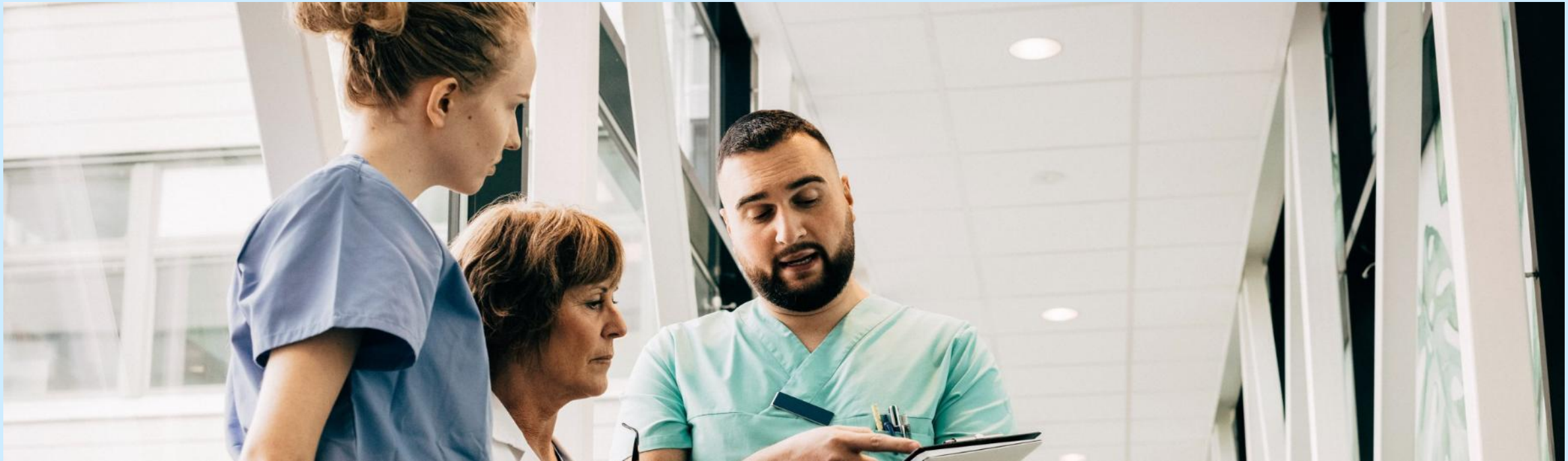
MARSH

October 20, 2026

Oregon Coordinated Care Organizations Technical Assistance

Laura Bass, FSA, MAAA
Dr. Catherine Brett, MD, MPH, FACPM
Teresa Gaskin, MSN, BSN, RN



Purpose of Meeting



The purpose of the meeting is to highlight care management strategies focused on identifying and leveraging opportunities to reduce low-acuity emergency department visits and potentially preventable hospital admissions.

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Agenda

1. Rate Setting Clinical Efficiency Background
2. Clinical Efficiency Overview
    A. Potentially Preventable Admissions
    B. Low-Acuity Non-Emergent
3. Coordinated Care Organization Opportunities
    A. Case Management
    B. Using Claims and Services to Identify Inefficiencies
    C. Provider Contracting Options and Accountability
4. Questions and Discussion

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Introductions



Laura Bass
Actuary



Teresa Gaskin
Clinician



Catherine Brett
Physician

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Acronyms, Part 1 of 2

ACA — Affordable Care Act

ADT — Admission, Discharge, and Transfer

AHRQ — Agency for Healthcare Research and Quality

ARTI — Acute Respiratory Tract Infections

CAHPS — Consumer Assessment Of Healthcare Providers and Systems

CCO — Coordinated Care Organization

CE — Clinical Efficiency

CGE — Clinical Global Exclusion

CHF — Congestive Heart Failure

COA — Category of Aid

COPD — Chronic Obstructive Pulmonary Disease

CY — Calendar Year

E&M — Evaluation and Management

ED — Emergency Department

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Acronyms, Part 2 of 2

HRSN — Health-Related Social Needs

ICU — Intensive Care Unit

LAN — Learning and Action Network

LANE — Low Acuity Non-Emergent

OHA — Oregon Health Authority

PCP — Primary Care Physician

PDI (Children) — Pediatric Quality Indicators

PIP — Performance Improvement Projects

PPA — Potentially Preventable Admissions

PQE — Prevention Quality Indicators in Emergency Department Settings

PQI (Adults) — Prevention Quality Indicators

QAPI — Quality Assurance and Performance Improvement

QIP — Quality Improvement Project

TEL — Targeted Efficiency Level

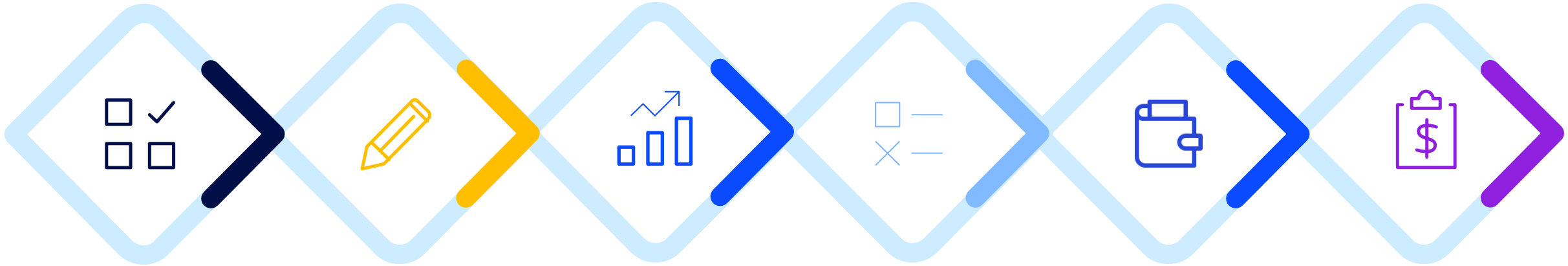
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Rate Setting Clinical Efficiencies Background

01

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Rate Methodology Overview



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Application of Clinical Efficiencies

42 CFR 438.5

In setting actuarially sound capitation rates, **the State must... make appropriate and reasonable adjustments**…. Each adjustment must reasonably support the development of an accurate base data set for purposes of rate setting… and be in accordance with generally accepted actuarial principles and practices.

Actuarial Standard of Practice (ASOP) 49

The actuary may apply managed care adjustments based on the **assumption that the program will move from the level of managed care underlying the base data to a different level of managed care during the rating period.** … If managed care adjustments are included, the changes reflected in the adjustments should be attainable in the rating period, in the actuary's professional judgment.

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Rate Development Objectives



- Medicaid managed care is to operate in an efficient, high-quality manner as part of an overall value-based purchasing strategy.
- Inefficient utilization of healthcare services currently exists as part of total expenditures.
- CEs are data-driven analyses that identify and eliminate a portion of inefficient spend during rate development. Levels of conservatism are part of each analysis to reflect considerations for geography, beneficiary adherence, various environmental factors, and the State's expectations for cost and utilization management.
- The ultimate adjustments do not represent the only inefficient spend in the system, but a quantifiable subset.
- Medicaid managed care entities determine individual programs to identify and improve upon inefficient spend that are not necessarily tied to clinical efficiencies.

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Clinical Efficiency Overview

02

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Key Terms

1

CGE

- Clinical conditions that exclude a member from the data set for the inpatient analysis
- ***Applies to PPA only***

2

Enrollment Duration

- Specified minimum duration for continuous enrollment for a members to be included in the analysis
- ***Applies to PPA only***

3

Replacement Cost

- A calculated amount included in a clinical efficiency analysis that accounts for care in an alternate setting such as alternative setting.
- ***Applies to LANE only***

4

TEL

- Amount of efficiency the program will target reflecting the State's value-based purchasing strategy.
- ***Customized by state — applies to LANE and PPA***

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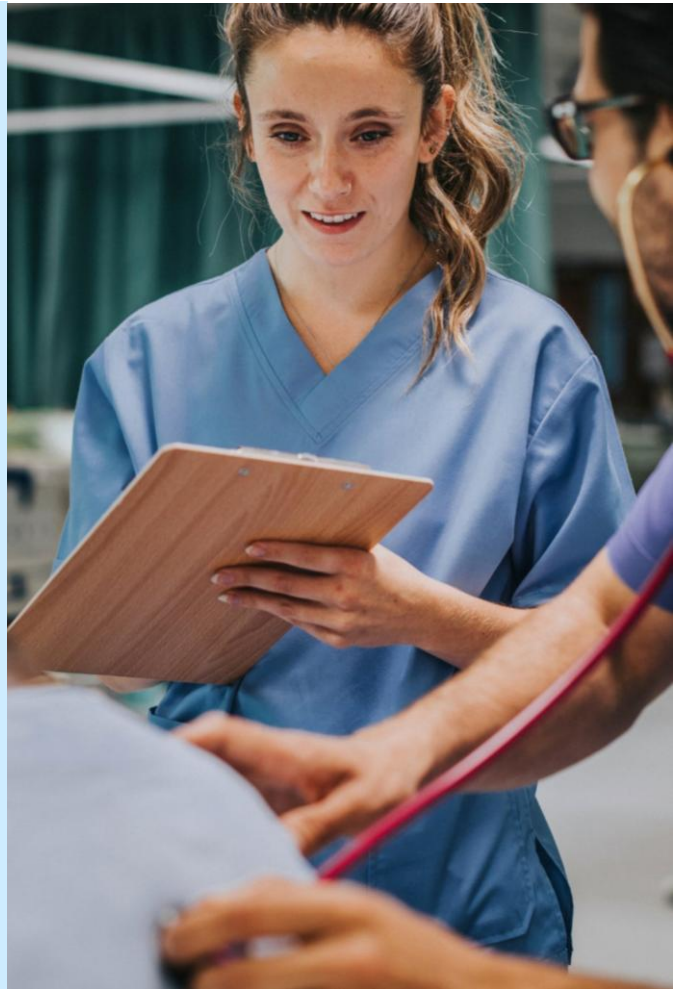
Potentially Preventable Admissions — Overview

Rationale:

PPAs are admissions to a hospital that may have reasonably been prevented with adequate access to ambulatory care and or managed coordinated care.

Approach:

- Identify all inpatient stays that occurred in the base data
- Apply AHRQ measures for PQI (Adults) and PDI (Children)
- Exclude admissions with insufficient enrollment duration
- Exclude admissions for members with a CGE diagnosis
- Reduce the final dollar amount by TEL



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Identifying and Using the PPA Universe

- The Marsh PPA rate setting adjustment use the AHRQ PQI (Adults) and PDI (Children) specifications from the AHRQ website. These are readily available for CCOs to run on a periodic basis to identify all members that have a PQI (Adults) and PDI (Children) event.
  - Prevention Quality Indicators in Inpatient Settings Overview | AHRQ Quality Indicators



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PPA — PQI (Adults) Enrollment Durations

AHRQ PQI #	PQI Description	Duration
1	Diabetes Short-Term Complications Admissions Rate	4 months
3	Diabetes Long-Term Complications Admissions Rate	6 months
5	COPD or Asthma in Older Adults Admission Rate	6 months
7	Hypertension Admission Rate	4 months
8	Heart Failure Admission Rate	4 months
11	Bacterial Pneumonia Admission Rate	2 months
12	Urinary Tract Infection Admission Rate	2 months
14	Uncontrolled Diabetes Admission Rate	4 months
15	Asthma in Younger Adults Admission Rate	4 months
16	Rate of Lower Extremity Amputation Diabetes	12 months

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PPA — PDI (Children) Enrollment Durations

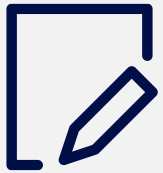
AHRQ PDI #	PDI Description	Duration
14	Asthma Admission Rate	3 months
15	Diabetes Short-Term Complications Admission Rate	4 months
16	Gastroenteritis Admission Rate	2 months
18	Urinary Tract Infection Admission Rate	2 months

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Clinical Global Exclusions



CGE logic identifies members with a specific excluded condition(s) that are so **complex that the member's admission is not considered preventable.**



CGE is applied **prior** to finalizing analysis



Based on literature supported clinical conditions that typically require higher levels of care, and that can be inherently unpredictable in clinical presentation and course of treatment:

- HIV/AIDS
- Trauma
- Extensive Burns treated in ICU
- Metastatic Malignancies
- Obstetrics/Pregnancy
- Neonatal/Infants (<12 months)
- Hospice
- Ventricular Shunt Revisions

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PQI (Adults) Adjustment for CY 2027 Rates

Statewide Summary of CY 2025 Data in Millions of Dollars

PQI	Total IP Dollars	Total PQI Dollars	Total PQI Dollars After Exclusions Pre-TEL	% of Total IP Dollars Pre-TEL
Formula	**(A)**	**(B)**	**(C)**	**(D) = (C) / (A)**
1 — Diabetes Short-Term Complication	$629.5M	$8.9M	$7.4M	1.2%
3 — Diabetes Long-Term Complication	$629.5M	$6.7M	$5.2M	0.8%
5 — COPD	$629.5M	$4.1M	$3.1M	0.5%
7 — Hypertension	$629.5M	$2.3M	$1.5M	0.2%
8 — CHF	$629.5M	$20.1M	$15.8M	2.5%
11 — Bacterial Pneumonia	$629.5M	$4.5M	$3.5M	0.6%

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PQI (Adults) Adjustment for CY 2027 Rates, Continued

Statewide Summary of CY 2025 Data in Millions of Dollars

PQI	Total IP Dollars	Total PQI Dollars	Total PQI Dollars After Exclusions Pre-TEL	% of Total IP Dollars Pre-TEL
Formula	**(A)**	**(B)**	**(C)**	**(D) = (C) / (A)**
12 — Urinary Tract Infection	$629.5M	$2.0M	$1.7M	0.3%
14 — Uncontrolled Diabetes	$629.5M	$1.2M	$0.9M	0.1%
15 — Adult Asthma	$629.5M	$0.6M	$0.5M	0.1%
16 — Diabetic Lower-Extremity Amputation	$629.5M	$4.9M	$3.0M	0.5%
Total	**$629.5M**	**$55.4M**	**$42.7M**	**6.8%**

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PDI (Children) Adjustment for CY 2027 Rates

Statewide Summary of CY 2025 Data in Millions of Dollars

PDI	Total IP Dollars	Total PDI Dollars	Total PDI Dollars After Exclusions Pre-TEL	% of Total IP Dollars Pre-TEL
Formula	**(A)**	**(B)**	**(C)**	**(D) = (C) / (A)**
14 — Asthma	$220.8M	$0.9M	$0.8M	0.4%
15 — Diabetes Short-Term Complications	$220.8M	$0.4M	$0.4M	0.2%
16 — Gastroenteritis	$220.8M	$0.4M	$0.3M	0.1%
18 — Urinary Tract Infection	$220.8M	$0.2M	$0.1M	0.1%
Total	**$220.8M**	**$1.7M**	**$1.7M**	**0.8%**

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Low Acuity Non-Emergent — Overview



Rationale:

LANE visits are ED services for a health condition that may not require emergency medical attention.

These visits create a significant financial impact and may not be the most appropriate site of service for the member.

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Identifying and Using the LANE Universe

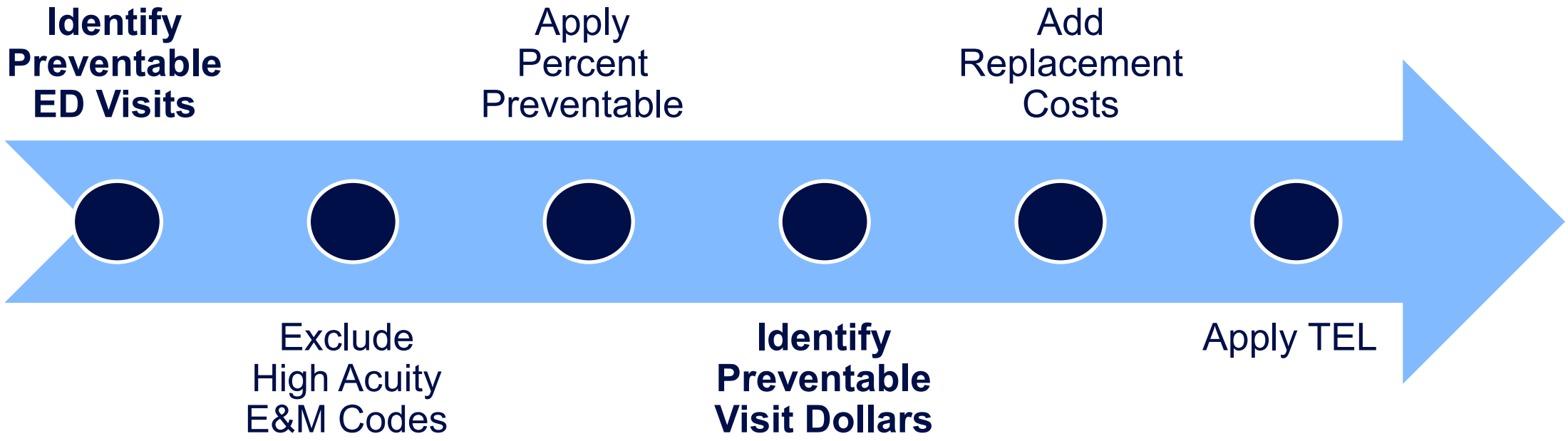
How do you create the universe?

Identification of your ED universe

- Identify all ED utilization for the time period.
- Exclude claims in which a member is admitted to the hospital or has an observational stay.
- Identify claims with both a facility and professional claim.
- Limit Evaluation and Management codes to 99281 through 99284.
- Proxy for your own analysis: AHRQ's PQE indicator with readily available.
  - Emergency Department Prevention Quality Indicators (PQE) Resources & Guidance | AHRQ Quality Indicators

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Implementing LANE — Adjusting the Results



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LANE Adjustment for CY 2027 Rates

Statewide Summary of CY 2025 Data in Millions of Dollars

COA	Total ED Dollars	Total LANE Dollars	Adjusted LANE Dollars	Replacement Cost Dollars	Net LANE Dollars Pre-TEL	% of Total ED Dollars Pre-TEL
Formula	**(A)**	**(B)**	**(C)**	**(D)**	**(E) = (C) – (D)**	**(F) = (E) / (A)**
ACA 19–34	$92.8M	$36.1M	$8.8M	$2.6M	$6.2M	6.6%
Child 06–18	$56.3M	$26.9M	$7.1M	$2.3M	$4.9M	4.3%
ACA 35–44	$61.1M	$22.0M	$5.1M	$1.5M	$3.6M	5.9%
PCR	$51.8M	$19.5M	$4.3M	$1.2M	$3.1M	5.9%
ACA 45-54	$54.1M	$17.3M	$4.0M	$1.1M	$2.9M	5.4%
ABAD & OAA	$55.7M	$15.5M	$3.5M	$1.0M	$2.5M	4.5%
Child 01–05	$23.3M	$13.8M	$3.6M	$1.2M	$2.4M	10.3%
Other	$98.7M	$28.8M	$5.7M	$1.6M	$4.0M	4.1%
Total	**$494.8M**	**$179.9M**	**$42.0M**	**$12.5M**	**$29.5M**	**6.0%**

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CCO Opportunities

03

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Discussion Question 1

Who attended Marsh's previous TA Session?

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Discussion Question 2

If you attended previous TA session, did it change your utilization of LANE and PPA reports?

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Clinical Efficiencies as Drivers for Care Coordination



LANE top 25 condition drivers

- Days of the week
- Region or provider
- Behavioral Health Emergency Visit initiative



PQI/PDI dollars and visits

- AHRQs PPA PQI/PDI logic
- Stratification applicability from Health Risk Assessments for coordination of care.



Network Adequacy Reporting

- Telehealth
- Contracting Options

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LANE Summary for CY 2027 Rates (1 of 3)

Top Diagnoses by Total LANE Dollars: All Populations, in Millions of Dollars

- Over 10% of Adjusted LANE Dollars comes from the Top 5 diagnosis code groupings
- Over 30% of Adjusted LANE Dollars comes from the Top 25 diagnosis code groupings

Diagnosis Code Grouping	Description	Adjusted LANE Dollars Pre-TEL
Top 5		$9.8M
R11	Nausea and vomiting	$2.8M
J069	Acute upper respiratory infection, unspecified	$2.2M
M796	Pain in limb, hand, foot, fingers and toes	$1.9M
H669	Otitis media, unspecified	$1.4M
K008	Other specified disorders of teeth and supporting structures	$1.4M
Next 20		$20.2M
Top 25		**$30.0M**
Other		**$54.1M**
Total		**$84.0M**

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LANE Summary for CY 2027 Rates (2 of 3)

Top Diagnoses by Total LANE Dollars: Adult Populations, in Millions of Dollars

- Over 10% of Total LANE Dollars comes from the Top 5 diagnosis code groupings
- Over 30% of Total LANE Dollars comes from the Top 25 diagnosis code groupings

Diagnosis Code Grouping	Description	Adjusted LANE Dollars Pre-TEL
Top 5		$7.1M
R11	Nausea and vomiting	$2.0M
M796	Pain in limb, hand, foot, fingers and toes	$1.5M
K008	Other specified disorders of teeth and supporting structures	$1.3M
L031	Cellulitis and acute lymphangitis of other parts of limb	$1.3M
R51	Headache	$1.1M
Next 20		$14.4M
Top 25		**$21.6M**
Other		**$38.0M**
Total		**$60.0M**

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LANE Summary for CY 2027 Rates (3 of 3)

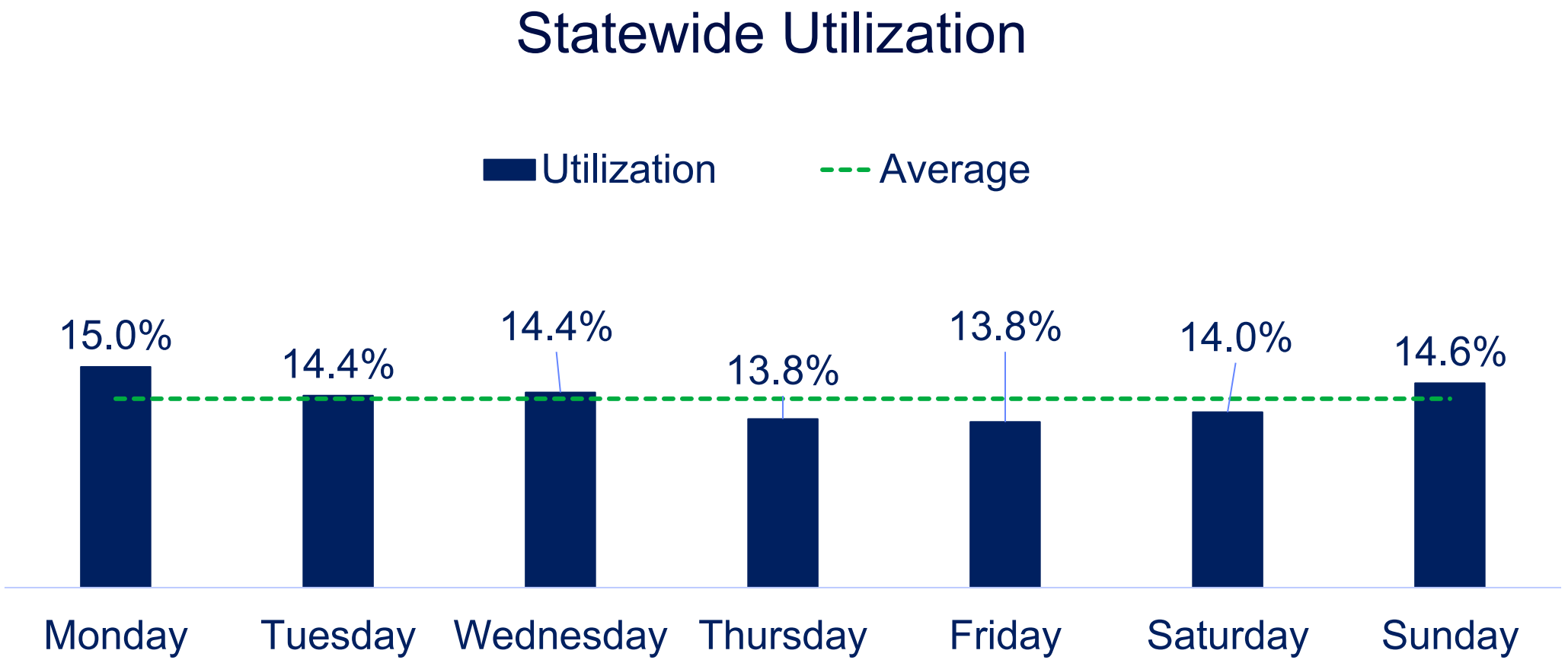
Top Diagnoses by Total LANE Dollars: Child Populations, in Millions of Dollars

- Nearly 20% of Total LANE Dollars comes from the Top 5 diagnosis code groupings
- Over 40% of Total LANE Dollars comes from the Top 25 diagnosis code groupings

Diagnosis Code Grouping	Description	Adjusted LANE Dollars Pre-TEL
Top 5		$4.7M
J069	Acute upper respiratory infection, unspecified	$1.5M
H669	Otitis media, unspecified	$1.1M
R11	Nausea and vomiting	$0.8M
R05	Cough	$0.7M
J020	Streptococcal pharyngitis	$0.6M
Next 20		$6.6M
Top 25		**$11.3M**
Other		**$13.2M**
Total		**$24.5M**

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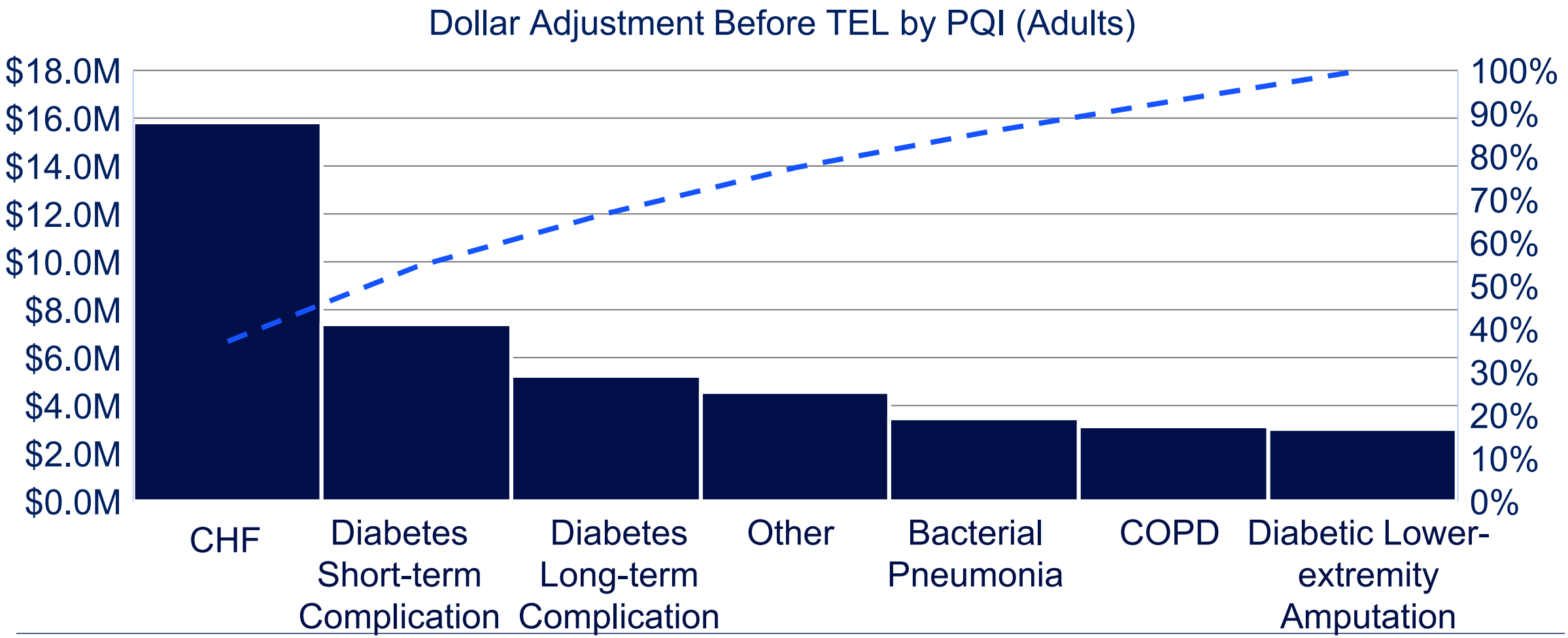
LANE Utilization by Day of Week



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PQI (Adults) Adjustment for CY 2027 Rates

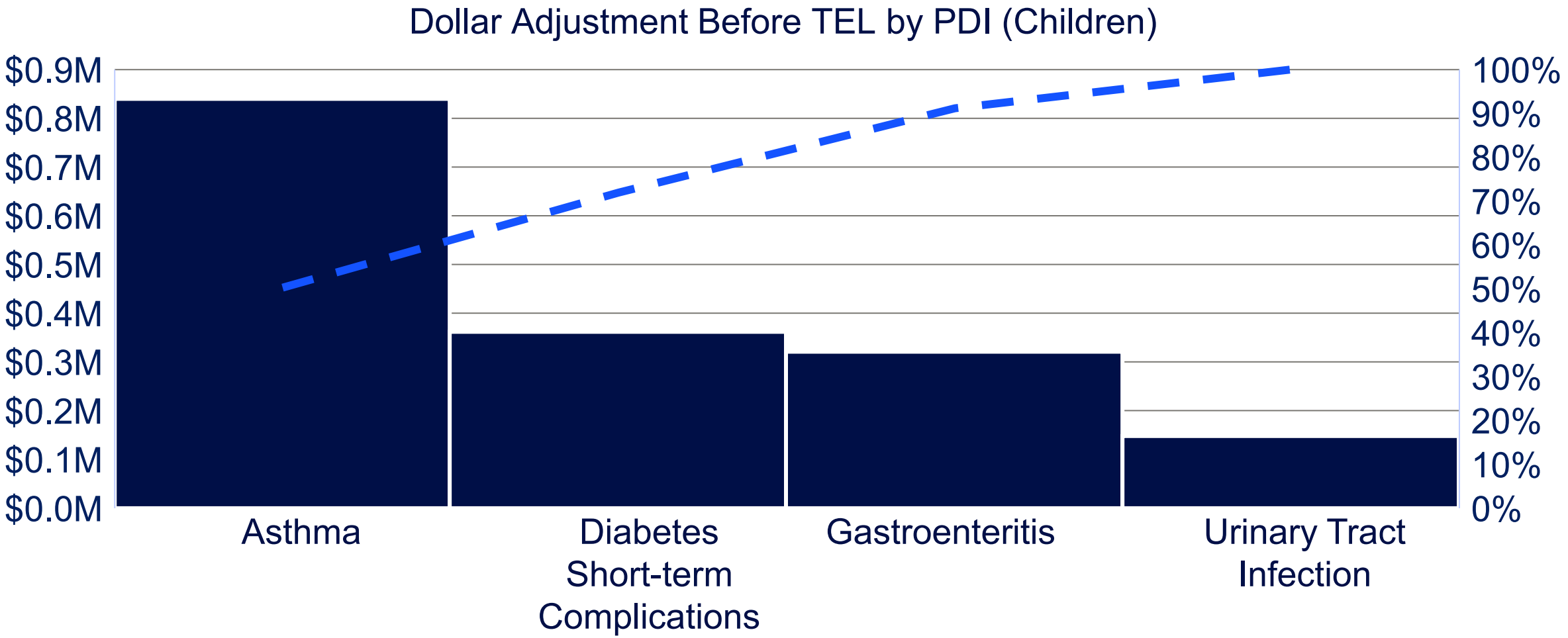
Statewide Summary of CY 2025 Data in Millions of Dollars



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PDI (Children) Adjustment for CY 2027 Rates

Statewide Summary of CY 2025 Data



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Discussion Question 3

In one word or short phrase, in general, how are you currently using LANE/PPA reports?

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Discussion Question 4

Do you utilize risk stratification to identify members with care management needs?

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Discussion Question 5

What data informs your risk stratification model?

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CCO Opportunities: Part 1

Identifying Inefficiencies Using Claims and Services



What can I learn from the report about needs in my membership?

- Physical health
- Mental well-being
- Health-Related Social Needs (HRSN)



How can I harness the report to improve population health in my membership?

- Process and Policy
- Care Management Services
- Provider Training
- Member Education



How can I utilize the report to stimulate further analysis?

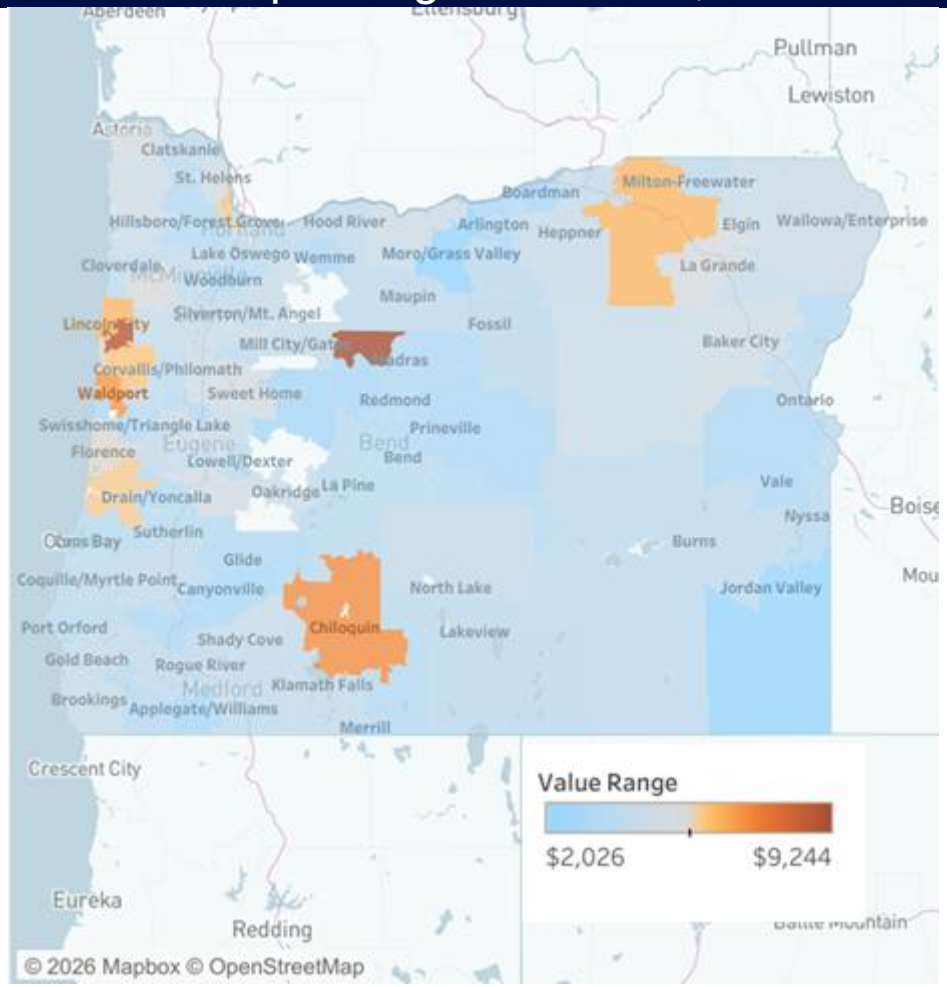
- Key Drivers
- Best Practices

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CCO Opportunities: Part 2

Identifying Trends and Outliers

Healthcare Spending Per Person, 2015–2023



What does your data tell you?

- Geographic Heat Mapping
- Provider Prescribing Patterns
- Member Demographic Trends

How does that compare to your Care Management data?

- HRSN Heat Mapping
- Member CAHPS Survey results
- National Reporting and Score Cards

Image: Healthcare Spending per Person by Service Area 2015-2023, Oregon Office of Rural Health, Accessed January 7, 2026.

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CCO Opportunities: Part 3

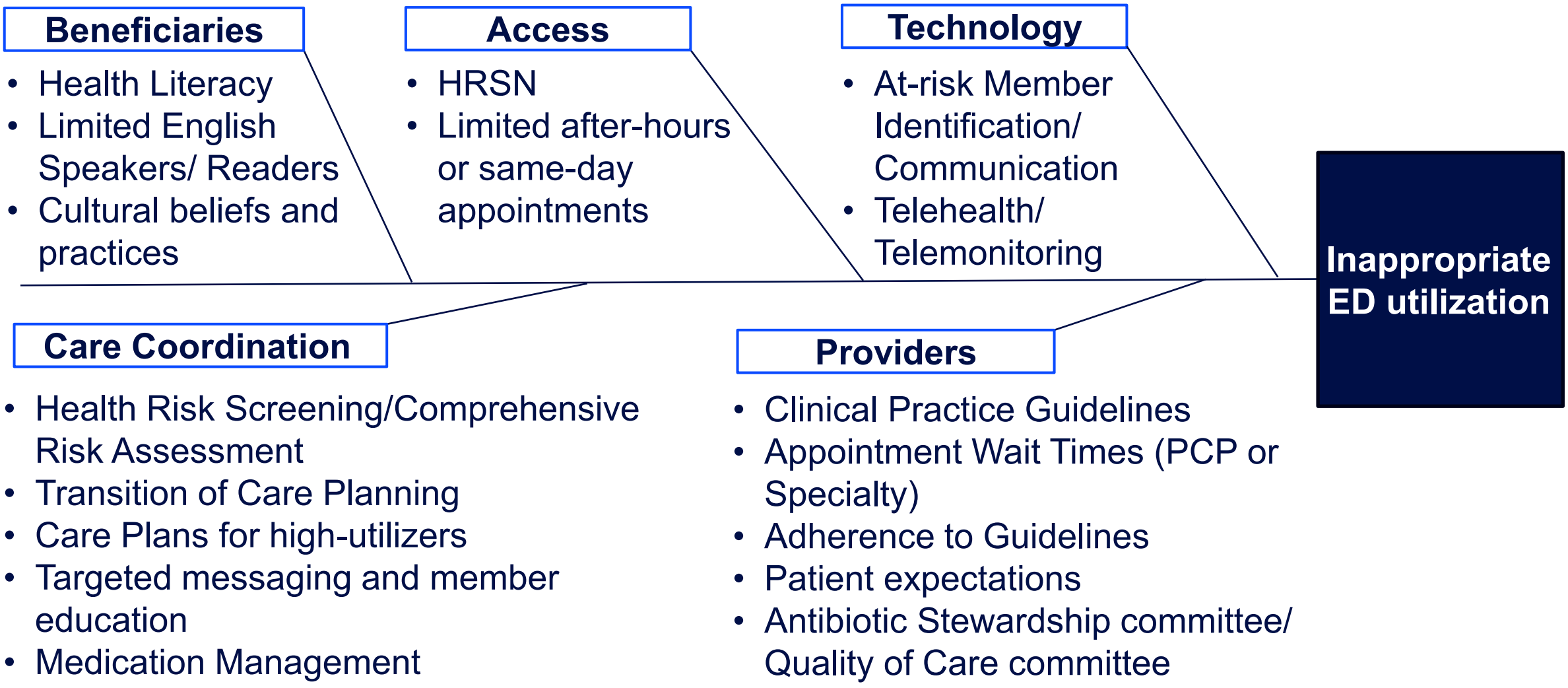
Identifying Trends and Outliers: CY 2025 PDI (Children) Data in Millions of Dollars

Diagnosis Code Grouping	Description	Adjusted LANE Dollars Pre-TEL
J069	Acute upper respiratory infection, unspecified	$1.5M
H669	Otitis media, unspecified	$1.1M
R11	Nausea and vomiting	$0.8M
…	…	…
S52	Fracture of forearm	$0.4M
L50	Urticaria	$0.4M
S62	Fracture at wrist and hand level	$0.3M
…	…	…
Total		**$24.5M**

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CCO Opportunities: Part 4

Example Root Causes and Solutions



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Discussion Question 6

What quality improvement activities were deployed after taking a deeper dive into the specific diagnosis of LANE pharyngitis visits last session?

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CCO Opportunities: Part 5

Beneficiary Beliefs and Experience

Figure 4: Barriers to Meeting Healthcare Needs with OHP (*N*=728)[1]

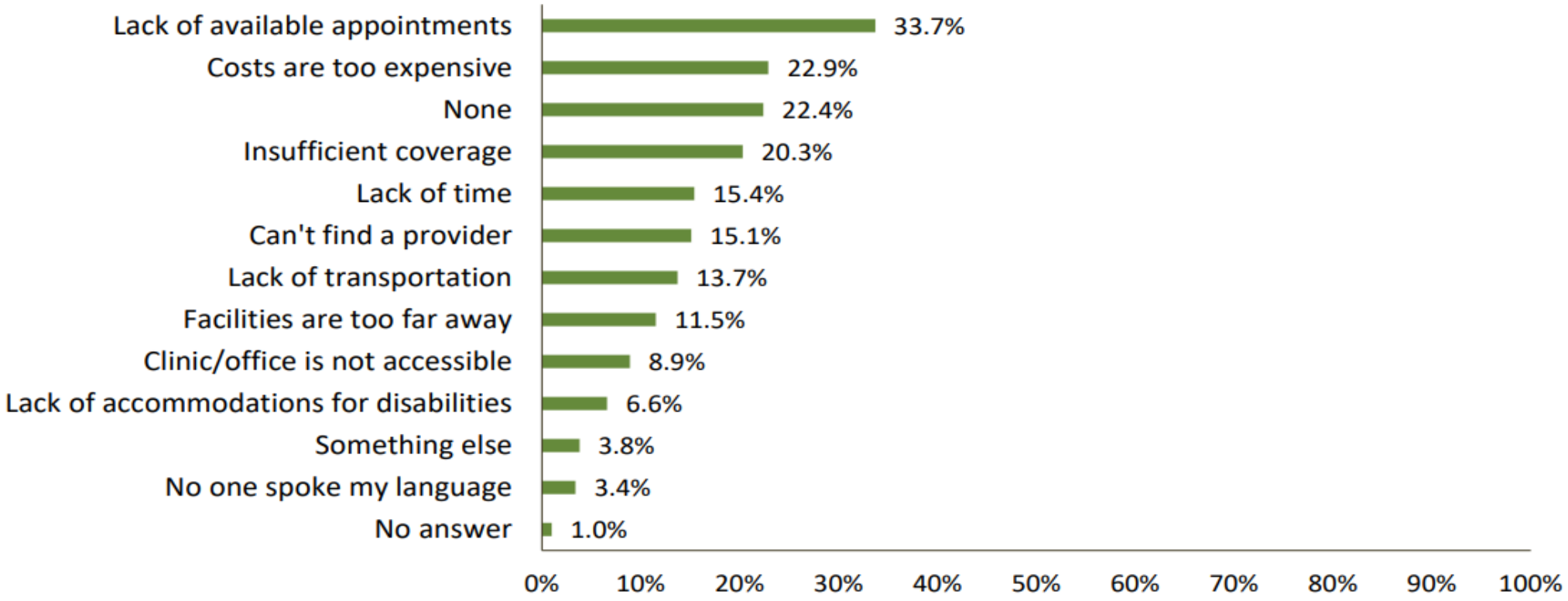


Image: Oregon Health Authority. "OHA Quality Incentive Program Study Findings Report." (2024)

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Discussion Question 7

What core components of care coordination and case management have been modified or strengthened based on the LANE/PPA reports?

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Discussion Question 8

What activities did you or your department/division review following the previous LANE/PPA TA session?

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CCO Opportunities: Part 6

Provider Contracting Options and Accountability

Improve Provider Networks

- Identify potential connection between performance data and provider network issues (e.g., appointment availability, provider shortages, telehealth opportunities).
- Enable timely access to relevant data, including provider score cards and ADT feeds.
- Partner with providers for performance improvement projects (e.g., avoiding preventable re-hospitalizations, deploying primary care teams to improve care and reduce preventable or unnecessarily costly utilization, ensuring appropriate care is delivered in appropriate settings).

Patient-Centered Primary Care Homes

- Tie required LAN Category 2A payments (i.e., infrastructure/operations payments) to better care/case management.

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CCO Opportunities: Part 6, Continued

Provider Contracting Options and Accountability

Value-Based Payment

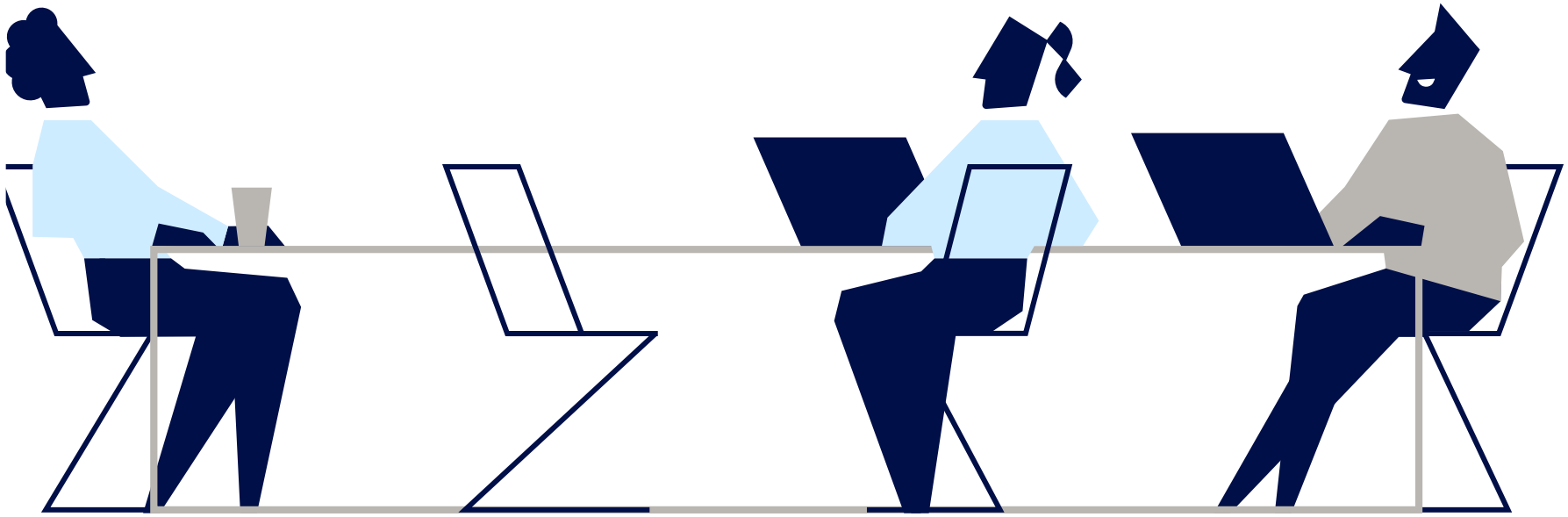
- Embed measures that relate to clinical efficiencies and priority quality measures.
- For CCOs in the same service area: Participate in the OHA-facilitated discussions to select performance measures and any other areas of alignment.

Quality Pool and Challenge Pool

- Distribute quality pool earnings to Participating Providers, including Social Determinants of Health and Equity and public health partners — rewarding efforts to improve better, more appropriate care.

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Questions and Discussion



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Additional Resources for the Review

- Agency for Healthcare Research and Quality. "Designing and Implementing Medicaid Disease and Care Management Programs,"
- Bakshi S, Carlson L, Gulla J, et al. "Improving Care Coordination and Reducing ED Utilization Through Patient Navigation," *The American Journal of Managed Care,* Volume 28 Issue 5 (2022)
- Baughman D, Waheed A, Khan M, Nicholson J. "Enhancing Value-Based Care With a Walk-in Clinic: A Primary Care Provider Intervention to Decrease Low Acuity Emergency Department Overutilization," (2021)
- CMSHHSgov. "Care Management Transformed Innovative Strategies for Personalized Patient Care and Access,"

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Additional Resources for the Review, Continued

- Jaramillo C. "Reducing Low-Acuity Preventable Emergency Room Visits by Utilizing Urgent Care Center Services via Mobile Health Unit Diversion Program," *Journal of Urgent Care Medicine, (2022)*
- Lyhne C, Bjerrum M, Riis A. "Interventions to Prevent Potentially Avoidable Hospitalizations: A Mixed Methods Systematic Review," (2022)
- Yang A, Durrani M, Simmons T, Pescatore, R. "Community Paramedicine and EMS Policy Issues" *Emergency Medicine Advocacy Handbook,* Section 30, Ch. 25

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MARSH

This presentation is prepared by Marsh Government Health Consulting (Marsh), part of Marsh Health & Benefits LLC, formerly Mercer Government Human Services Consulting.

This presentation is prepared on behalf of the State of Oregon and is intended to be relied upon by the Oregon Health Authority Office of Actuarial and Financial Analytics (OAFA) for purposes of communicating with Coordinated Care Organizations (CCOs) about Clinical Efficiency Adjustments within the CY 2027 capitation rates for the CCO Program. The information provided in this presentation is confidential, should be read in its entirety and in conjunction with the forthcoming CY 2027 capitation rate certification, and is not complete without oral comment. This presentation has been prepared under the direction of Laura Bass, FSA, MAAA, who is a member of the American Academy of Actuaries and meets its US Qualification Standard for issuing the statements of actuarial opinion herein.

To the best of Marsh's knowledge, there are no conflicts of interest in performing this work.

Marsh has developed models to estimate the values in this presentation. We have reviewed the inputs, calculations, and outputs of the models for reasonableness and evaluated them to be appropriate for the intended purpose. Models relied upon by Marsh are in compliance with generally accepted actuarial practice and all relevant actuarial standards of practice. These models may not be appropriate for any other purpose.

Marsh's analysis relied on eligibility and encounter data provided to Marsh by OAFA. The suppliers of data are solely responsible for its validity and completeness. Marsh has reviewed the data and information for internal consistency and reasonableness, but we did not audit it. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

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