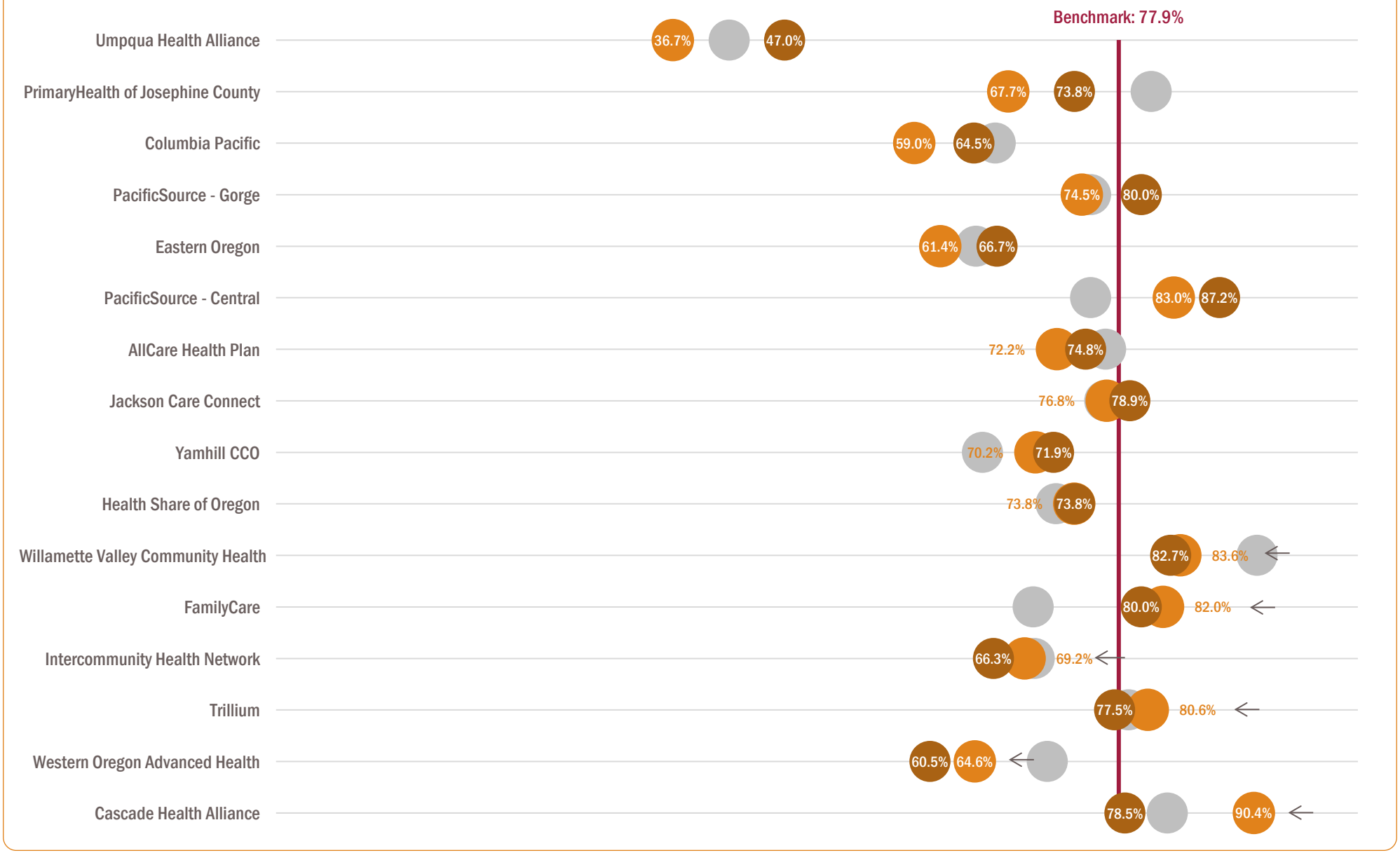
Gray dots represent 2011. Data missing for 9.6% of respondents. Each race category excludes Hispanic/Latino.
~ Data suppressed (n<30)



APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Nine of 16 CCOs improved appropriate testing for children with pharyngitis between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



CERVICAL CANCER SCREENING

Cervical cancer screening

Measure description: Percentage of women (ages 21 to 64) who received one or more Pap tests for cervical cancer during the past three years.

Purpose: A Pap test helps find early signs of cancer in the cervix when the disease is easier and less costly to treat. Treating cervical cancer in its earliest stages also increases the five-year survival rate to 92 percent, according to the American Cancer Society.

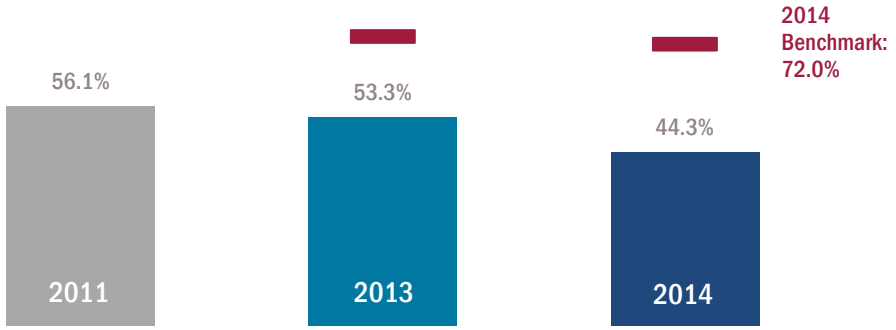
2014 data (n=133,531)

The percentage of women receiving cervical cancer screening continued to decline in 2014. Likewise, screening declined for all races and ethnicities, with the steepest decline occurring among the Hispanic/Latino population.

The decreased screening may be due to a number of factors, including changes in national guidelines reported in 2012, which recommend women wait three to five years between Pap tests (his report only looks at tests within a three-year period). Decreased screening also may be due to new members who gained coverage in 2014 and have not been screened.

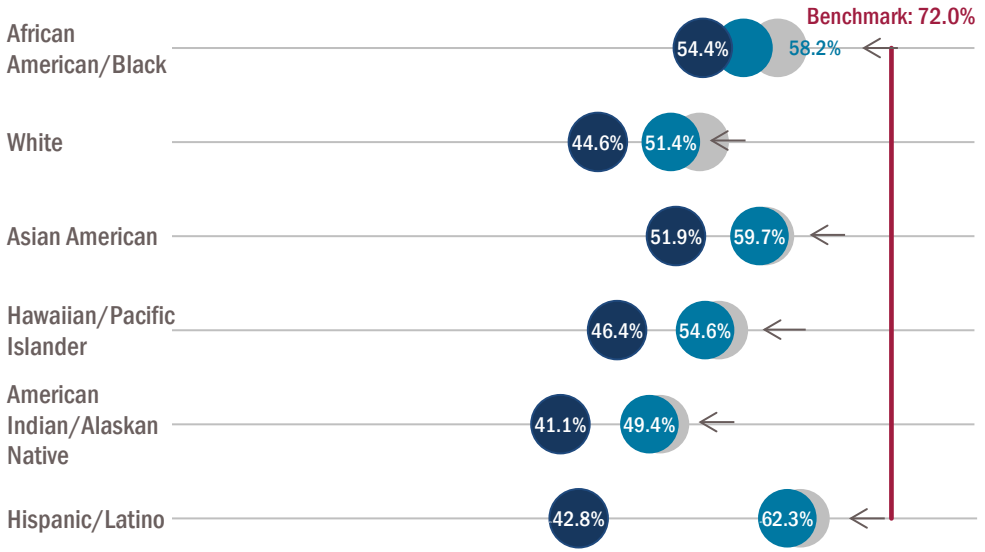
Statewide, cervical cancer screening has declined.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 75th percentile



Cervical cancer screening declined for all races and ethnicities between 2013 and 2014.

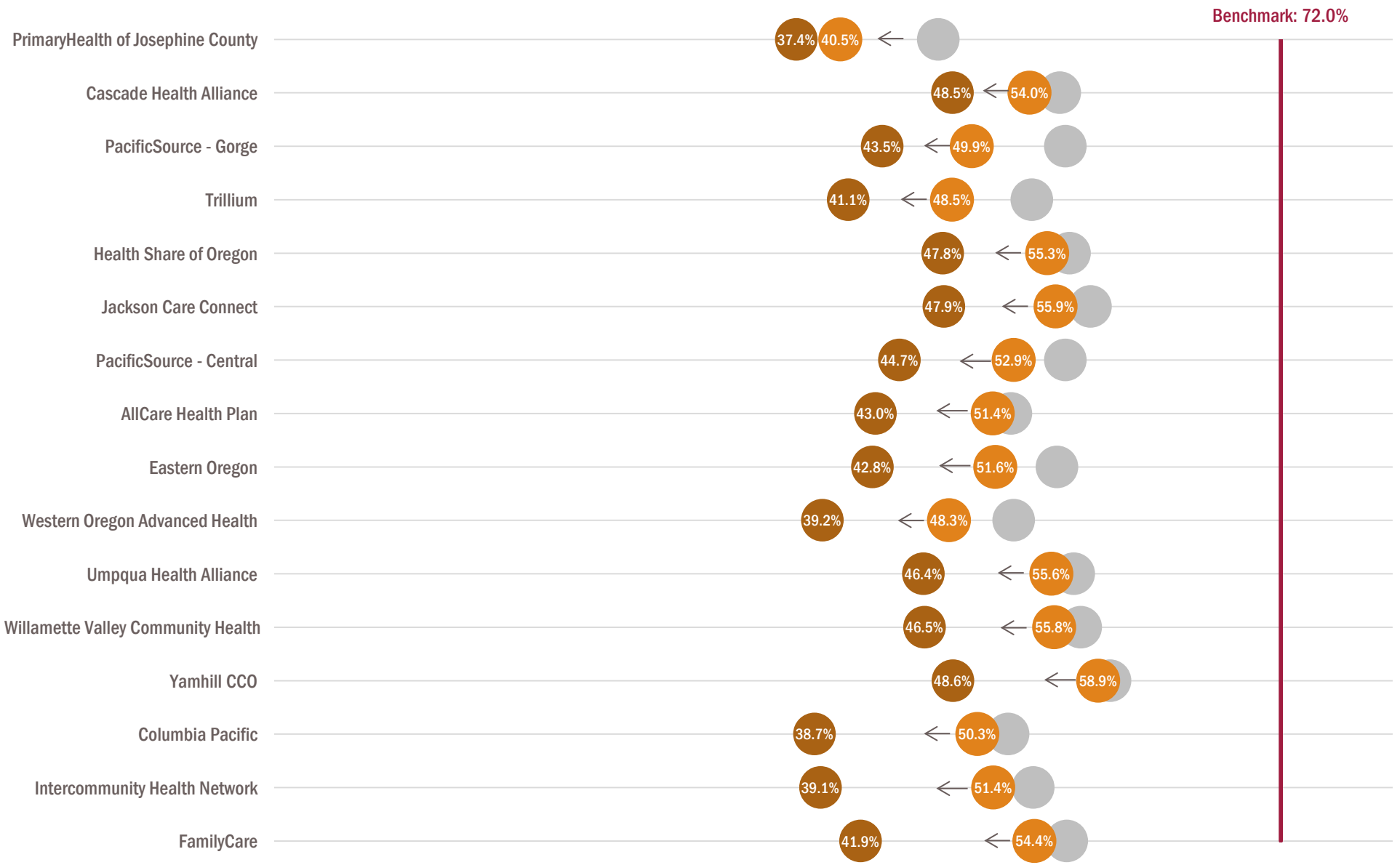
Gray dots represent 2011. Data missing for 9.4% of respondents. Each race category excludes Hispanic/Latino.



CERVICAL CANCER SCREENING

All CCOs experienced a reduction in cervical cancer screening between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (ALL AGES)

Childhood and adolescent access to primary care providers (all ages)

Measure description: Percentage of children and adolescents (ages 12 months – 19 years) who had a visit with a primary care provider.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider ensure youth are receiving necessary services to support their development and health.

2014 data (n=326,370)

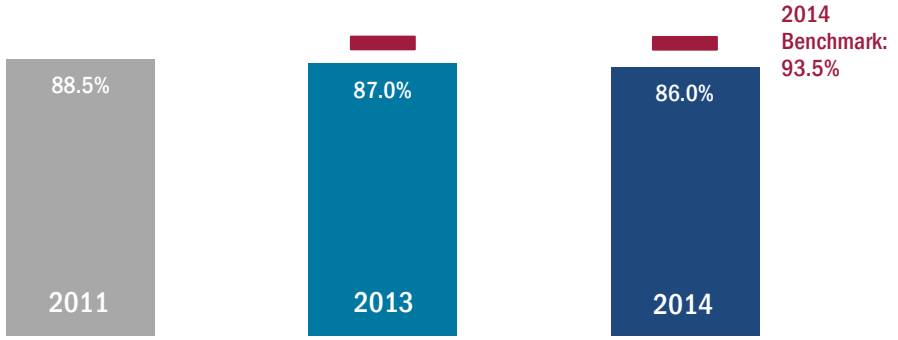
This measure tracks child and adolescent access to primary care providers by measuring the percentage of children who had a visit with a primary care provider during the past year. The measure is reported for all ages and four age ranges. This set of metrics is an area with opportunity for improvement because access to primary care providers has declined or remained steady across all age categories. In particular, the youngest children experienced the greatest decline, perhaps because new members who gained coverage in 2014 as part of the ACA expansion have not yet had a primary care visit.

Children ages 7-19 who are new to OHP are not included in the measure because the age group is required to be enrolled with a CCO for two continuous years

Data at the CCO level are not available for this measure.

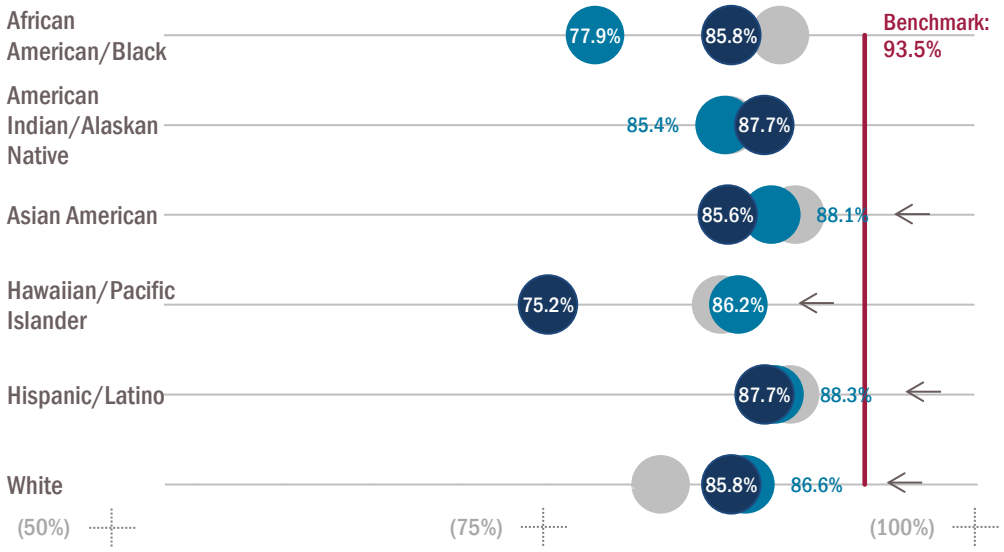
Statewide, access to primary care providers declined slightly for children and adolescents (all ages)

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 75th percentile (average of the four age breakouts for this measure



African American children and adolescents experienced the greatest improvement in access between 2013 and 2014.

Gray dots represent 2011. Data missing for 9.7% of respondents. Each race category excludes Hispanic/Latino.



CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (12-24 MONTHS)

Childhood and adolescent access to primary care providers (12-24 months)

Measure description: Percentage of children and adolescents (ages 12-24 months) who had a visit with a primary care provider.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

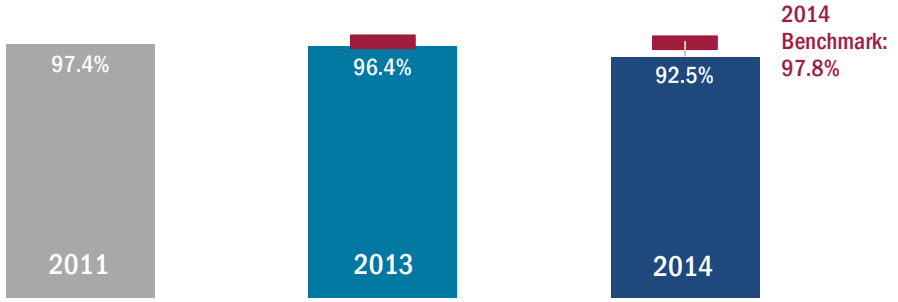
2014 data (n=25,390)

Access to primary care providers among children ages 12-24 months declined at a statewide level and among all racial and ethnic groups between 2013 and 2014. However, the benchmark, an indicator of national performance on this metric, also declined slightly. Access remained below the benchmark for all races and ethnicities in this age category.

Children who gained coverage in 2014 are included in the measure. Data at the CCO level are not available for this measure.

Statewide, access to primary care providers declined for children ages 12-24 months.

Data source: Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 75th percentile



Access declined for all races and ethnicities ages 12-24 months between 2013 and 2014.

Gray dots represent 2011. Data missing for 13.5% of respondents. Each race category excludes Hispanic/Latino.

CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (25 MONTHS-6 YEARS)

Childhood and adolescent access to primary care providers (25 months - 6 years)

Measure description: Percentage of children and adolescents (ages 25 months - 6 years) who had a visit with a primary care provider.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

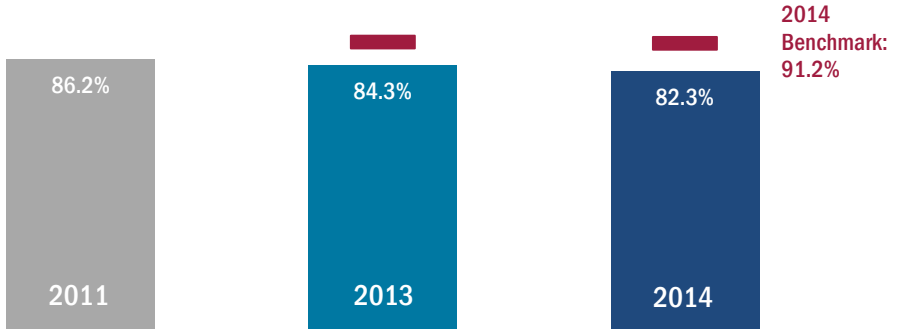
2014 data (n=112,308)

Access to primary care providers among children ages 25 months – 6 years declined at a statewide level and among all racial and ethnic groups between 2011, 2013, and 2014. However, the benchmark, an indicator of national performance on this metric, also declined slightly. All races and ethnicities were below the benchmark in 2014. Access remains particularly low among the Hawaiian/Pacific Islander population, with 70.0 percent of children in this age group visiting a primary care provider in 2014, compared to the benchmark of 91.2 percent.

Children who gained coverage in 2014 are included in the measure. Data at the CCO level are not available for this measure.

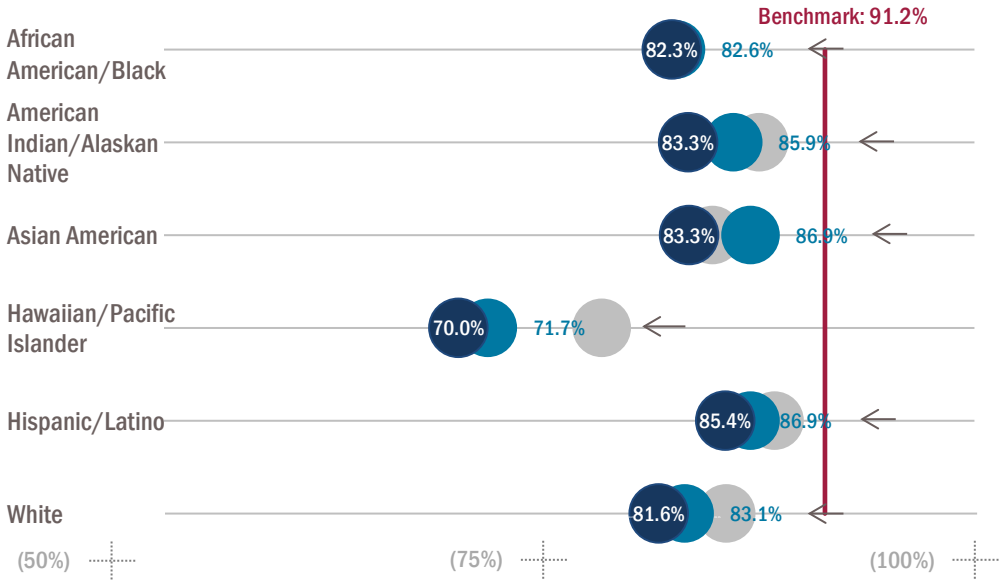
Statewide, access to primary care providers for children ages 25 months - 6 years declined.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 75th percentile



Access declined slightly for all races and ethnicities of children ages 25 months - 6 years between 2013 and 2014.

Gray dots represent 2011. Data missing for 11.4% of respondents. Each race category excludes Hispanic/Latino.



CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (7-11 YEARS)

Childhood and adolescent access to primary care providers (7-11 years)

Measure description: Percentage of children and adolescents (ages 7-11 years) who had a visit with a primary care provider.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

2014 data (n=83,330)

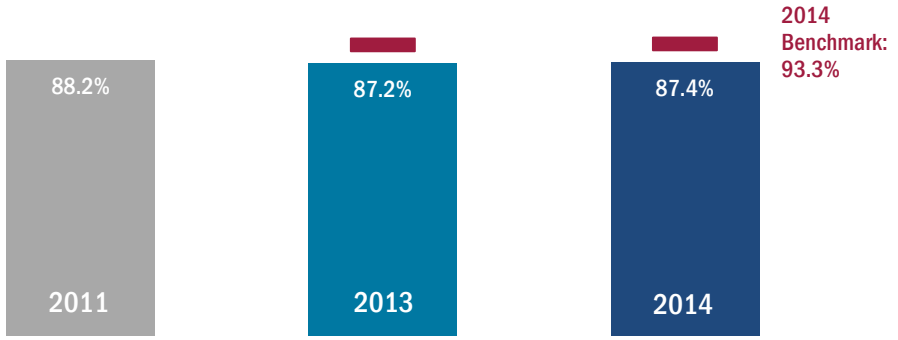
Access to primary care providers among children ages 7-11 years remained steady at a statewide level between 2013 and 2014. This is the only age group for whom access did not decrease during the measurement year.

All races and ethnicities, with the exception of Hawaiian/ Pacific Islander, experienced increased access. However, results statewide and for each race and ethnicity remained below the benchmark.

Due to measure criteria, this age group does not include children who gained coverage in 2014. Data at the CCO level are not available for this measure.

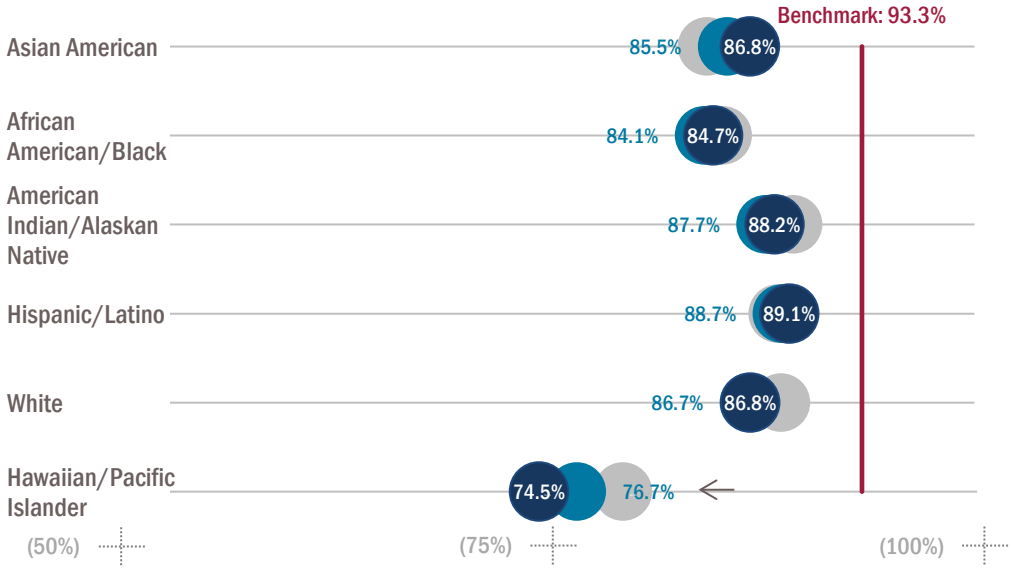
Statewide, access to primary care providers remained steady for children and adolescents ages 7-11 years.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 75th percentile



Asian American children ages 7-11 years experienced the greatest improvement in access to primary care between 2013 and 2014.

Gray dots represent 2011. Data missing for 8.6% of respondents. Each race category excludes Hispanic/Latino.



CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (12-19 YEARS)

Childhood and adolescent access to primary care providers (12-19 years)

Measure description: Percentage of children and adolescents (ages 12-19 years) who had a visit with a primary care provider.

Purpose: Access to a primary care provider is important for the healthy growth and development of children and teens. Measuring visits with a primary care provider helps to identify and address barriers to services that can keep youth healthy.

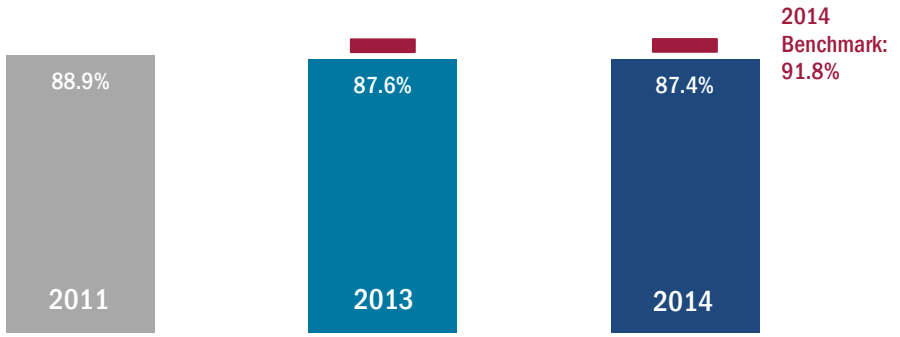
2014 data (n=105,342)

Access to primary care providers among adolescents ages 12-19 years remained steady at the statewide level between 2013 and 2014. White and Hawaiian/Pacific Islander populations experienced a decrease in access during the measurement period, while all other races and ethnicities experienced increased access in this age group.

Due to measure criteria, this age group does not include children who gained coverage in 2014. Data at the CCO level are not available for this measure.

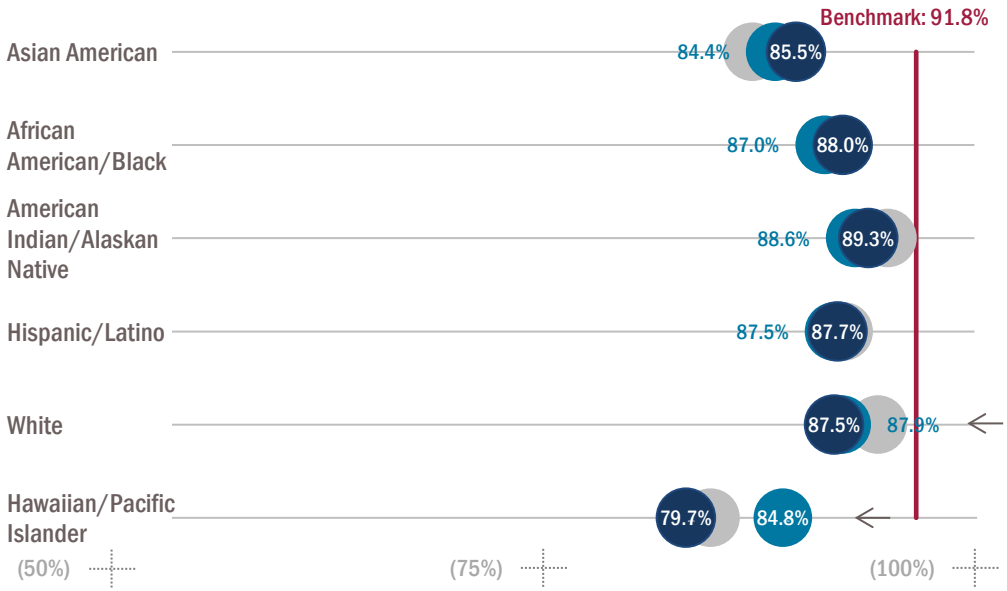
Statewide, access to primary care providers remained steady for adolescents ages 12-19 years.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 75th percentile



Asian Americans ages 12-19 experienced the greatest improvement in access to primary care between 2013 and 2014.

Gray dots represent 2011. Data missing for 7.9% of respondents. Each race category excludes Hispanic/Latino.



CHILDHOOD IMMUNIZATION STATUS

Childhood immunization status

Measure description: Percentage of children who received recommended vaccines before their second birthday.

Purpose: Vaccines are one of the safest, easiest and most effective ways to protect children from potentially serious diseases. Vaccines are also cost-effective tools which help to prevent the spread of serious diseases which can sometimes lead to widespread public health threats.

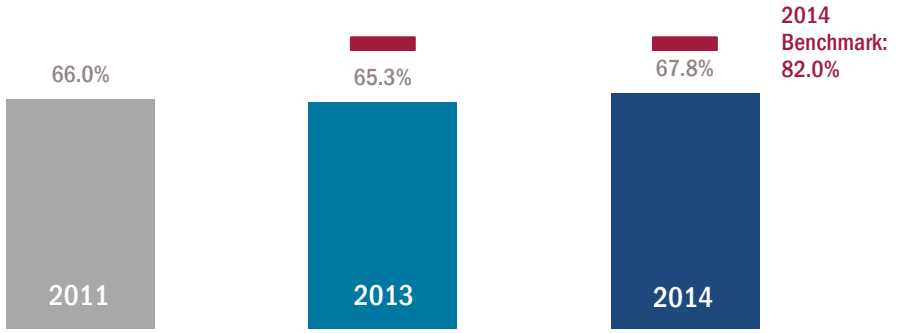
2014 data (n=15,108)

Childhood immunization remained fairly steady from 2011 baseline, with a slight improvement in 2014. At 67.8 percent, statewide performance was still well below the benchmark of 82.0 percent.

Childhood immunization improved slightly for African American, White, and Hispanic/Latino members since 2013, but decreased slightly for other races and ethnicities. However, childhood immunization improved for all but two CCOs between 2013 and 2014.

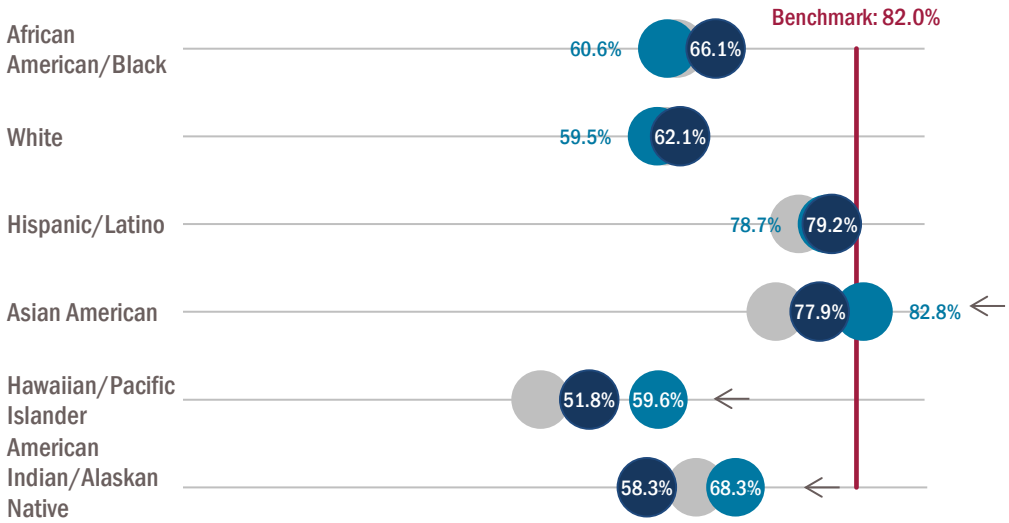
Statewide, childhood immunizations improved.

Data source: Administrative (billing) claims and ALERT Immunization Information System
2014 benchmark source: 2013 National Medicaid 75th percentile



Hispanic/Latino and Asian American children received immunizations more frequently than other members in 2013 and 2014.

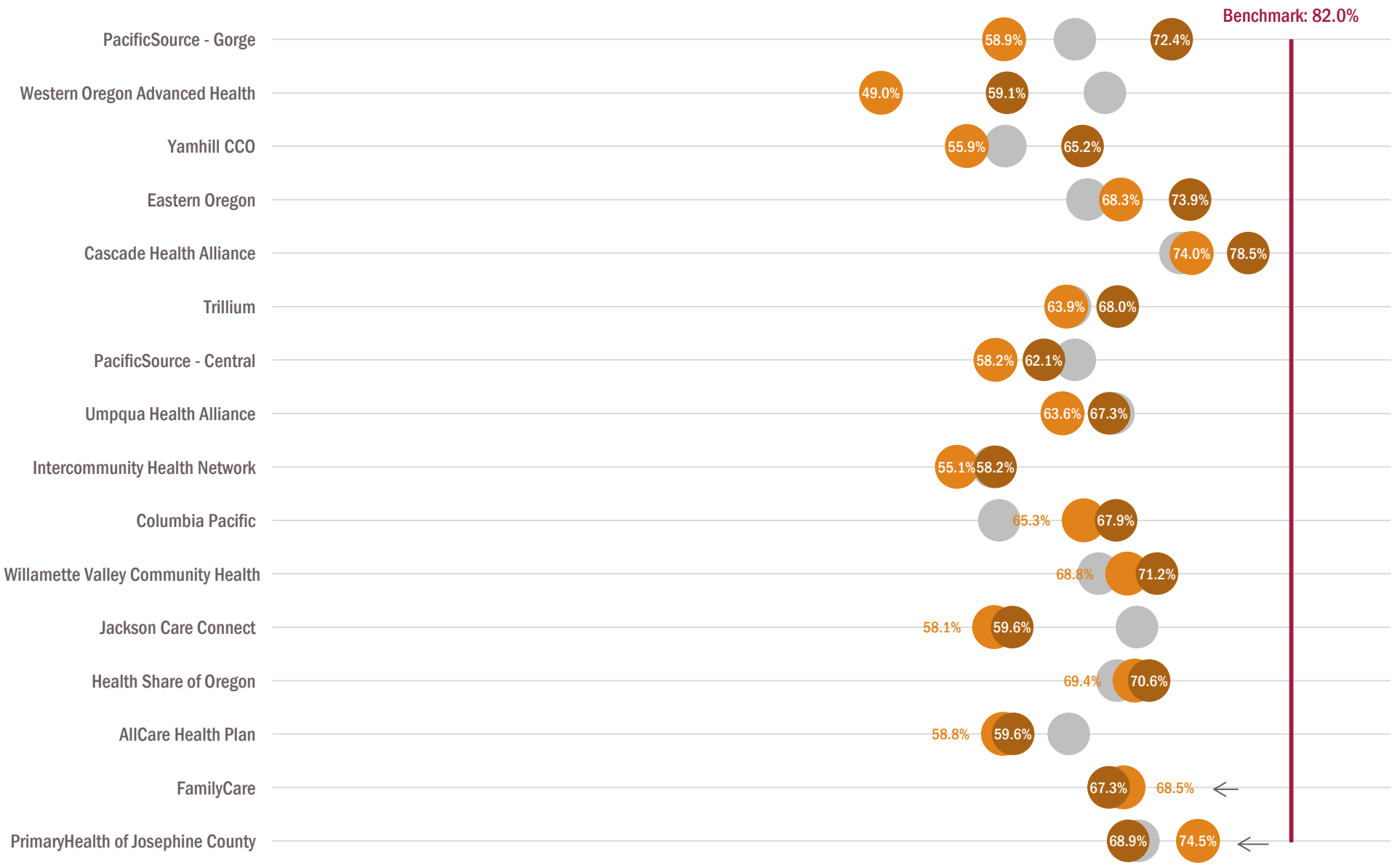
Gray dots represent 2011. Data missing for 8.9% of respondents. Each race category excludes Hispanic/Latino.



CHILDHOOD IMMUNIZATION STATUS

Fourteen of 16 CCOs improved childhood immunizations between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.Baseline data for PacificSource Central and Gorge are combined.



CHLAMYDIA SCREENING IN WOMEN AGES 16-24

Chlamydia screening in women ages 16-24

Measure description: Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection.

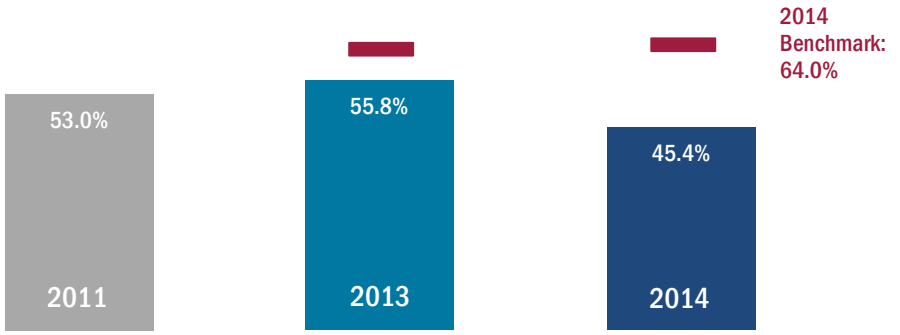
Purpose: Chlamydia is the most common reportable illness in Oregon. Since there are usually no symptoms, routine screening is important to find the disease early so that it can be treated and cured with antibiotics. If chlamydia is not found and treated early, it can lead to pelvic inflammatory disease, which can cause infertility.

2014 data (n=26,957)

Chlamydia screenings have continued to decrease since 2011 at a statewide level. The percentage of women ages 16-24 screened for chlamydia also decreased across all races and ethnicities and for 15 of 16 CCOs.

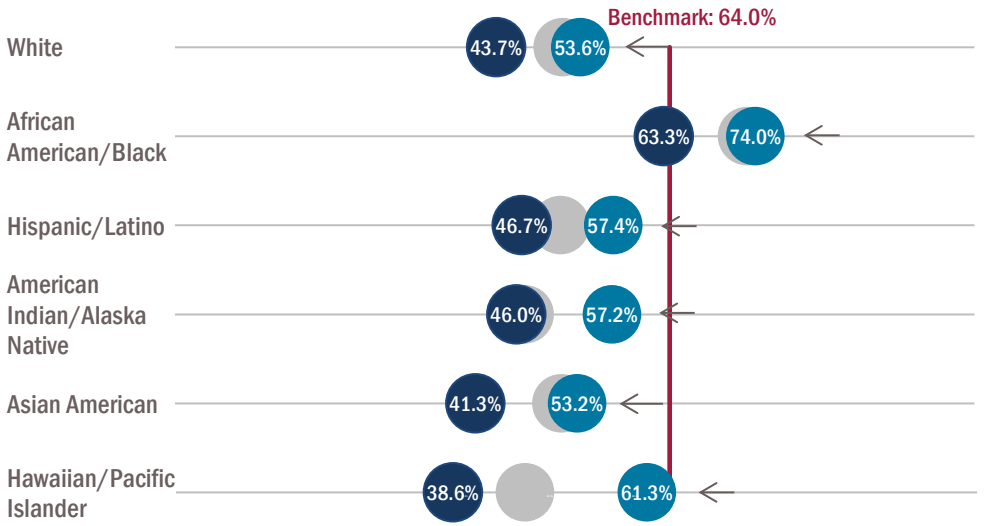
Statewide, chlamydia screening decreased in 2014.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 75th percentile
2011 and 2013 data have been updated and may differ from earlier reports.



Chlamydia screening declined for all races and ethnicities between 2013 and 2014.

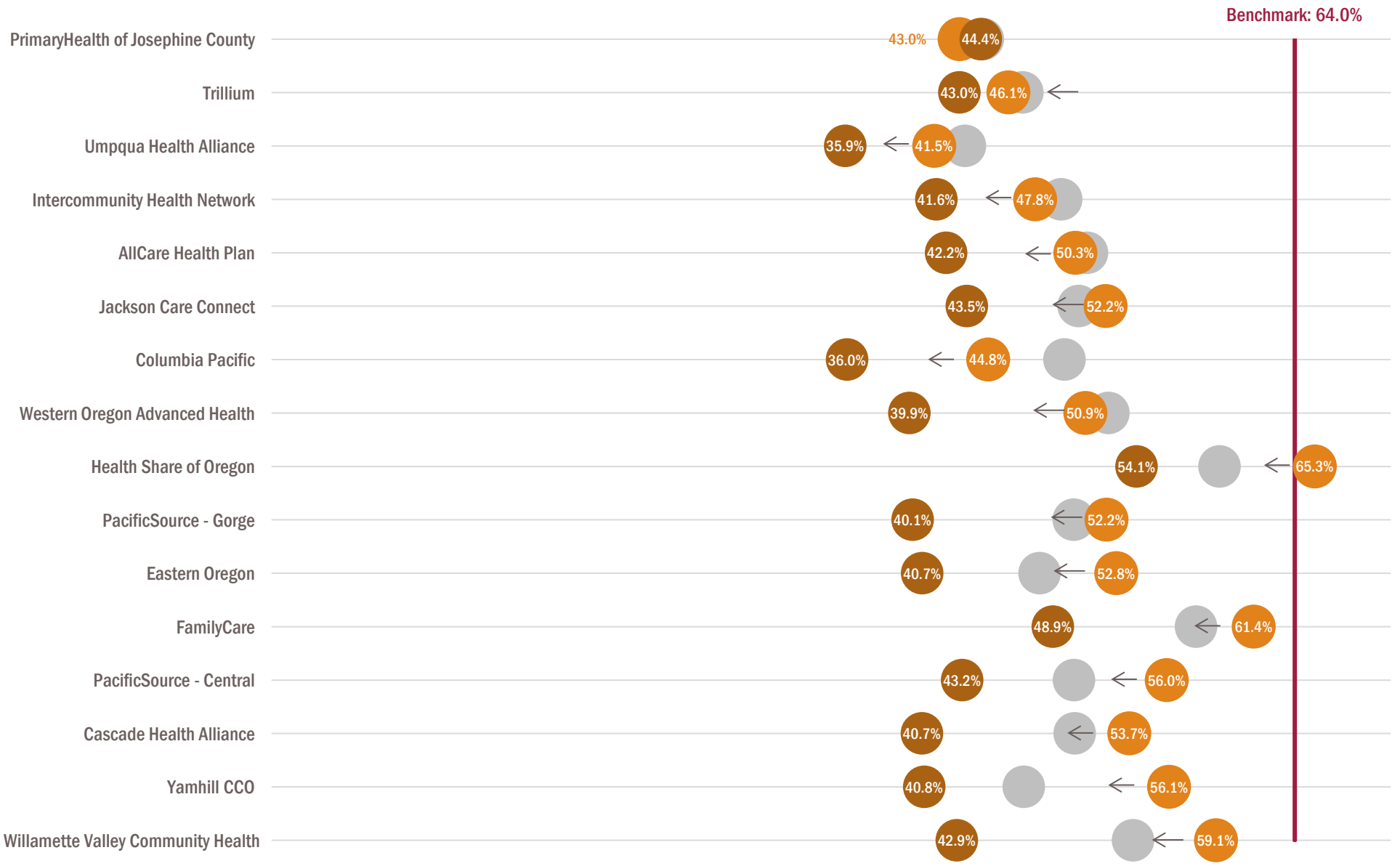
Gray dots represent 2011. Data missing for 8.2% of respondents. Each race category excludes Hispanic/Latino.
2011 and 2013 data have been updated and may differ from earlier reports.



CHLAMYDIA SCREENING IN WOMEN AGES 16-24

Only two CCOs increased chlamydia screening between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined. 2011 and 2013 data have been updated and may differ from earlier reports.



COLORECTAL CANCER SCREENING

Colorectal cancer screening

Measure description: Percent of adult members (ages 50-75) who had appropriate screening for colorectal cancer.

Purpose: Colorectal cancer is Oregon's second leading cause of cancer deaths. With appropriate screening, abnormal growths in the colon can be found and removed before they turn into cancer. Colorectal cancer screening saves lives while also keeping overall health care costs down.

2014 data (n=6,566)

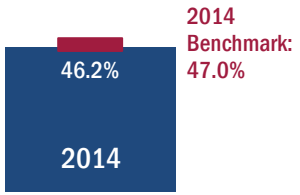
The measure specifications for colorectal cancer screening were updated beginning in 2014 to use medical record data. Previously, rates were calculated using administrative data and were reported per 1,000 member months. Performance in 2014 is thus not comparable to earlier years.

Statewide, 46.2 percent of adult members had appropriate screening. This is near the benchmark of 47.0 percent and is comparable to the 49.8 percent of Medicaid members surveyed in the Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) survey who said they were current on colorectal cancer screening in 2014. However, compared to national data for Medicare and commercial populations (where the 75th percentile is 70.0 and 66.0 percent, respectively), Oregon's colorectal cancer screening rate still has room for improvement.

In 2014, CCO performance ranged from a low of 29.7 percent to a high of 54.0 percent.

Statewide, colorectal cancer screening was just below the benchmark in 2014.

Data source: Administrative (billing) claims and medical record review
Benchmark source: Metrics and Scoring Committee consensus
2014 data are not comparable to earlier years due to changed methodology



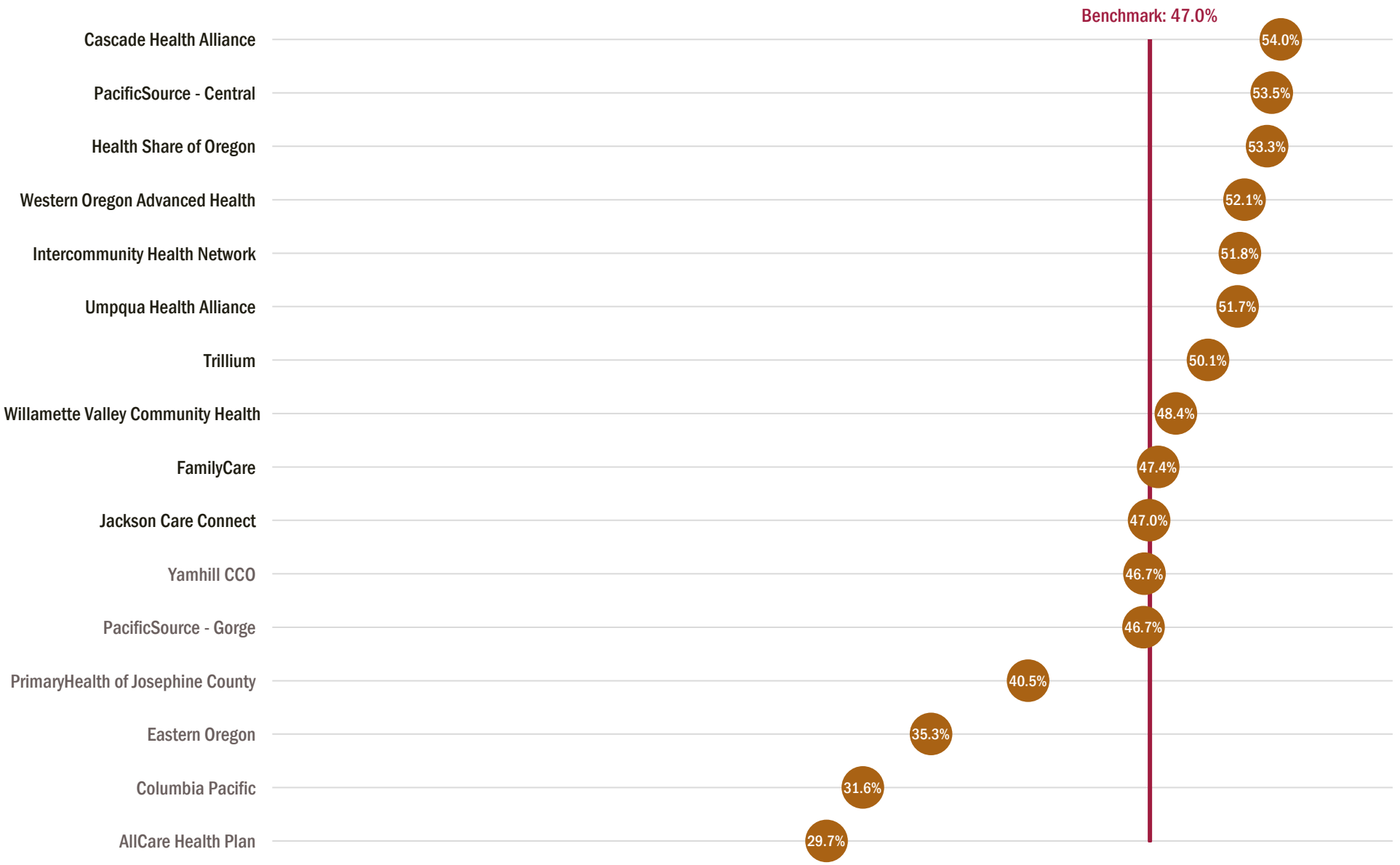
Race and ethnicity data.

Race/ethnicity data for this measure are not available.

COLORECTAL CANCER SCREENING

Ten of 16 CCOs met the benchmark for colorectal cancer screening in 2014. .

Bolded names met benchmark. This measure does not have an improvement target for 2014.
2014 data are not comparable to earlier years due to changed methodology.



COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

Comprehensive diabetes care: HbA1c testing

Measure description: Percentage of adult patients (ages 18-75) with diabetes who received at least one A1c blood sugar test.

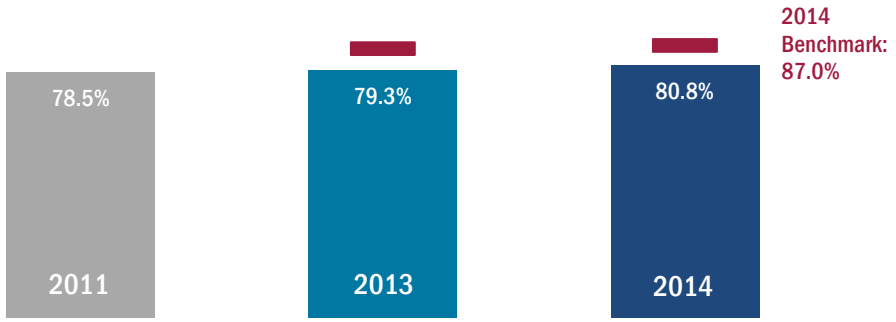
Purpose: Controlling blood sugar levels is important to help people with diabetes manage their disease. It also is a key way to assess the overall effectiveness of diabetes care in Oregon. By improving the quality of care for diabetes, Oregon can help members avoid complications and hospitalizations that lead to poor health and high costs.

2014 data (n=27,332)

Testing for blood sugar (HbA1c) among members with diabetes has shown continual improvement since 2011. Testing among Hispanic/Latino and White members also increased, while testing for all other races and ethnicities decreased. Thirteen of 16 CCOs showed an increase for this metric, with several CCOs approaching the benchmark. This improvement was achieved even with a 36 percent increase in the denominator due to the ACA expansion.

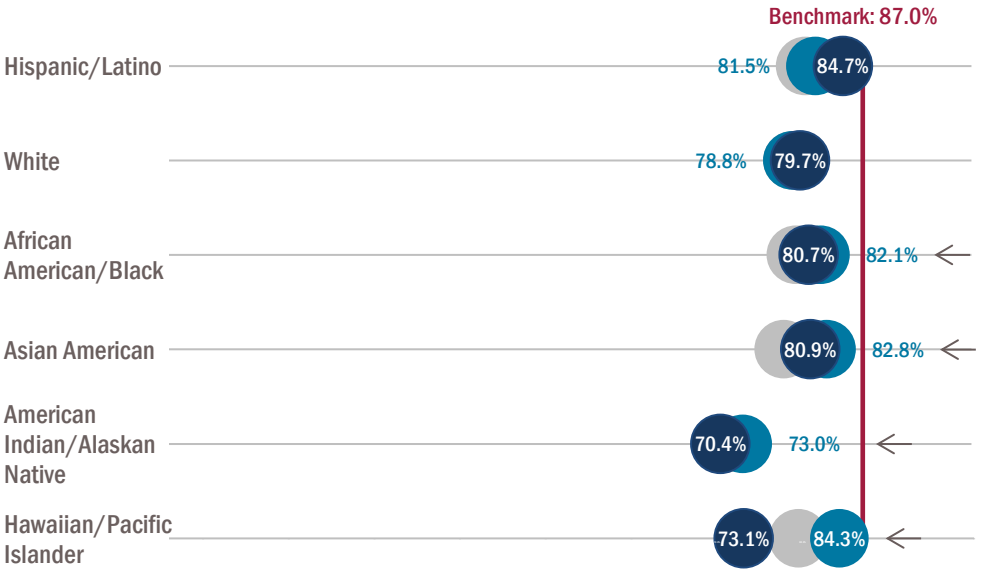
Statewide, hemoglobin A1c testing has increased slightly.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 75th percentile



HbA1c testing increased the most for Hispanic/Latino members with diabetes between 2013 and 2014.

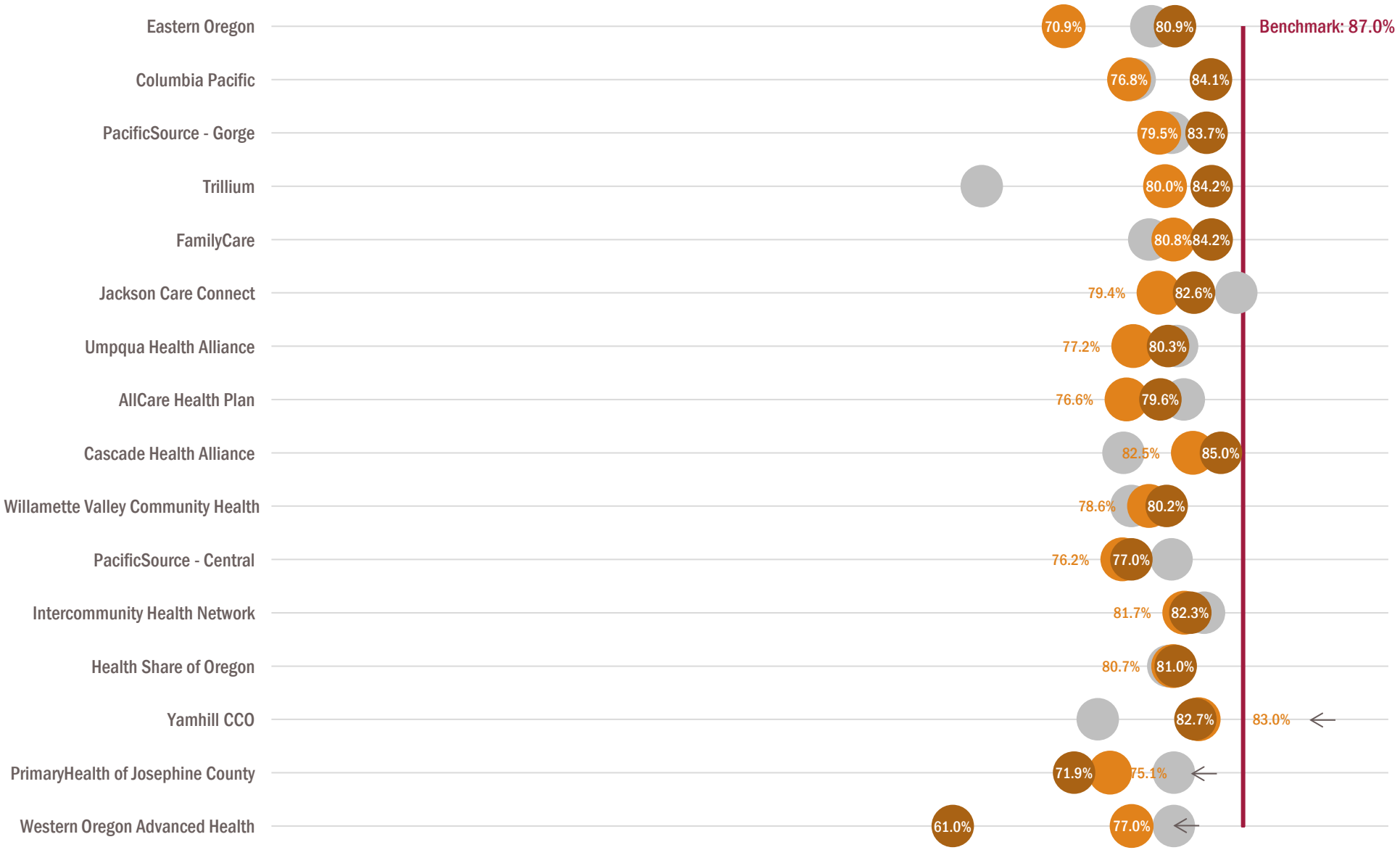
Gray dots represent 2011. Data missing for 5.9% of respondents. Each race category excludes Hispanic/Latino.



COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

Thirteen of 16 CCOs improved hemoglobin A1c testing for members with diabetes between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



COMPREHENSIVE DIABETES CARE: LDL-C SCREENING

Comprehensive diabetes care: LDL-C screening

Measure description: Percentage of adult patients (ages 18-75) with diabetes who received an LDL-C (cholesterol) test.

Purpose: This test helps people with diabetes manage their condition by measuring the level of "bad" cholesterol (LDL-C) in the blood. Managing cholesterol levels can help people with diabetes avoid problems such as heart disease and stroke.

2014 data (n=27,332)

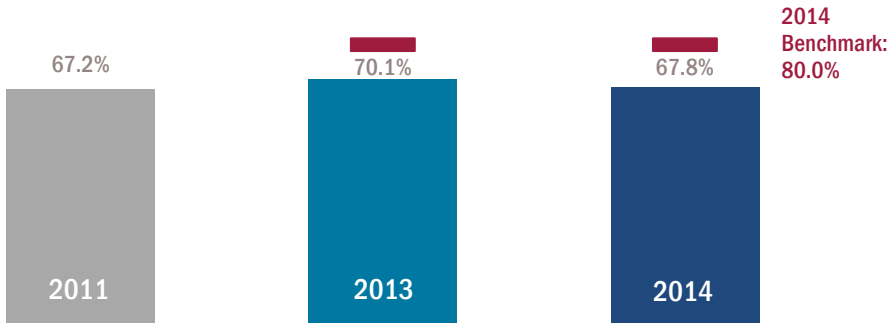
The percentage of LDL-C (cholesterol) screening at the statewide level decreased between 2013 and 2014. Screenings held steady or declined among all races and ethnicities. Historically, the measure showed improvement between 2011 and 2013 before declining during the current measurement period.

The decline in LDL-C screening may be partially due to updated guidance for the treatment of blood cholesterol from the American College of Cardiology / American Heart Association in 2013, which focus on statin therapy for patients rather than LDL-C control or screening.

Three of 16 CCOs showed improvement on this metric.

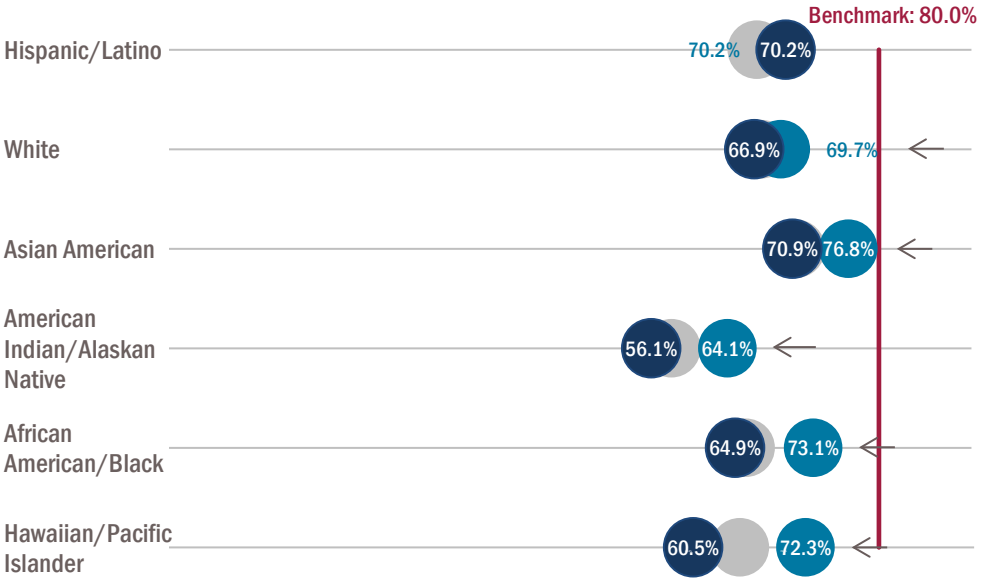
Statewide, LDL-C screenings for people with diabetes declined in 2014.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 75th percentile



LDL-C screenings declined for most races and ethnicities between 2013 and 2014.

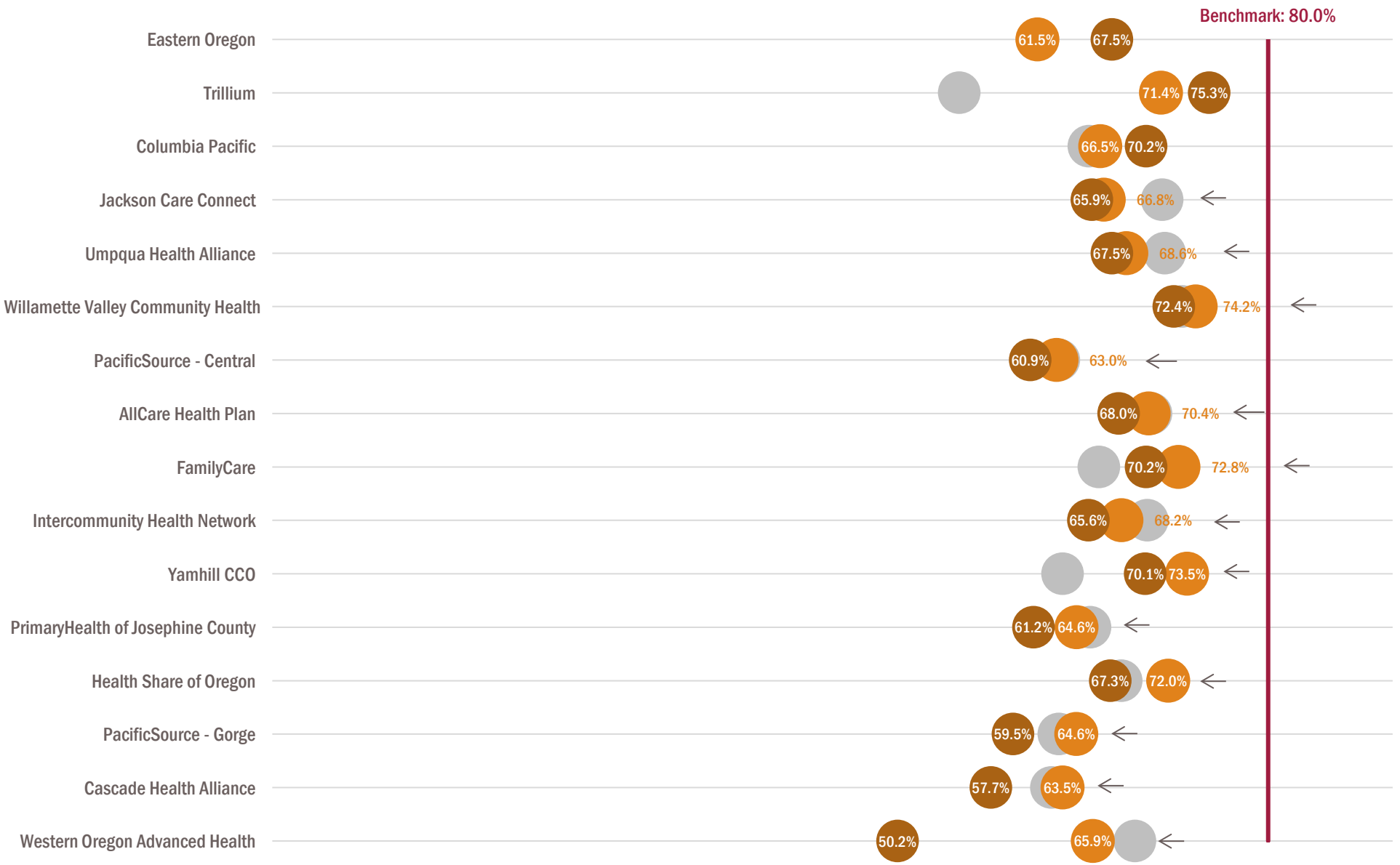
Gray dots represent 2011. Data missing for 5.9% of respondents. Each race category excludes Hispanic/Latino.



COMPREHENSIVE DIABETES CARE: LDL-C SCREENING

Three of 16 CCOs showed improvement on LDL-C screening for members with diabetes between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



CONTROLLING HIGH BLOOD PRESSURE

Controlling high blood pressure

Measure description: Percentage of patients 18-85 years of age who had a diagnosis of hypertension (high blood pressure) and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

Purpose: Uncontrolled hypertension can have serious complications, including heart disease and stroke. Better control of blood pressure has been shown to reduce the probability that these complications will occur.

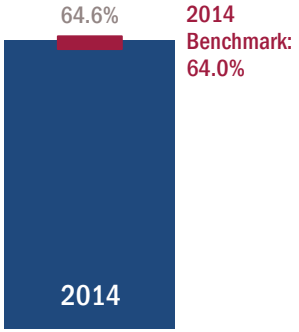
2014 data

Statewide, 64.6 percent of adults with high blood pressure had their blood pressure adequately controlled in 2014. This surpasses the benchmark of 64.0 percent. Eight of 16 CCOs also met the benchmark. Results by CCO ranged from a high of 72.5 percent to a low of 52.2 percent. As 2014 marks the first year of results on this measure, comparison data are not available.

Statewide in 2014, 28.3 percent of adults on Medicaid reported that a doctor told them they have high blood pressure, according to the Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) Survey.

Statewide, 64.6 percent of adults with high blood pressure had their blood pressure adequately controlled in 2014.

Data source: Clinical data - Electronic Health Records
Benchmark source: 2013 National Medicaid 75th percentile.



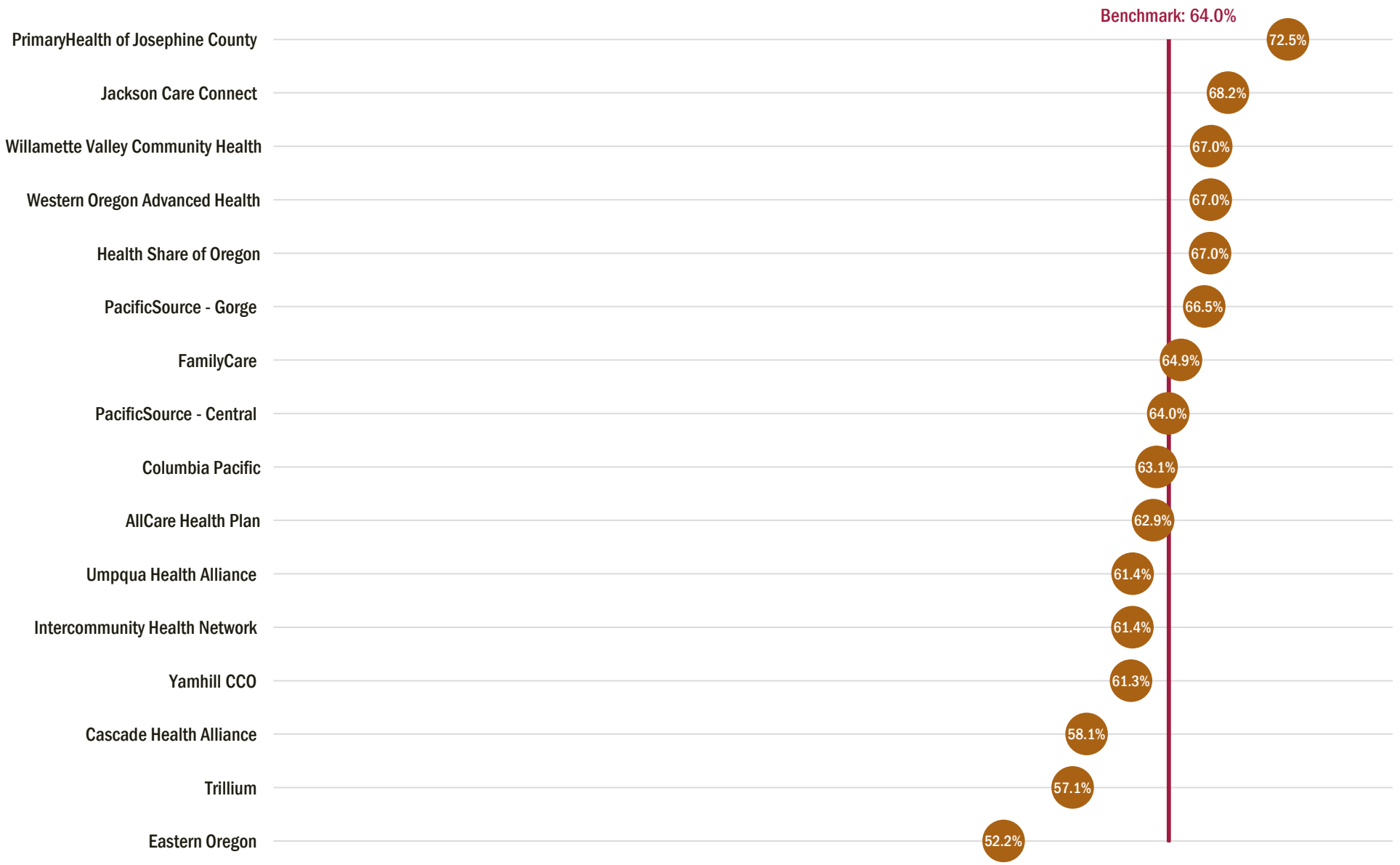
Race and ethnicity data.

Race and ethnicity data are not available for this measure.

CONTROLLING HIGH BLOOD PRESSURE

CCO performance on controlling high blood pressure ranged between 52.2 and 72.5 percent in 2014.

All CCOs received credit for submitting Year Two Technology Plans and required data for this measure.
2011 and 2013 data are not available for this measure.



DEPRESSION SCREENING AND FOLLOW-UP PLAN

Screening for clinical depression and follow-up plan

Measure description: Percentage of patients ages 12 years and older who were screened for clinical depression using an age-appropriate standardized depression screening tool AND if positive, have a documented follow-up plan.

Purpose: Depressive disorders are highly prevalent, chronic and costly, affecting medical outcomes, economic productivity and quality of life. Comprehensive screening in primary care may help providers identify undiagnosed depression and initiate appropriate treatment, improving these members' depression and alleviating their suffering sooner or more thoroughly than if they had not been screened.

2014 data

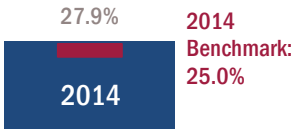
Statewide, results on depression screening and follow-up met the benchmark in 2014. CCO results varied widely, ranging from a high of 68.1 percent to a low of 3.3 percent. The range of CCO performance on this measure in part reflects the challenges of adopting and implementing electronic health record functionality that enables the reporting of all data elements required for this measure.

2014 is the first year results are reported for this measure, so comparison data are not available.

Statewide in 2014, 36.8 percent of adults on Medicaid reported that a doctor told them they have depression, according to the 2014 Medicaid Behavioral Risk Factor Surveillance System Survey.

Statewide, depression screening and follow-up was higher than the benchmark in 2014.

Data source: Clinical data - Electronic Health Records
Benchmark source: Metrics and Scoring Committee consensus.



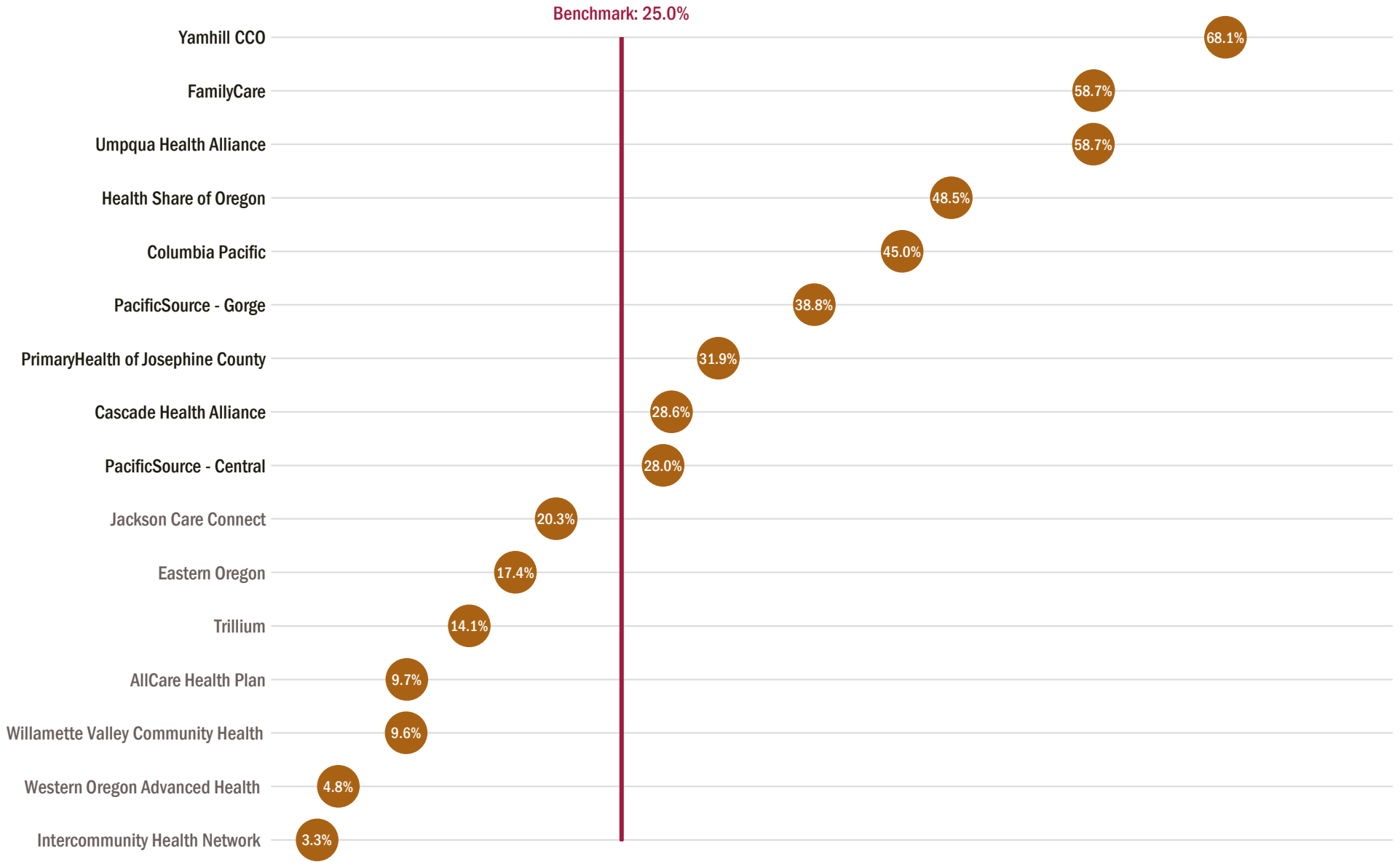
Race and ethnicity data.

Race and ethnicity data are not available for this measure.

DEPRESSION SCREENING AND FOLLOW-UP PLAN

CCO performance on depression screening and follow-up was varied in 2014.

All CCOs received credit for submitting Year Two Technology Plans and required data. **Bolded names** received credit for achieving the benchmark for this measure.
2011 and 2013 data are not available for this measure.



DEVELOPMENTAL SCREENING IN THE FIRST 36 MONTHS OF LIFE

Developmental screenings in the first 36 months of life

Measure description: Percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday.

Purpose: Early childhood screening helps find delays in development as early as possible, which leads to better health outcomes and reduced costs. Early developmental screening provides an opportunity to refer children to the appropriate specialty care before problems worsen. Often, developmental delays are not found until kindergarten or later -- well beyond the time when treatments are most helpful.

2014 data (n=52,839)

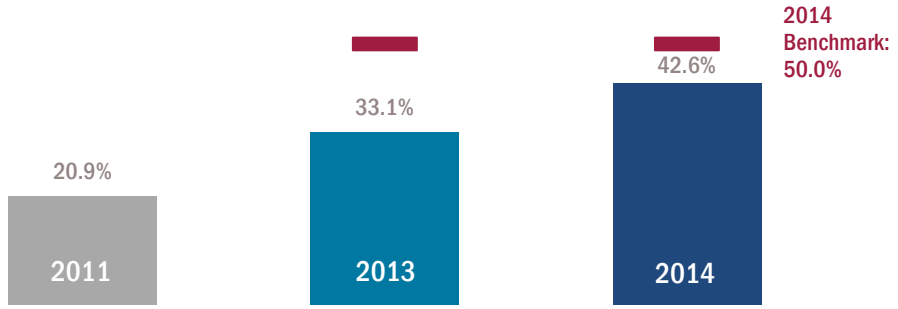
The percentage of children who received a developmental screen in the first 36 months of life increased from 33.1 percent in 2013 to 42.6 percent in 2014, making progress toward the benchmark of 50.0 percent.

Developmental screening increased for all races and ethnicities between 2013 and 2014, although screening was below the benchmark for all. CCOs exhibited consistent improvement with 14 of 16 CCOs improving performance in 2014 and 15 meeting their improvement target or benchmark.

Examples of interventions CCOs have taken to improve developmental screening include provider training and education, collaborating with early learning hubs, and developing alternate payment methodologies for providers to incentivize increased screening.

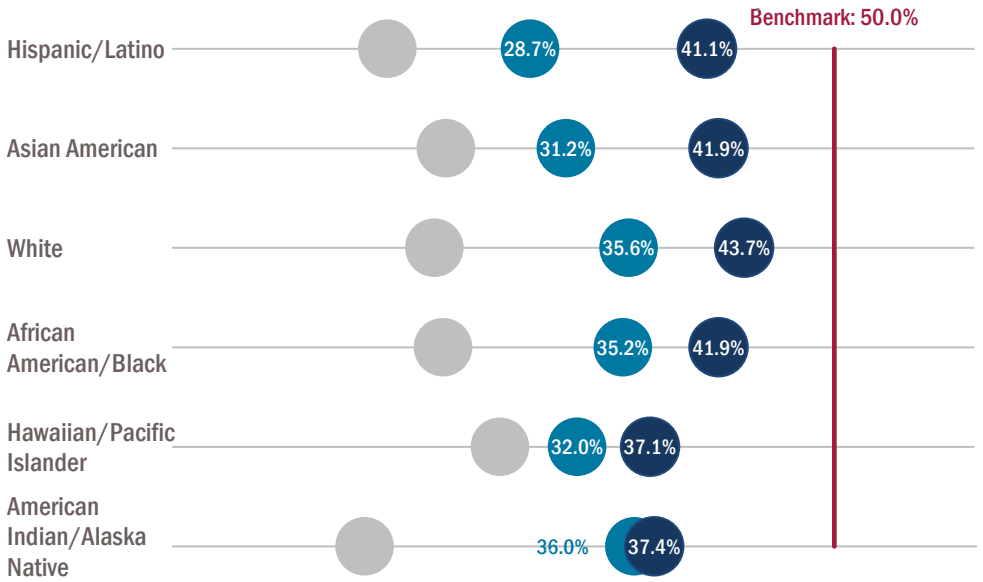
Statewide, developmental screening continued to increase.

Data source: Administrative (billing) claims
2014 benchmark source: Metrics and Scoring Committee consensus



Developmental screening increased across all races and ethnicities between 2013 and 2014.

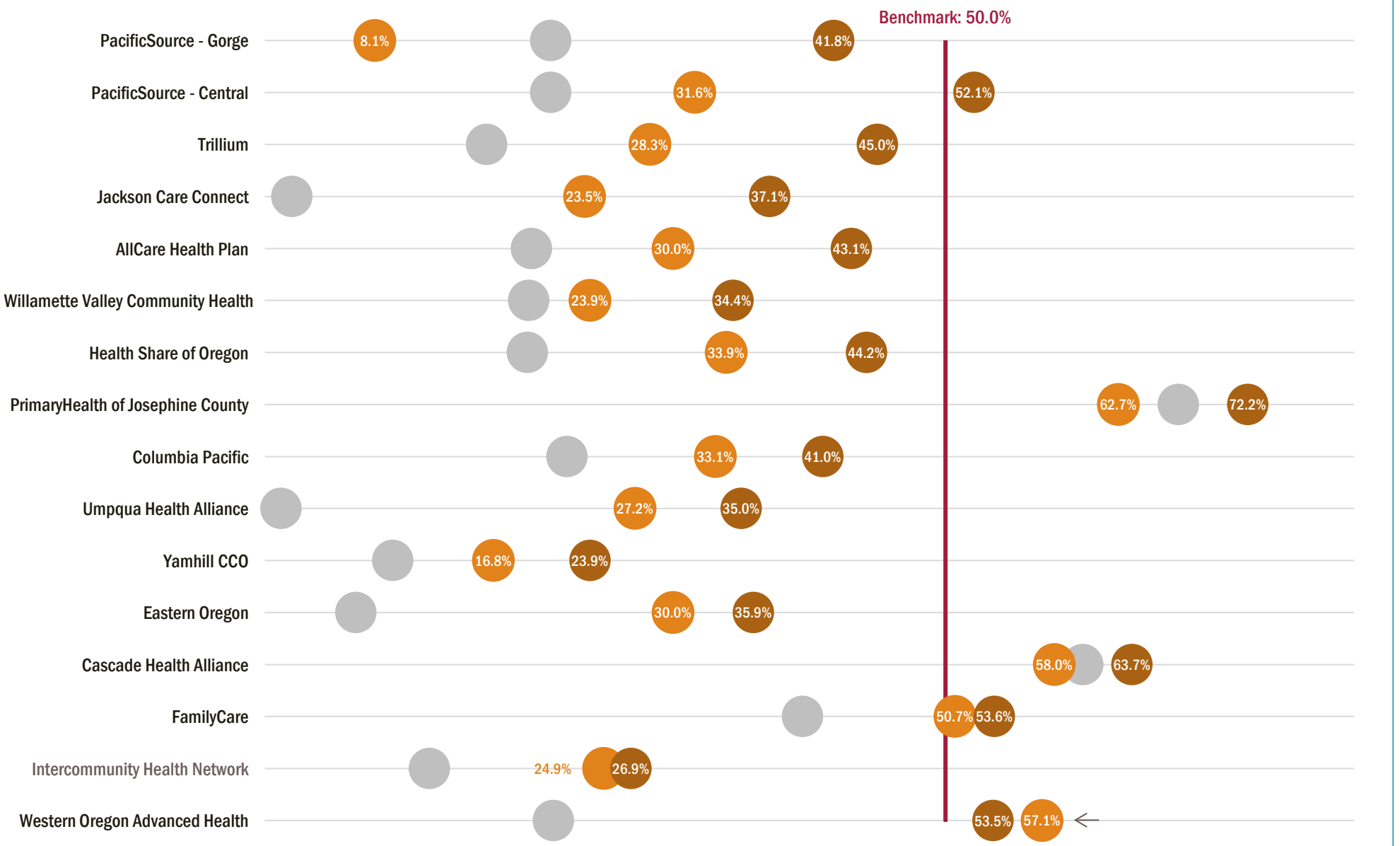
Gray dots represent 2011. Data missing for 10.0% of respondents.Each race category excludes Hispanic/Latino



DEVELOPMENTAL SCREENINGS IN THE FIRST 36 MONTHS OF LIFE

Overall, CCOs increased developmental screenings between 2013 and 2014, and 15 of 16 achieved the benchmark or improvement target.

Bolded names met benchmark or improvement target.
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



DIABETES HbA1c POOR CONTROL

Diabetes HbA1c poor control

Measure description: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period (lower scores on this measure are better).

Purpose: Diabetes is a leading cause of death and disability in the United States. Poor glycemic control (as evidenced by HbA1c > 9.0%) increases the likelihood of complications, including poor circulation and nerve damage.

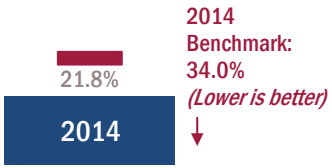
2014 data

Statewide, only 21.8 percent of members exhibited poor HbA1c control, better than the national benchmark of 34.0 percent. All CCOs were also better than the benchmark, with results ranging from 11.5 percent to 32.9 percent. 2014 is the first year results are reported for this measure, so comparison data are not available.

Statewide in 2014, 11.6 percent of adults on Medicaid reported that a doctor told them they have diabetes, according to the 2014 Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) Survey, compared to 8.5 percent of the general population.

Statewide, only 21.8 percent of people with diabetes had poorly controlled diabetes in 2014.

(Lower scores are better)
Data source: Clinical data - Electronic Health Records
Benchmark source: 2013 National Medicaid 75th percentile.



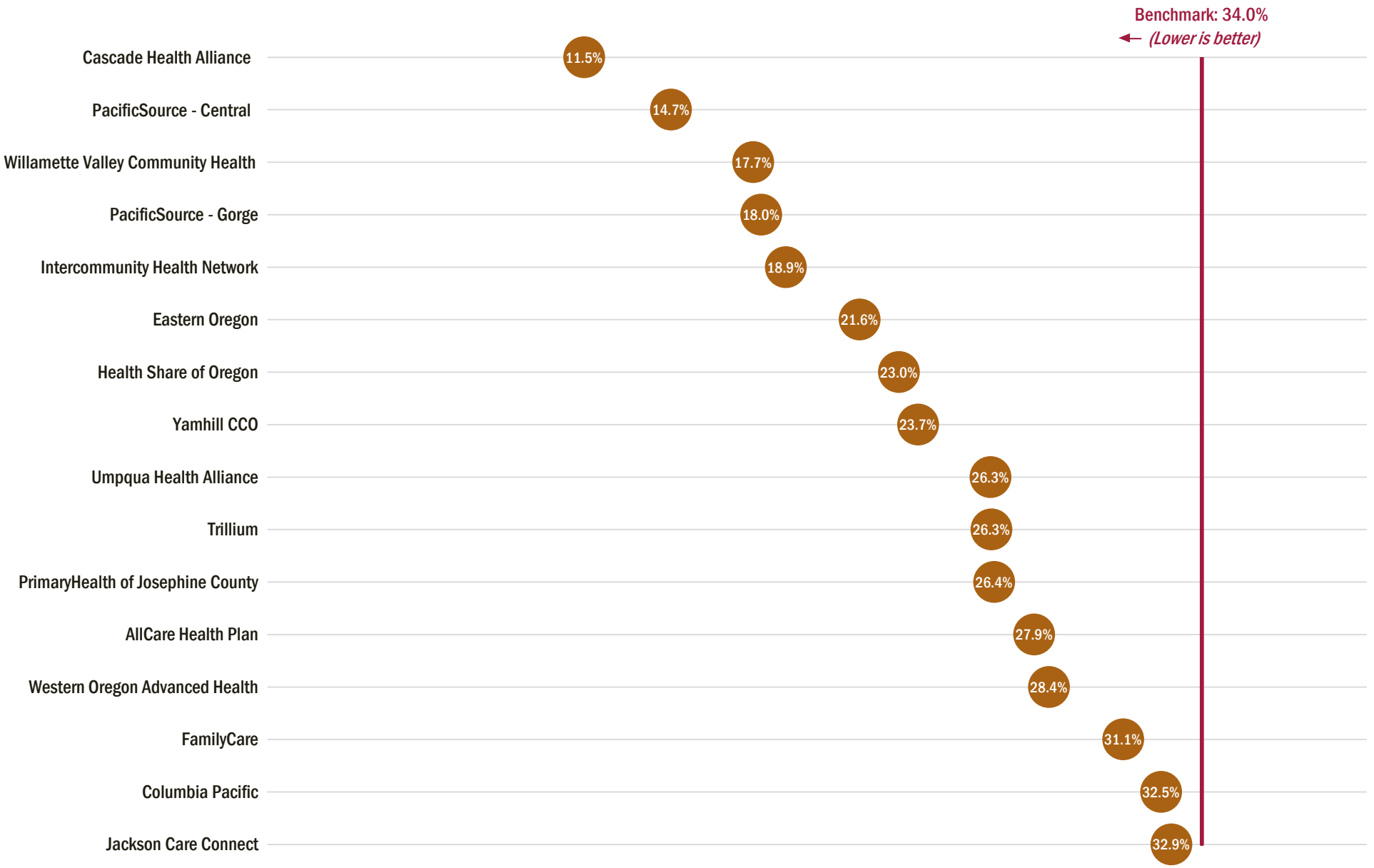
Race and ethnicity data.

Race and ethnicity data are not available for this measure.

DIABETES HbA1c POOR CONTROL

All 16 CCOs met the benchmark for diabetes HbA1c poor control in 2014.

All CCOs received credit for 1) submitting Year Two Technology Plans and required data and 2) achieving the benchmark for this measure.
2011 and 2013 data are not available for this measure.



EARLY ELECTIVE DELIVERY

Early Elective Delivery

Measure description: Percentage of women who had an elective delivery between 37 and 39 weeks of gestation. (A lower score is better.)

Purpose: There is a substantial body of evidence showing that an infant born at 37 weeks has worse health outcomes than one born at 40 weeks. Specifically, stays at the neonatal intensive care unit are higher in children at 37-38 weeks than children who completed at least 39 weeks. Because of this, it has become a national and state priority to limit elective deliveries to pregnancies that have completed at least 39 weeks gestation.

2014 data (n=2,789)

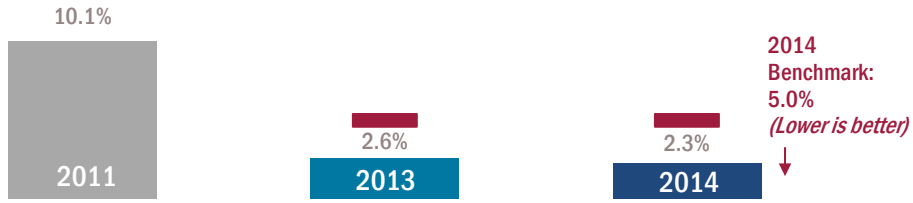
Elective deliveries before 39 weeks decreased 77 percent across the state between 2011 and 2014, from a baseline of 10.1 percent to just 2.3 percent. All CCOs were below the benchmark of five percent in both 2013 and 2014 for this measure, showing continued success across Oregon for better and safer care for mothers and babies.

This promising decrease is likely due to a concerted statewide effort, led by a partnership between the Oregon Association of Hospitals and Health Systems, March of Dimes, Oregon Perinatal Steering committee, and the Northwest Perinatal Network, to eliminate early elective deliveries at all Oregon hospitals.

Due to the steady success on this measure, it will be discontinued as an incentive measure in 2015. However, the state will continue to monitor and report on progress.

Statewide, early elective deliveries remained below the benchmark.

Data source: Administrative (billing) claims, Vital Records, and hospitals
Benchmark source: Metrics and Scoring Committee consensus



Race and ethnicity data.

Race and ethnicity data for this measure are not available.

EARLY ELECTIVE DELIVERY

All 16 CCOs remained below the benchmark on early elective deliveries in 2013 and 2014.

All CCOs met benchmark or improvement target.
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

ELECTRONIC HEALTH RECORD ADOPTION

Electronic health record (EHR) adoption

Measure description: Percentage of eligible providers within a CCO's network and service area who qualified for a "meaningful use" incentive payment during the measurement year through the Medicaid, Medicare, or Medicare Advantage EHR Incentive Programs.

Purpose: Electronic health records have the potential to improve coordination of care, increase patient safety, reduce medical error, and contain health care costs by reducing costly, duplicative tests. Physicians who use electronic health records use information available to make the most appropriate clinical decisions.

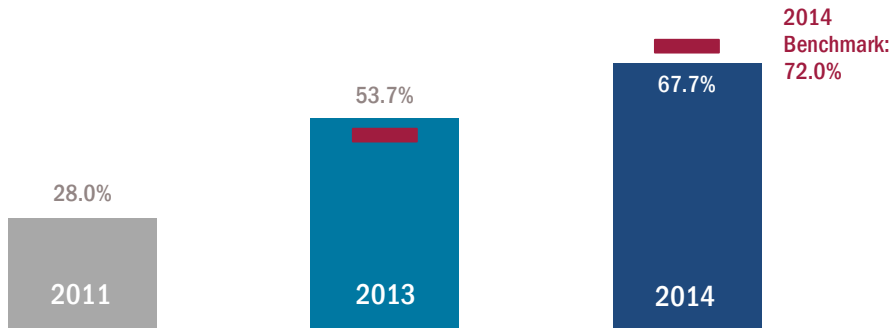
2014 data (n=9,221, total number of eligible providers)

Electronic health record adoption among eligible providers continued to increase dramatically across Oregon. In 2011, 28.0 percent of eligible providers had adopted certified EHRs, but by 2014, 67.7 percent of eligible providers had adopted certified EHRs, an increase of 142 percent. All CCOs improved electronic health record adoption between 2013 and 2014.

The adoption of EHRs is a critical step toward electronic reporting of Clinical Quality Measures (eCQMs). Continuously measuring and electronically reporting clinical quality measures helps ensure that our health care system can deliver effective, safe, efficient, patient-centered, equitable, and timely care. The CCOs' improvements in this area will help in providing better health, better care and lower costs.

Statewide, electronic health record adoption increased markedly.

Data source: State and Federal EHR Incentive Programs
Benchmark source: Metrics and Scoring Committee consensus, based on highest performing CCO in July 2013



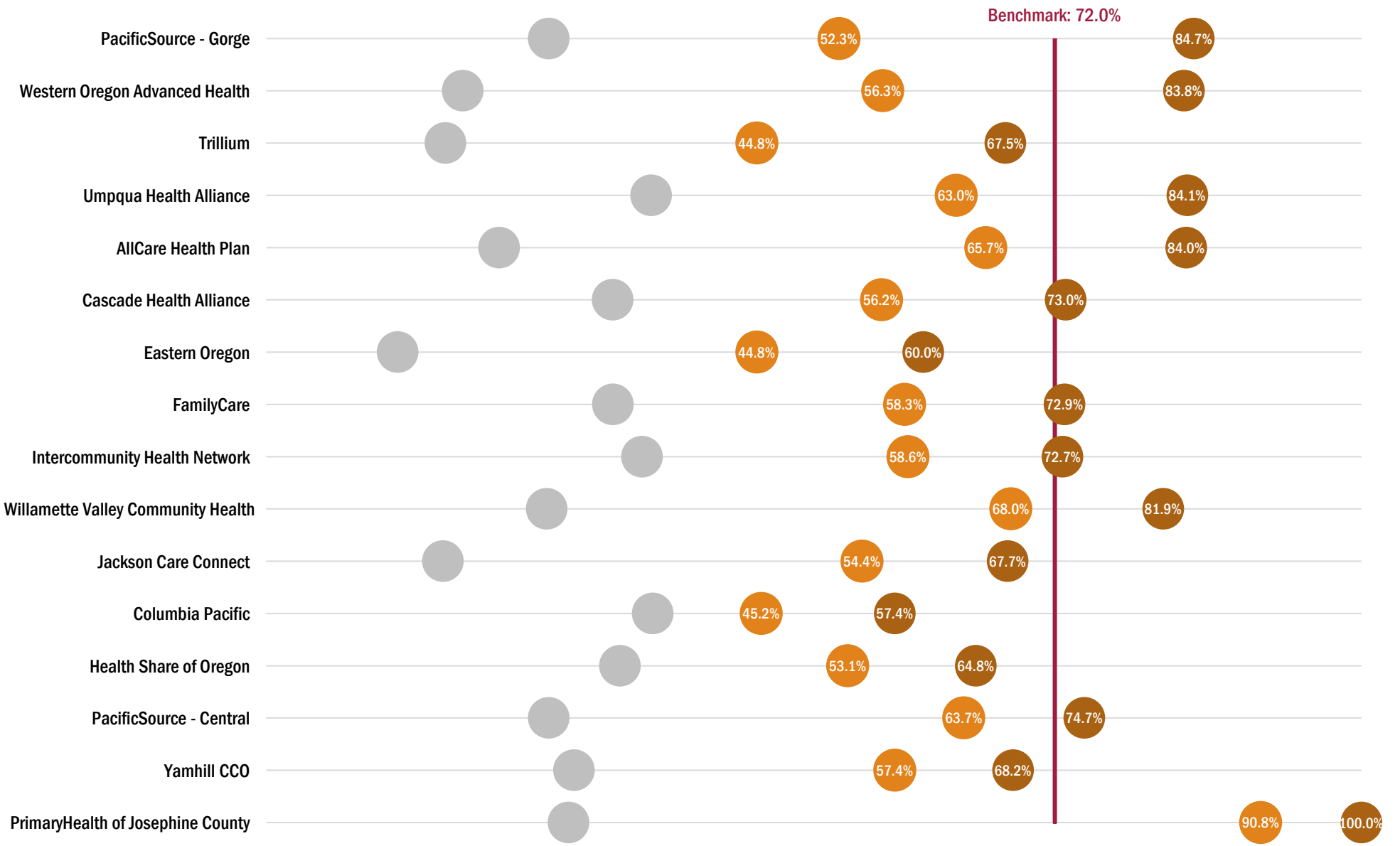
Race and ethnicity data.

Race and ethnicity data for this measure are not available.

ELECTRONIC HEALTH RECORD ADOPTION

All 16 CCOs increased electronic health record adoption between 2013 and 2014, and 10 achieved the benchmark.

All CCOs met benchmark or improvement target.
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-up after hospitalization for mental illness

Measure description: Percentage of members (ages 6 and older) who received a follow-up visit with a health care provider within seven days of being discharged from the hospital for mental illness.

Purpose: Follow-up care is important to help members make progress and feel better after being in the hospital for mental illness. This measure addresses an important issue for chidren and adults by suggesting timely follow-up for members.

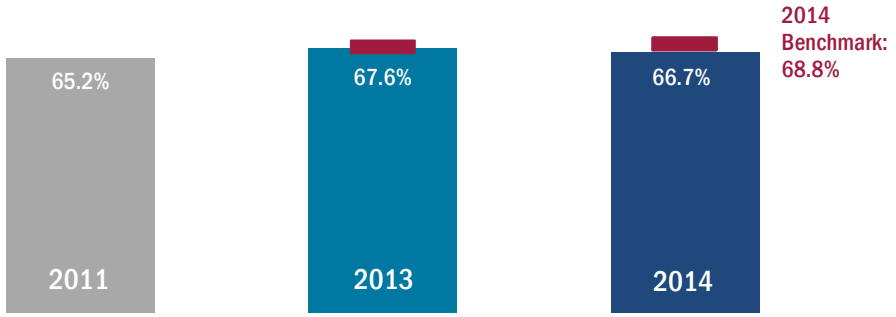
Additionally, research shows that follow-up care helps keep members from returning to the hospital, providing an important opportunity to reduce health care costs and improve health.

2014 data (n=2,873)

Follow-up after hospitalization for mental illness declined slightly at a statewide level from 2013 to 2014 and remains just below the benchmark. Follow-up was varied among the three reportable races and ethnicities, with no clear pattern emerging. Six CCOs improved their performance from 2013 to 2014; five of those also met their improvement target or benchmark.

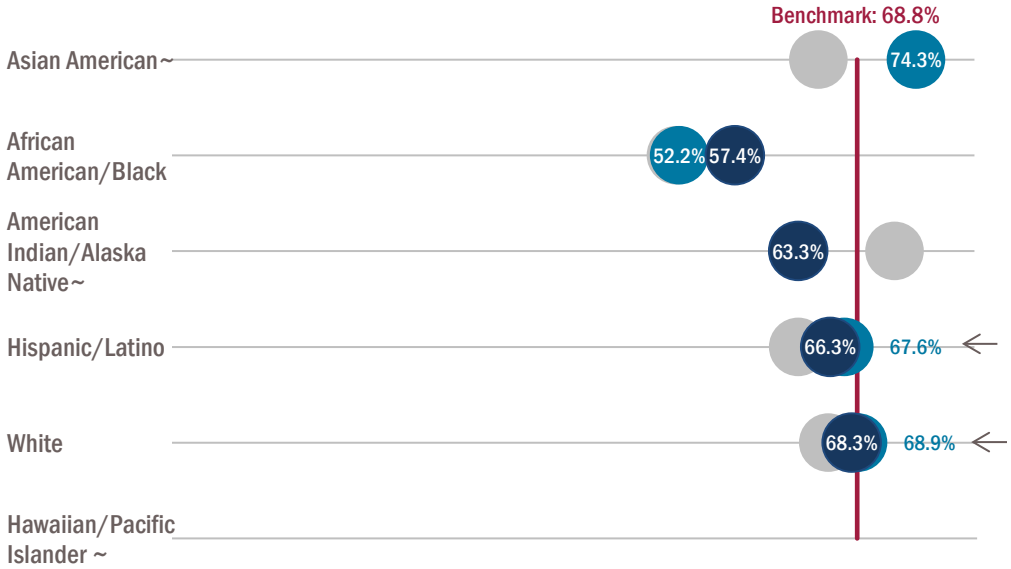
Statewide, follow-up after hospitalization for mental illness remained steady between 2013 and 2014.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 90th percentile



Follow-up after hospitalization was varied among reportable races and ethnicities in 2013 and 2014.

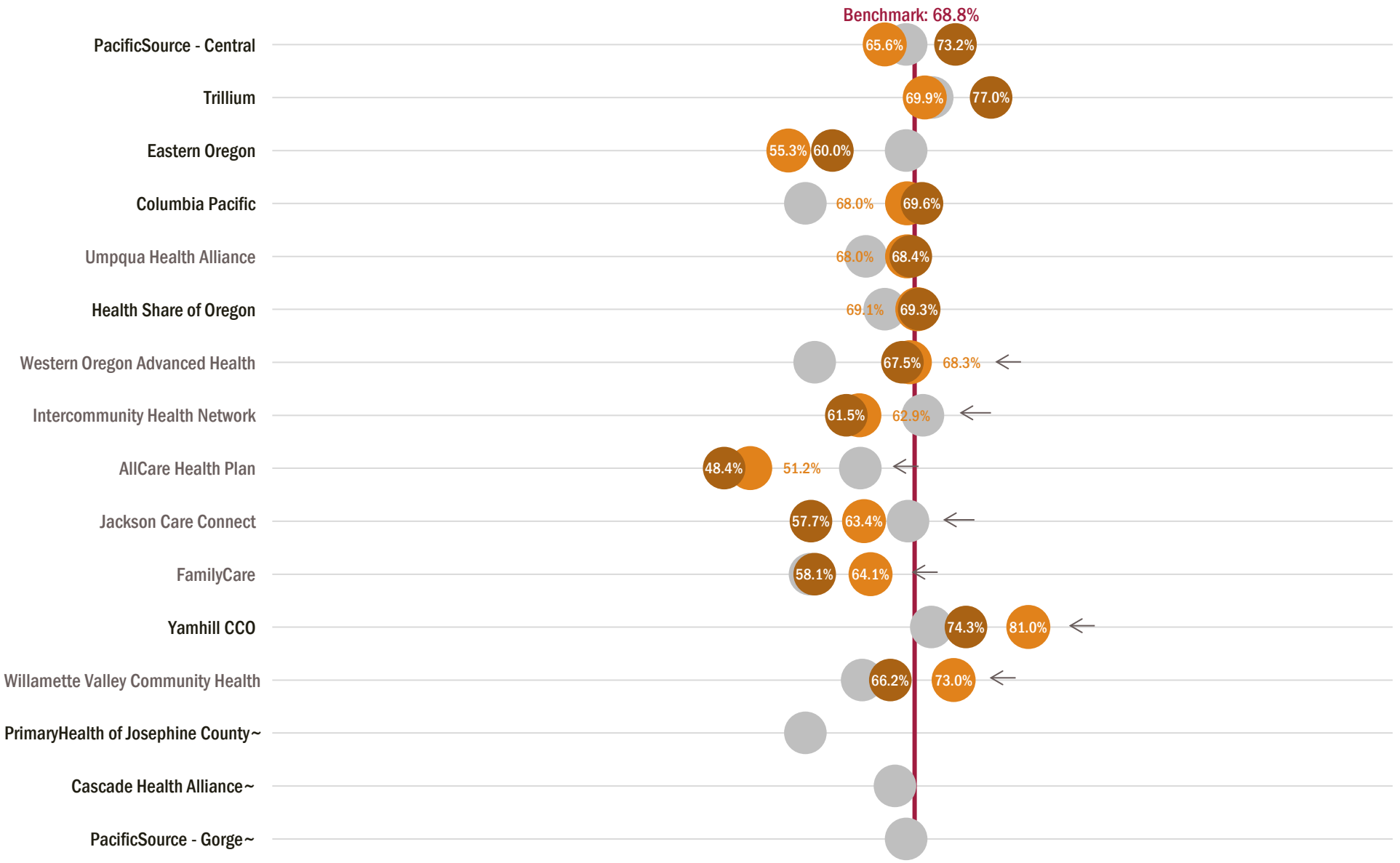
Gray dots represent 2011. Data missing for 7.3% of respondents. Each race category excludes Hispanic/Latino.
~ Data suppressed (n<30)



FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

CCO performance on follow-up after hospitalization was mixed between 2013 and 2014.

Bolded names met benchmark or improvement target.
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.
~ Data suppressed (n<30)



FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

Follow-up care for children prescribed ADHD medication (initiation phase)

Measure description: Percentage of children (ages 6-12) who had at least one follow-up visit with a provider during the 30 days after receiving a new prescription for attention deficit hyperactivity disorder (ADHD) medication.

Purpose: Children with attention deficit hyperactivity disorder can be greatly helped by ADHD medication. One critical component of care is that children have follow-up visits once they are on the medication. After a child receives ADHD medication, a primary care provider should continue to assess learning and behavior and help manage the condition.

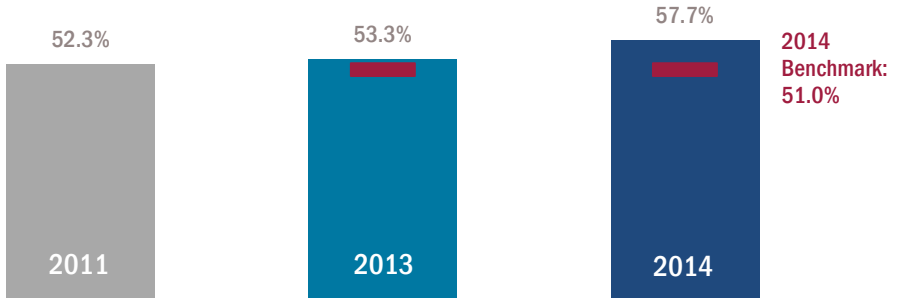
2014 data (n=2,192)

Statewide, initiation of follow-up care for children prescribed ADHD medication continued to improve and remained above the benchmark. Follow-up care improved for all reportable races and ethnicities to exceed the benchmark. Twelve of 16 CCOs improved performance during the measurement period and 14 CCOs met or remained above the benchmark.

Due to these successes, this measure has been retired as a CCO incentive measure for calendar year 2015, although Oregon will continue monitoring and reporting on it.

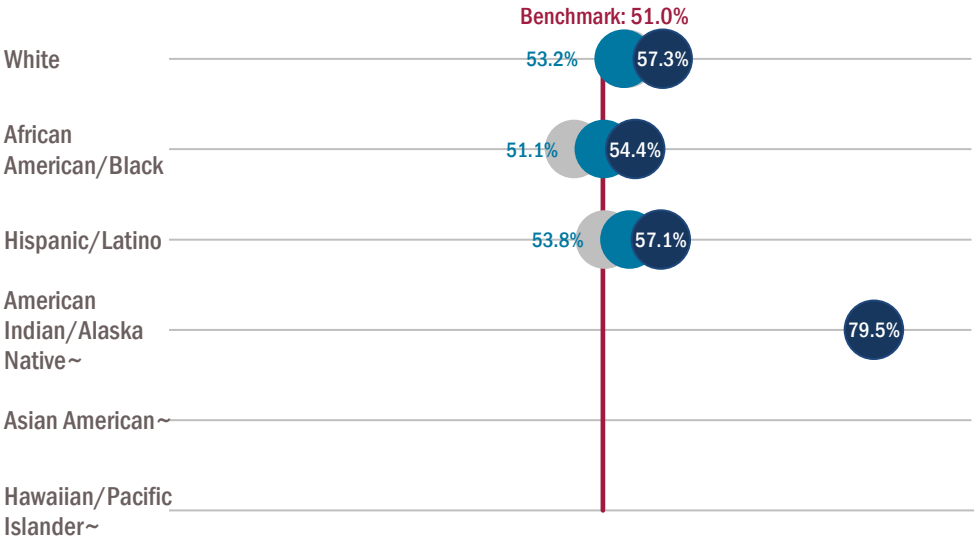
Statewide, initiation of follow-up care for children newly prescribed ADHD medication improved in 2014.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 90th percentile



Initiation of follow-up for ADHD medication improved for all reportable races and ethnicities between 2013 and 2014.

Gray dots represent 2011. Data missing for 10.9% of respondents. Each race category excludes Hispanic/Latino.
~ Data suppressed (n<30)



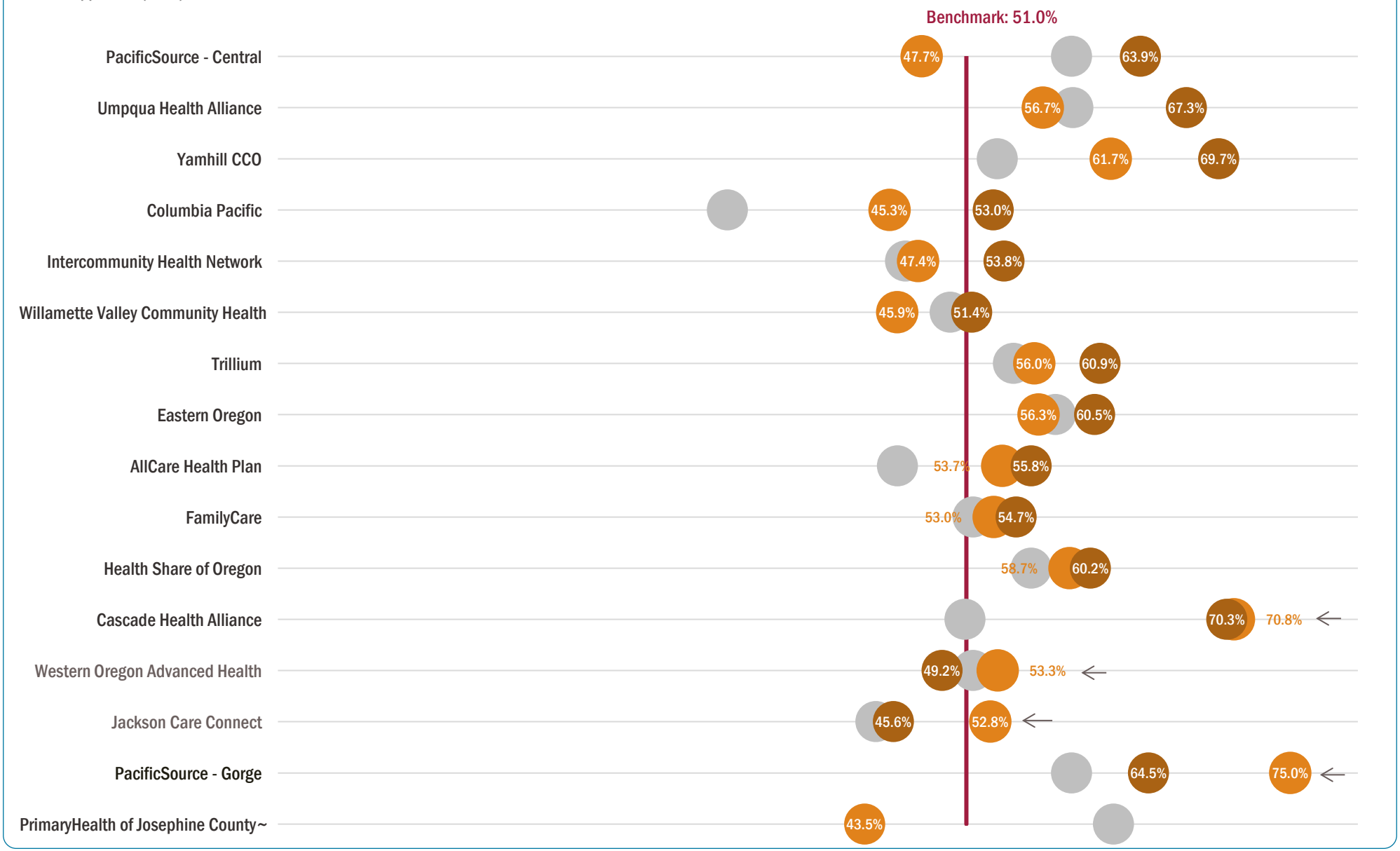
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

Twelve of 16 CCOs increased follow-up care for children prescribed ADHD medication between 2013 and 2014, and 14 met the benchmark.

Bolded names met benchmark or improvement target.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

~ Data suppressed (n<30)



FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (CONTINUATION AND MAINTENANCE PHASE)

Follow-up care for children prescribed ADHD medication (continuation and maintenance phase)

Measure description: Percentage of children (ages 6-12) who remained on attention deficit hyperactivity disorder (ADHD) medication for 210 days after receiving a new prescription and who had at least two follow-up visits with a provider within 270 days after the initiation phase (see page 57).

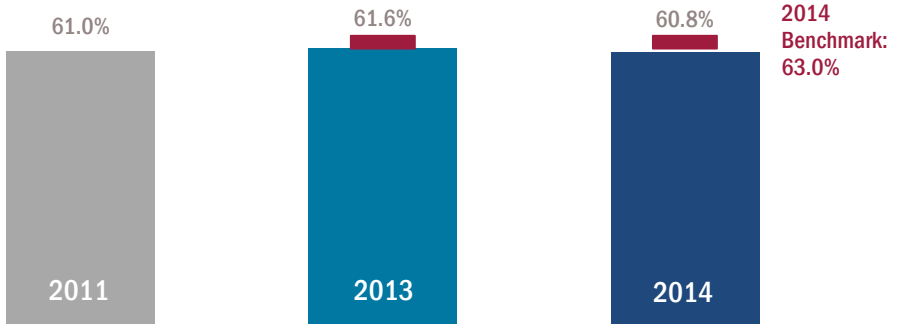
Purpose: Children with attention deficit hyperactivity disorder can be greatly helped by ADHD medication. One critical component of care is that children have follow-up visits once they are on the medication. After a child receives ADHD medication, a primary care provider should continue to assess learning and behavior and help manage the condition.

2014 data (n=1,097)

Ongoing follow-up care for children prescribed ADHD medication has held fairly steady since 2011. Rates declined slightly in the current measurement period. White and Hispanic/Latino children experienced an increase while the African American/Black population showed a decrease on this measure. Data for other races and ethnicities were suppressed due to small populations. Data are not available at the CCO level for 2014.

Statewide, ongoing follow-up for children prescribed ADHD medication remained steady.

Data source: Administrative (billing) claims
Benchmark source: 2013 National Medicaid 90th percentile



African American members with ADHD experienced a decline in ongoing follow-up care between 2013 and 2014.

Gray dots represent 2011. Data missing for 10.1% of respondents. Each race category excludes Hispanic/Latino.
~Data suppressed due to low numbers (n<30)

HEALTH STATUS (CAHPS)

Health status (CAHPS)

Measure description: Percentage of Medicaid members (adults and children) who report their overall health as good, very good, or excellent.

Purpose: Self-reported health status is a good predictor of future disability, hospitalization, and mortality. Programs to prevent or manage diseases and increase healthy behaviors can all lead to improved health status.

2014 data

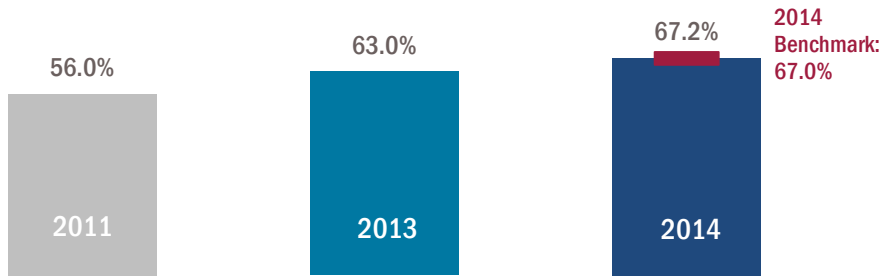
The percentage of adult Medicaid members who reported their overall health is good, very good, or excellent has improved from 2013 to 2014. This improvement may be due in part to the influx of new Medicaid members after the ACA took effect January 1, 2014. Prior to 2014, a higher percentage of adult members were eligible for Medicaid due to disability. With the influx of new, previously ineligible members in 2014, the proportion of healthier members may have increased.

The percentage of children whose parents or guardians reported that they feel healthy has not changed much since 2013.

The only race and ethnicity among whom both children and adults reported feeling healthier between 2013 and 2014 were White members. Hispanic/Latino were the only group among whom both children and adults reported feeling less healthy between 2013 and 2014.

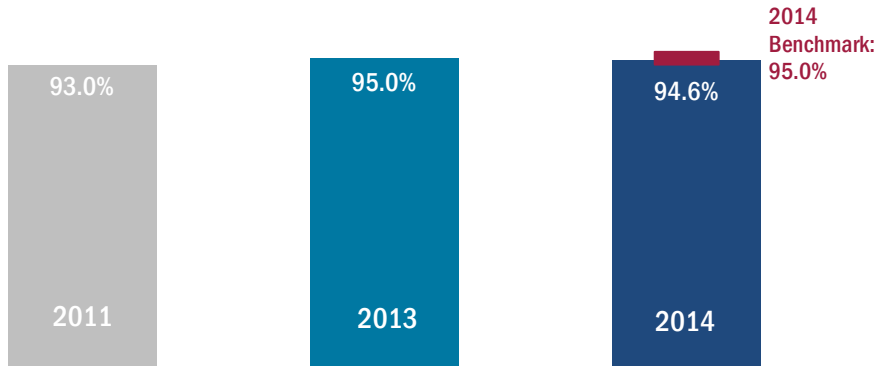
Statewide, more adults reported good overall health in 2014 than in 2013.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
2014 benchmark source: National CAHPS benchmarking database



Statewide, children's self-reported health status remained fairly steady.

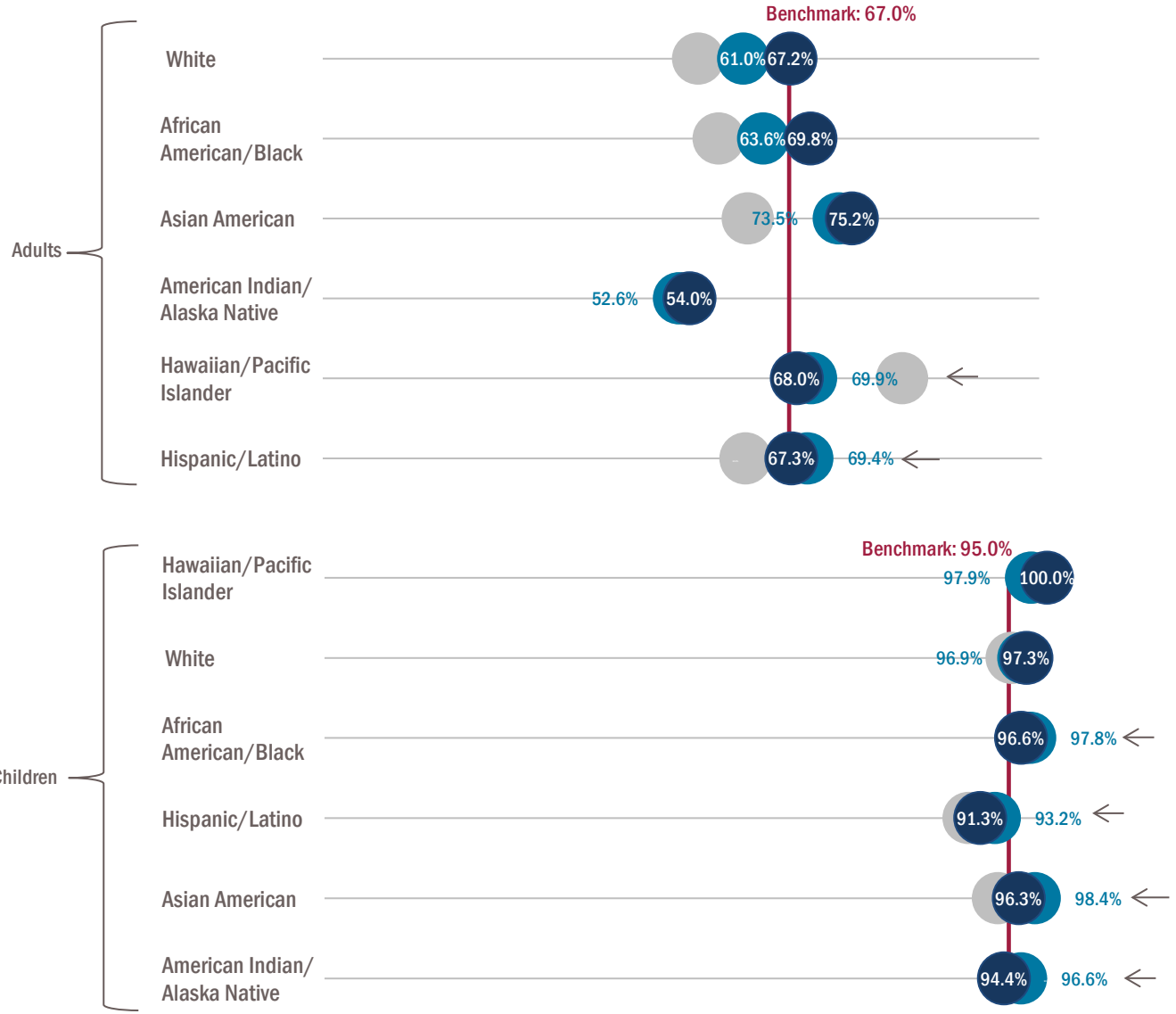
Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
2014 benchmark source: National CAHPS benchmarking database



HEALTH STATUS (CAHPS)

Hispanic/Latino members were the race and ethnicity in which both adults and children reported feeling less healthy in 2014 than in 2013.

Gray dots represent 2011. Data missing for 9.2% of adults and 8.5% of children. Each race category excludes Hispanic/Latino.



HEALTH STATUS (CAHPS)

Adult self-reported health status improved in a greater number of CCOs than child health status between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

IMMUNIZATION FOR ADOLESCENTS

Immunization for adolescents

Measure description: Percentage of adolescents who received recommended vaccines before their 13th birthday.

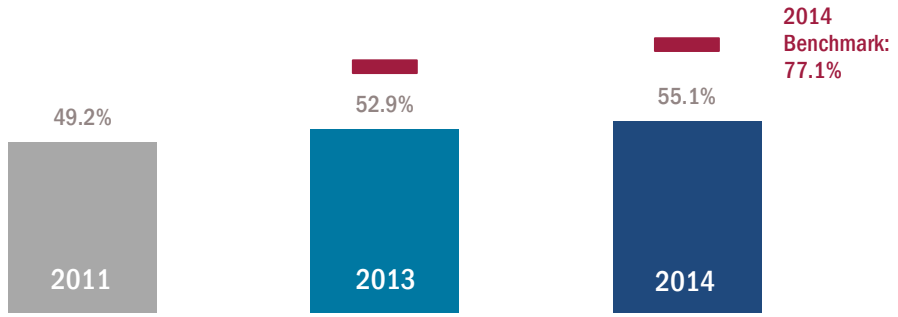
Purpose: Like young children, adolescents also benefit from immunizations. Vaccines are a safe, easy and cost-effective way to prevent serious disease. Vaccines are also cost-effective tools that help to prevent the spread of serious and sometimes fatal diseases.

2014 data (n=13,719)

Although adolescent immunizations continued to increase statewide over 2011 baseline and reached 55.1 percent in 2014, there is still much improvement needed to reach the benchmark (77.1 percent). Adolescent immunizations improved for all races and ethnicities for whom data are published, and ten of 16 CCOs.

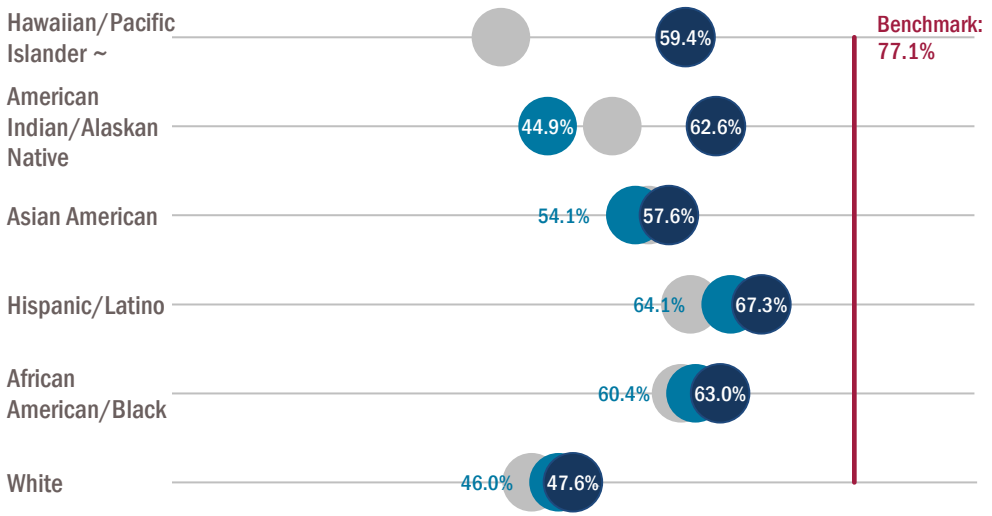
Statewide, adolescent immunizations improved.

Data source: Administrative (billing) claims and ALERT Immunization Information System
2014 benchmark source: 2013 National Medicaid 75th percentile



Adolescent immunizations improved for all races and ethnicities between 2013 and 2014.

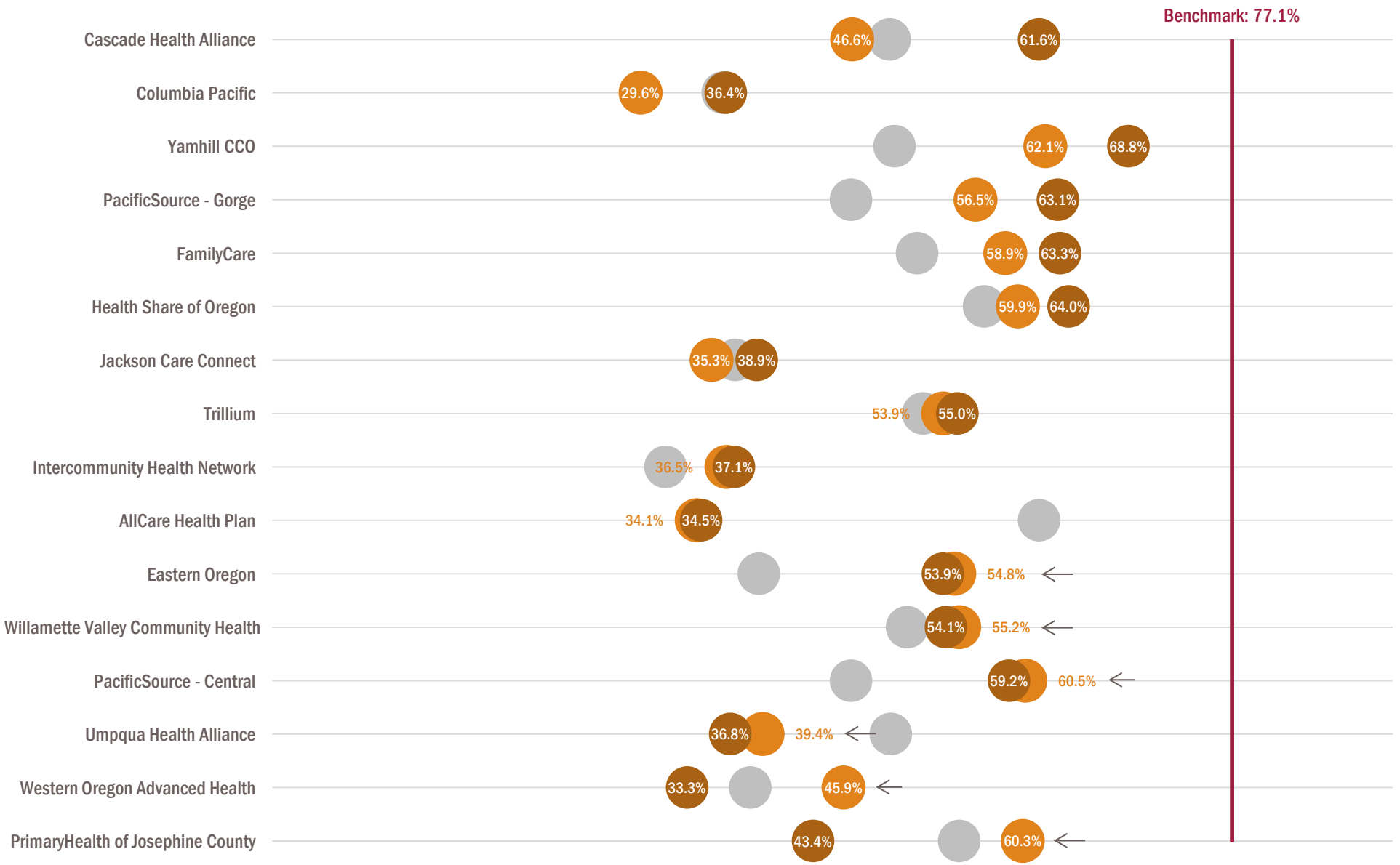
Gray dots represent 2011. Data missing for 7.1% of respondents. Each race category excludes Hispanic/Latino.
~ Data suppressed (n<30)



IMMUNIZATION FOR ADOLESCENTS

While many CCOs improved between 2013 and 2014, adolescent immunizations remain below the benchmark.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)

Initiation and engagement of alcohol or other drug treatment (initiation phase)

Measure description: Percentage of members (ages 13 and older) newly diagnosed with alcohol or other drug dependence and who began treatment within 14 days of the initial diagnosis.

Purpose: There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition.

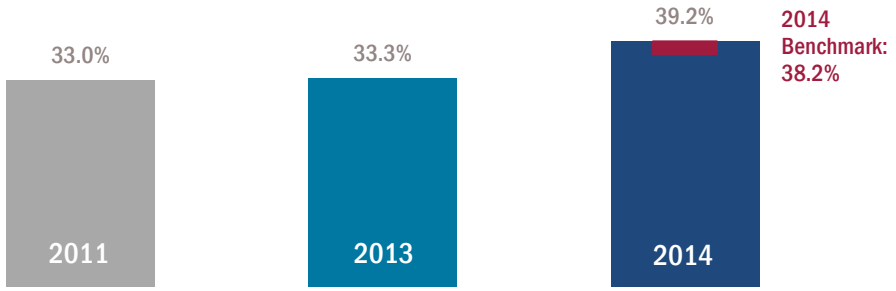
Deliberate efforts to reach those with alcohol or other drug dependence and keep them engaged in treatment can improve health outcomes and save on health care costs.

2014 data (n=13,404)

Statewide, the percentage of members ages 13 and older newly diagnosed with alcohol or drug dependence who began treatment within 14 days of diagnosis surpassed the benchmark in 2014. Nine of 16 CCOs performed above the benchmark (2013 national Medicaid median). However, with fewer than 40 percent of newly diagnosed members receiving timely alcohol or drug treatment, there is much room for improvement.

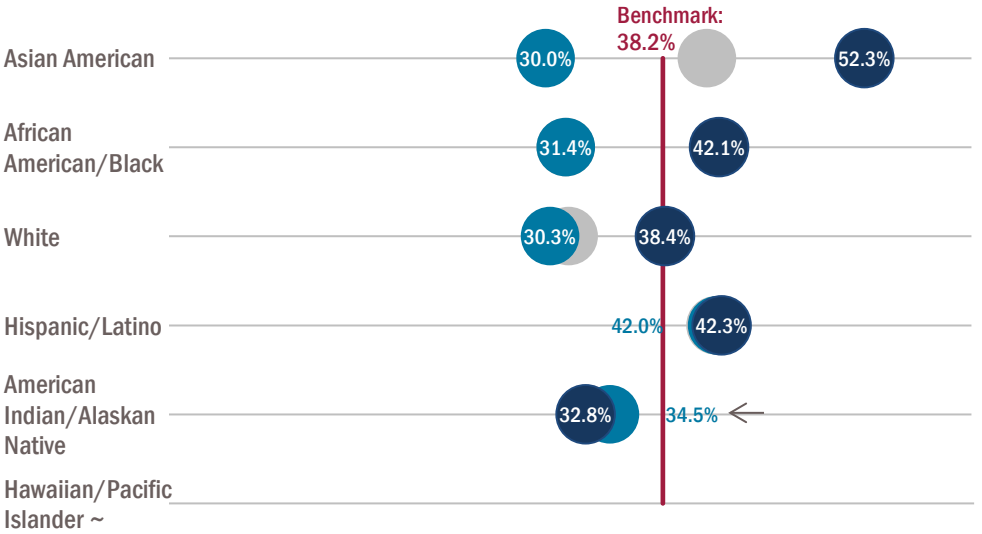
Statewide, initiation of alcohol or other drug treatment improved.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 national Medicaid median



Initiation improved markedly for Asian American members between 2013 and 2014.

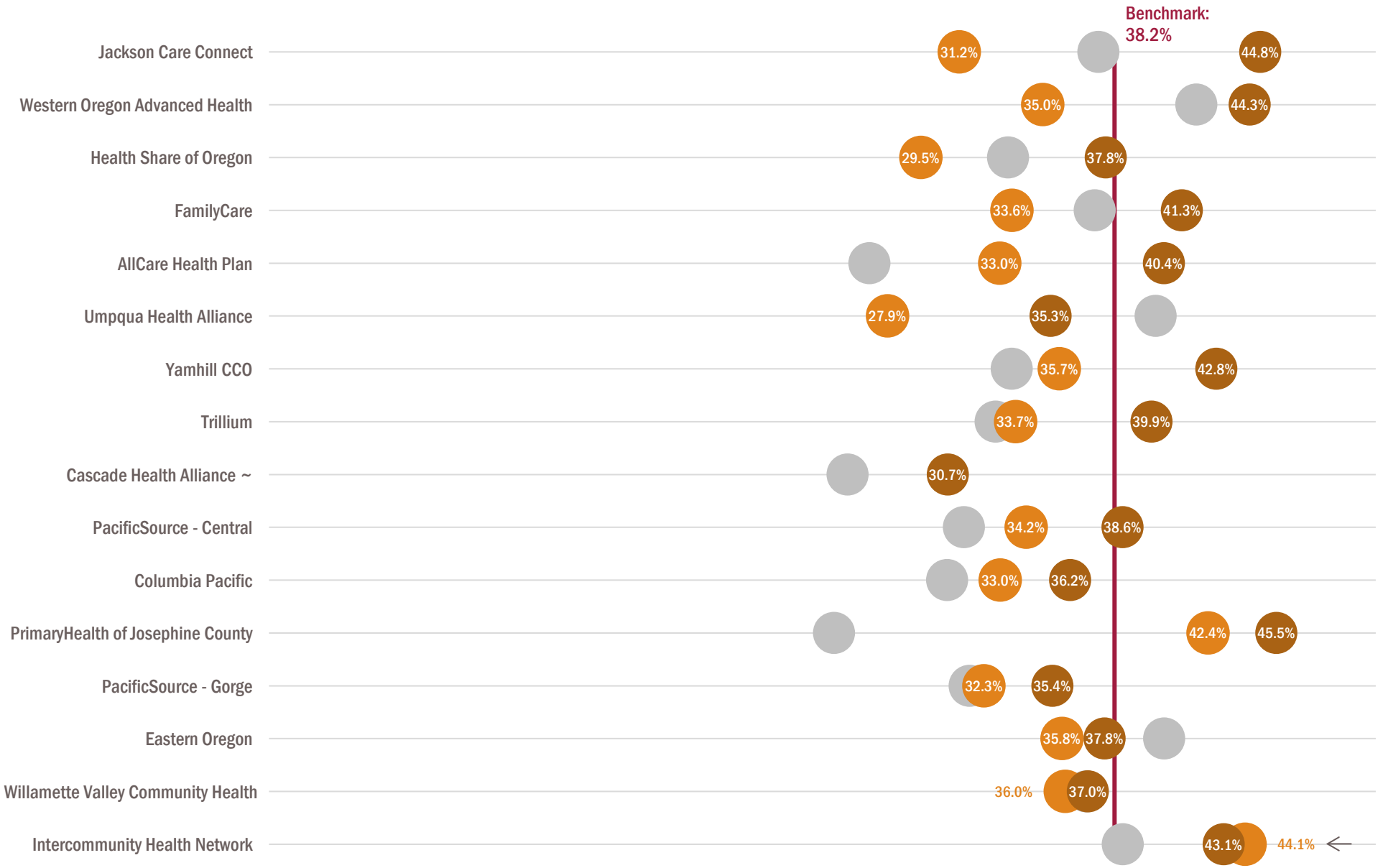
Gray dots represent 2011. Data missing for 9.7% of respondents. Each race category excludes Hispanic/Latino.
~ Data suppressed (n<30)



INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)

Fifteen of sixteen CCOs improved initiation of alcohol or other drug treatment between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.
~ Data suppressed (n<30)



INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

Initiation and engagement of alcohol or other drug treatment (engagement phase)

Measure description: Percentage of members (ages 13 and older) who had two or more additional services for alcohol or other drug dependence within 30 days of their initial treatment.

Purpose: Many individuals with alcohol and other drug disorders leave treatment prematurely, even though individuals who remain in treatment longer have better outcomes. Ongoing engagement is an important step between the first visit and completing a full treatment.

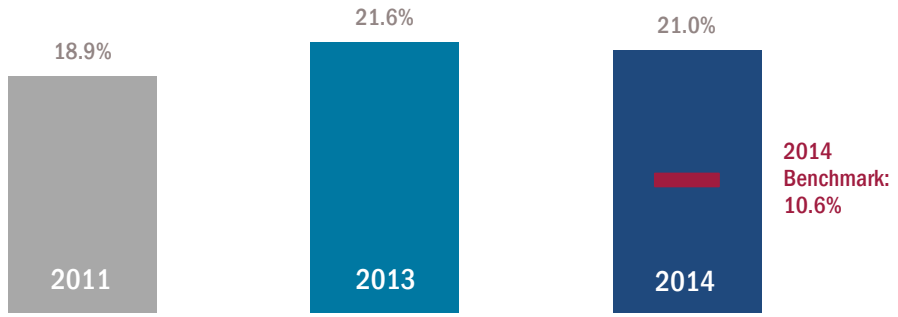
Deliberate efforts to reach those with alcohol or other drug dependence and keep them engaged in treatment can improve health outcomes and save on health care costs.

2014 data (n=13,404)

Statewide, the percentage of members ages 13 and older with two or more services for alcohol or drug dependence within 30 days of initial treatment dropped very slightly (less than 1 percentage point) from 2013 to 2014. This metric decreased in many CCOs, although all were above the benchmark. Nationally, performance on this metric is low with a Medicaid median of 10.6 percent.

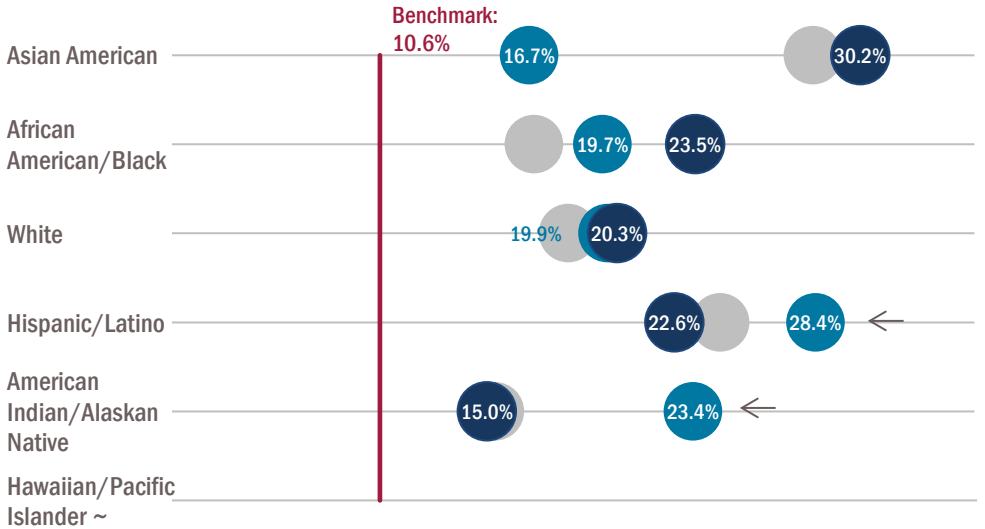
Statewide, engagement of alcohol or other drug treatment remained steady.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 national Medicaid median



Asian American members experienced the greatest improvement between 2013 and 2014.

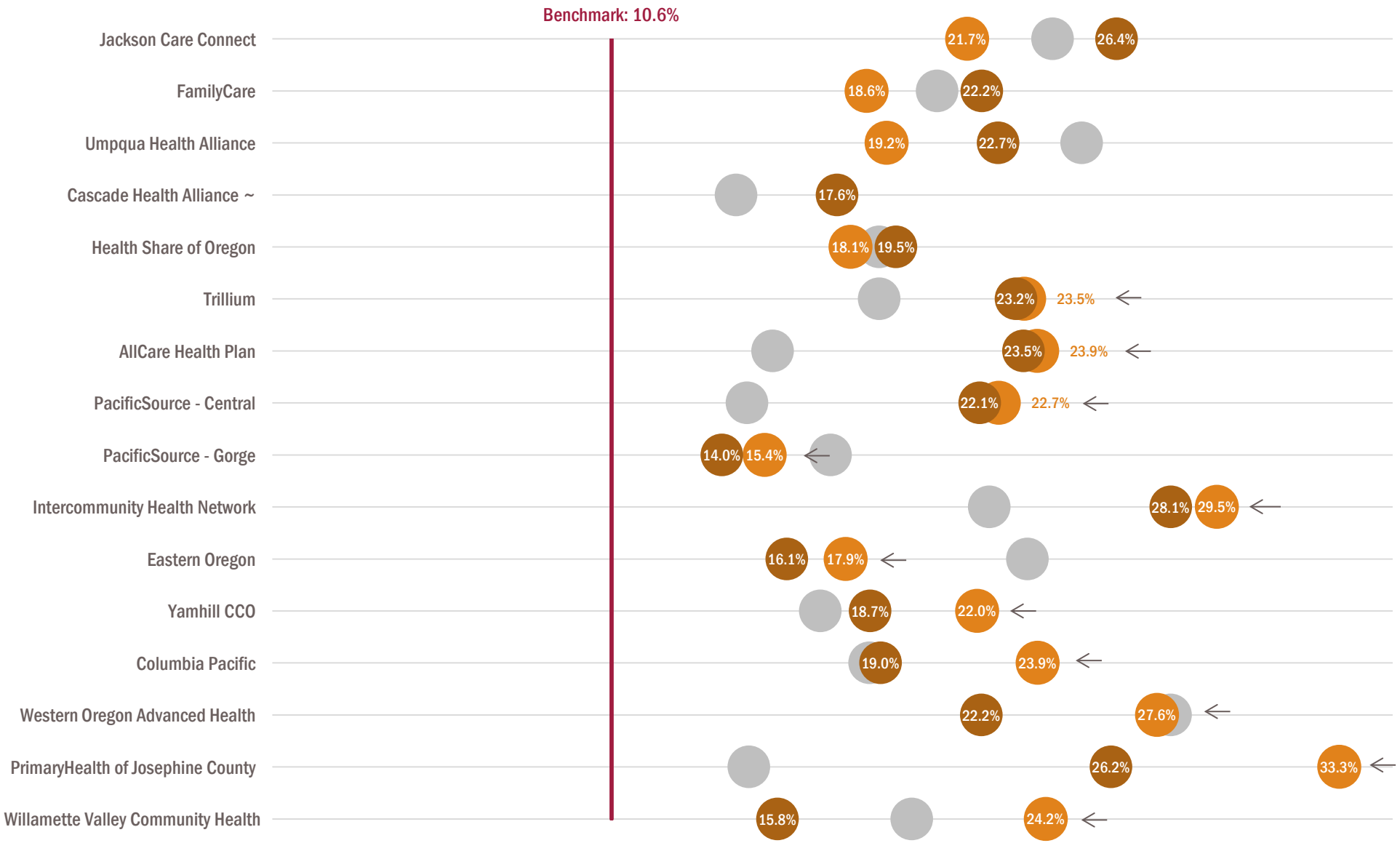
Gray dots represent 2011. Data missing for 9.7% of respondents. Each race category excludes Hispanic/Latino.
~ Data suppressed (n<30)



INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

Engagement in alcohol or other drug treatment declined in 11 CCOs between 2013 and 2014, although all 16 were above the benchmark.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (COMPONENT 1)

Medical assistance with smoking and tobacco use cessation: doctor advised to quit

Component 1: Percentage of adult tobacco users advised to quit by their doctor.

Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

2014 data

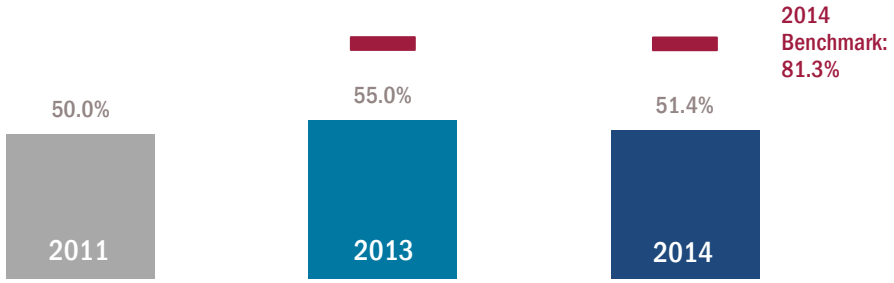
Statewide, the percentage of tobacco users who were advised by their doctor to quit declined from 55.0 percent in 2013 to 51.4 percent in 2014. Performance on this measure remained well below the benchmark of 81.4%.

According to the 2014 Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) survey, 76.4 percent of smokers want to quit and 62.2 percent of smokers have attempted to quit in the last year. Provider advice to quit is an important motivator for members attempting to quit smoking.

While Asian American members had the lowest tobacco use prevalence than any other group (see page 96), a lower percentage of Asian American tobacco users received advice to quit than other races and ethnicities. Half of CCOs improved performance on this measure in 2014, and performance ranged from 42.4 percent to 61.6 percent.

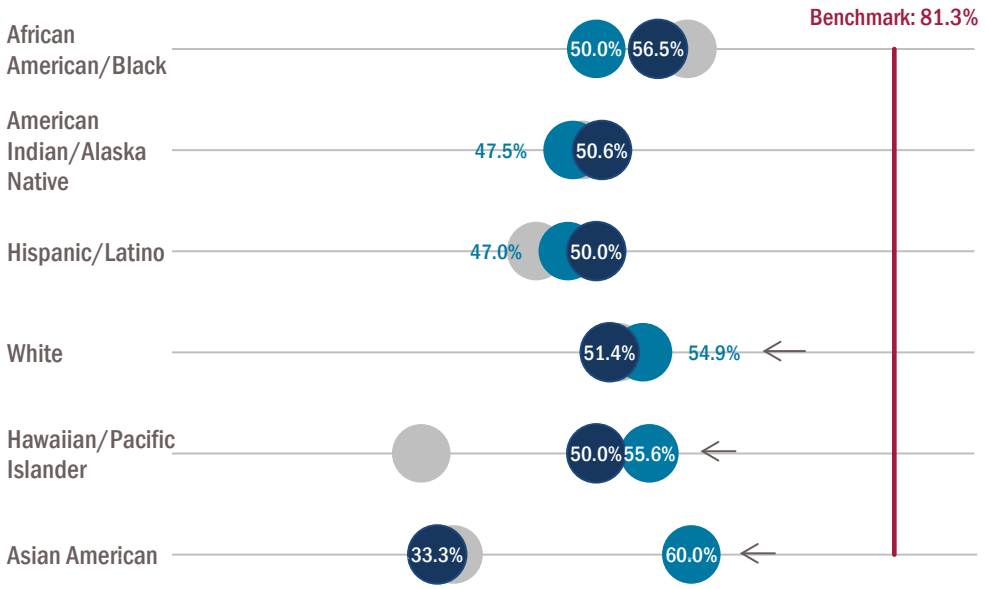
Statewide, the percentage of tobacco users who were advised by their doctor to quit declined in 2014.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
2014 benchmark source: 2013 National Medicaid 90th percentile



A lower percentage of Asian American tobacco users received advice to quit in 2014 than in 2013.

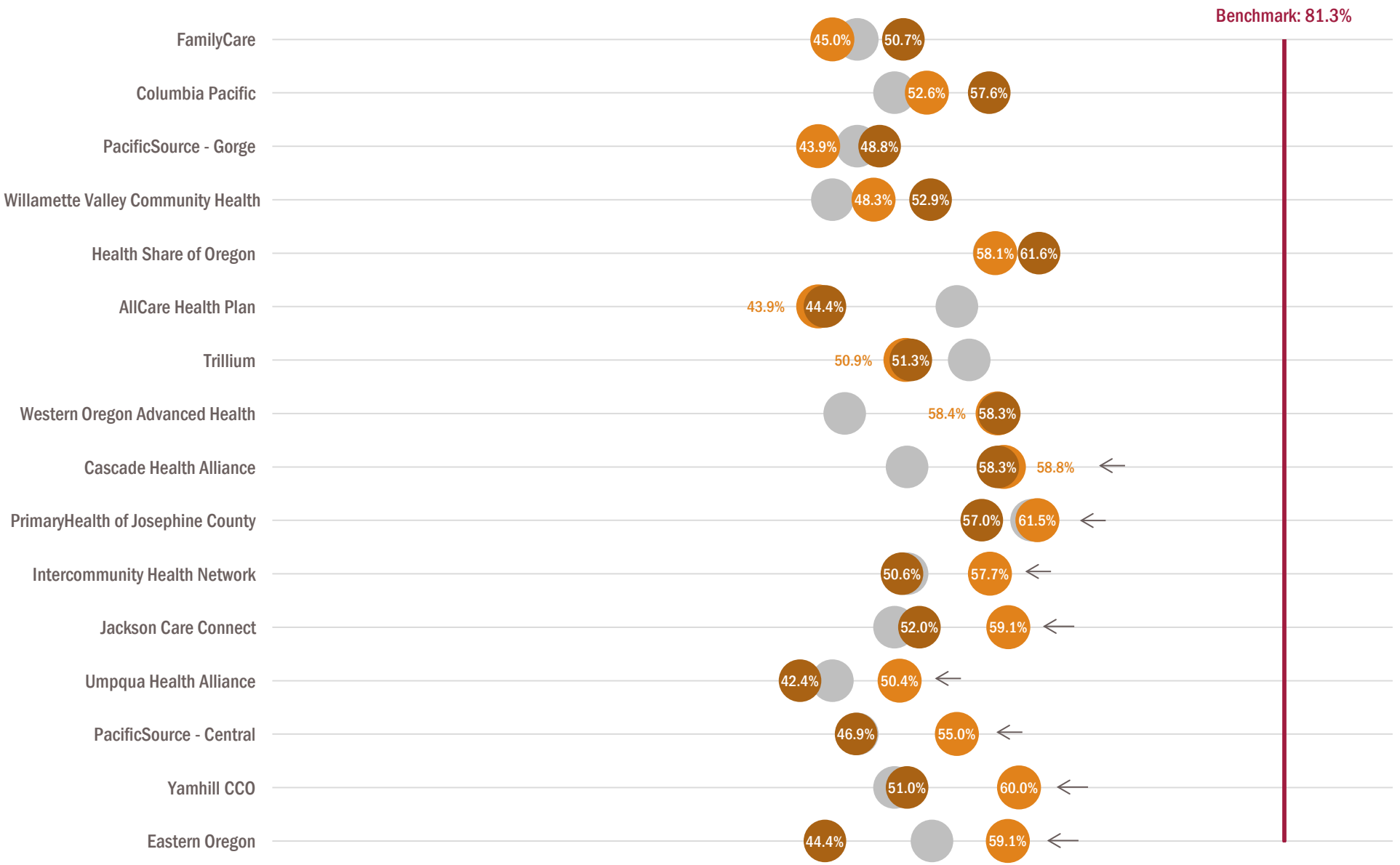
Gray dots represent 2011. Data missing for 9.2% of respondents. Each race category excludes Hispanic/Latino.



MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (COMPONENT 1)

The percentage of tobacco users who were advised to quit by their doctor increased in half of CCOs between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (COMPONENT 2)

Medical assistance with smoking and tobacco use cessation: doctor recommended medication to quit

Component 2: Percentage of adult tobacco users whose doctor discussed or recommended medication to quit smoking.

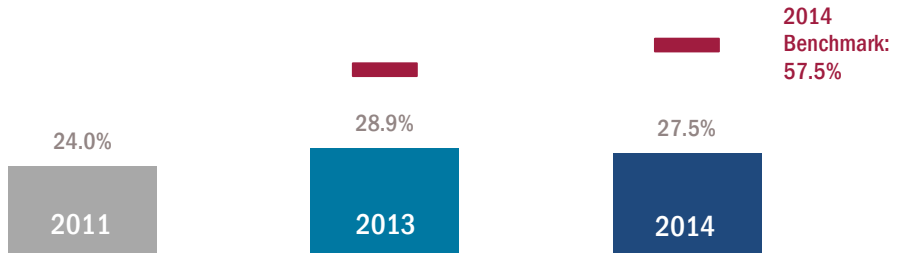
Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

2014 data

Across the state, doctors were less likely to recommend medication to quit smoking in 2014 (27.5 percent) than in 2013 (28.9 percent). Doctors were more likely to recommend medication to quit smoking to Hawaiian / Pacific Islander members in 2014 than to any other race and ethnicity. Only five of 16 CCOs showed an increase in this measure in 2014 as compared to 2013.

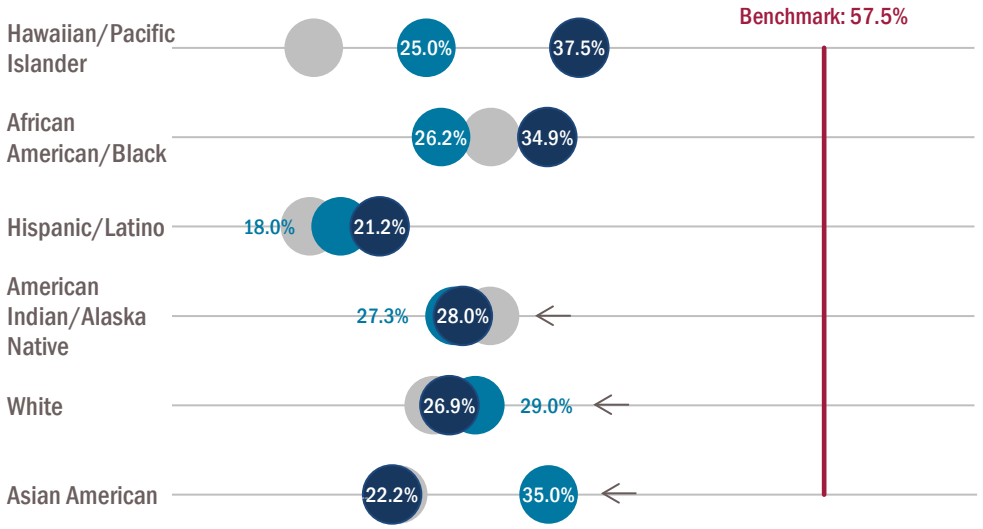
Statewide, a lower percentage of tobacco users said their doctor recommended medication to quit smoking in 2014 than in 2013.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
2014 benchmark source: 2013 National Medicaid 90th percentile



The percentage of Asian American members whose doctor recommended medication to quit smoking decreased between 2013 and 2014.

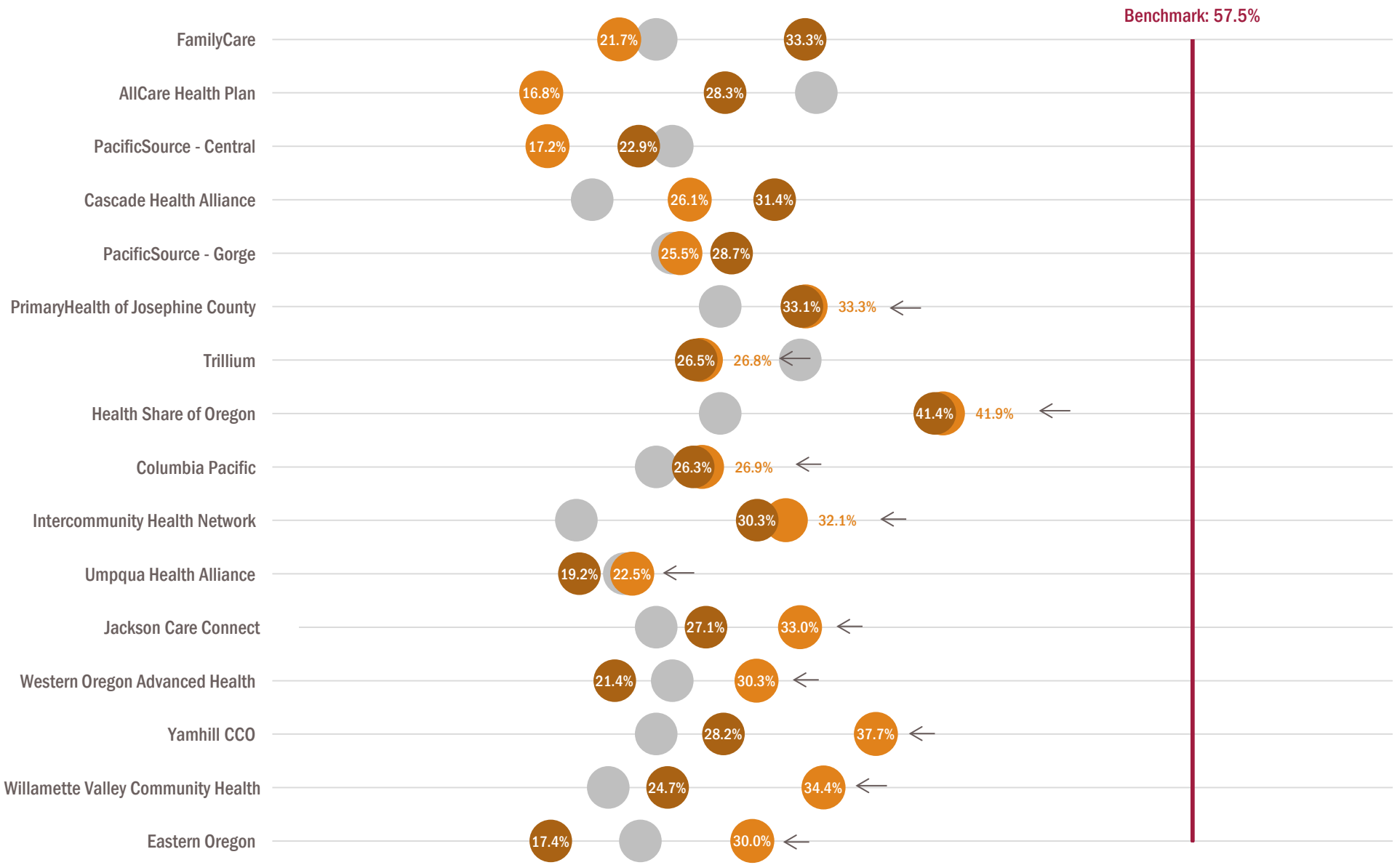
Gray dots represent 2011. Data missing for 9.2% of respondents. Each race category excludes Hispanic/Latino.



MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (COMPONENT 2)

The percentage of tobacco users whose doctor recommended medication to quit decreased in 11 of 16 CCOs between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (COMPONENT 3)

Medical assistance with smoking and tobacco use cessation: doctor recommended strategies to quit

Component 3: Percentage of adult tobacco users whose doctor discussed or recommended strategies to quit smoking.

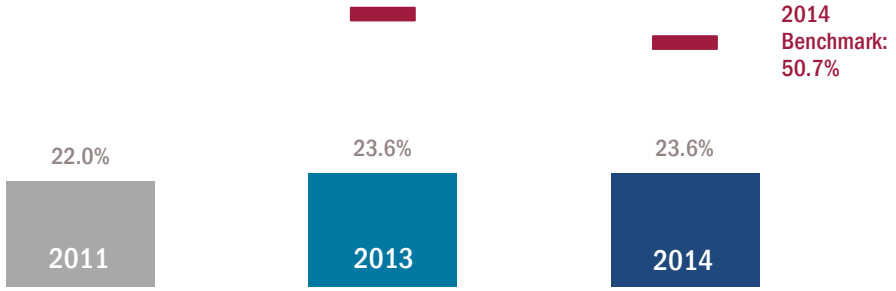
Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

2014 data

The percentage of tobacco users whose doctor discussed or recommended strategies to quit smoking held steady at 23.6 percent in 2014 at the statewide level. Hawaiian / Pacific Islander members were most likely to learn about strategies to quit from their doctor in both 2013 and 2014. Nine of 16 CCOs showed an increase in this measure in 2014 as compared to 2013.

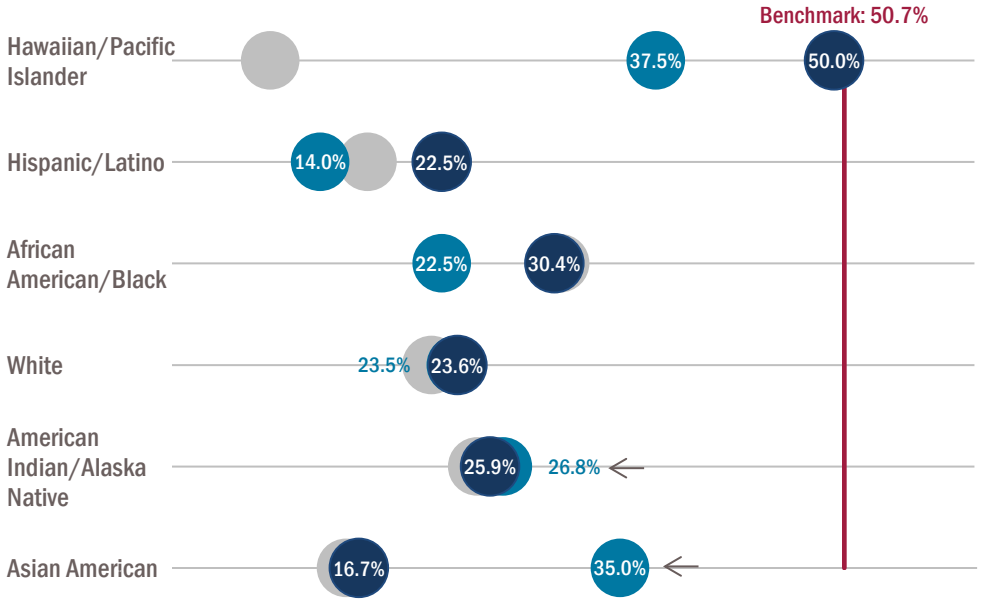
Statewide, the percentage of tobacco users whose doctor recommended strategies to quit smoking remained steady.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
2014 benchmark source: 2013 National Medicaid 90th percentile



Hawaiian/Pacific Islander tobacco users learned strategies to quit from their doctor more frequently than other members in both 2013 and 2014.

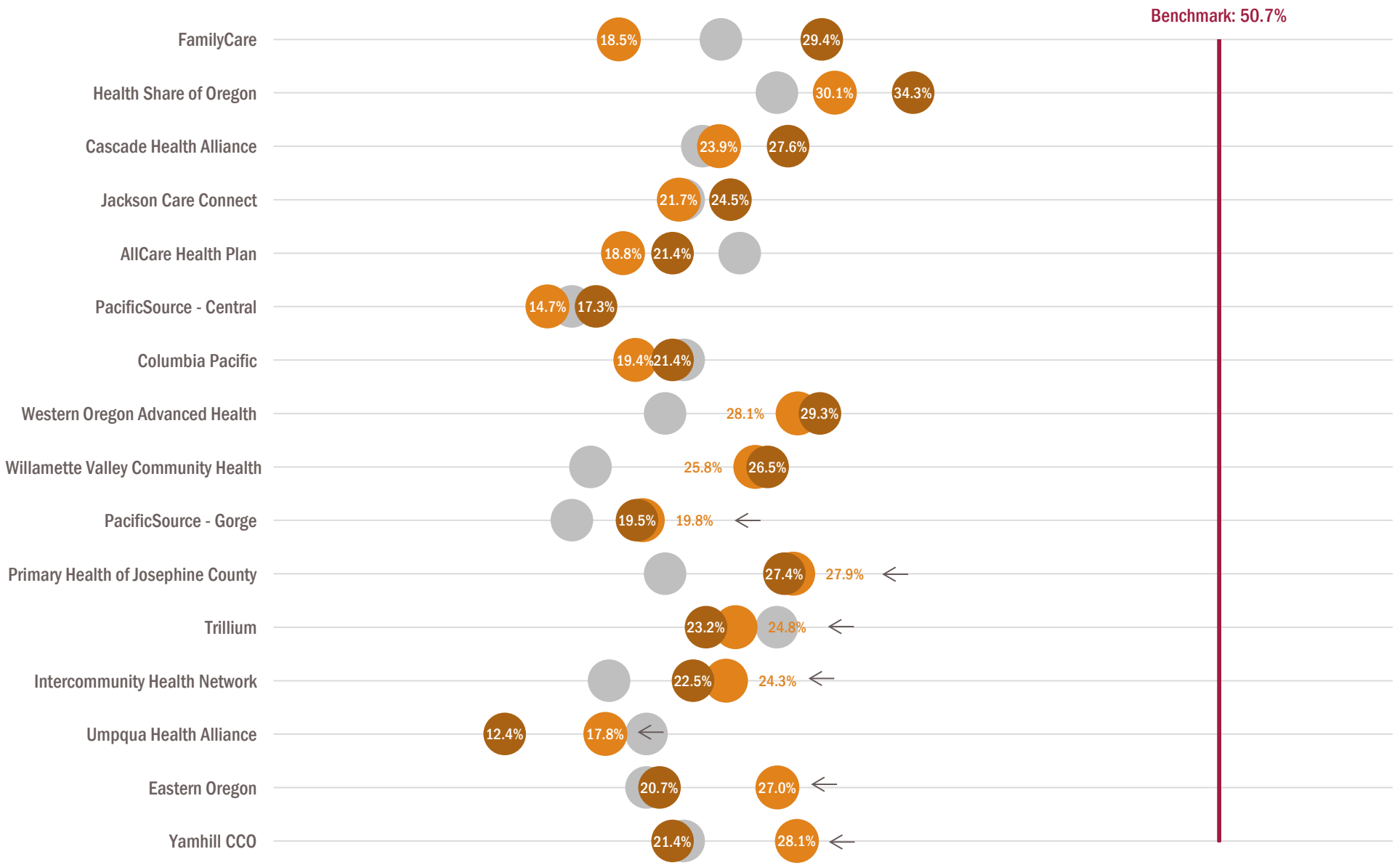
Gray dots represent 2011. Data missing for 9.2% of respondents. Each race category excludes Hispanic/Latino.



MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (COMPONENT 3)

The percentage of adult tobacco users whose doctor recommended strategies to quit smoking increased in 9 CCOs between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



MENTAL AND PHYSICAL HEALTH ASSESSMENTS WITHIN 60 DAYS FOR CHILDREN IN DHS CUSTODY

Mental and physical health assessments within 60 days for children in DHS custody

Measure description: Percentage of children age 4+ who receive a mental health assessment and physical health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care). Physical health assessments are required for children under age 4, but not mental health assessments.

Purpose: Children who have been placed in foster care should have their mental and physical health checked so that an appropriate care plan can be developed. Mental and physical health assessments are a requirement for the foster program because of their importance to improving the health and well-being of a child in a trying situation.

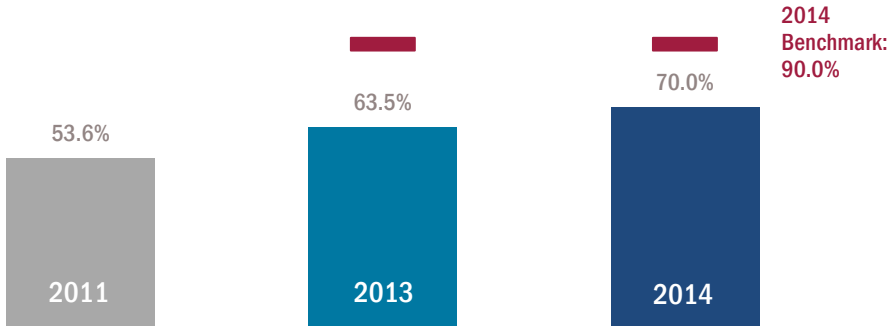
2014 data (n=1,467)

The percentage of children receiving timely a physical and mental health assessment has continually increased since 2011. In 2014, the statewide results were 70 percent, still substantially below the benchmark of 90 percent. Mental and physical health assessments were fairly consistent for all reportable races and ethnicities.

Thirteen CCOs with reportable data both improved their performance and met their improvement targets for this measure in 2014. One CCO achieved timely physical and mental health assessments for 100% of their enrolled children in DHS custody.

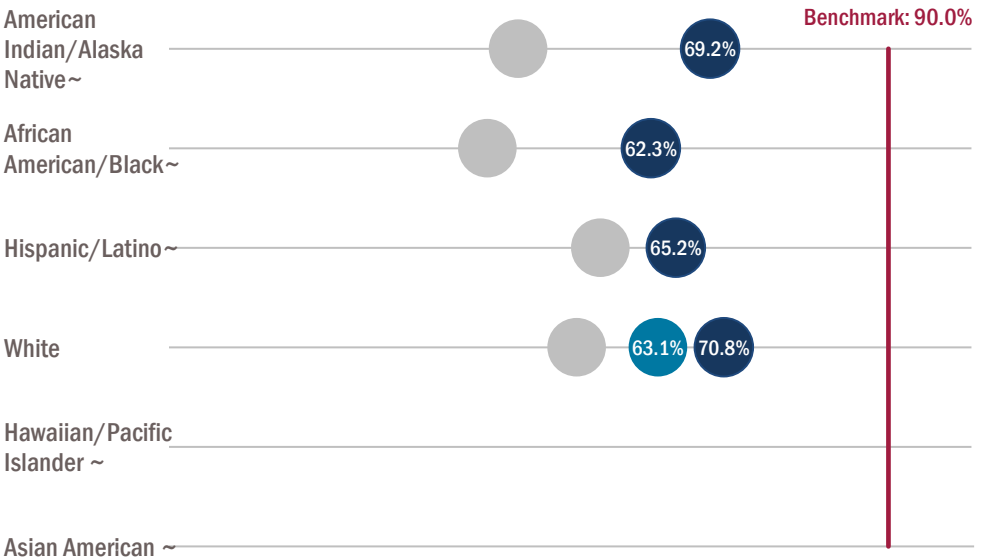
Statewide, assessments for children in DHS custody increased in 2014.

Data source: Administrative (billing) claims + ORKids
2014 benchmark source: Metrics and Scoring Committee consensus



Assessments were below the benchmark for all reportable races and ethnicities in both 2013 and 2014.

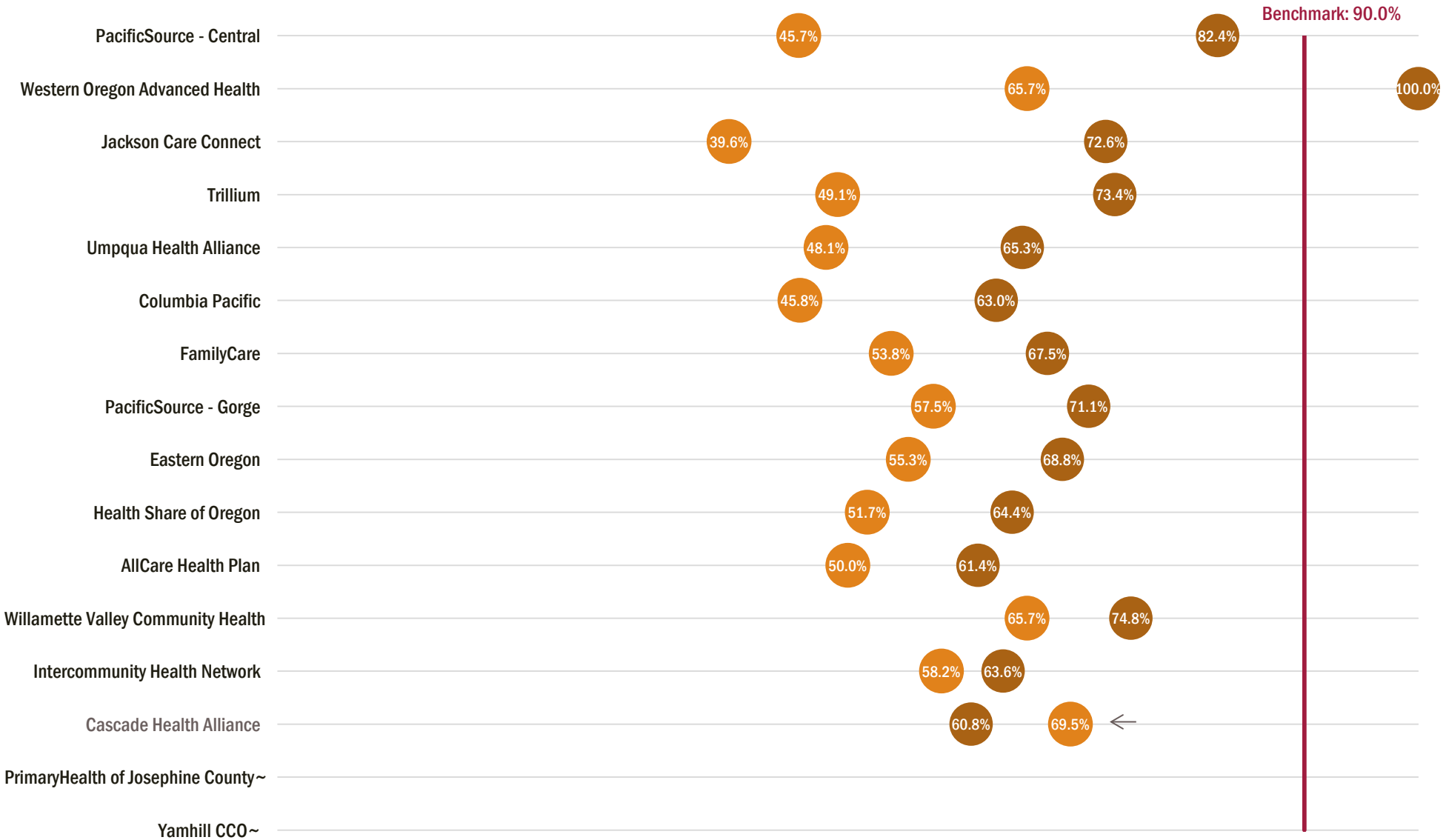
Gray dots represent 2011. Data missing for 2.8% of respondents. Each race category excludes Hispanic/Latino.
~ Data suppressed (n<30)



MENTAL AND PHYSICAL HEALTH ASSESSMENTS WITHIN 60 DAYS FOR CHILDREN IN DHS CUSTODY

Overall, CCOs improved markedly on this measure between baseline and 2014, with 15 of 16 meeting the benchmark or improvement target.

Bolded names met benchmark or improvement target.
Baseline data represent combined 2011 and 2013 performance. These combined data provide larger denominators and are more comparable to 2014 performance.
~ Data suppressed (n<30)



OBESITY PREVALENCE AMONG ADULTS

Obesity prevalence

Measure description: Percentage of adult Medicaid members (ages 18 and older) who are obese, defined as body mass index greater than 30.

Purpose: Obesity is the second leading cause of preventable death in Oregon and is a major risk factor for many conditions including diabetes, cancer, and heart disease. In addition to improving health outcomes, helping people reach a healthy weight can reduce health care costs.

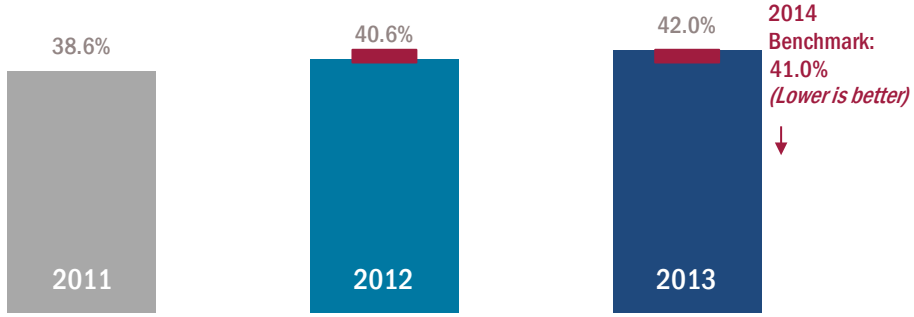
2013 data

Obesity prevalence increased from 2012 to 2013 and surpassed the benchmark (lower rates are better). In 2013, 42.0 percent of CCO members were obese. By contrast, 26.9 percent of the general population was obese. 2013 is the most recent year data from the Oregon Behavioral Risk Factor Surveillance System (BRFSS) survey are available.

However, Oregon's 2014 Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) survey found that 36.2 percent of Medicaid members were obese. This slightly lower rate may be due to the inclusion of new members enrolled after the ACA expansion, who may be healthier overall.

Statewide, obesity prevalence increased slightly.

Data source: Oregon Behavioral Risk Factor Surveillance System (BRFSS) survey
2014 benchmark source: Oregon's 1115 demonstration waiver goals
2012 data have been corrected from previous reports.



Race and ethnicity data.

Race and ethnicity data for this measure are unavailable.

PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Patient-centered primary care home enrollment

Measure description: Percentage of CCO members who were enrolled in a recognized patient-centered primary care home (PCPCH).

Purpose: Patient-centered primary care homes are clinics that have been recognized for their commitment to quality, patient-centered, coordinated care. Patient-centered primary care homes help improve a patient's health care experience and overall health.

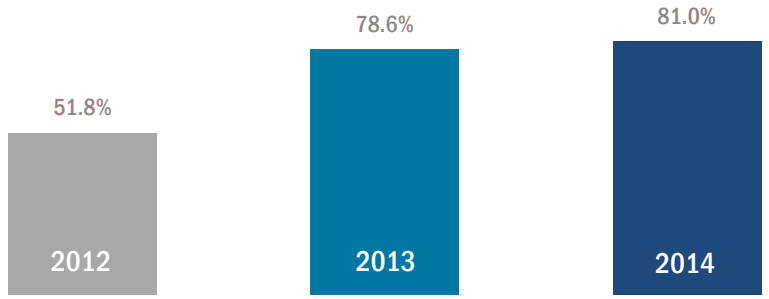
2014 data

Enrollment in patient-centered primary care homes increased by 56 percent since 2012, the baseline year for this metric. This improvement is impressive considering that CCO enrollment increased more than 60 percent in 2014 due to the ACA Medicaid expansion (see graph at right). See pages 100-109 for more information on the Medicaid population in 2014.

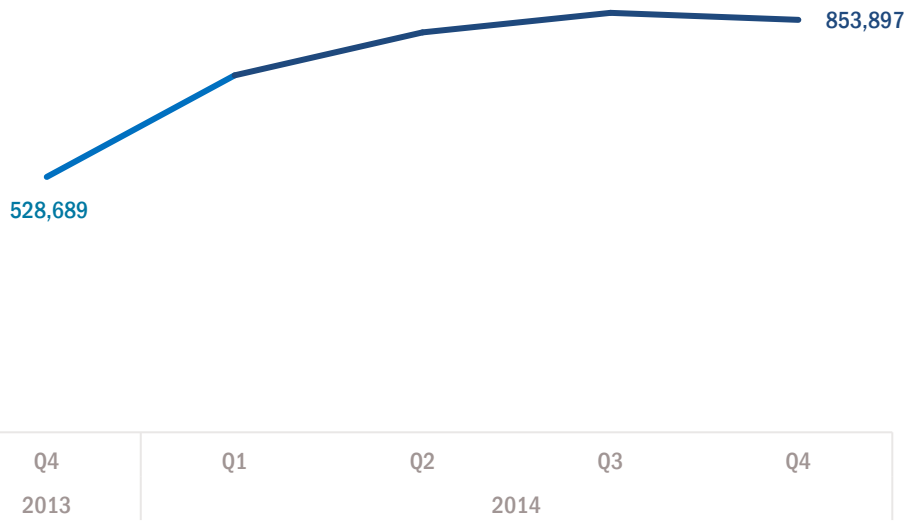
Race and ethnicity data are not available for this measure.

Statewide, patient-centered primary care home enrollment continued to increase, despite Medicaid expansion.

Data source: CCO quarterly report
2014 benchmark source: n/a



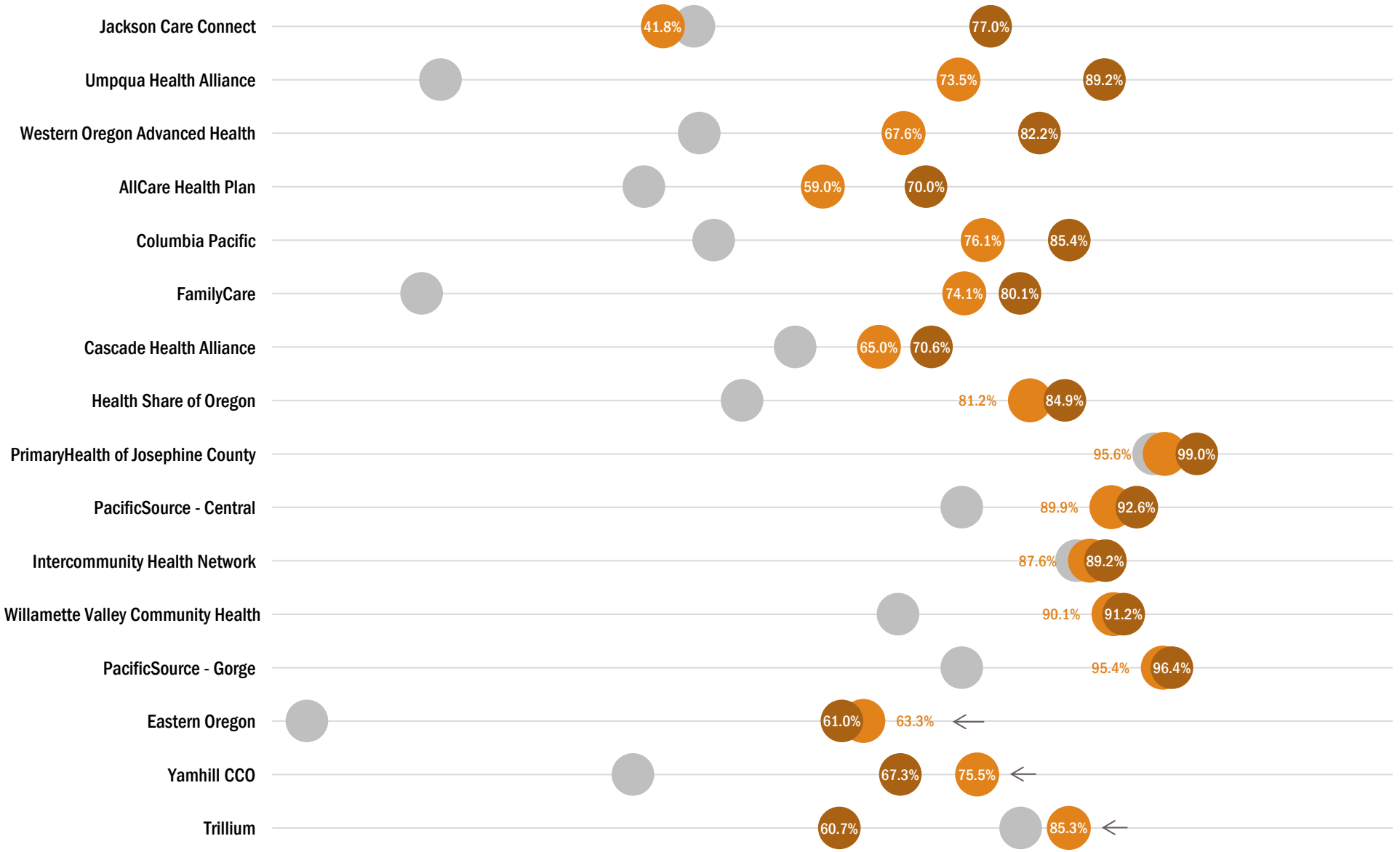
CCO enrollment increased more than 60 percent between 2013 and 2014.



PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Overall, PCPCH enrollment continued to increase between 2013 and 2014.

All CCOs met requirement for quality pool payment (at least 60% enrollment).
Gray dots represent 2012 baselines, which are pre-CCO and based upon a predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

Diabetes short term complications admission rate

Measure description: Rate of adult members (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease. Rates are reported per 100,000 member years. A lower score is better.

PQI stands for Prevention Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays is also helps to reduce the costs of health care.

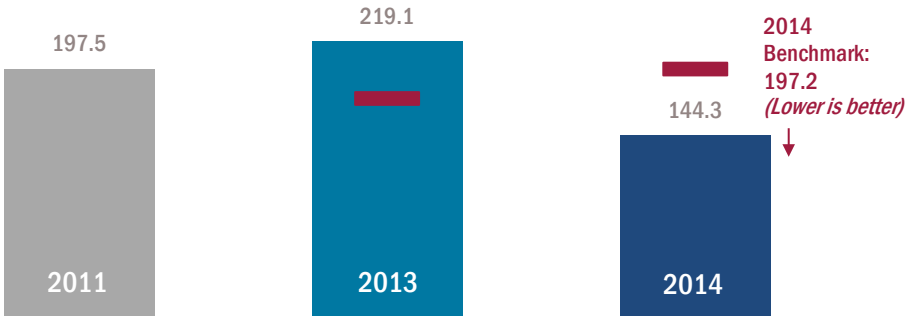
2014 data (n=5,495,358 member months)

The statewide diabetes short-term complication admission rate declined dramatically from 2013 to 2014 and achieved the benchmark for the first time. Lower is better for this measure.

All races and ethnicities experienced a decrease in diabetes short-term complication admission rates with the exception of African American/Black members. CCO results were slightly more mixed, with 11 of 16 showing improvement.

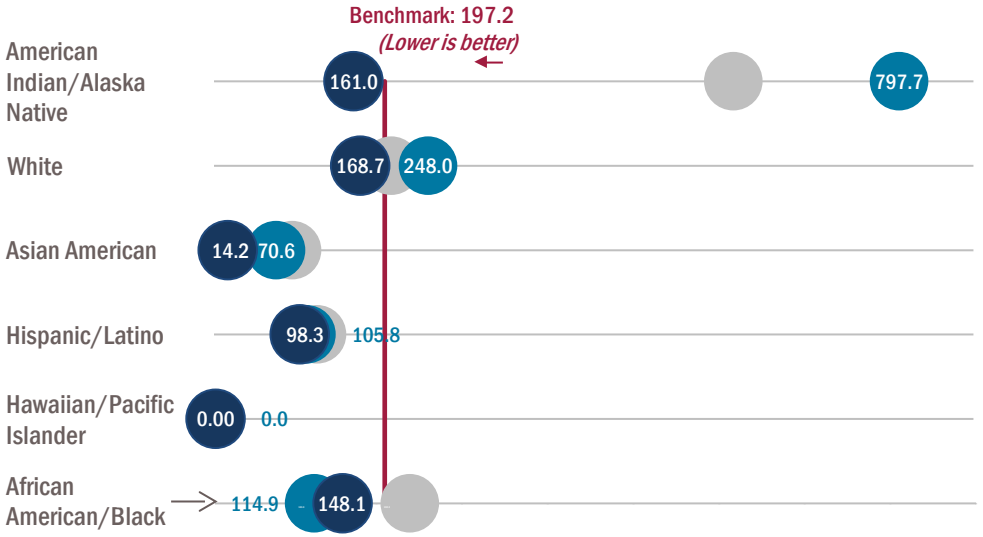
Statewide, the diabetes short-term complication admission rate improved.

Data source: Administrative (billing) claims
Benchmark source: 10% reduction from previous year's statewide rate
2011 and 2013 data have been updated and may differ from earlier reports



American Indian / Alaska Native members experienced the greatest improvement in admission rates due to short term complications of diabetes between 2013 and 2014.

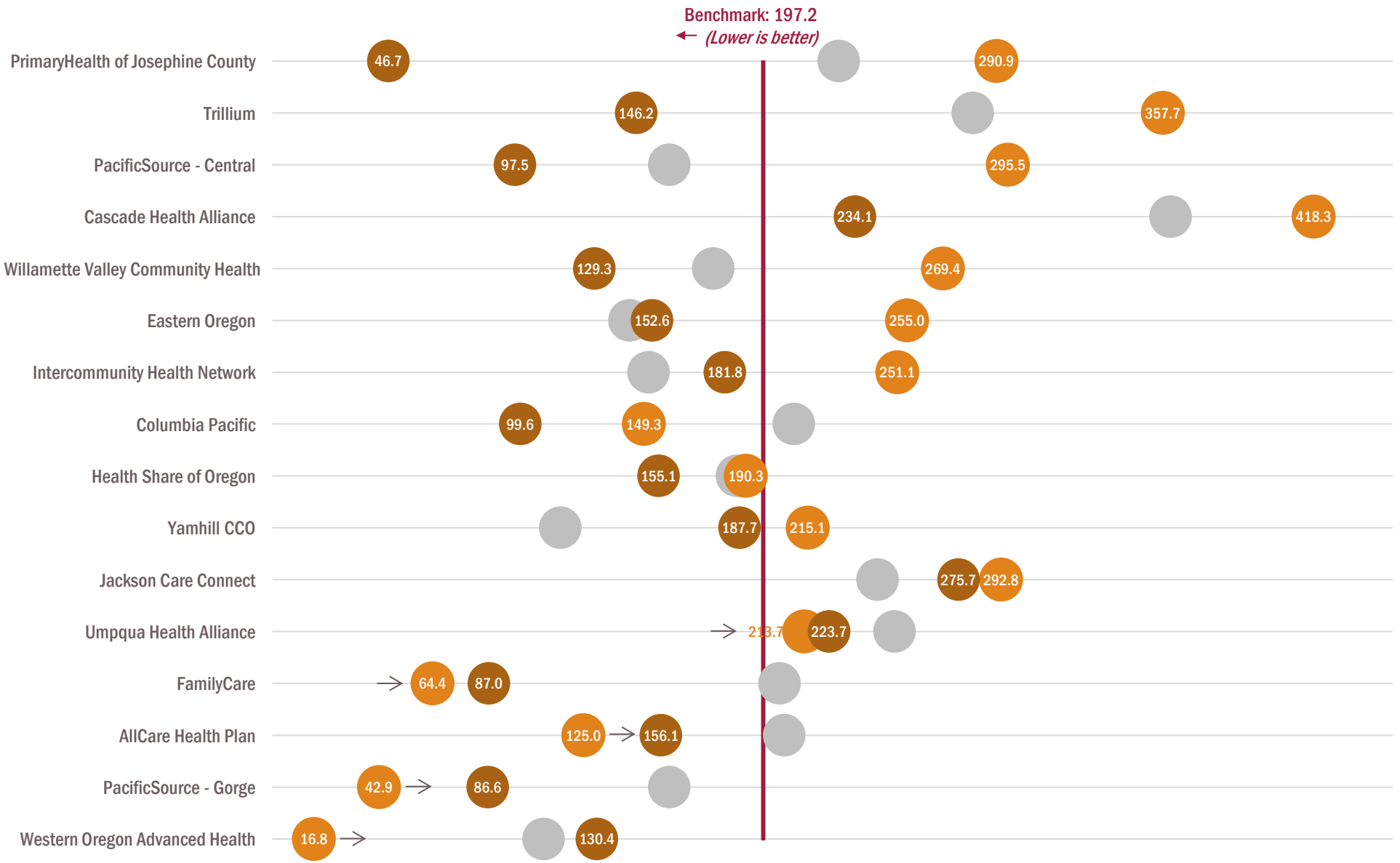
Gray dots represent 2011. Data missing for 11.2% of respondents. Each race category excludes Hispanic/Latino.
2011 and 2013 data have been updated and may differ from earlier reports.



PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

Eleven of 16 CCOs improved diabetes short-term complication admission rates between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined. 2011 and 2013 data have been updated and may differ from earlier reports.



PQI 05: CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE

Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate

Measure description: Rate of adult members (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma. Rates are reported per 100,000 member years. A lower score is better.

PQI stands for Prevention Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

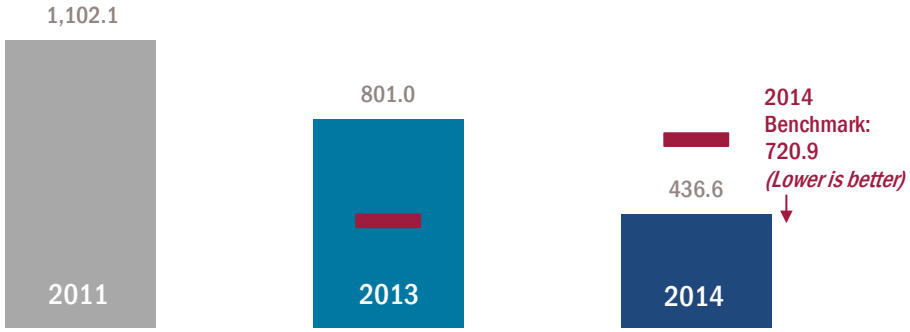
Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce health care costs.

2014 data (n=2,572,352 member months)

Statewide, the admission rate of older adults for COPD or asthma continued to decline from 2013 to 2014. The rate was well below the benchmark for the first time in 2014. Lower is better for this measure. Admission rates improved among all races and ethnicities, although African American/Black members had the highest admission rate. Fourteen of 16 CCOs improved their performance in 2014.

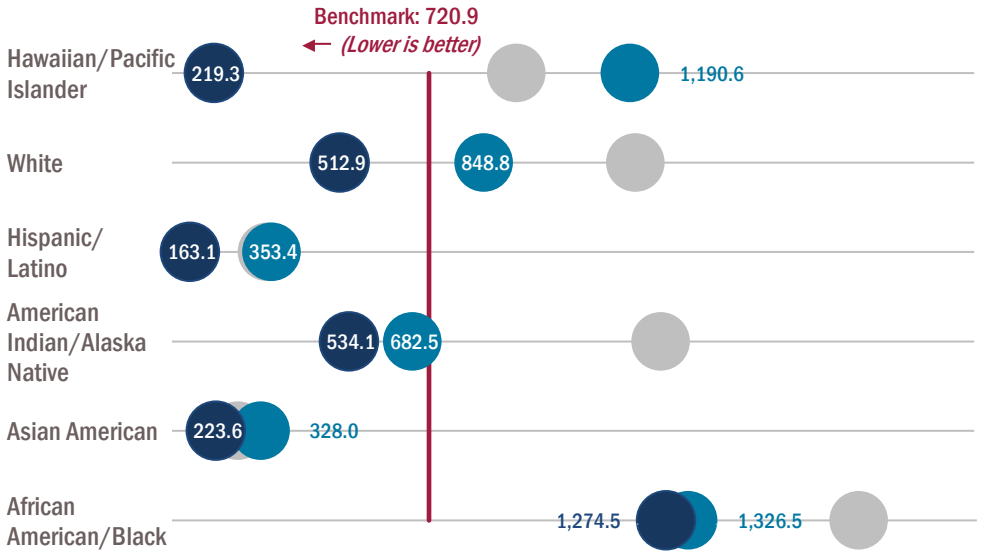
Statewide, the COPD or asthma admission rate improved in 2014.

Data source: Administrative (billing) claims
Benchmark source: 10% reduction from previous year's statewide rate
2011 and 2013 data have been updated and may differ from earlier reports.



Admission rates for COPD/asthma varied widely but improved for all races and ethnicities between 2013 and 2014.

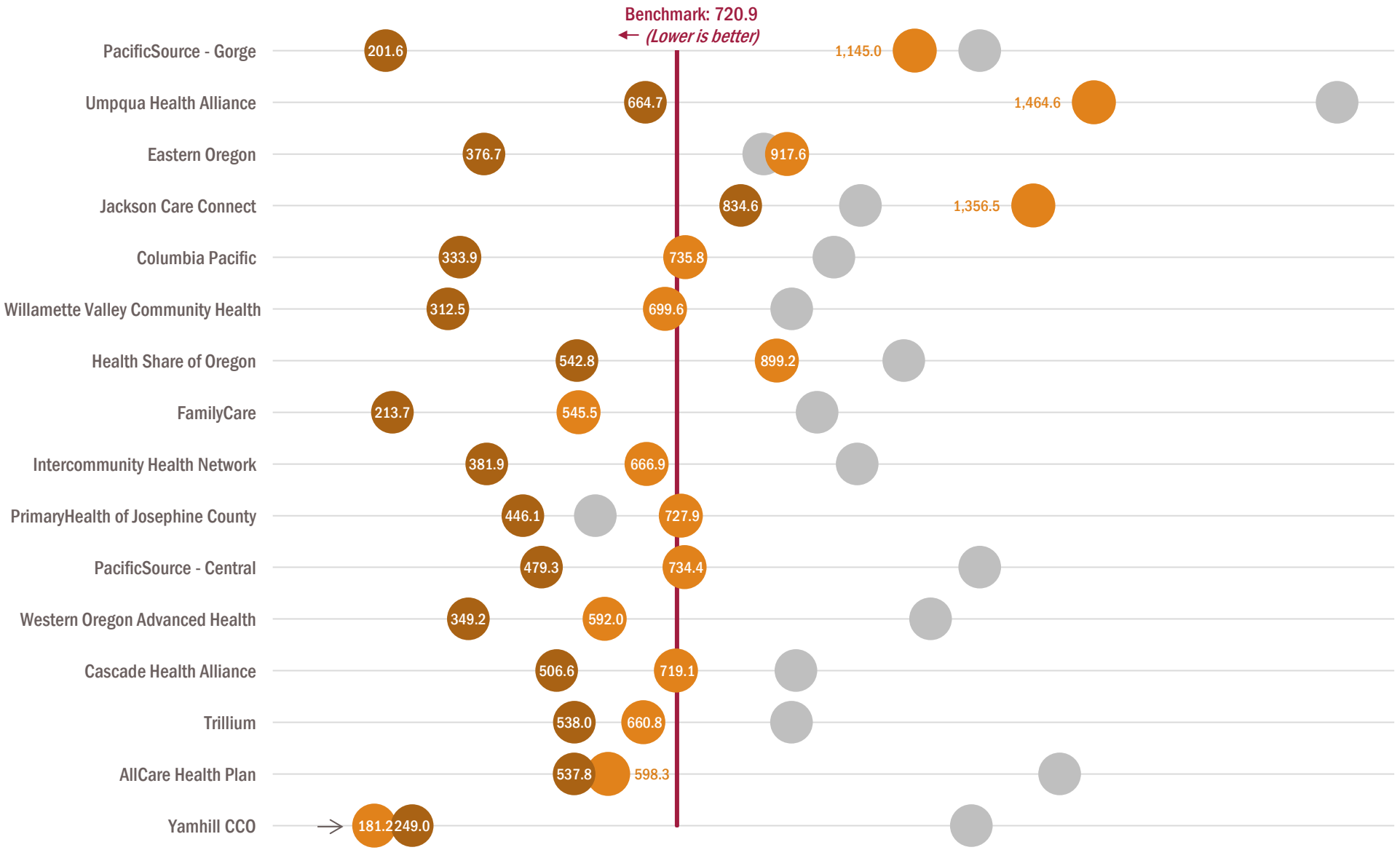
Gray dots represent 2011. Data missing for 10.4% of respondents. Each race category excludes Hispanic/Latino.
2011 and 2013 data have been updated and may differ from earlier reports.



PQI 05: CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE

Overall, CCOs improved admission rates for COPD or asthma in older adults between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.
2011 and 2013 data have been updated and may differ from earlier reports.



PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Congestive heart failure admission rate

Measure description: Rate of adult members (ages 18 and older) who had a hospital stay because of congestive heart failure. Rates are reported per 100,000 member years. A lower score is better.
PQI stands for Prevention Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

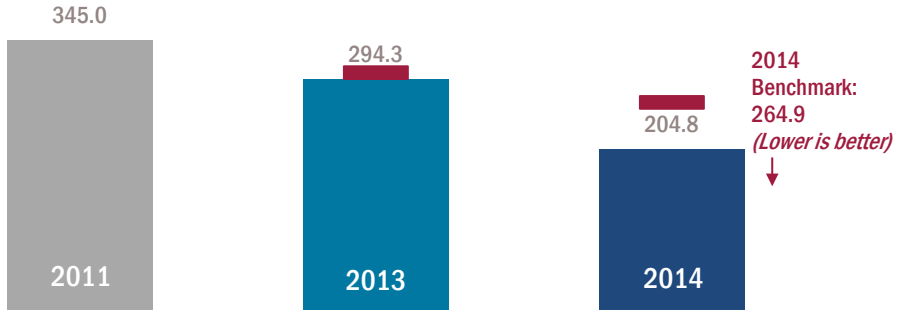
Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce health care costs.

2014 data (n=5,495,358 member months)

Admission rates for congestive heart failure continued to improve and remained below the benchmark in 2014. Lower is better for this measure. Admission rates for all races and ethnicities improved in 2014, but African American/Black members had the highest admission rate, with 833.3 admissions per 100,000 member years. The second highest admission rate was for Asian American members with just 233.83 admissions per 100,000 member years. Fourteen CCOs improved their performance on this measure between 2013 and 2014.

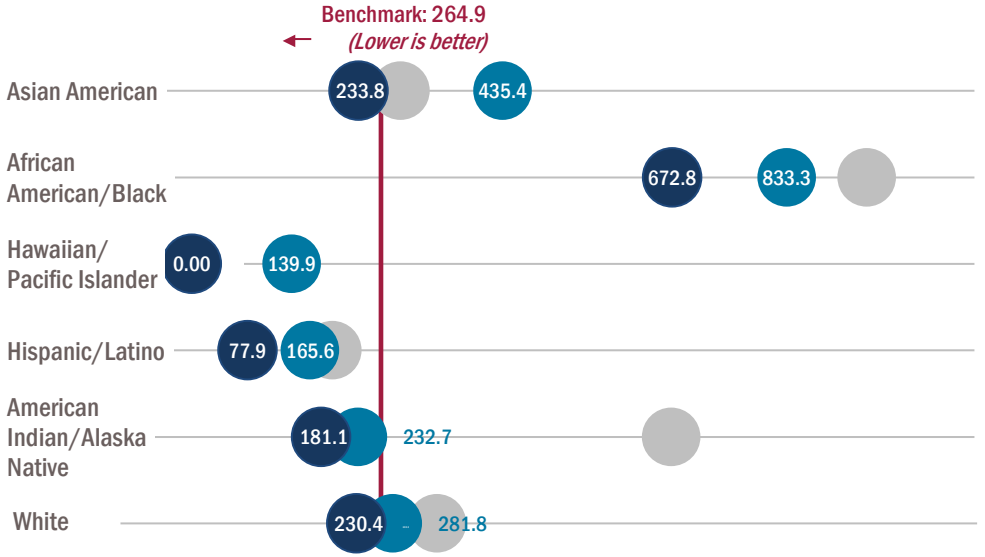
Statewide, the congestive heart failure admission rate improved again in 2014.

Data source: Administrative (billing) claims
Benchmark source: 10% reduction from previous year's statewide rate
2011 and 2013 data have been updated and may differ from earlier reports.



All races and ethnicities experienced improvement in congestive heart failure admission rates between 2013 and 2014.

Gray dots represent 2011. Data missing for 11.2% of respondents. Each race category excludes Hispanic/Latino.
2011 and 2013 data have been updated and may differ from earlier reports.



PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Fourteen of 16 CCOs improved admission rates for congestive heart failure between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.
2011 and 2013 data have been updated and may differ from earlier reports.

PQI 15: ADULT ASTHMA ADMISSION RATE

Adult (ages 18-39) asthma admission rate

Measure description: Rate of adult members (ages 18-39) who had a hospital stay because of asthma. Rates are reported per 100,000 member years. A lower score is better.

PQI stands for Prevention Quality Indicators, which is a set of indictors developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospitalization. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce health care costs

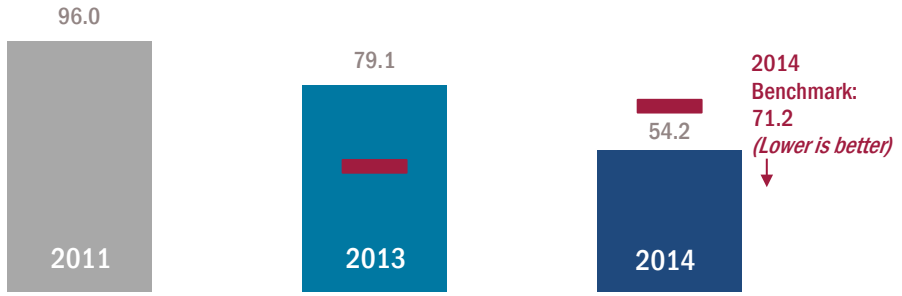
2014 data (n=2,293,006 member months)

The statewide adult asthma admission rate improved in 2014 and reached the benchmark for the first time. Lower is better for this measure. Adult asthma admission rates improved for races and ethnicities except White between 2013 and 2014.

CCO results were mixed, with ten of 16 CCOs improving their performance and seven achieving the benchmark in 2014.

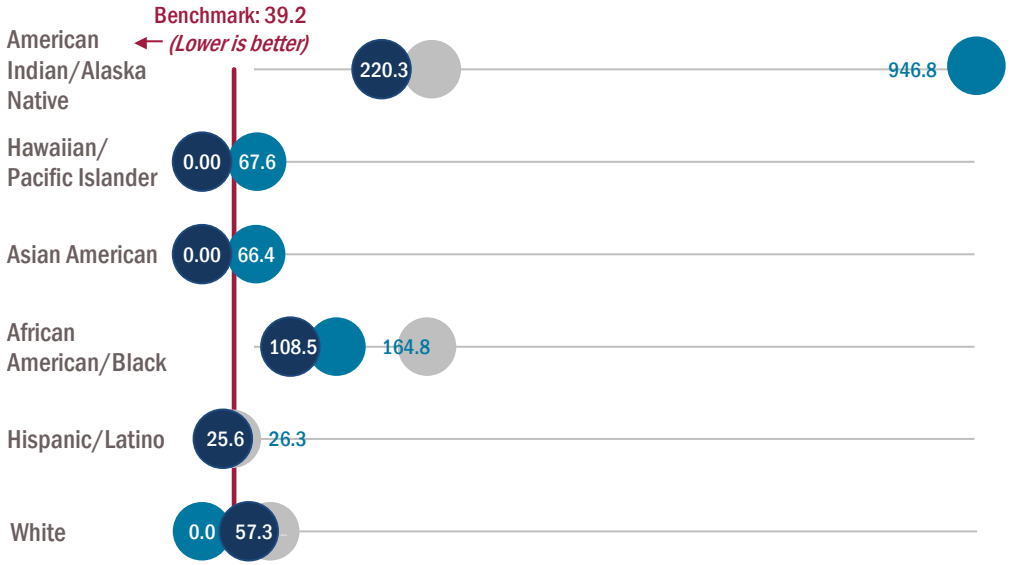
Statewide, the adult asthma admission rate improved.

Data source: Administrative (billing) claims
Benchmark source: 10% reduction from previous year's statewide rate
2011 and 2013 data have been updated and may differ from earlier reports.



Adult asthma admission rates varied among races and ethnicities between 2013 and 2014.

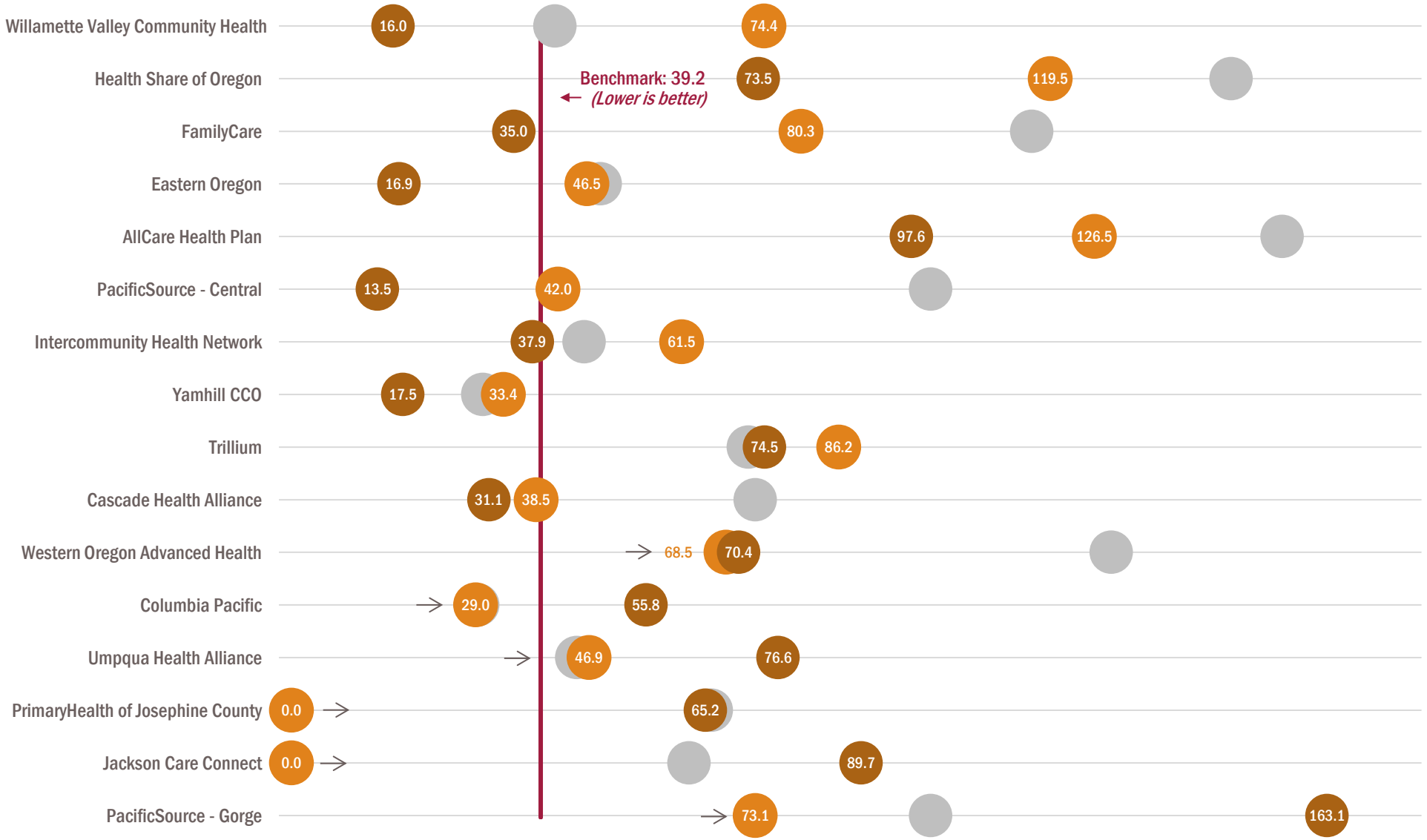
Gray dots represent 2011. Data missing for 11.8% of respondents. Each race category excludes Hispanic/Latino.
2011 and 2013 data have been updated and may differ from earlier reports.



PQI 15: ADULT ASTHMA ADMISSION RATE

Ten of 16 CCOs improved adult asthma admission rates between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined. 2011 and 2013 data have been updated and may differ from earlier reports.



PRENATAL AND POSTARTUM CARE: TIMELINESS OF PRENATAL CARE

Timeliness of prenatal care

Measure description: Percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in Medicaid.

Purpose: Care during a pregnancy (prenatal care) is widely considered the most productive and cost-effective way to support the delivery of a healthy baby. This measure helps ensure timeliness by tracking the percentage of women who receive an early prenatal care visit (in the first trimester). Improving the timeliness of prenatal care can lead to significantly better health outcomes and cost savings - as more than 40 percent of all babies born in Oregon are covered by Medicaid.

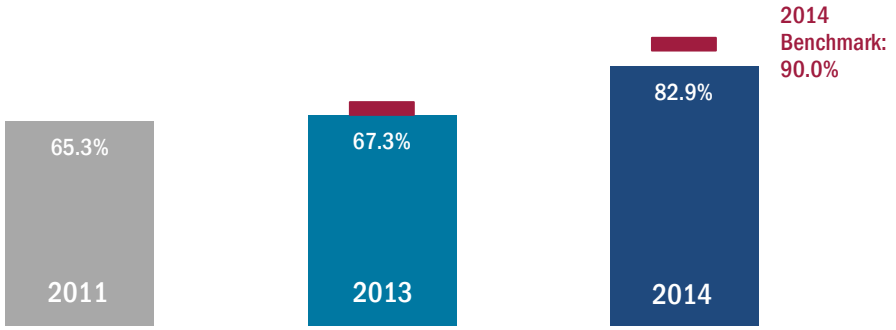
2014 data

The measure specifications for timeliness of prenatal care were updated beginning in 2014 to use medical record data. Previously, this measure used administrative data only; 2014 results are thus not directly comparable to earlier years.

Statewide in 2014, 82.9 percent of pregnant women received a prenatal care visit within the first trimester of pregnancy. All 16 CCOs met the benchmark or improvement target in 2014.

Statewide, four out of five pregnant members received timely prenatal care in 2014.

Data source: Administrative (billing) claims and medical record review
2014 benchmark source: 2013 National Medicaid 75th percentile
2014 data are not directly comparable to earlier years due to changed methodology



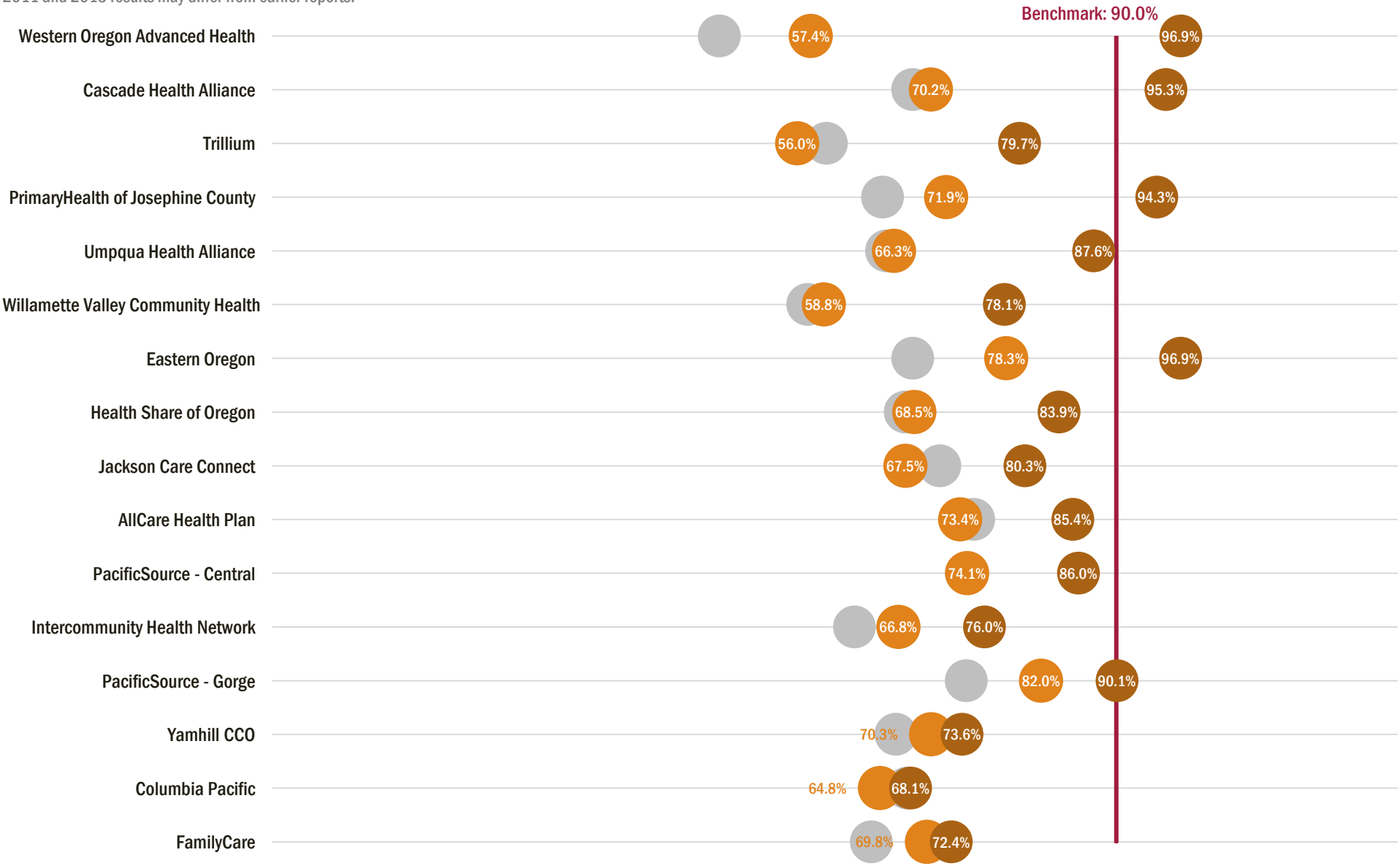
Race and ethnicity data.

Race and ethnicity data are not available for this measure.

PRENATAL AND POSTARTUM CARE: TIMELINESS OF PRENATAL CARE

All 16 CCOs met the benchmark or improvement target in 2014.

All CCOs met benchmark or improvement target.
Light orange dogs represent 2013. 2014 results include information from medical records in addition to administrative data; prior years are administrative data only and are not directly comparable to 2014.
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.
2011 and 2013 results may differ from earlier reports.



PRENATAL AND POSTPARTUM CARE: POSTPARTUM CARE

Postpartum care

Measure description: Percentage of women who had a postpartum care visit on or between 21 and 56 days after delivery.

Purpose: Having a timely postpartum care visit helps increase the quality of maternal care and reduces the risks for potential health complications associated with pregnancy. Women who have a visit between 21 and 56 days after delivery can have their physical health assessed and can consult with their provider about infant care, family planning and breastfeeding.

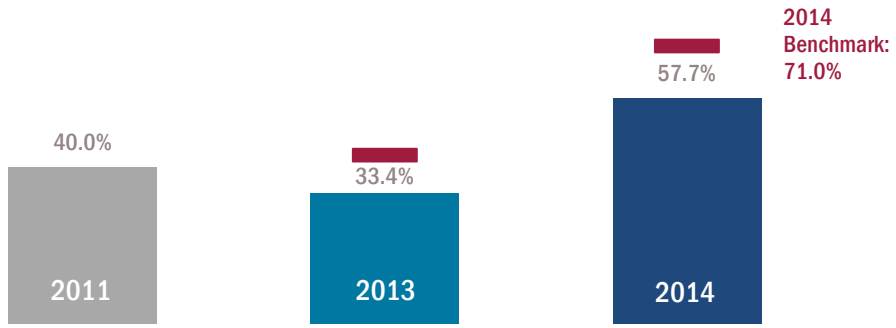
2014 data (n=5,246)

Statewide, 57.7 percent of women who had a baby during the measurement period also had a postpartum care visit. This is below the benchmark of 71.0 percent. Performance among the 15 CCOs who reported data ranged widely between 24.5 and 80.2 percent.

Measure specifications for postpartum care were updated beginning in 2014 to include medical records. Previously, only administrative claims were used. 2014 results are thus not directly comparable to earlier years.

Statewide, the percentage of women receiving postpartum care was below the benchmark in 2014.

Data source: Administrative (billing) claims and medical record review 2014
Benchmark source: 2013 National Medicaid 75th percentile



Race and ethnicity data.

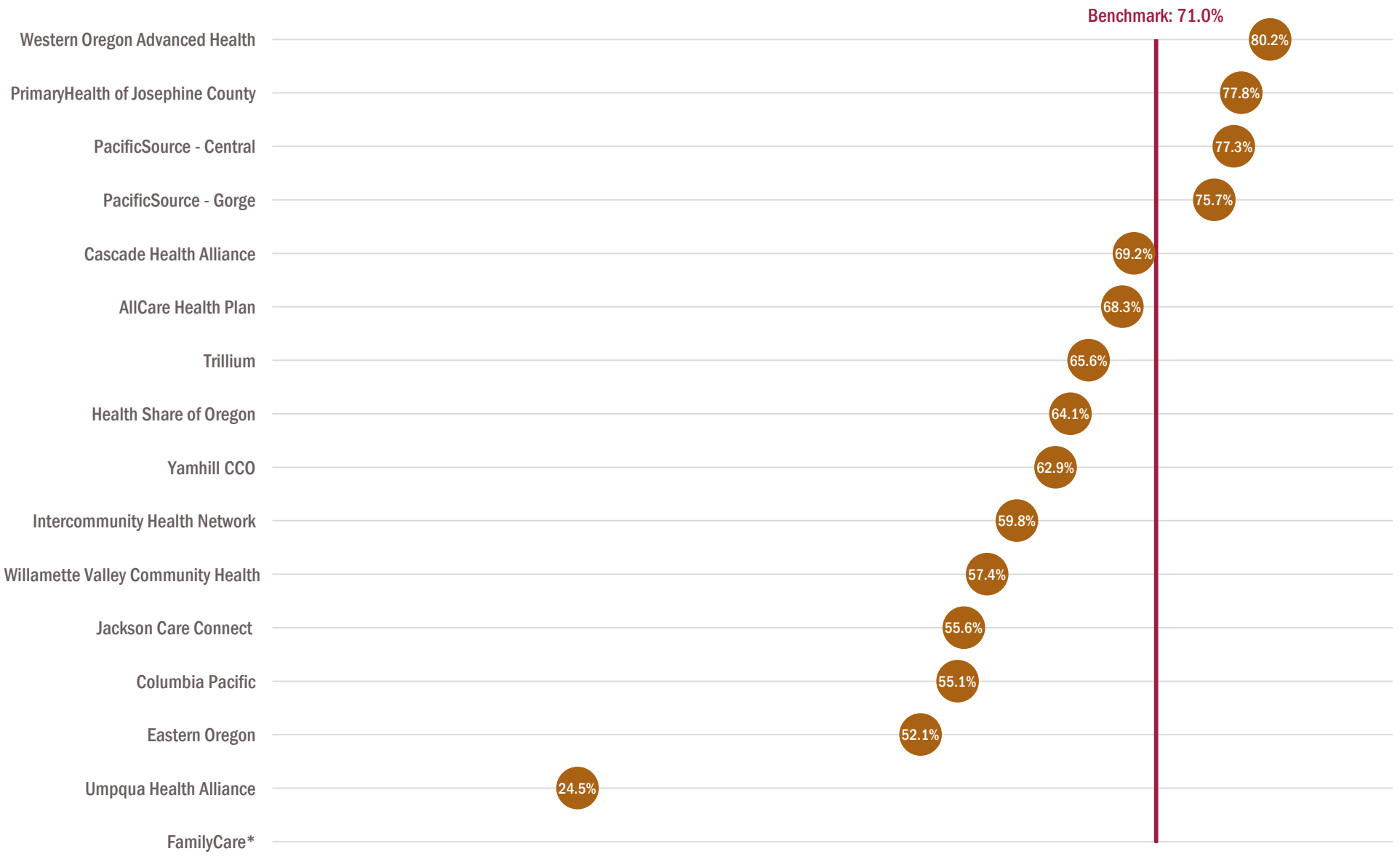
Race and ethnicity data for this measure are not available.

PRENATAL AND POSTPARTUM CARE: POSTPARTUM CARE

The percentage of women who had a postpartum care visit ranged between 24.5 and 80.2 percent between CCOs in 2014.

2011 and 2013 data for this measure are not available at the CCO level.

* CCO did not submit data for this measure.



PROVIDER ACCESS QUESTIONS FROM THE PHYSICIAN WORKFORCE SURVEY

Component 1: Extent to which providers are accepting new Medicaid patients

Measure description: Percentage of providers who are accepting new Medicaid/Oregon Health Plan patients.

Component 2: Extent to which providers currently see Medicaid patients

Definition: Percentage of providers who currently care for Medicaid/Oregon Health Plan participants. This information does not include "don't know" or missing survey responses.

Component 3: Current payer mix at practices

Definition: Percentage of Medicaid payers at practices.

Purpose: Access to care leads to better health outcomes and more affordable health care. Improving care access for low-income Oregonians can also help reduce health disparities and overall health care costs.

2014 data

The 2014 Physician Workforce Survey showed that more providers were accepting new Medicaid patients as well as seeing Medicaid patients in 2014 than 2012. Statewide, Medicaid comprised a greater share of the payer mix in 2014 (23.0 percent) than in 2012 (17.0 percent).

In 2014, only 5.8 percent of respondents reported that they were completely closed to Medicaid, a notable decrease from 2009 (17.9 percent).

Statewide, more providers were **accepting** new Medicaid patients in 2014 than 2012.

Data source: Oregon Physician Workforce Survey
Benchmark: TBD

Statewide, more providers were **seeing** Medicaid patients in 2014 than 2012.

Data source: Oregon Physician Workforce Survey
Benchmark: TBD

Statewide, Medicaid made up a larger share of provider **payer mix** in 2014 than 2012.

Data source: Oregon Physician Workforce Survey
Benchmark: TBD

SATISFACTION WITH CARE (CAHPS)

Satisfaction with care (CAHPS)

Measure description: Percentage of members (adults and children) who received needed information or help and thought they were treated with courtesy and respect by customer service staff.

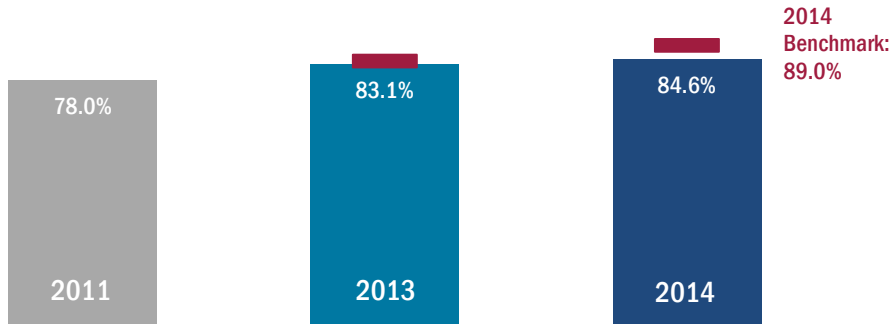
Purpose: According to the Agency for Healthcare Research and Quality, the ability of health plans to deliver high-quality clinical and administrative service to their members depends in part on their understanding of basic customer service principles. As in any other service industry, a satisfied member creates value over the course of lifetime: through repeat visits, trusting relationships with the provider, following provider's advice, etc. Existing members are an invaluable source of information that can help health plans understand how to improve what they do.

2014 data

The percentage of individuals reporting they received needed information and were treated with courtesy and respect by their health plan's customer service improved slightly from 83.1 percent in 2013 to 84.6 percent in 2014, but remained below the benchmark of 89.0 percent. Among the adult population, all races and ethnicities reported improved satisfaction. Ten of 16 CCOs improved their performance from 2013 to 2014, five met their improvement targets and one CCO met the benchmark.

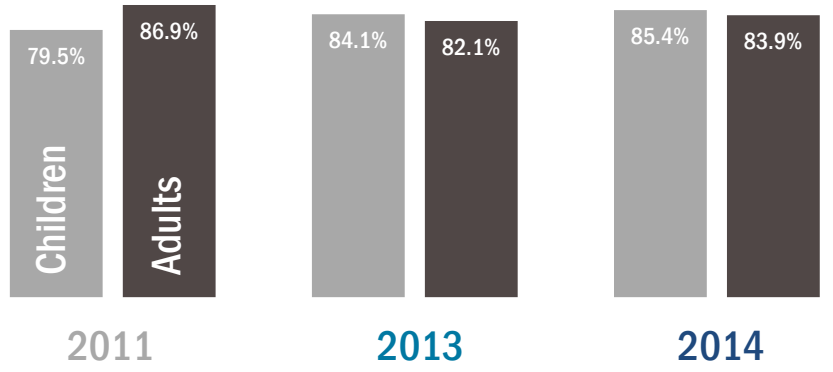
Statewide, members reported improved satisfaction with care.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: average of the 2013 national Medicaid 75th percentiles for adults and children



Satisfaction with care statewide results: children vs. adults.

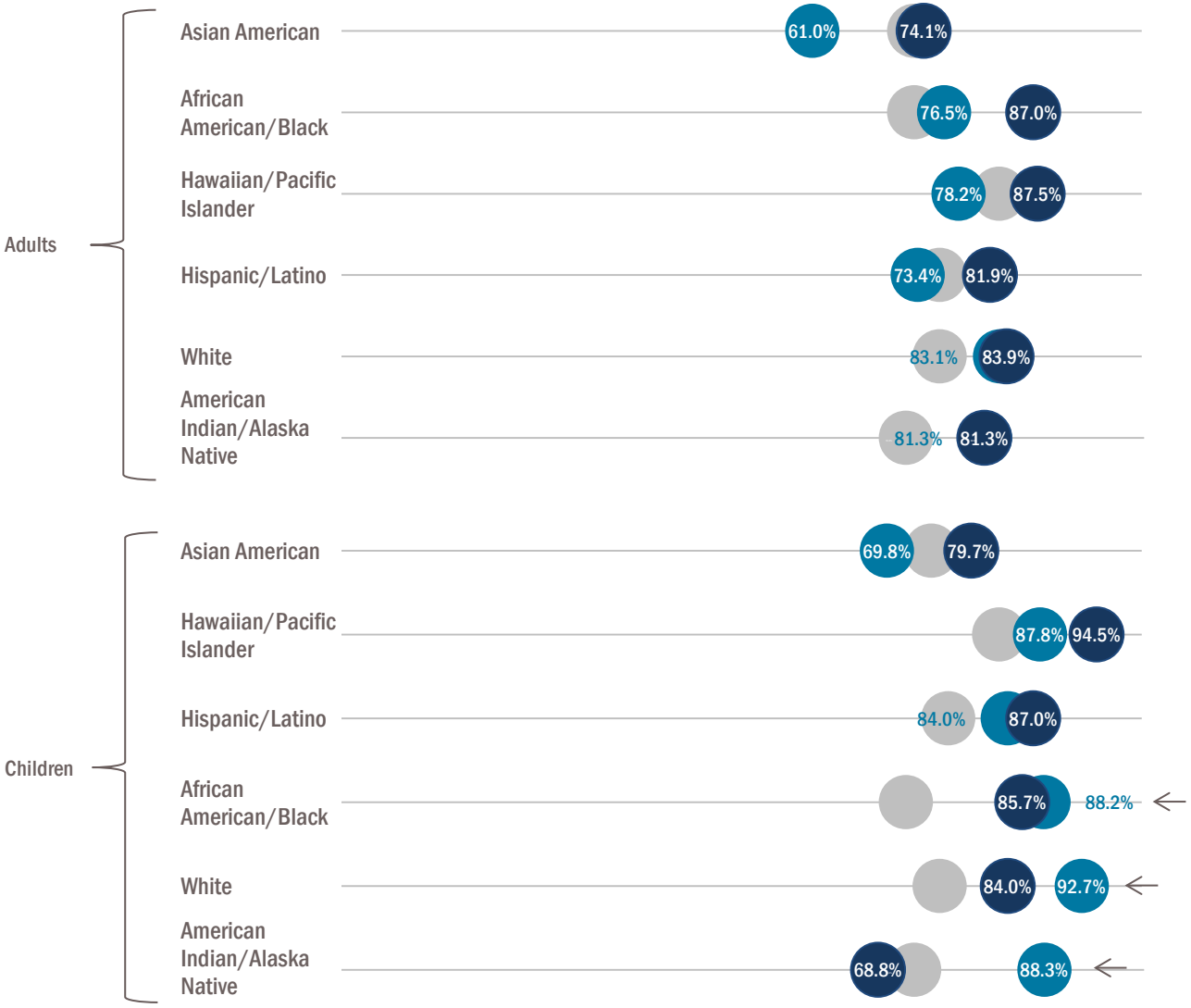
Assessment of Healthcare Providers and Systems (CAHPS)



SATISFACTION WITH CARE (CAHPS)

Asian American members reported the greatest improvement in satisfaction with care between 2013 and 2014.

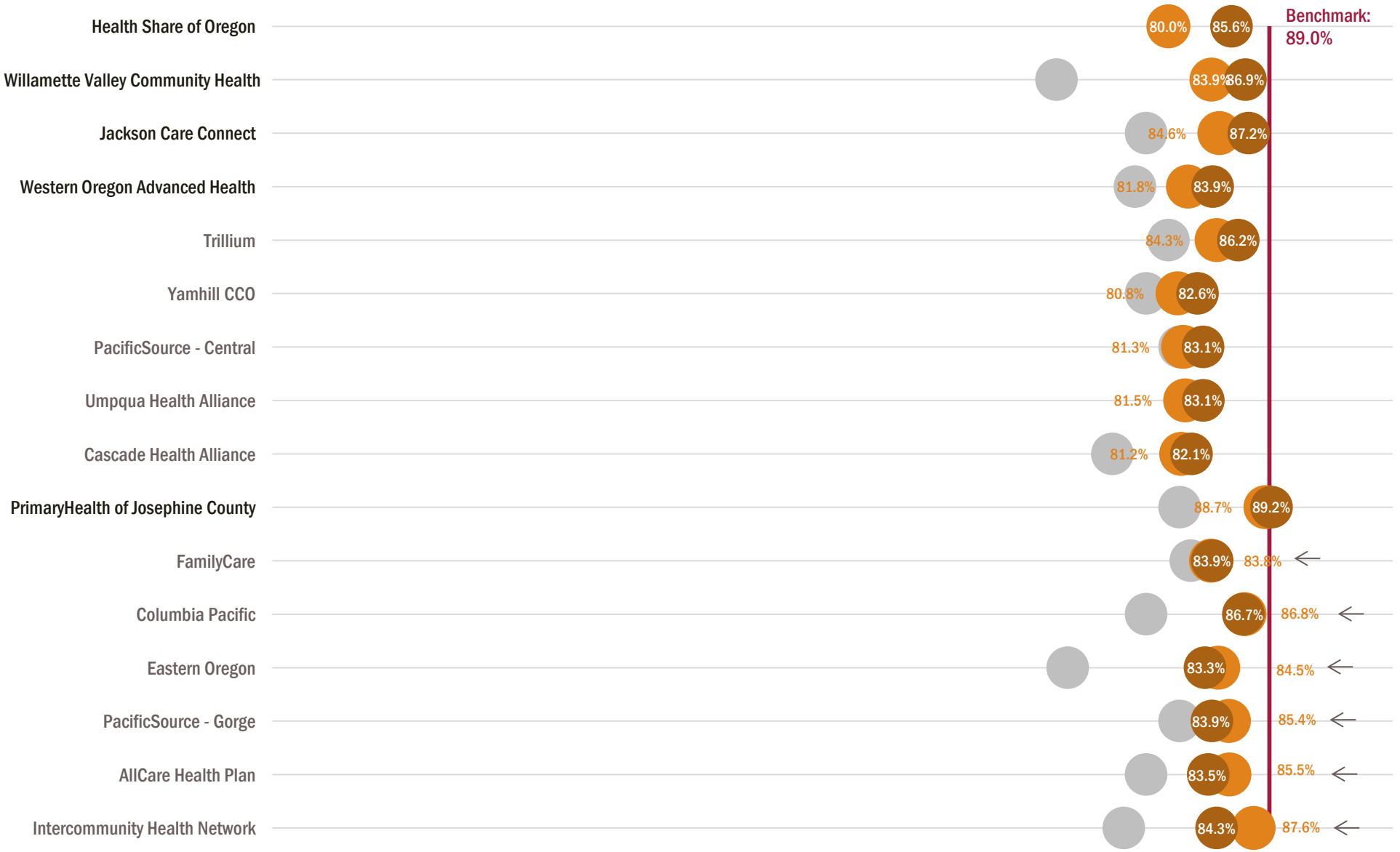
Gray dots represent 2011. Data missing for 8.5% of adults and 9.2% of children. Each race category excludes Hispanic/Latino.



SATISFACTION WITH CARE (CAHPS)

Members in 10 of 16 CCOs reported improved satisfaction with care between 2013 and 2014.

Bolded names met benchmark or improvement target.
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



TOBACCO USE PREVALENCE

Tobacco use prevalance

Measure description: Percentage of adult Medicaid members (ages 18 and older) who currently smoke cigarettes or use other tobacco products

Purpose: Tobacco use causes many diseases and quitting can have immediate and long-term health benefits. In addition to improving health outcomes, helping people quit smoking also reduces the costs of treating health problems caused by using tobacco, such as lung cancer and heart disease.

2014 data

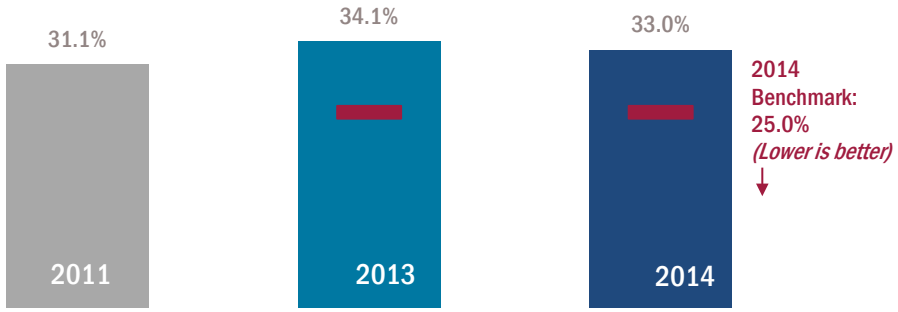
At the statewide level, tobacco use prevalence decreased from 34.1 percent in 2013 to 33.0 percent in 2014. Lower is better for this measure. Despite the slight decline, Medicaid tobacco use prevalence remained substantially higher than the general population (20.8 percent in 2013) and also remained well above the benchmark of 25.0 percent.

When stratified by race and ethnicity, tobacco use prevalence increased among Hispanic/Latino, Hawaiian/Pacific Islander and Asian American populations, and decreased among all others. Interestingly, those races and ethnicities whose rates decreased still had higher prevalence of tobacco use than those groups whose rates increased.

CCO performance was also mixed, with tobacco use prevalence decreasing in 10 of 16 CCOs.

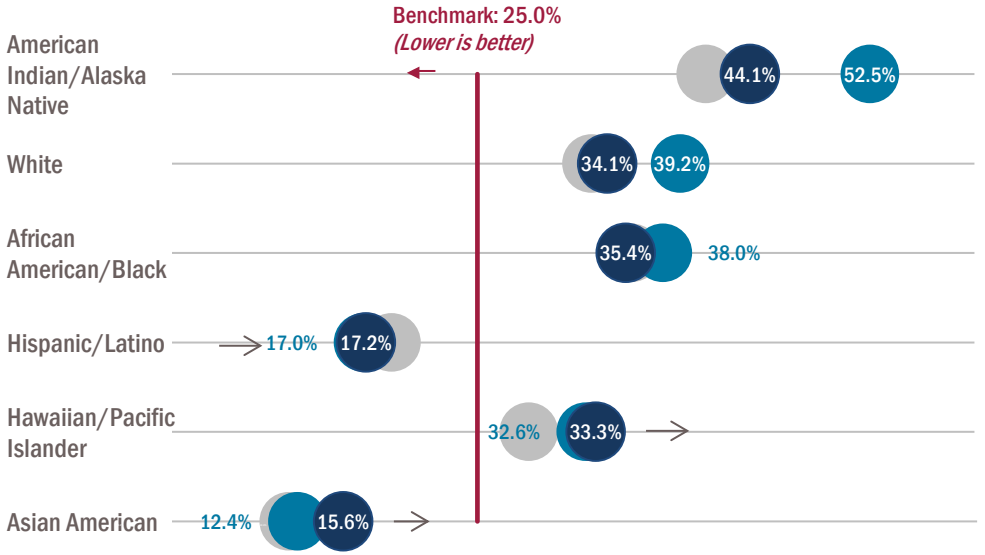
Statewide, tobacco use prevalance decreased slightly between 2013 and 2014.

Data source: Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Benchmark source: Oregon's 1115 demonstration waiver goals



Tobacco use prevalance improved most for American Indian/Alaska Native members between 2013 and 2014.

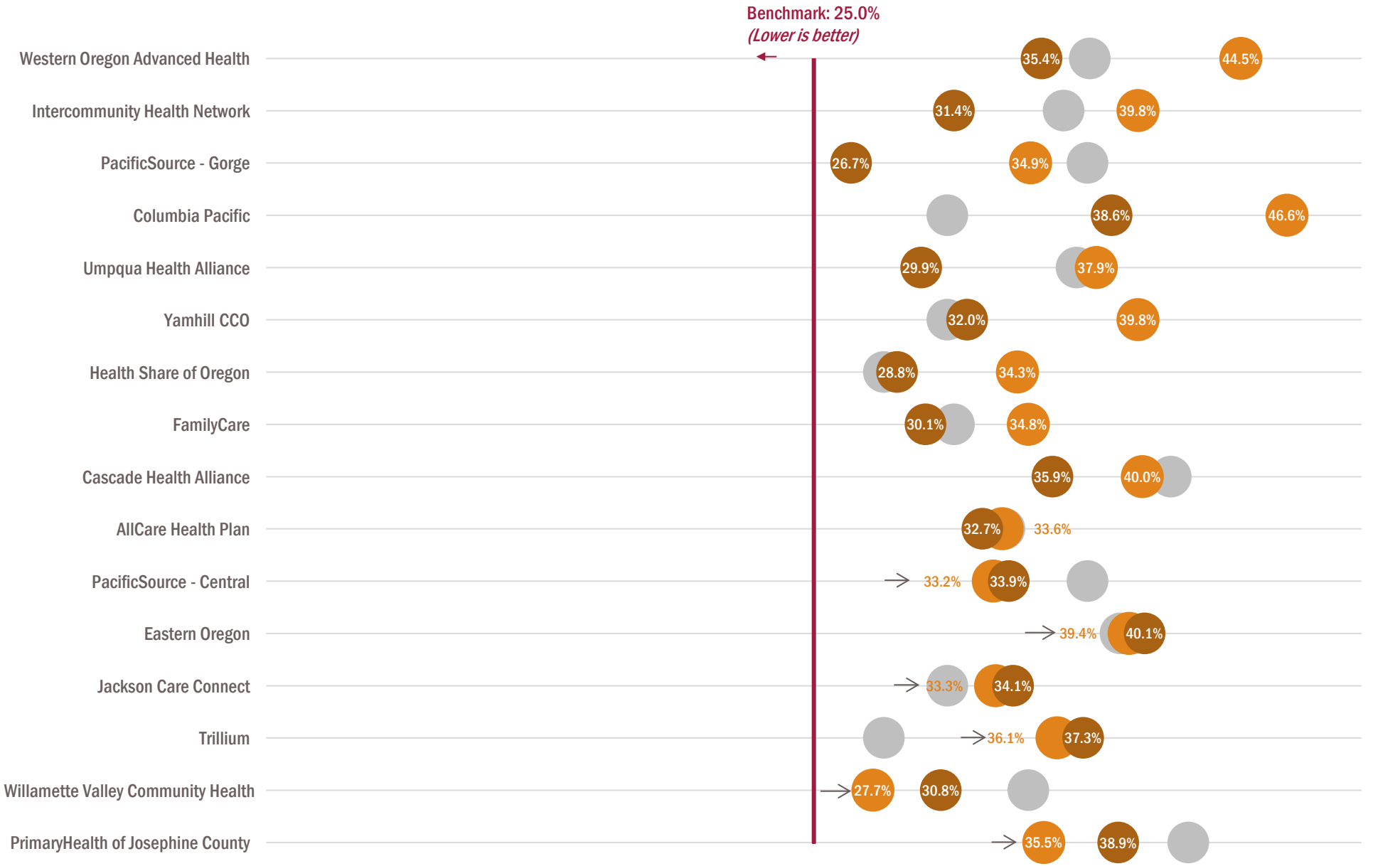
Gray dots represent 2011. Data missing for 9.2% of respondents. Each race category excludes Hispanic/Latino.



TOBACCO USE PREVALENCE

Tobacco use prevalence improved in 10 of 16 CCOs between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

Well-child visits in the first 15 months of life

Measure description: Percentage of children who had six visits with their health care provider prior to reaching 15 months of age.

Purpose: Regular well-child visits are one of the best ways to detect physical, developmental, behavioral and emotional problems in infants. They are also an opportunity for providers to offer guidance and counseling to parents.

2014 data (n=16,880)

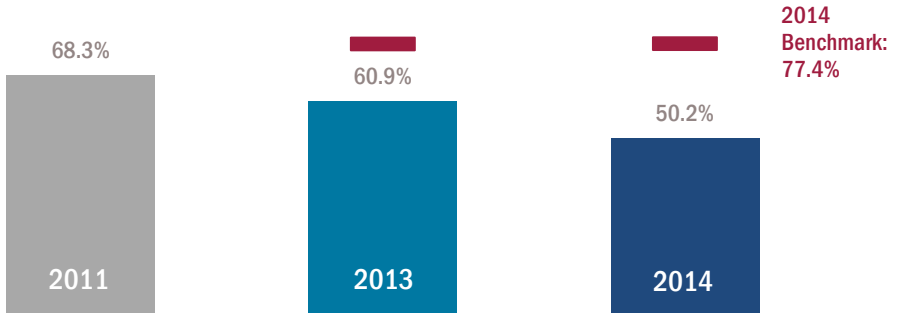
Statewide, the percentage of children who had six or more well-child visits in the first 15 months of life remained below the benchmark in 2014, and declined in 13 of 16 CCOs.

The apparent decline between 2013 and 2014 can likely be attributed to a small denominator in 2013: fewer children were counted in the measure due to the statewide transition to CCOs and continuous enrollment criteria for this measure. 2014 results are more representative than 2013.

The low percentage of children receiving well child visits in 2014 maybe also be due to new members not receiving all six visits within 15 months. Statewide, 71.6 percent of children received at least four well-child visits in the first 15 months of life, and 63.8 percent of children received at least five visits.

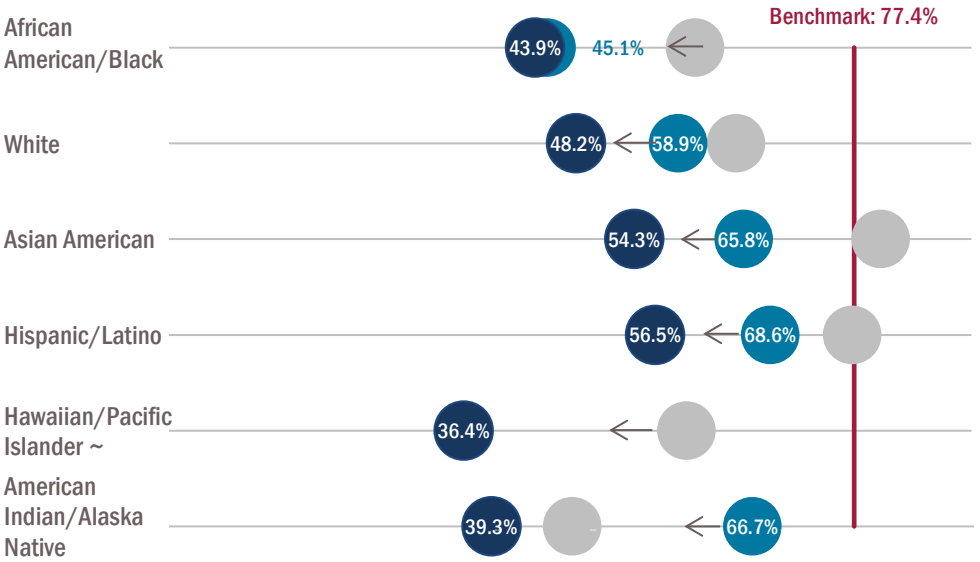
Statewide, well-child visits remained below the benchmark.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 90th percentile



Hispanic-Latino children were most likely to have six or more well-child visits in both 2013 and 2014.

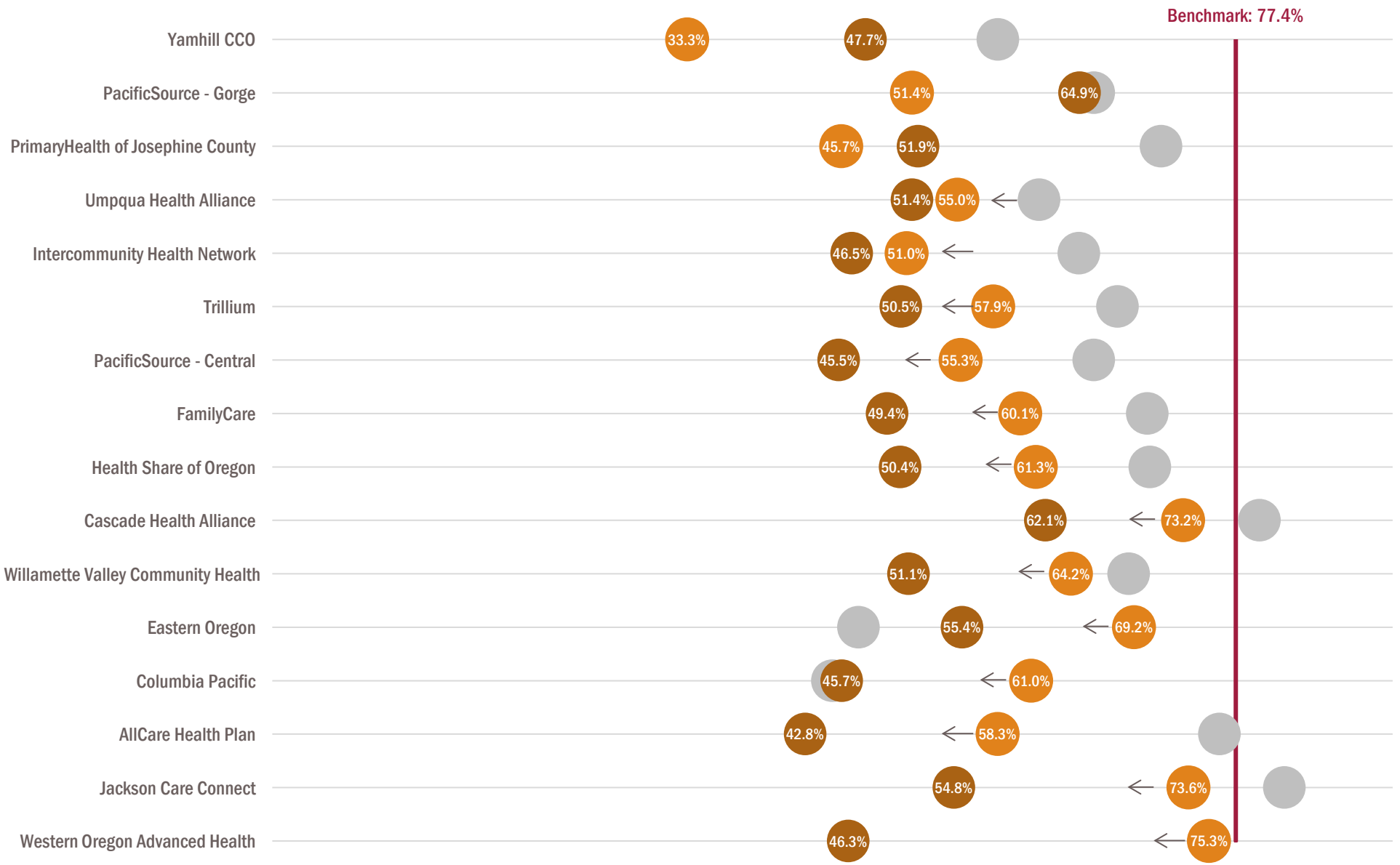
Gray dots represent 2011. Data missing for 10.9% of respondents. Each race category excludes Hispanic/Latino.
~ Data suppressed (n<30)



WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

Three of 16 CCOs increased the percentage of children receiving six or more well-child visits between 2013 and 2014.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



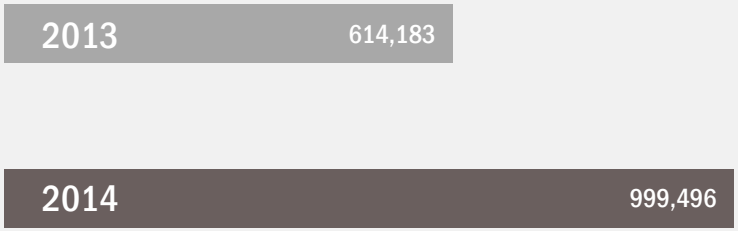
POST-ACA POPULATION

Overview

With the Affordable Care Act (ACA) coverage expansion, an increasing number of Oregonians receive health insurance through the Oregon Health Plan (Medicaid). More than 385,313 Oregonians gained coverage in 2014, meaning approximately 999,496 Oregonians were enrolled by the end of the year. Enrollment has continued to increase in 2015, with approximately 1.1 million members enrolled as of April.

This section of the report highlights these changes. This section of the report also provides more detailed information on three utilization measures since the ACA expansion: emergency department utilization, avoidable emergency department utilization, and outpatient utilization. Data are presented for calendar year 2014, and are broken out by three groups of members: **existing**, **returning**, and **new** (see definitions below).

Total Medicaid enrollment



2014 enrollment by member status

"Existing" members are clients whose enrollment in the Oregon Health Plan began prior to 2014.

"Returning" members are clients who were not enrolled in the Oregon Health Plan during calendar year 2013 but were at some time prior to 2013.

"New" members are clients who were newly enrolled in the Oregon Health Plan in 2014 and were not eligible before that point.

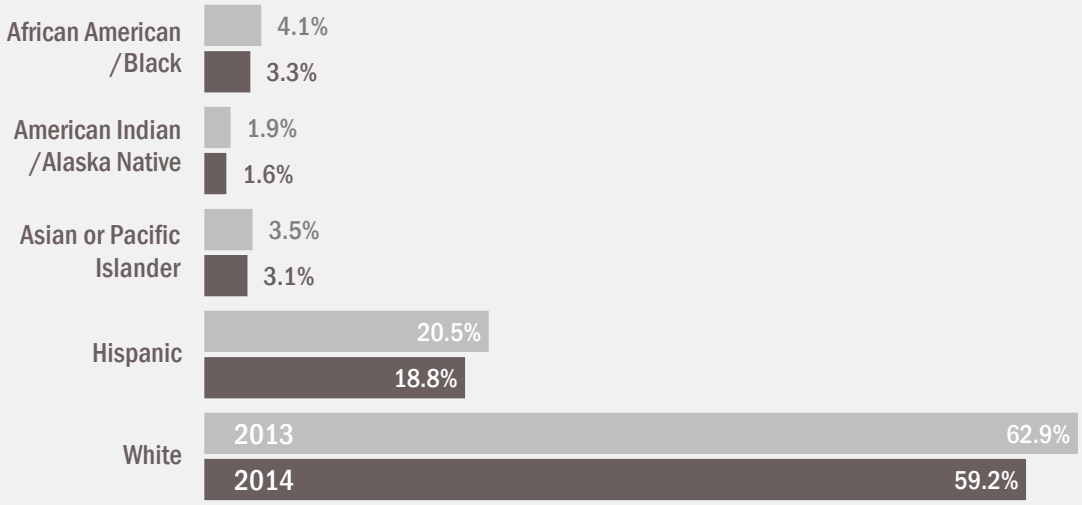
POST-ACA POPULATION

2014

Despite the influx of more than 385,000 new members in 2014, the demographic composition of the Medicaid population remains largely consistent. However, race and ethnicity data were unknown for a larger portion of the population in 2014, which could be masking any demographic changes.

Despite the influx of new members, the racial and ethnic makeup of Medicaid enrollment has not changed much between 2013 and 2014.

Composition based on unique member counts as of December. Data missing: 8% in 2013 and 14% in 2014.



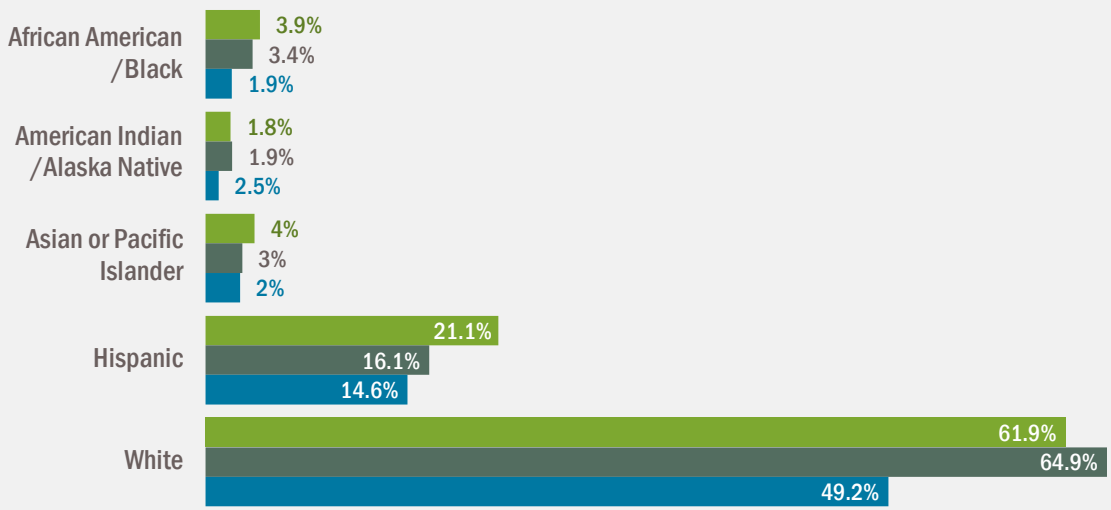
"Existing" members: these are individuals who were enrolled in the Oregon Health Plan during 2013, prior to the expansion beginning in 2014.

"Returning" members: these are individuals who were not enrolled in the Oregon Health Plan during calendar year 2013 but were previously enrolled in Medicaid some time prior to 2014.

"New" members: these are individuals who were newly enrolled in the Oregon Health Plan in 2014 as part of the expansion. These new members were not eligible for Medicaid prior to the expansion.

Race and ethnicity by member status in 2014

Composition based on unique member count as of December 2014. Data missing for 14% of population.

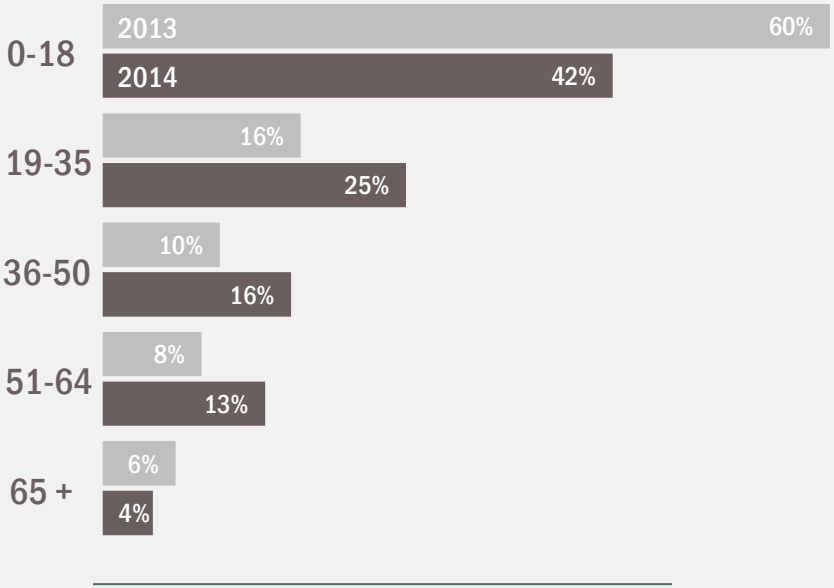


POST-ACA POPULATION

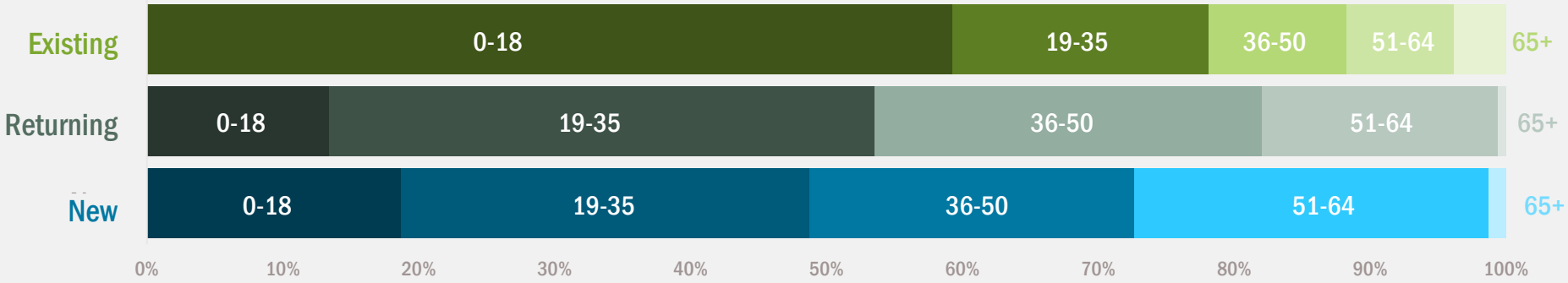
2014

Prior to the Medicaid expansion in 2014, the majority of the population were children and adolescents. In 2014, more adults were eligible for Medicaid and the proportion of members ages 19-64 increased, with the greatest increase being members ages 19-35. When broken out by enrollment history, we see that most children and adolescents had previously been enrolled in Medicaid.

The proportion of members ages 19-35 enrolled in Medicaid increased more than other age groups between 2013 and 2014.



OHP 2014 Enrollment by Member Status and Age Distribution



"Existing" members are clients whose enrollment in the Oregon Health Plan began prior to 2014.

"Returning" members are clients who were not enrolled in the Oregon Health Plan during calendar year 2013 but were at some time prior to 2013.

"New" members are clients who were newly enrolled in a the Oregon Health Plan in 2014 and were not eligible before that point.

POST-ACA POPULATION: EMERGENCY DEPARTMENT UTILIZATION

Emergency department utilization in 2014

Measure description: Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of this care.

2014 data (n= 9,707,039 member months)

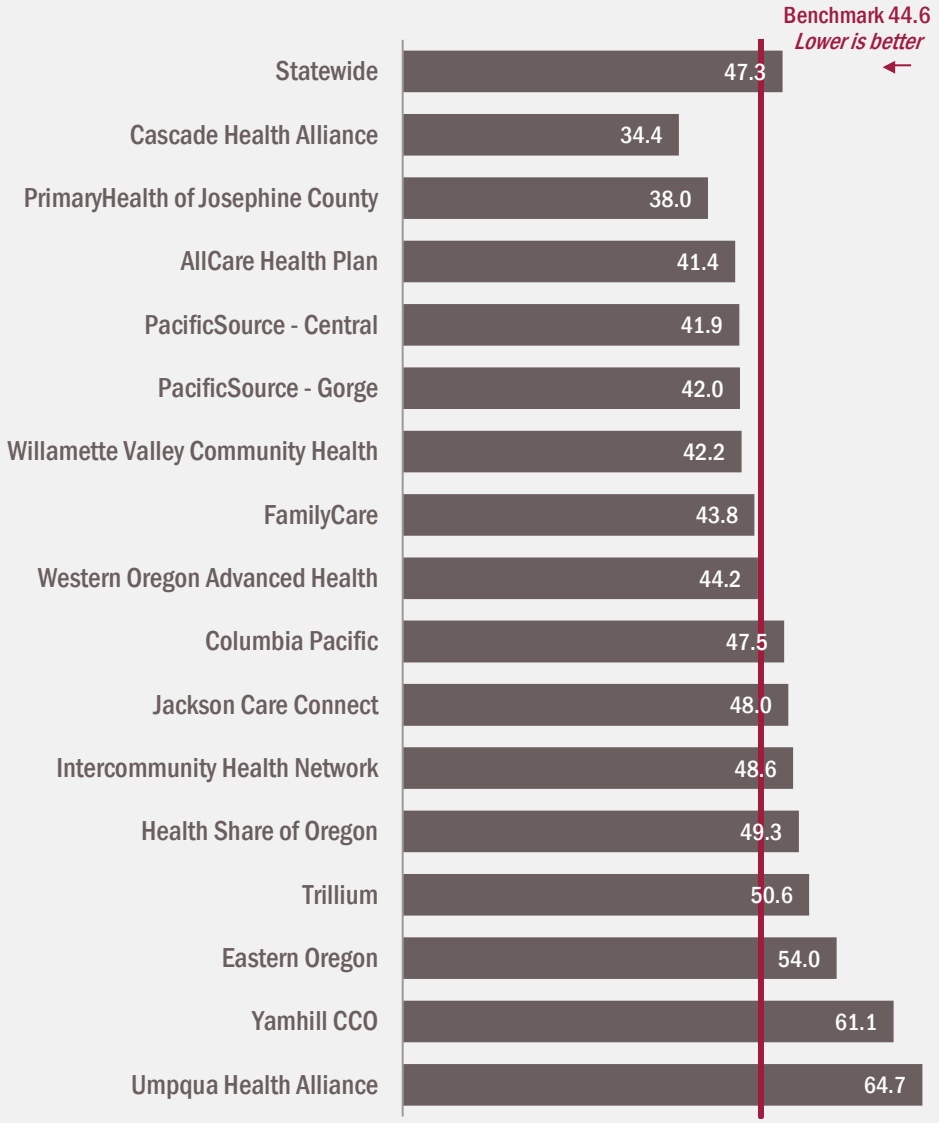
This graph shows emergency department visit rates for all CCO members between January 1, 2014 and December 31, 2014.

The 2014 rate of 47.3 per 1,000 member months has continued to decline from the 2013 rate of 50.7 (see page 18), despite the influx of new Medicaid members.

While some of this decline may be attributed to state and national trends in reduced emergency department utilization, much credit is also due to CCO efforts such as identifying high utilizers, providing care management, and improving access to primary care clinics.

Emergency department utilization during 2014

Rates are reported per 1,000 member months
Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 90th percentile



POST-ACA POPULATION: EMERGENCY DEPARTMENT UTILIZATION

Emergency department utilization during 2014, by member type.

2014 data (n= 9,707,039 member months)

New members used the emergency department less frequently than members who have prior enrollment experience (33.9 versus 49.6 and 56.9 per 1,000 member months).

Members returning to Medicaid in 2014 had the highest rate of emergency department visit use (56.9 per member months).

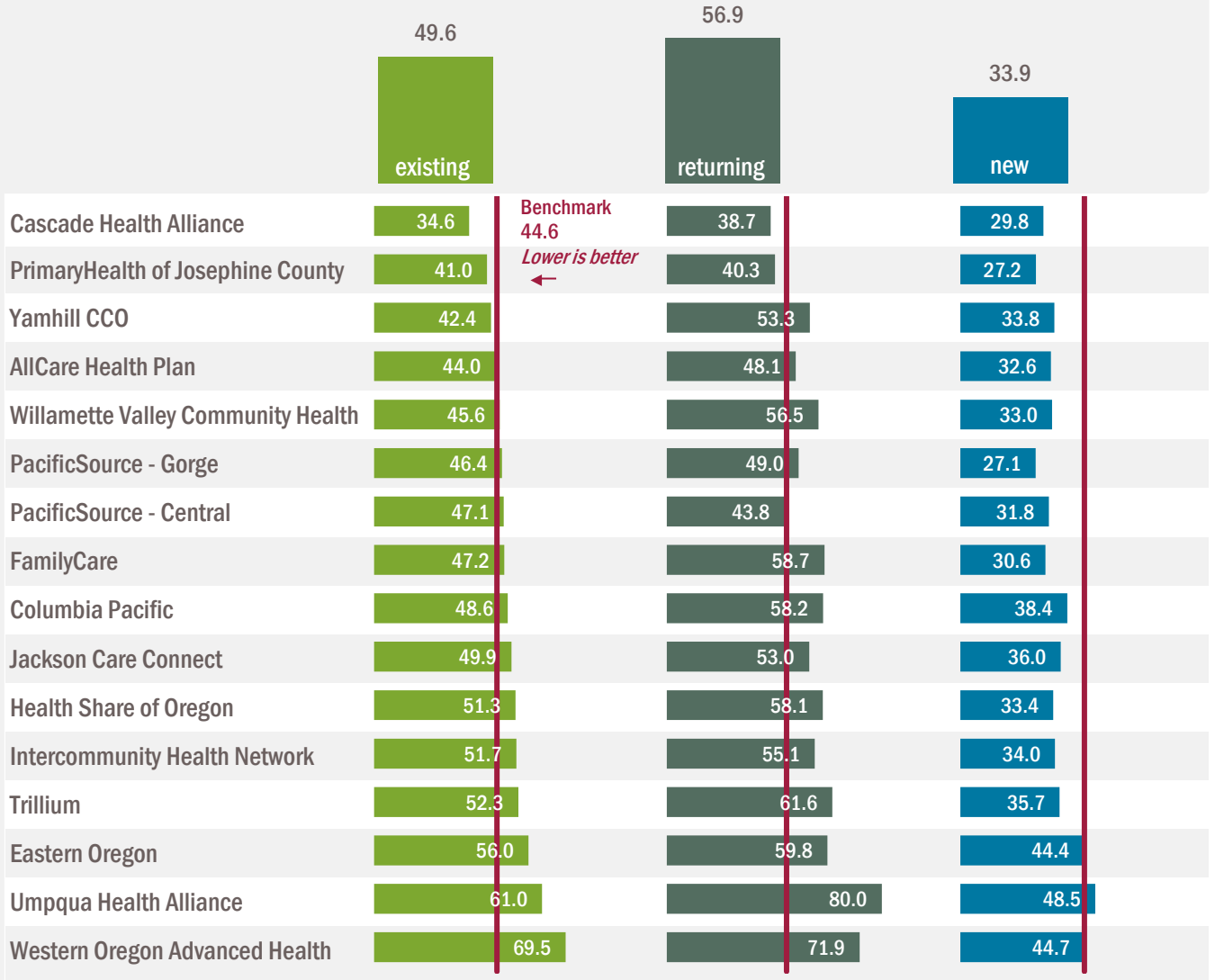
"Existing" members are clients whose enrollment in the Oregon Health Plan began prior to 2014.

"Returning" members are clients who were not enrolled in the Oregon Health Plan during calendar year 2013 but were at some time prior to 2013.

"New" members are clients who were newly enrolled in the Oregon Health Plan in 2014 and were not enrolled prior to 2014.

Statewide, new members with no prior Medicaid enrollment used emergency departments at lower rates than other members.

Rates are reported per 1,000 member months
Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 90th percenite.



POST-ACA POPULATION: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization in 2014

Measure description: Rate of patient visits to an emergency department for conditions that could have been more appropriately managed by or referred to a primary care provider in an office or clinic setting.

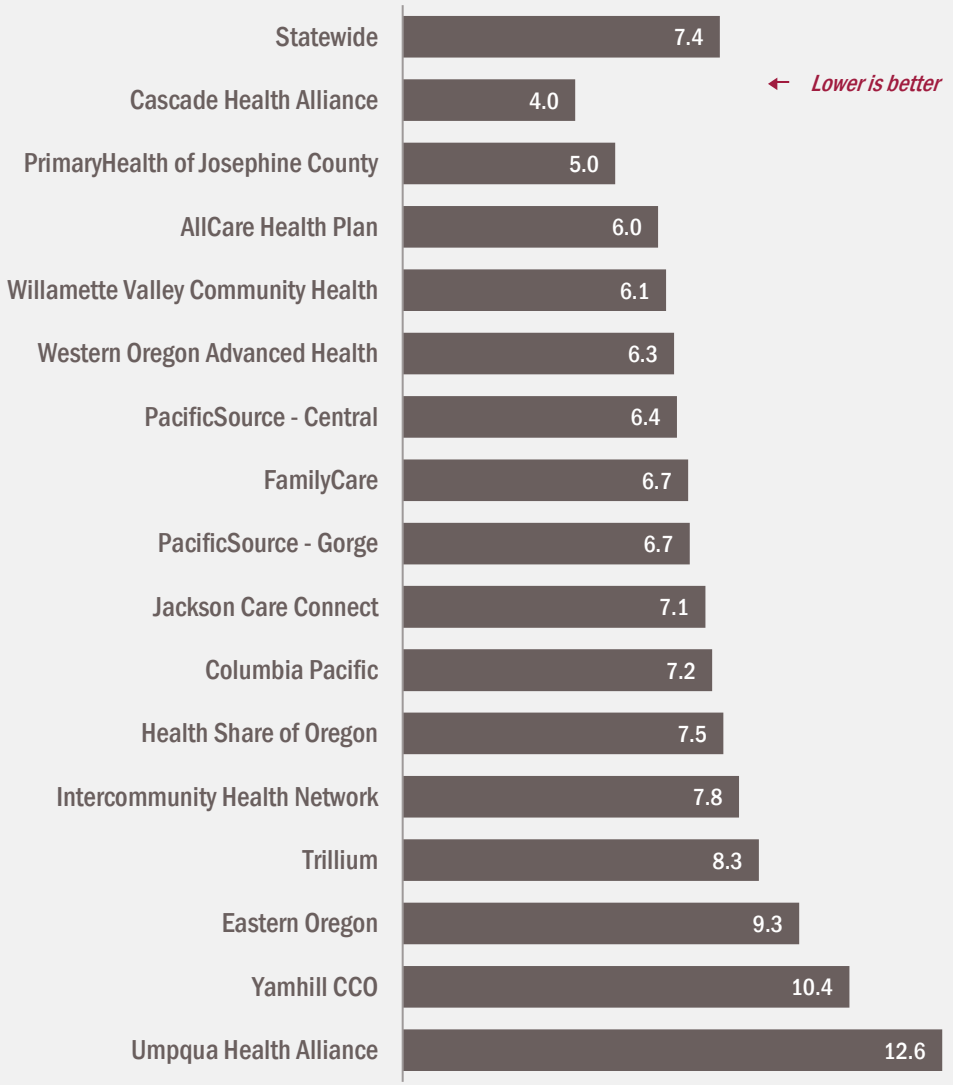
Rates are derived from the ambulatory care: emergency department utilization measure and are reported per 1,000 member months. A lower rate suggests more appropriate emergency department utilization.

2014 data (n= 9,707,039 member months)

This graph shows avoidable emergency department visit rates for all CCO members between January 1, 2014 and December 31, 2014. The observed statewide rate of 7.4 is below the 2013 rate of 8.6 (see page 20) despite the large influx of new Medicaid members.

Avoidable emergency department utilization during 2014

Rates are reported per 1,000 member months
Data source: Administrative (billing) claims
Lower is better



POST-ACA POPULATION: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization in 2014, by member type

2014 data (n= 9,707,039 member months)

New members enrolled in a CCO in 2014 but with no prior Oregon Health Plan enrollment (blue bars) have fewer avoidable emergency department visits than other members (4.7 versus 8.2 and 7.5 per 1,000 member months).

Members enrolled in a CCO in both 2013 and 2014 (green bars) had the highest rate of avoidable emergency department visits in 2014.

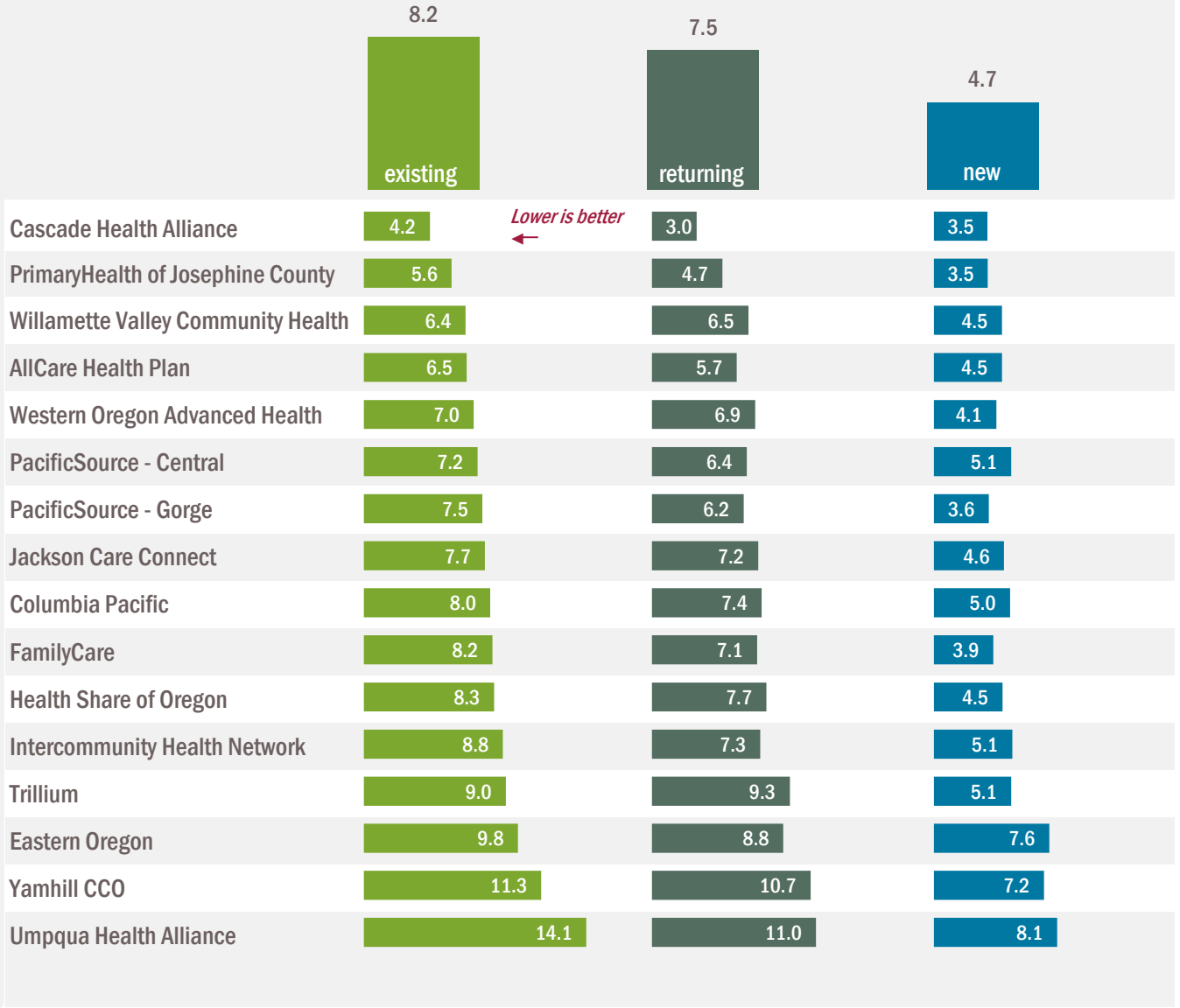
"Existing" members are clients whose enrollment in the Oregon Health Plan began prior to 2014.

"Returning" members are clients who were not enrolled in the Oregon Health Plan during calendar year 2013 but were at some time prior to 2013.

"New" members are clients who were newly enrolled in the Oregon Health Plan in 2014 and were not enrolled prior to 2014.

Statewide, new members had lower rates of avoidable emergency department utilization than other members.

Rates are reported per 1,000 member months
Data source: Administrative (billing) claims
Lower is better.



POST-ACA POPULATION:UTILIZATION BY AGE AND MEMBER TYPE

Emergency department utilization and avoidable emergency department utilization by age and member type

2014 data (n= 9,707,039 member months)

With the influx of new members due to the ACA expansion, emergency department and avoidable emergency department utilization vary not only by age, but by member type.

Children who returned to Medicaid in 2014 (some prior enrollment experience) had lower emergency department utilization rates than returning adults, but among new members with no prior enrollment experience, older adults have the lowest rates of emergency department utilization. And across all member types, adults ages 36-50 have the highest ED utilization.

Adults generally have lower rates of avoidable emergency department utilization than children, with the exception of new children with no prior Medicaid experience, potentially indicating they have not yet established a source for regular care.

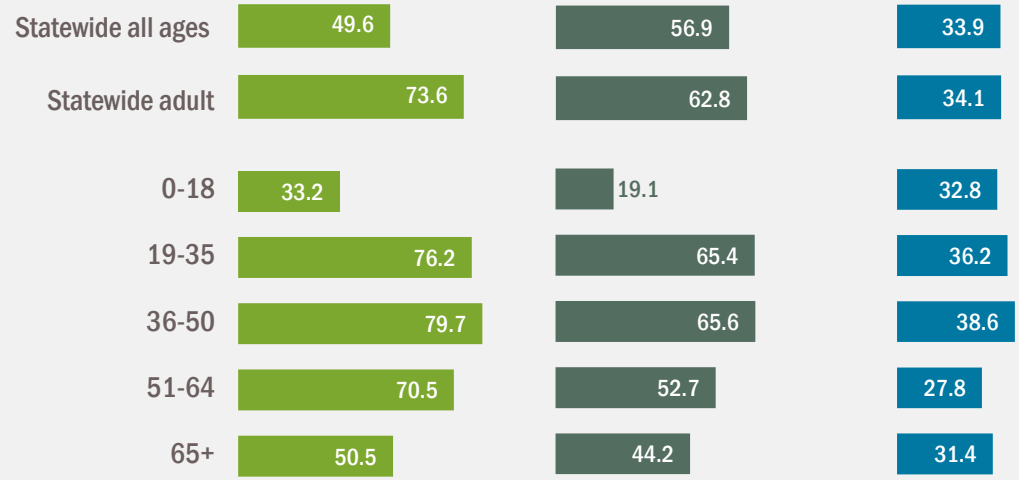
"Existing" members are clients whose enrollment in the Oregon Health Plan began prior to 2014.

"Returning" members are clients who were not enrolled in the Oregon Health Plan during calendar year 2013 but were at some time prior to 2013.

"New" members are clients who were newly enrolled in the Oregon Health Plan in 2014 and were not enrolled prior to 2014.

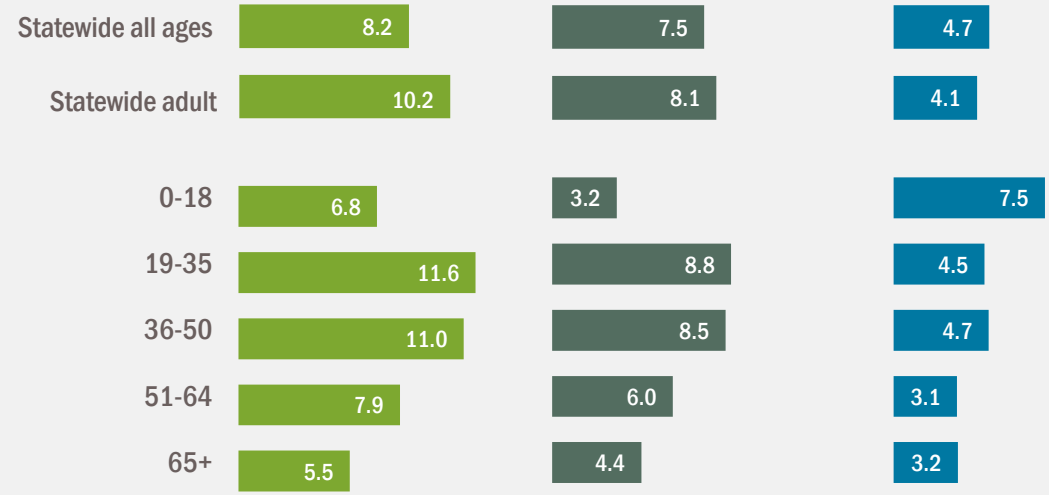
Emergency department utilization is highest for existing adults and lowest for returning children.

Per 1,000 member months.



Avoidable emergency department utilization is highest among new children and existing adults.

Per 1,000 member months.



POST-ACA POPULATION: OUTPATIENT UTILIZATION

Outpatient utilization in 2014

Measure description: Rate of outpatient services, such as office visits, home visits, nursing home care, urgent care and counseling or screening services. Rates are reported per 1,000 member months.

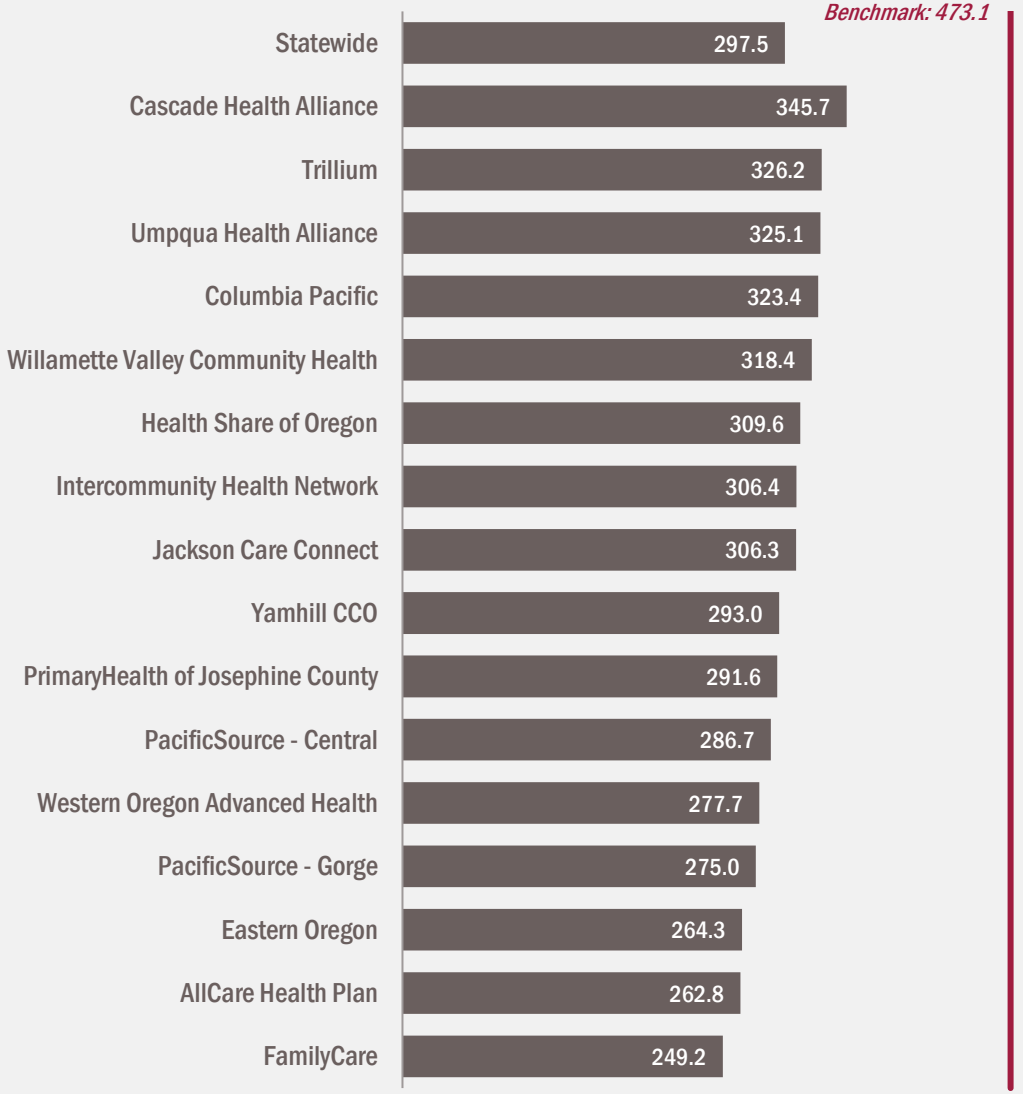
2014 data (n= 9,707,039 member months)

This graph shows outpatient utilization rates for all CCO members between January 1, 2014 and December 31, 2014.

The observed statewide rate of 297.4 is below the 2013 rate of 323.5 (see page 22).

Ambulatory outpatient utilization during 2014.

Data source: Administrative (billing) claims
Benchmark source: 2013 National Medicaid 90th percentile



POST-ACA POPULATION: OUTPATIENT UTILIZATION

Outpatient utilization in 2014, by member type

2014 data (n= 9,707,039 member months)

New members enrolled in a CCO in 2014 but with no prior Oregon Health Plan enrollment (blue bars) used outpatient services more frequently than existing members and returning members with prior enrollment experience (301.2 versus 297.8 and 289.0 per 1,000 member months). This is promising, indicating new members are accessing services at the same rate as other members despite the 60 percent increase in enrollment due to the ACA expansion.

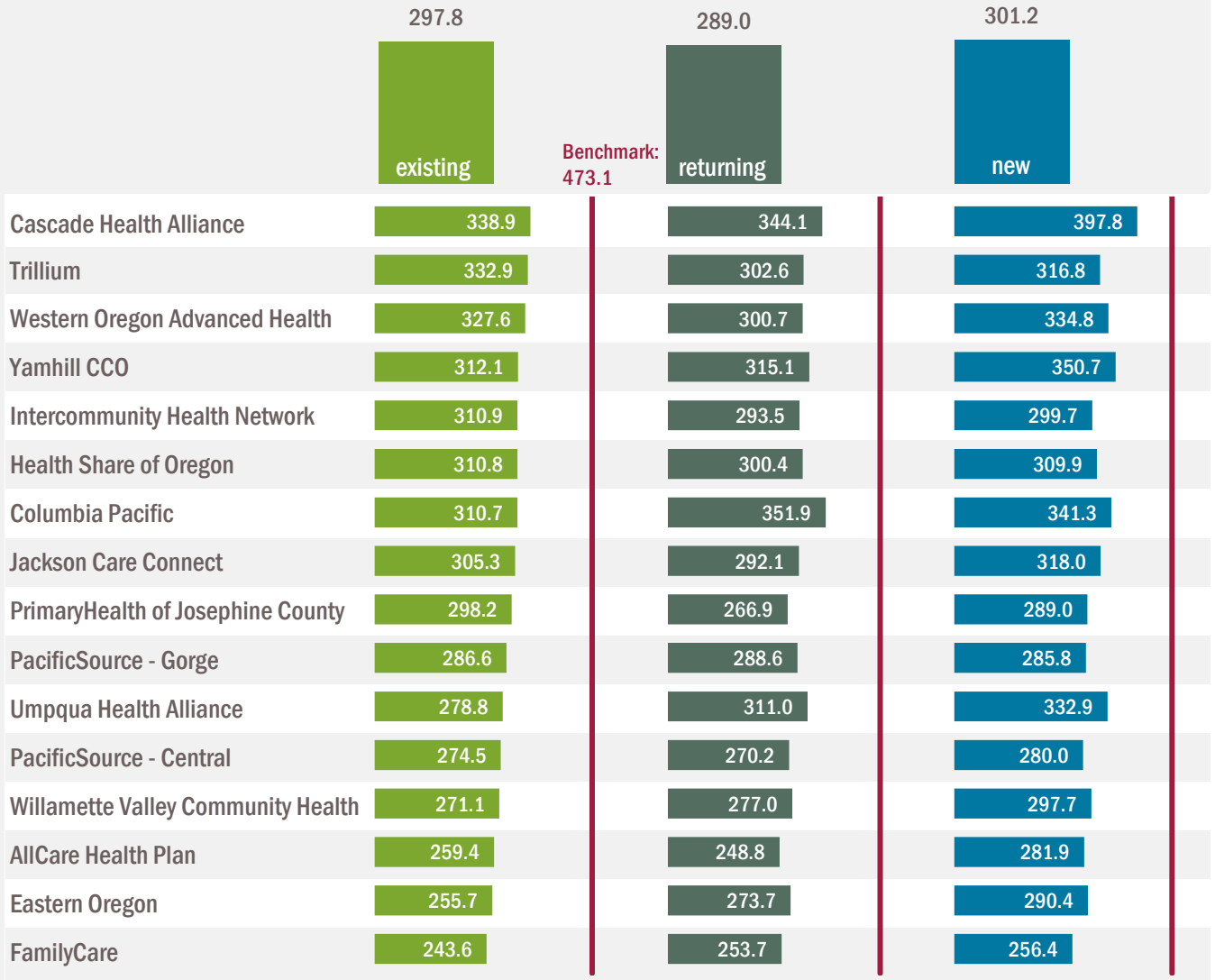
"Existing" members are clients whose enrollment in the Oregon Health Plan began prior to 2014.

"Returning" members are clients who were not enrolled in the Oregon Health Plan during calendar year 2013 but were at some time prior to 2013.

"New" members are clients who were newly enrolled in the Oregon Health Plan in 2014 and were not eligible before that point.

Statewide, new members utilize care in an outpatient setting at slightly higher rates than other members.

Rates are reported per 1,000 member months
Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 90th percentile



COST AND UTILIZATION

Overview

This section of the report contains cost and utilization data for Medicaid spanning calendar years 2011 – 2014. OHA uses Milliman's MedInsight Health Cost Guidelines (HCG) Grouper software to classify claims. Cost and utilization data reported here are comparable to reports produced from Oregon's All-Payer All-Claims database for commercial and Medicare populations.

This report does not include data on services that have occurred but have not yet been recorded or encountered. Data may be incomplete due to lags in submitting data to OHA. Future reports will be updated as more complete data are submitted.

FINANCIAL: INPATIENT COST

Hospital inpatient care

Description: Per member per month cost of hospital inpatient services. Costs are calculated by dividing the total paid for services by the total member months.

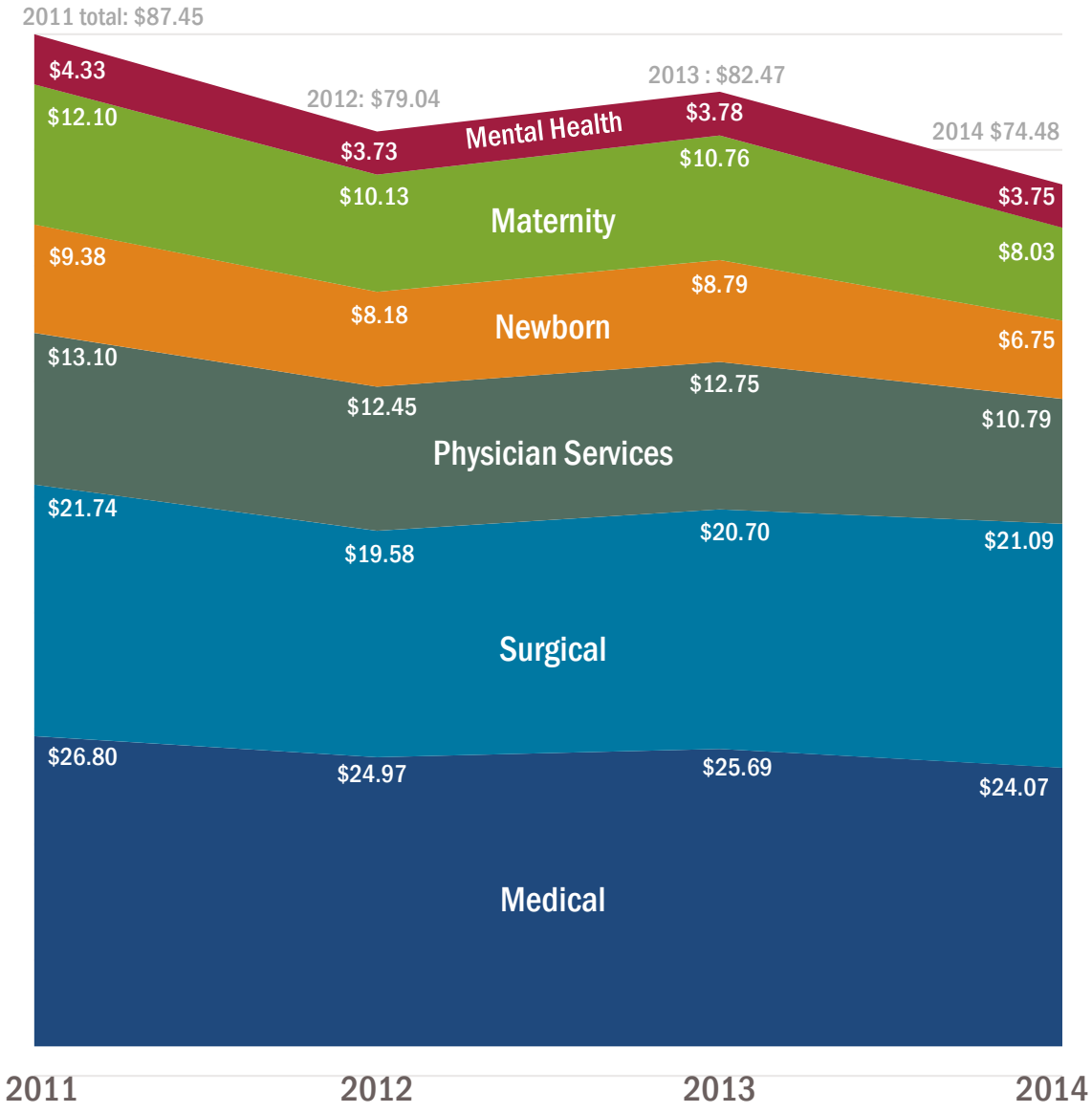
Purpose: Different hospital inpatient interventions require different levels of resource use. With the coordinated model, utilization of these services is also expected over time.

2014 data:

Per-member per-month costs for inpatient hospital services have decreased by 14.8 percent since 2011, the baseline year. This came at a time when more members were in coordinated care since the 2012 creation of CCOs, and when more individuals had access to health care through the Affordable Care Act beginning in 2014. This indicates utilization was held in check as more members enrolled in Medicaid and the inpatient dollars were spread to a larger population.

Overall, inpatient costs have decreased since 2011.

Figures are U.S. dollars per member, per month



FINANCIAL DATA: OUTPATIENT COST

Outpatient costs

Measure description: Per member per month cost of outpatient services. Costs are calculated by dividing the total paid for services by the total member months.

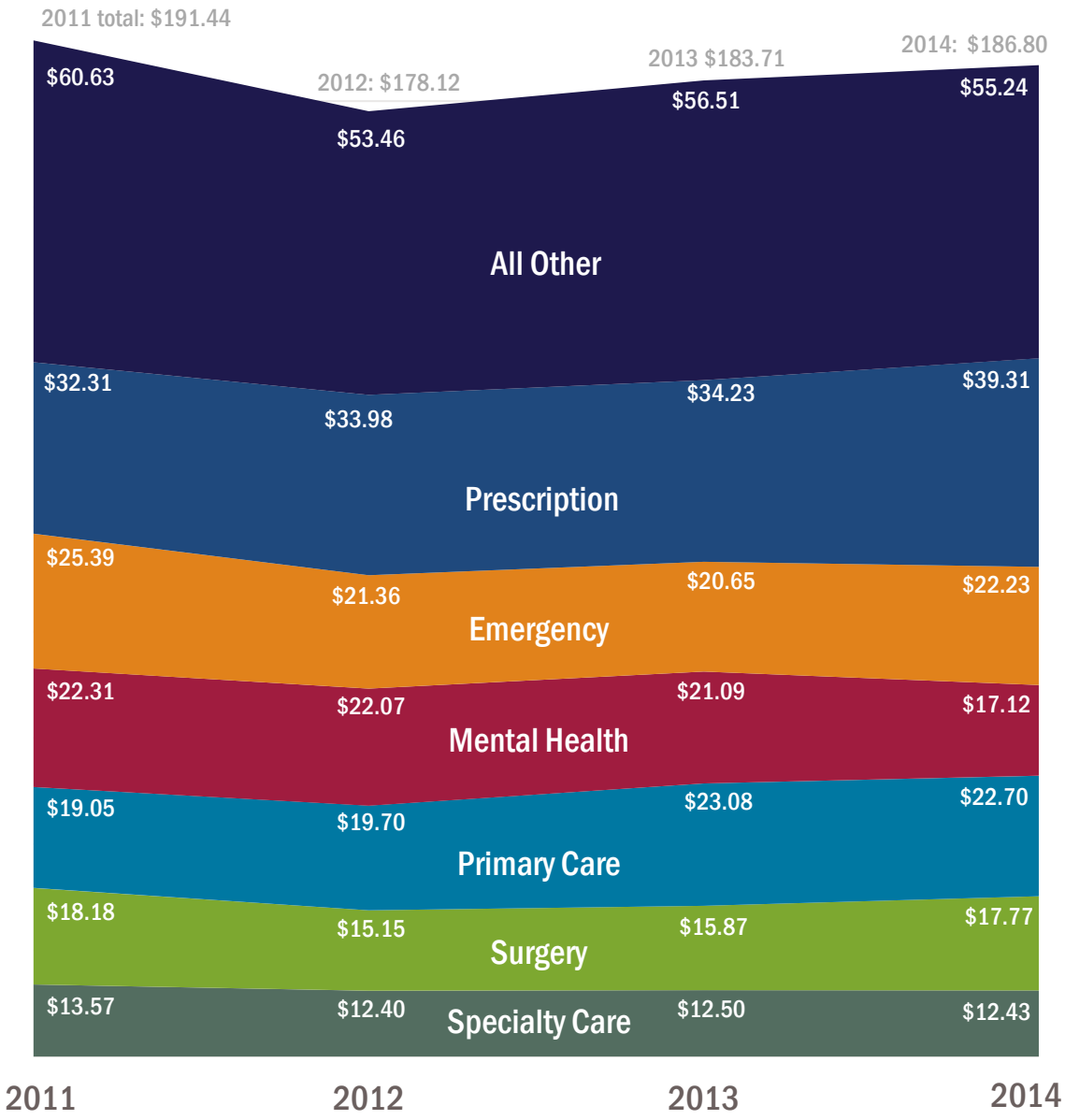
Purpose: Different hospital outpatient interventions require different levels of resource use. With the coordinated model, utilization of these services is also expected over time.

2014 data:

As overall outpatient per member, per month costs have decreased since 2011, two sub-categories have increased: primary care and prescription drugs. With the inception of CCOs, a key focus has been to increase resources at the primary care level to ensure that members are accessing care and treatment plans are initiated in a way that is effective for the patient.

Overall, outpatient costs have decreased slightly since 2011.

Figures are U.S. dollars per member, per month



FINANCIAL DATA: OUTATIENT COST AND UTILIZATION

Primary care and emergency department costs

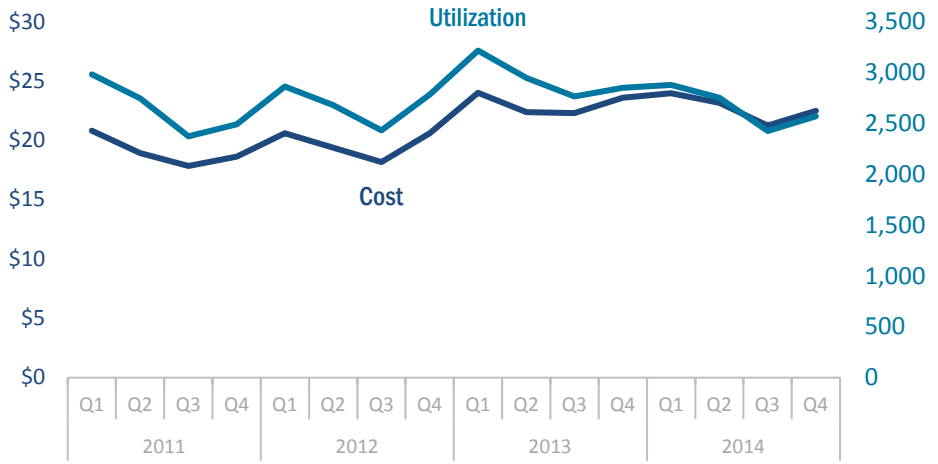
Measure description: Per member per month cost of primary care services displayed with primary care utilization. Costs are calculated by dividing the total claims paid by the total member months and utilization by dividing total primary care visits annually by 1,000 members.

Per member, per month costs of emergency services are calculated as total costs divided by member months.

Purpose: Primary care and emergency department visits may be influenced by the coordinated care model with the focus on patient-centered primary care enrollment.

Primary care cost and utilization have similar trends.

Costs shown are U.S. dollars, per member per month; utilization is annualized/1,000 members.



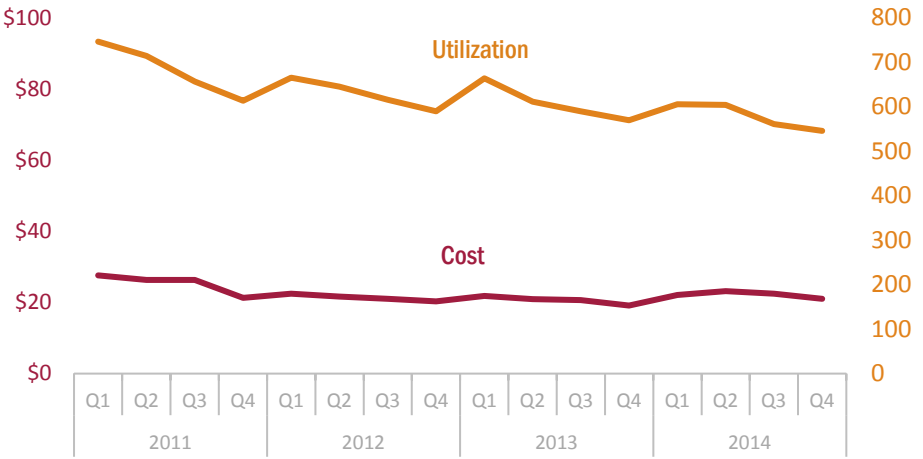
2014 data

Primary care costs and utilization continue to trend closely together, declining in the first half of 2014 and then showing a slight increase in the second half. This trend is consistent with previous years and appears to be holding steady in 2014, despite the increase in the Medicaid population due to ACA expansion.

Emergency department costs increased slightly in the first half of 2014 but resumed their decline in the second half, again consistent with the continued decline in emergency department utilization (see pages 18–19). Costs increased slightly the first quarter of each year between 2011 and 2014, suggesting a seasonal trend.

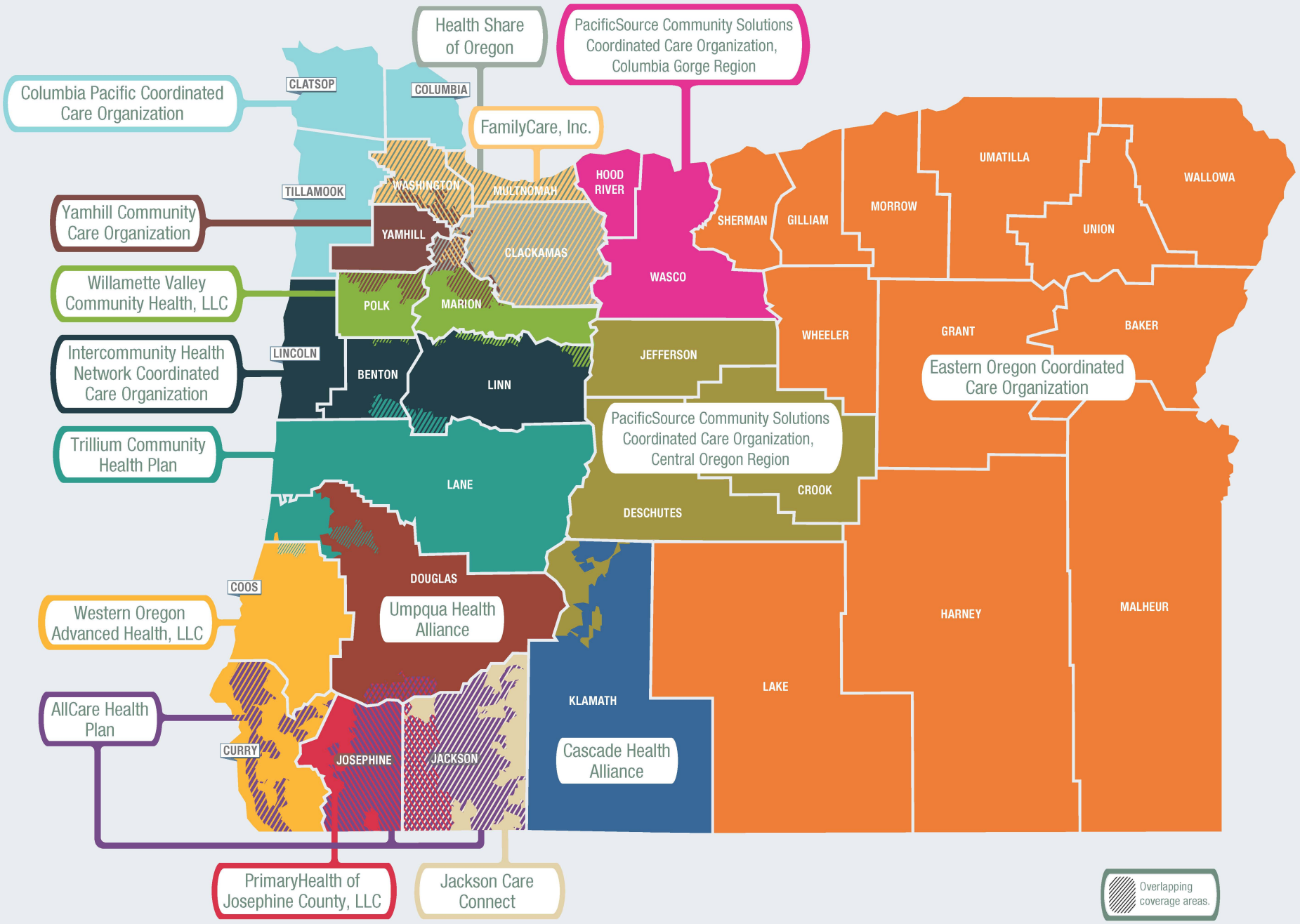
ED cost and utilization.

Costs shown are U.S. dollars, per member per month; utilization is annualized/1,000 members.



Coordinated Care Organization Service Areas

(as of May 2015)



OHA CONTACTS AND ONLINE INFORMATION

For questions about performance metrics, contact:

Lori Coyner
Director of Health Analytics
Oregon Health Authority
Email: lori.a.coyner@state.or.us

For questions about financial metrics, contact:

Jeff Fritsche
Finance Director
Oregon Health Authority
Email: jeffrey.p.fritsche@state.or.us

For more information about technical specifications for measures, visit: www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

For more information about coordinated care organizations, visit: www.health.oregon.gov

VERSION CONTROL

July 17, 2015

- Chlamydia screening statewide bar graph (page 35) - 2013 was corrected from 56.0**%** to **55.8%**; and 2014 was corrected from 43.2% to **45.4%**.
- PCPCH ernollment graph (page 78) was corrected to show CCO enrollment (original publication used total OHP enrollment).

September 9, 2015

- CCO graph for PQI 5 (page 83) was updated with revised 2014 data.

September 30, 2015

- CCO graphs for PQI 8 (page 85) and PQI 15 (page 87) were updated with revised 2014 data.

October 13, 2015

- Post-ACA Outpatient Utilization graph (page 108) was corrected (the original publication was incorrect due to a sorting error).