Office of Health Analytics

Data Profiles

These profiles describe the ten main data sources that are owned and/or managed by the Oregon Health Authority's Office of Health Analytics. Each profile begins with a high-level description of the data source and examples of what the data can tell us, and then includes five key sections:

- **Regular reporting:** How, when, and where the data are made publicly available.
- **About the data:** An overview of the data elements. Includes things like how they are collected; who is represented in the data; whether the data are REALD and SOGI compliant; and things to remember when interpreting the data.
- **Requesting data:** Details about how to request each data source.
- **In action:** Examples of how the data source has been used to answer research questions or inform policymaking in Oregon.
- **Quick facts**: A reference sheet with key information about each data source.

These profiles can also be found online at www.oregon.gov/oha/HPA/ANALYTICS/Pages/Data.aspx. Please email HPA.IDEA.Team@odhsoha.oregon.gov if you find an error or something that needs to be updated in this document. Profiles will be updated annually.

You can get this document in other languages, large print, braille, or a format you prefer. Email HPA.IDEA.Team@odhsoha.oregon.gov.

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All Payer All Claims (APAC)

HPA Data Profile

Oregon's All Payer All Claims (APAC) database contains information about Oregon's insured population and the health care services they receive — such as diagnoses, visits, and payments made. The information comes from administrative records kept by insurers (also known as payers).

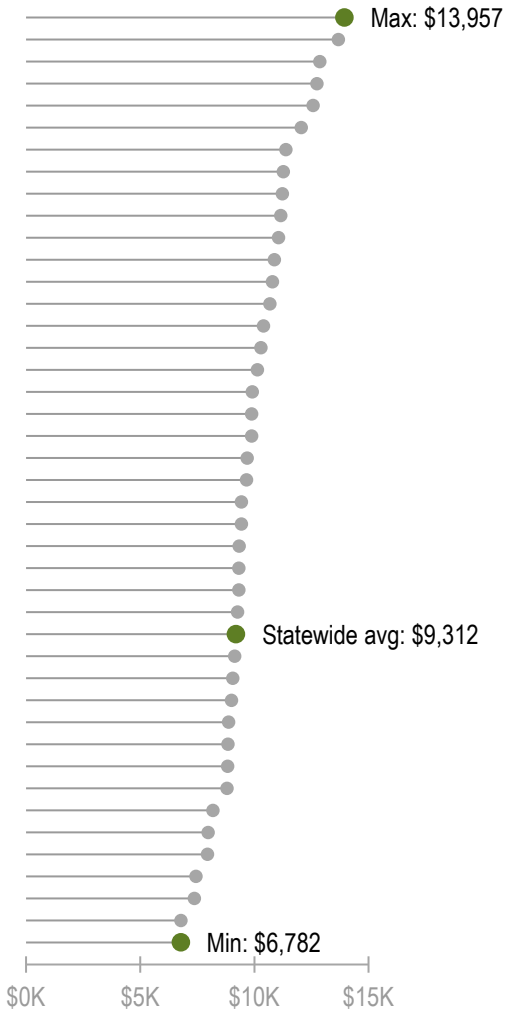
APAC is a unique resource for statewide health care improvement efforts. With data collected from all major public and private payers, APAC is the most comprehensive database on health care costs, quality, and utilization in Oregon.

A few examples of the things APAC data can tell us include:

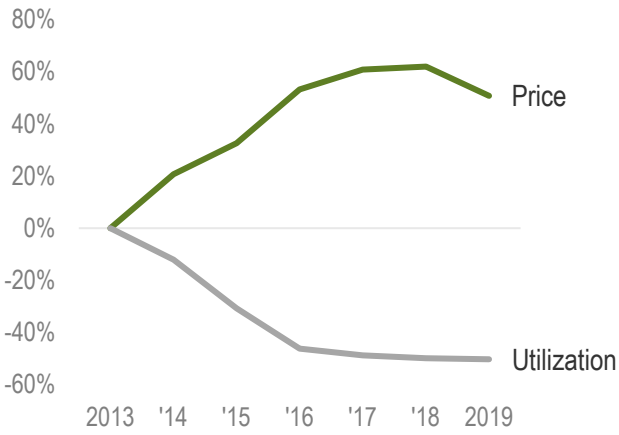
Did you know?

APAC is one of several All-Payer Claims Databases (APCDs) in the country, with many more in development. Other states use these initiatives in similar ways as Oregon: to inform new policies around health care cost, quality, and access; to evaluate existing programs; and to bring transparency to the health care system.

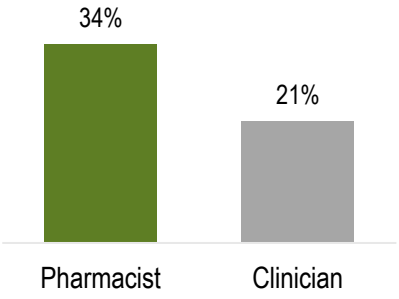
The median price of a normal delivery varied widely across Oregon hospitals in 2021.



In the commercial insurance market the prices of inpatient services have increased over time, *while utilization has decreased.*



People who receive a contraceptive prescription from a pharmacist are more likely to continue use for 12 months *compared with prescriptions from clinicians*



Regular reporting

OHA publishes several regular reports and data dashboards that use APAC data:

Hospital Payment Report

The *Hospital Payment Report* is an interactive dashboard that shows the amounts commercial insurance companies pay different hospitals in Oregon for common procedures each year. The dashboard allows users to compare the median price of more than one hundred different procedures across Oregon's 60 hospitals. The dashboard also shows the price variation of procedures *within* each hospital, and how median payments have changed over time.

The dashboard is published every year in July on the Hospital Reporting Program webpage. View the 2020 dashboard.

Payment Arrangements

Beginning in 2018, Oregon became one of just a few states that collects a valuable type of information from insurance payers in its database: How they pay health care providers outside the normal "fee-for-service" model. (Learn more about this type of data and why it's important in Appendix A on page 11). OHA publishes an annual dashboard that tracks the different types of payment arrangements that health insurers use to pay the providers in their networks.

Oregon's Health Care Payment Arrangements is published annually on the APAC webpage.

Primary Care Spending

The *Primary Care Spending Report* is an annual report to the Legislature. It describes how much different health care payers spend (as a percentage of total spending) toward primary care each year. For example, the 2022 report showed that on average, commercial health plans allocated a greater share of their total spending toward primary care than Coordinated Care Organizations (which are plans that provide Medicaid coverage to people in Oregon) or Medicare Advantage plans.

The report is published annually on the Primary Care Spending webpage as an interactive dashboard and short executive summary. View the 2020 dashboard.

In addition to the above reports, Oregon's Health Care Cost Growth Target and Health Care Market Oversight programs also rely heavily on APAC data and regularly publish reports that use APAC data. Learn more in the APAC in Action section on pages 8-9.

About the data

This section includes some helpful information about where APAC data come from, what types of information are available, and important things to keep in mind when using these data. To learn more, visit the APAC website.

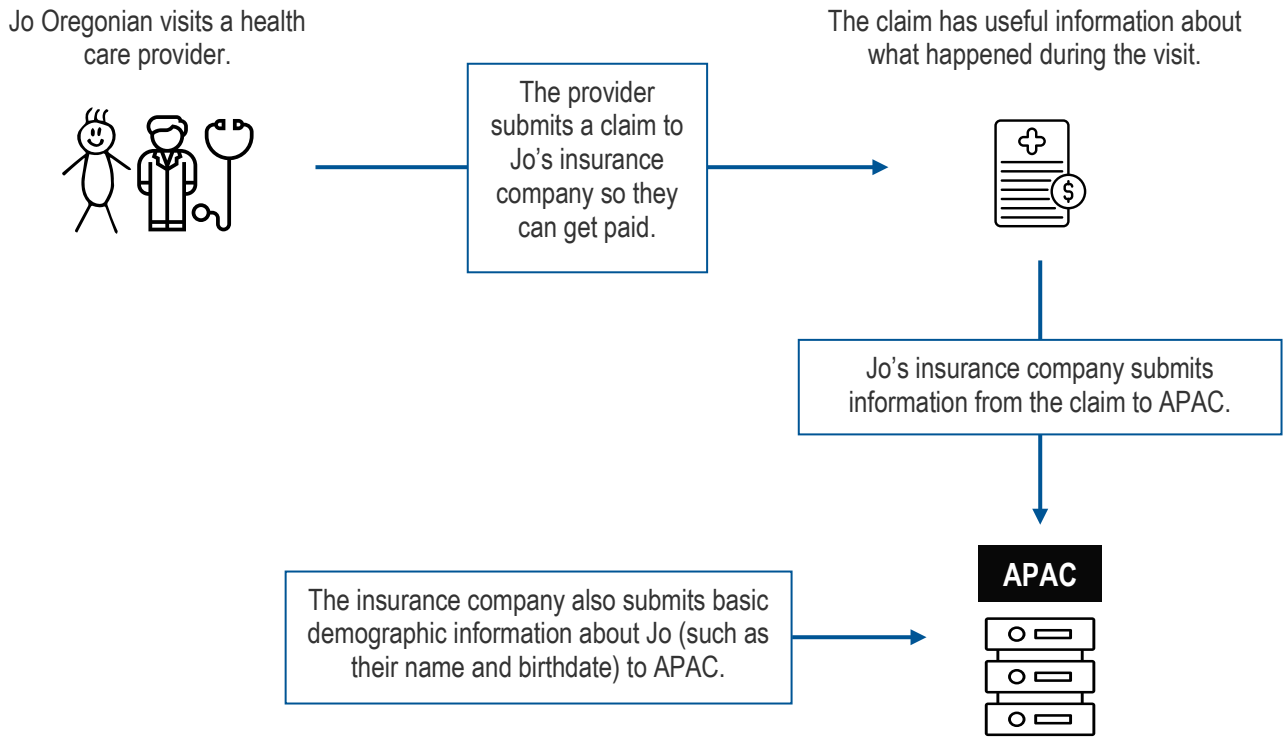
Health care insurers submit data to APAC. Every time a patient visits a health care provider or fills a prescription, the provider submits invoices (called *insurance claims*, or just *claims*) to the patient's insurance company (or *payer*) so that they can get paid.

Health care claims contain information that can give researchers and policymakers a rare view into how the health care system is operating. For example, claims include information about:

- **Diagnoses, treatments, and procedures** that occurred at each visit;
- **The amount of money that was paid** by the insurer and by the patient for the services that occurred at a visit; and
- **Health care providers** and locations for the visit.

In addition to the claims data, payers submit **basic demographic information** about all the members enrolled in their health care plans, and the amount of money those members pay in **monthly premiums**.

Figure 1. Payers submit information from health care claims to the APAC database.



Payment Arrangement Files

In 2017, APAC also began collecting information about non-claims payments that payers make to providers as part of "alternative payment models" (or APMs). These data are called Payment Arrangement Files and are distinct from other APAC data in important ways.

Learn about Payment Arrangement Files in Appendix A on page 11.

Overview of data elements

The list below is not exhaustive, but gives an idea of the types of information in APAC:

Medical, pharmacy and dental claims, which include:

- Diagnosis and procedure codes
- Where the service occurred
- The line of business (Medicare, Medicaid, or commercial) that paid the claim
- The amount that was charged to the insurer (learn more in the box below)
- Payments made by the insurer
- Expected payments from patients (such as copayment, coinsurance, or deductible)

Enrollment and eligibility information, which includes:

- Member demographics that *don't* specifically identify a person, such as sex, age, race, ethnicity and primary language
- Member demographics that *do* specifically identify a person, such as date of birth, date of death, address, zip code and county
- The amount members pay in monthly insurance premiums

Detailed data dictionaries can be found on the APAC Data Request webpage.

> **The importance of amounts charged *and* paid**
>
> While other Oregon data sets collect the amounts *charged* for health care services covered by commercial insurance, APAC is the only health data set in Oregon that contains the amount charged *and the amount paid*.
>
> This is valuable information, because charged amounts and paid amounts often differ based on the arrangements negotiated between the provider and the payer. It can also help us understand cost burden for consumers (for example, is the amount that the patient is expected to pay increasing over time?).
>
> Understanding the amounts that were actually paid for health care services, rather than just the amount charged, provides a more accurate and useful sense of health care prices and spending.

Who is represented in APAC data

APAC contains enrollment information for most people in Oregon who have health insurance. In 2020, the APAC database represented about 94 percent of Oregon residents, or more than 4 million people. (According to the Oregon Health Insurance Survey, 94 percent of people were insured in 2019.)

Insured people in Oregon who are **not** represented in APAC include those who are covered by:

- very small (fewer than 5,000 covered lives) commercial insurance companies
- some "self-funded" health plans
- federal programs such as Veterans Affairs, Indian Health Services, or health insurance plans for federal employees

In addition to most insured people in Oregon, APAC also includes a small amount of data for people who live outside the state. That's because payers who provide coverage to state employees must submit data for all their members, some of whom live in other states such as Washington. In 2020, about one percent of people represented in APAC lived outside the state.

Who submits data to APAC

As described earlier, health payers submit data to APAC. State law **requires** many payers to submit data to APAC. For example:

- Commercial insurers (such as Moda or Aetna) and licensed third-party administrators (TPAs)[1] with at least 5,000 members in Oregon
- Pharmacy benefits managers (companies that manage prescription drug benefits on behalf of health insurers) that provide services for people in Oregon
- Coordinated Care Organizations (also known as CCOs, which are plans that provide Medicaid coverage to people in Oregon)[2]
- Any payer that provides coverage through Oregon's Health Insurance Marketplace or to state government employees

In addition to the mandatory reporters listed above, self-funded health plans that are regulated by a 1974 federal law called "ERISA" may also submit to APAC. However, because of a Supreme Court decision in 2016, such plans are not required to submit data. Learn more about ERISA.

Finally, APAC receives data from the federal government for Medicare fee-for-service members (known as Medicare Parts A and B). However, this isn't required, and those data cannot be released to data users because of an agreement between OHA and the federal government.

Timing and frequency

APAC data are available back to calendar year 2011. **A full calendar year of APAC data becomes available to users thirteen months after the close of the year.**[3] For example, calendar year 2022 data will become available in January 2024. That's because claims data can have a long lag time: While sometimes a payer will process (pay) a claim (invoice) within a couple of months of the date of the service, other times it may take up to a year. And sometimes, claims will be adjusted after they are initially paid. This can happen, for example, if someone discovers an error in the bill. For these reasons, **it takes a year for claims data submitted to APAC to be considered final.** Read the box below for more details.

> **Data submission and lag**
>
> Payers submit claims data to the APAC database at the beginning of every quarter. Each submission contains claims from the previous four quarters. But the most recent three quarters are considered provisional and still subject to change.
>
> Each quarter's data is submitted several more times until they considered complete and final. (See the diagram in Appendix B on page 12 for a more detailed look at the data submission schedule.)
>
> Using a "rolling" data submission schedule like this means that data submitters and the APAC program don't need to individually track every claim that is updated or revised, which would be very complicated.

[1] TPAs provide administrative services for self-funded health plans (also known as self-insured health plans)
[2] In practice, the Oregon Health Authority submits data on behalf of CCOs. OHA also submits data for members who receive insurance through Medicaid but are not enrolled in a CCO (known as "fee-for-service" or FFS)
[3] Users can also request data on a different schedule than calendar years (for example fiscal years) but the 13-month data lag still applies

REALD and SOGI

What are REALD and SOGI?

REALD and SOGI[4] are types of standardized demographic information. REALD stands for: **R**ace, **E**thnicity **a**nd **L**anguage, **D**isability. SOGI stands for: **S**exual **O**rientation and **G**ender **I**dentity.

Collecting data with REALD and SOGI standards help us identify and address health disparities, and support data justice in communities that are most affected by health disparities. Learn more on OHA's website.

REALD and SOGI data standards are not currently implemented in APAC

The demographic information in APAC is not REALD or SOGI compliant. That's primarily because commercial insurance companies—which submit about three-quarters of the claims in APAC—have not historically been required to collect REALD or SOGI demographic information. However, House Bill 3159, which was passed by the Oregon Legislature in 2021, will require all insurers to eventually collect demographic REALD and SOGI information from their members. Once that is implemented (the exact timeline is unknown), APAC will include REALD and SOGI data.

As of this publication, APAC does include *some* information on race, ethnicity, and language. However, race is reported as "unknown" for most people included in APAC (about sixty percent). The majority of known race or ethnicity data comes from Medicaid and Medicare Advantage payers. APAC contains data on primary language for only around half of the people included in APAC; the remaining half are reported as unknown or missing.

Things to remember when interpreting APAC data

Purpose of administrative data

While there are many benefits to APAC data, it's important to remember that the *reason these data are collected* by payers is for the administration of health insurance plans. The purpose of claims is to receive payment. A claim might show that a person received a certain type of lab test so the provider can get paid for that lab test, but the claim will not describe the results of that test, because that information is not relevant to being paid. Similarly, insurers only collect demographic information that they need for their business purposes, such as to identify a member (name, date of birth), establish premiums (location, age) or determine covered services (age, sex designated at birth).

Although provider information is captured in claims data, the information is complex

It's very challenging to identify specific providers and locations across APAC data. Providers are identified in claims data in two ways, each of which presents a different challenge:

1. **Provider identifiers that are unique to each payer.** Payers use a unique code to identify each provider they work with. However, those identifier codes are not standardized *across* payers.
2. **National Provider Identifiers (NPIs).** NPI codes *are* standardized across payers, but sometimes identify a facility or provider group, rather than a single provider. Learn more about NPIs.

[4] As of this publication, only draft SOGI data collection standards have been released

Claims are not visits

A single health care visit might generate multiple claims. For example, suppose a person visits an emergency department for a condition. A provider examines their condition, blood is drawn and sent to a laboratory for tests, an X-ray and MRI are completed, and treatment is provided. Such a visit might generate claims from multiple entities: The emergency department facility, laboratory, imaging service, and each provider who delivered a service. Also, some people are covered by more than one insurer. In that case, each insurer will receive claims for the same visit.

Other sources of Medicaid claims data

OHA has another database, the Medicaid Management Information System (MMIS), that stores claims and enrollment data from Medicaid payers. OHA submits Medicaid data from MMIS to APAC. The data fields in APAC are different than how the data are stored in MMIS, so the process requires reformatting the data to "fit" into the APAC database. For that reason, the Medicaid administrative data that are stored in MMIS may be different than the data stored in APAC. **If users are interested in analyzing *only* Medicaid data, they should use MMIS rather than APAC. However, if they want to *compare* administrative data across different payers (for example Medicaid versus commercial) then it's recommended to use APAC.**

Requesting APAC data

This section provides a brief overview of how external OHA partners can request APAC data. Internal requesters (that is, OHA staff) should use the APAC agency application. To learn more, visit the APAC Data Requests webpage.

There are two types of data products

Depending on your research question and how you plan to use APAC data, you may need to request either 1) Public Use data or 2) Limited data. Which type of data you need depends on your research question. The main difference between the two is the level of detail:

- **Public use** data sets are premade and only include certain fields. The data are at the statewide level only. They exclude any data elements that might allow users to identify a person, such names, birth dates, or ZIP codes. Files are created by year of service and have many millions of rows of data. Public Use data cannot be linked to other datasets.
- **Limited** data are created for specific requests. As custom files, they are usually smaller and more detailed than public use datasets. Limited data sets may contain personal health information (PHI) and can be linked to other datasets (with permission from the APAC program).

To request a Public Use dataset...

To request a Public Use dataset, complete and submit an APAC-2 form online. The APAC-2 form asks for a brief description of how you plan to use the data.

OHA staff will review the APAC-2 form. If the request is approved, then you'll be asked to sign a data use agreement and submit payment. (The cost depends on what you are requesting; learn more on the APAC website.) Once those items are received, your request will be processed. The processing normally takes about 2-4 weeks.

To request a Limited dataset…

The process for requesting a Limited dataset is much more involved because it includes sensitive information. Data privacy and security are key priorities for OHA and APAC so each limited dataset request is carefully considered, investigated and monitored.

The first step is to complete an APAC-3 form and a Data Elements Workbook (available online). The APAC-3 form includes detailed questions such as your specific research questions and how the results of your analysis will be used or published. Applications must describe how the data will be secured. Research requests must also include Institutional Review Board approval (or finding of exemption). APAC offers consultations for anyone requesting APAC data, and it is highly recommended that new limited dataset requesters schedule a consultation in order to ask questions and refine their request.

The information will be reviewed by OHA's Data Review Committee (DRC). The committee evaluates whether the proposed project scope is allowed under OHA policies and state/federal laws, and determines the minimum amount of data needed to complete the project as requested.

The DRC typically meets on the fourth Monday of each month. APAC staff must submit your completed APAC-3 form to the committee *at least two weeks* prior to meeting. If an application is received in too little time to prepare it for submission to the DRC meeting, then it will have to wait until the following month to be reviewed. The committee might also need to request additional information after the initial review. For all these reasons, it can take 3-6 months for your application to go through the data request process. It's helpful to be aware of the DRC meeting schedule, complete the APAC-3 form as thoroughly as possible, and communicate promptly and regularly with APAC staff.

> ***OHA is here to help!***
>
> The data request process will go more smoothly if you provide all the needed information in your application from the beginning.
>
> The APAC team is available to answer your questions and help ensure your application is complete. Email apac.admin@odhsoha.oregon.gov to request a meeting.

Using APAC data to eliminate racial injustice

APAC may offer an incentive (for example, priority processing or waiver of fees) to data requesters whose project aims to eliminate health inequities stemming from historical and contemporary racial injustices and the inequitable distribution of resources and power. Learn more about this option and how to apply here.

APAC in action

The APAC Use Case Document demonstrates the breadth of ways APAC data have been used by researchers and policymakers across categories like population health, health care spending, utilization, and more. This section highlights a few additional examples:

Helping policymakers and the public understand the impact of health care consolidation

Nationally over the past decade, there has been a trend toward health care entities (such as hospitals, health insurance companies, and health care provider groups) combining into larger,

consolidated companies. Policymakers know that this type of consolidation can result in higher prices for consumers with no improvements to quality or outcomes.

To promote transparency around proposed business deals, and to monitor impacts after they occur, the Oregon Legislature created the Health Care Market Oversight (HCMO) program in 2021. HCMO analyzes APAC and other data sources to make sure such business deals support—and don't hurt—Oregon's health care goals across four domains: cost, equity, access and quality.

The program's analytical framework identifies a list of specific analyses and data sources that may be used within each domain. APAC is the only data source listed across *all four* domains, demonstrating the breadth of insights that the database can provide. Just a few examples of possible analyses within each domain that would use APAC data include:

- **Cost:** Annual spending growth (overall and by major spending category)
- **Access:** The share of health care services the entity provides in a geographic region
- **Equity:** Whether the entity's patient population is representative of the community
- **Quality:** Quality measures such as hospital readmissions or medication safety

The exact analyses conducted for each business deal will vary based on the nature of the health care entities involved (for example, an analysis of a deal involving a dental clinic would use different measures than a deal involving emergency department providers). Explore the reports for completed reviews to learn the many ways APAC data have supported this important work.

> **In addition to APAC,** HCMO's Analytical Framework relies on these other HPA data sources:
> - Hospital discharge data
> - Audited hospital financial data
> - Hospital and CCO financial reporting
> - Hospital community benefit reporting
> - Consumer Assessment of Health Plans and Systems (CAHPS) Survey data
>
> Read the data profiles to learn about each of these sources.

Evaluating outcomes of a new law intended to improve access to birth control

In 2016, Oregon became the first state in the nation to allow pharmacists to prescribe hormonal contraceptives (such as a pill, patch, or ring). One goal of this policy was to reduce barriers to accessing contraceptives, such as requiring an appointment at a health clinic or having a regular health care provider. This is important, because contraceptives must be used *consistently* to be effective—and studies have shown that as few as 22 percent of people receive timely refills without a break in contraceptive coverage.

In 2022, researchers from Oregon Health & Science University (OHSU) published results of a study using APAC data on whether people who received a prescription from a pharmacist had higher rates of 12-month continuous contraceptive use, compared with people who received a prescription from a health care clinician. The researchers analyzed APAC data from 2016-2018. Some of the data elements used in their analysis included:

- Prescriptions for different types of contraceptives and the number of days dispensed
- What type of provider (pharmacist or clinician) prescribed the contraceptive
- Demographics of the patients (such as age and geography)
- Type of insurance (commercial coverage)

The researchers also used claims data to *exclude* cases where the patient was not capable of becoming pregnant by looking at things like diagnosis codes for menopause or procedure codes for tubal ligation.

The analysis found that pharmacist prescriptions were associated with continuous contraceptive use: 34 percent of people who received a prescription from a pharmacist were continuing their method after 12 months, compared with 21 percent who received a prescription from a clinician. However, fewer than one percent of contraceptive prescriptions were written by a pharmacist. Compared with their peers, women who lived in urban areas, had commercial coverage, or were between the ages of 25-34 were more likely to get a prescription from a pharmacist.

This use of APAC data provides policymakers and health care researchers with evidence that allowing pharmacists to prescribe contraception is a good strategy for improving access to contraception, but also that the strategy is not widely used across Oregon.

Supporting a law to limit "surprise billing" for Oregon consumers

In 2018, Oregon became one of the first states in the nation to pass a law protecting health care consumers from surprise billing. "Surprise bills" occur when a person is unknowingly treated by an out-of-network provider. This might happen, for example, if a person has surgery at a hospital that is in their health insurance network, but one member of the care team (such as the anesthesiologist) is not part of the network. The patient doesn't know the anesthesiologist is out-of-network until they receive a bill from the hospital requiring payment for the "out-of-network" service. Surprise medical billing used to be a common problem and could cause people to go into debt and lose trust in the health care system.

The 2018 law made it illegal in Oregon for providers to bill patients for out-of-network services provided at in-network facilities (such as the anesthesiologist example above). Because an out-of-network provider does not have an agreement for how much they can charge a patient's insurance plan (learn more in the box at right) **the law also used APAC data to standardize the prices that could be charged and paid between out-of-network providers and insurance plans.** Specifically, reimbursement for out-of-network services would be based on the median amount that commercial insurers paid for that service to in-network providers in calendar year 2015, adjusted for geographic variation. This was an important part of Oregon's law because it provided transparency and predictability for everybody involved: health care providers, insurance plans and patients.

The policies established in Oregon in 2018 created momentum and helped pave the way for a federal law, the No Surprises Act, which protects people in all states from surprise billing.

Health insurance networks 101

When a provider is **in-network** with a health insurance plan, it means they have an agreement to accept the insurance payment as full payment. The patient might be responsible for some out-of-pocket costs, such as a copay or deductible, but they won't be billed any additional charges from the provider.

An **out-of-network** provider has no such agreement with the insurance plan. Some plans cover a small portion of out-of-network charges, while others pay nothing. Before Oregon's law went into effect in 2019, the **patient** would be responsible for paying the balance of the bill.

If the patient was never informed that the provider was out-of-network, such a bill would come as a very unwelcome surprise!

Appendix A

Payment Arrangement Files

Background: Paying for quality instead of quantity

As described in this data profile, the APAC database includes information from health care invoices, or *claims*. Claims data are an excellent way to understand health care utilization under traditional *fee-for-service* payment models. Fee-for-service (or FFS) means that health care providers are paid a specific amount for each service they provide. Insurers and providers negotiate on what those specific amounts will be, resulting in big differences in the amounts paid for the same services across various regions, providers, and insurance plans.

In the fee-for-service model, a provider submits claims to the patient's insurance plan to be reimbursed for the services they provided. The more tests providers run or surgeries they perform, the more they are paid. As such, the FFS model can encourage health care providers to do more—sometimes unnecessary and expensive—procedures. In recent years policy makers and industry leaders have highlighted the negative effects of paying for volume instead of paying for value, such as health care costs increasing without increases in quality.

Some insurers (also known as *payers* because they pay for health care services) use **alternative payment methodologies** (or APMs), a term that encompasses all non-FFS payments. Unlike the FFS model, alternative payment methodologies are designed to incentivize high-quality procedures that lead to improved health outcomes. One common type of APM are **value-based payments** (VBPs), which include financial incentives to health care providers to focus on the *quality* of services and patients' *health outcomes*. An example of a VBP might be a bonus payment to a clinic if they increase the number of patients receiving a screening for depression and include a follow-up plan in the patients' medical charts.

There's a wide range of APM and VBP models. Some models might still *mostly* follow the traditional FFS payment model but include some extra payments for care coordination or quality reporting. On the other end of the spectrum are "integrated finance and delivery" models, where providers are prepaid a set budget and must demonstrate high-quality care for their patients. Learn more about VPB models and Oregon's efforts to advance the use of these models in the health care system.

Payment arrangements and APAC

In addition to submitting claims data to APAC, since 2018, payers are also required to annually submit information about the types of alternative payment models that they have arranged with their provider networks. This information is stored in "Payment Arrangement Files" within the APAC database and is separate and unique from regular claims-based APAC data.

Accessing Payment Arrangement Files

OHA publishes an annual dashboard that allows users to explore APAC Payment Arrangement data. The dashboard shows the percentage of total payments that coordinated care organizations (or CCOs, which are Oregon's Medicaid health plans) and commercial health insurance carriers paid toward different types of value-based payment models. The dashboards are published on the APAC program webpage.

Appendix B

Understanding APAC data submission schedule and lag

Page 5 of this profile explained the timing and frequency of APAC data. The illustration below illustrates an example of when a calendar year (2022) of data is final and available to data requesters.

Figure 1. Each data submission includes four quarters (12 months) of data

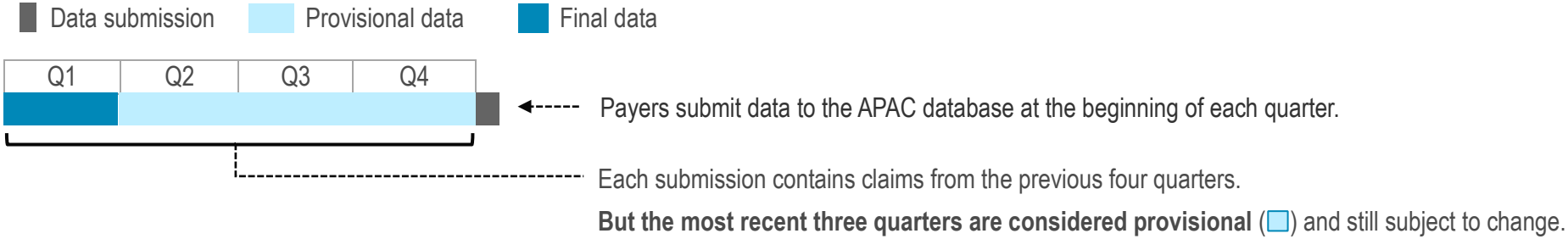
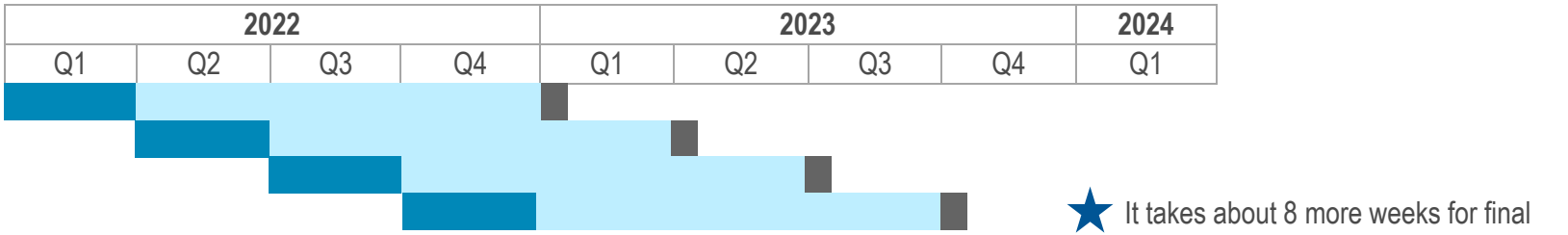


Figure 2. All four quarters of CY 2022 are final (■) by the October 2023 (Q4) data submission



★ It takes about 8 more weeks for final data to be cleaned, organized, and ready for data users, so **calendar year 2022 data are available for request by January 2024.**

Quick Facts

Name	All Payer All Claims database
Acronym	APAC
Summary	Administrative (claims and enrollment) health care data from most health care payers in Oregon
Data type	Administrative
Populations	Insured people in Oregon
Frequency	Annual datasets
Available since	2011
Required?	Yes (HB 2009 in 2009)
Regular reporting	Three annual data dashboards use APAC data: *Hospital Payment Report*, *Oregon's Health Care Payment Arrangements*, and *Primary Care Spending Report*. Learn more on page 2 of this profile.
Website	https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx
Primary/Lead staff	Karen Hampton
Internal requests	Submit agency application and data elements workbook (available on the APAC data request webpage)
External requests	Complete APAC-2 or APAC-3 form (depending on the type of request) and data elements workbook. Limited data sets (APAC-3) require review by OHA's Data Review Committee. Learn more and access forms on the APAC data request webpage.
Security level[5]	Level 3
Data dictionary?	Yes (available on APAC program webpage)
REALD and SOGI	Not currently implemented, primarily because commercial insurers are not required to collect demographic data according to REALD and SOGI standards. Learn more on page 6 of this profile.
Suggested citation	Oregon Health Authority. (YYYY). All Payer All Claims Reporting Program. [Data analytic views, version #]. Salem, Oregon: Oregon Health Authority

[5] Learn more: https://www.oregon.gov/das/policies/107-004-050.pdf

Medicaid Management Information System

HPA Data Profile

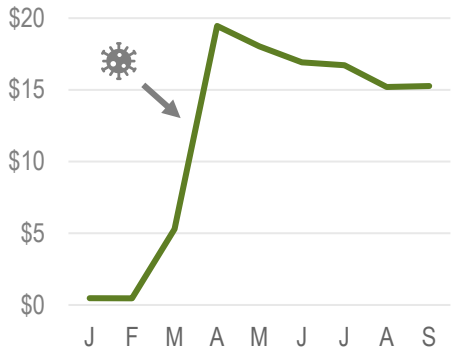
Medicaid is a federal health insurance program that's administered by states. As the agency responsible for Oregon's Medicaid program (known as the Oregon Health Plan or OHP), the Oregon Health Authority (OHA) receives and generates large amounts of data **about Medicaid enrollees**, and **health care services that were paid by Medicaid**. These data are collected and stored in a database called the Medicaid Management Information System, or MMIS.

Data collected in MMIS (which are sometimes collectively called "Medicaid administrative data") are used by researchers and policymakers to monitor, report on, and improve Oregon's Medicaid delivery system.

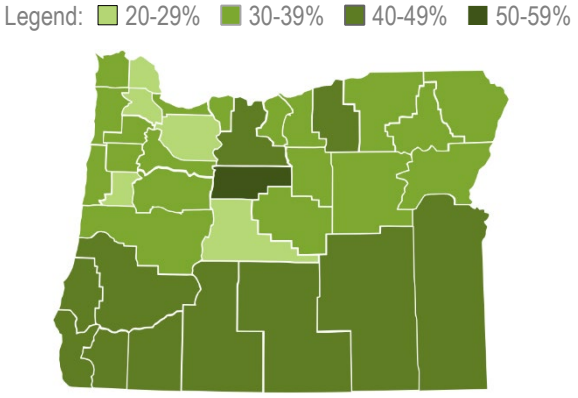
A few examples of the things MMIS data can tell us include:

Telehealth use among Medicaid members increased dramatically when the COVID-19 pandemic began.

Based on allowed (billed) amounts



The percentage of the population covered by Medicaid varies by county.

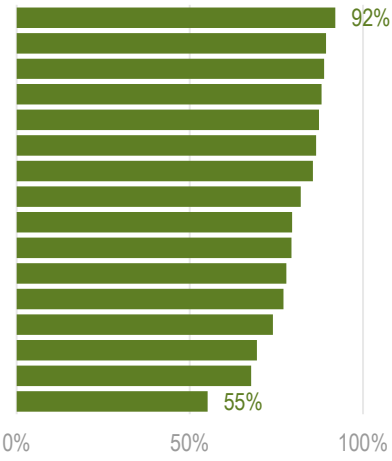


Medicaid enrollment in July 2022. Population estimates are from July 2021 (PSU Population Research Center)

In 2021, about 1 in 4 adult Medicaid members with diabetes received an oral health evaluation.

About 1 in 3 adolescent Medicaid members received recommended vaccines before their 13th birthday.

The percentage of pregnant women who had a prenatal visit in the first trimester varied by CCO in 2021.



Regular reporting

OHA publishes a monthly dashboard called the Medicaid Monthly Population Report. The dashboard provides a snapshot of who is eligible and enrolled in Medicaid each month, and shows different breakouts of the Medicaid population such as by demographic groups, plan types, or county.

MMIS data are also used in many ongoing health policy programs, such as:

- Calculating many of the quality metrics that are used to assess how well the Medicaid system is performing; and
- Determining how much coordinated care organizations (CCOs) get paid to deliver care to Medicaid members.

See the *MMIS data in action* section on page 8 to learn more.

Did you know?

Every state is required by federal law to have a Medicaid Management Information System.

One of the purposes of the MMIS database is to collect and report information about the state's Medicaid program to federal regulators.

About the data

This section includes some helpful information about where MMIS data come from and are stored, what types of information are available, and important things to keep in mind when using these data.

How MMIS data are collected

The Medicaid administrative data in MMIS originate when members interact with the Medicaid system in these two ways:

1. **Eligibility data:** When people sign up for their Medicaid benefits, demographic information is collected to determine their eligibility. The demographic information includes things like the person's income; family and household size; and race, ethnicity, language and disability information. Most Medicaid members (about 95 percent) sign up for coverage through the Oregon Eligibility (ONE) system.[1] Read a paper version of Oregon's Medicaid application to get a sense of the data fields that are collected during the eligibility determination process.
2. **Claims and encounter data:** When Medicaid members visit a health care provider or fill a prescription, the provider documents a summary of the visit. That summary includes valuable information such as when and where the service occurred, diagnoses and treatments that were made, and who received and provided the service. Sometimes these summaries also include how much money Medicaid paid for the services provided.

Both types of information flow into the MMIS database.

Claims and encounter data

Whether the summary includes information about payment amounts depends on whether the Medicaid member is part of a Coordinated Care Organization (CCO) or receives "Fee-for-Service" (FFS) Medicaid. Learn more in the section called "Claims versus encounter data" on page 5, and Appendix B on page 11.

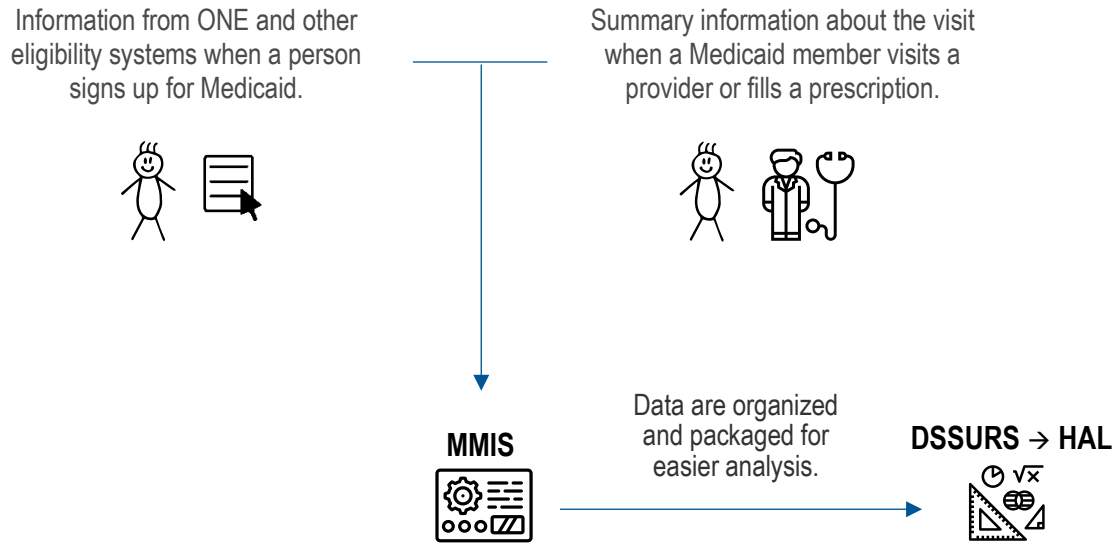
[1] Other ways people may sign up are through OR-Kids (for youth in foster care); the Juvenile Justice Information System; and Mainframe (also known as Legacy)

Where MMIS data are stored

MMIS is a transactional database used to administer the Medicaid program and fulfill mandatory federal reporting requirements. Although some people—like Medicaid providers and OHA staff who work on the Medicaid program—have direct access to MMIS, the database isn't designed to support other types of research or analysis. For that reason, **MMIS data are transferred to the Decision Support and Surveillance Utilization Review System (DSSURS), where they are cleaned up and "packaged" into more usable information.** Approved users can access MMIS data through the DSSURS warehouse to understand and make informed decisions about Oregon's Medicaid program design.[2]

Finally, data from DSSURS are passed through and reorganized one more time in the Health Analytics Library (HAL). Generally speaking, both DSSURS and HAL are simply different ways to store and access the data that originate in MMIS.

Figure 1. *Information is collected in the MMIS database, and then transferred to the DSSURS warehouse.*



Timing and frequency

Data are available in MMIS almost immediately after they are collected. However, as described above, MMIS data are typically accessed for research and policymaking through the DSSURS warehouse. DSSURS is refreshed with data from MMIS weekly, and processing occurs over the weekend so that data are available early in the week. DSSURS stores data back to 2002.

The Health Analytics Library (HAL) is updated monthly. Data for each month are typically available the first week of the following month. For example, data for July 2022 are available in early August 2022. HAL stores data back to 2011.

[2] In addition to the data from MMIS, some information about Medicaid services administered by the Oregon Department of Human Services (such as Aging and People with Disabilities and Long-Term Services and Supports) also feeds into DSSURS.

Data from both systems are considered preliminary for three months before they are considered final. For example, the data that are available in DSSURS in March are subject to change until June.

Overview of data elements

The list below is not exhaustive but gives an idea of the types of information in MMIS data:

Information about **Medicaid members** (derived from eligibility data)

- Eligibility categories (the specific type of Medicaid people have)
- Household members
- Demographics like the person's federal poverty level, birth date, address, race, ethnicity, and whether they have any disabilities
- Dates of enrollment in the Medicaid program

> ***Eligibility categories*** are encoded in MMIS with "PERC" codes (Program Eligibility Resource Codes).

Information about **health care services** that were paid by Medicaid (derived from claims and encounter data)

- Diagnoses, treatments, or procedures that occurred at a visit
- Medications that were dispensed (including details like the dosage and who prescribed the drug)
- The type of place where the service occurred (for example a hospital, clinic, residence, school, homeless shelter, mobile unit, etc.)
- The date the service occurred
- The name and provider ID of the provider
- Identifying information about the patient (such as name and Medicaid ID)
- *For claims data only:* The amount of money charged and paid for the service

Information about **providers and facilities** where the service occurred—such as specialty codes, rates, and tax IDs.

READLD and SOGI

What are READLD and SOGI?

READLD and SOGI are types of standardized demographic information. READLD stands for: Race, Ethnicity and Language, Disability. SOGI stands for: Sexual Orientation and Gender Identity.

Collecting data with READLD and SOGI[3] standards helps us identify and address health disparities, and support data justice in communities that are most affected by health disparities. Learn more on OHA's website.

READLD and SOGI in MMIS data

A member's READLD and SOGI information are collected when they sign up for Medicaid benefits through the Oregon Eligibility (ONE) system. The demographic questions in the ONE application portal have been compliant with READLD standards since March 2022; and MMIS began receiving and storing READLD-compliant data from the ONE system in June 2022. However, MMIS does not currently receive or store free text field values. That means that if a person identifies their race or ethnicity by "filling in the blank" then that information does not transfer from ONE to MMIS. For

[3] As of this publication, only draft SOGI data collection standards have been released

that reason, as of this publication (January 2023), ONE is the better source of information for REALD-compliant demographic information. **Learn how to request data from the ONE system** in the appendix on page 10.

However, REALD and SOGI information are often missing or incomplete in MMIS (and ONE) data. There are two main reasons:

1. **REALD and SOGI demographic questions are sometimes skipped by the person enrolling in Medicaid through the ONE system.** The purpose of ONE and other enrollment systems is to determine whether a person is eligible for Medicaid. A person may skip or decline to answer REALD demographic questions, which are optional to answer since the information doesn't impact their eligibility.
2. **REALD and SOGI demographic questions are *only asked* when a person *first enrolls* in Medicaid though the ONE system.** Once the person is enrolled, their eligibility will periodically be "redetermined" to check if they should stay enrolled in Medicaid. Federal law requires that staff make this redetermination to the best of their ability w*ithout contacting the Medicaid member* for more information. And, if they must contact the member, staff can only request information *relevant to the person's eligibility.* Since demographic information about a person's race, ethnicity, or language is not relevant to a person's Medicaid eligibility, such demographic information is only collected when they are initially enrolling (and not when their coverage renews).

Finally, as described on page 2 of this profile, a small percentage (around 5%) of members sign up for Medicaid through an application system other than ONE. These other application systems do not currently collect demographic information according to REALD or SOGI standards.

Things to remember when interpreting MMIS data

Claims versus encounter data

As described earlier in this profile, one of the two main types of information that flows into the MMIS database comes from "summaries" that are documented every time a Medicaid member receives a health care service. These summaries flow into MMIS in two different forms: claims and encounter data. **There are important differences between claims and encounter data:**

- Claims data include the exact services that were provided, and OHA makes sure the information is accurate. Claims data also include the amount that was paid by Medicaid for the services.
- Encounter data may be less complete, and do not include amounts paid.

About 90 percent of the information about health care services in MMIS is encounter data; and the remaining ten percent is claims data. That's because encounter data occur when a Medicaid member is enrolled in a coordinated care organization (CCO), while claims data occur when a person has fee-for-service (FFS) Medicaid coverage. To learn more about these differences and why they impact the data in MMIS, see Appendix B

Purpose of administrative data

While benefits of MMIS data are that they are robust and frequently updated, it's important to remember that the *reason these data are collected* is for the administration of the Medicaid

program. As such, there may be limitations or gaps when the data are used for research, policy, or evaluation.

The purpose of claims data is to receive payment; and the purpose of encounter data is to summarize services that were provided. Information about a member's diagnosis, for example, is included to describe the reason why a provider delivered a particular service, NOT to paint a complete picture of the person's health.

The purpose of data from ONE and other systems is to determine whether a person is eligible for Medicaid. **Data that are not relevant to a person's eligibility may be incomplete or less reliable.** For example, a person may skip or decline to answer questions that don't impact their eligibility, such as demographic questions about their race or ethnicity. Another example of information that may not be reliable is income information that was collected during the COVID-19 public health emergency (learn more below).

During the pause in Medicaid disenrollment that began in March 2020, income information in MMIS may not be accurate for many members

When a Public Health Emergency (PHE) was declared in March 2020 because of the COVID-19 pandemic, the federal government directed states to pause disenrolling people from Medicaid except in limited circumstances. One result of this policy is that income information in MMIS may not accurately reflect a person's real income during this time.

As described in the REALD and SOGI section on page 5 of this profile, when a person has Medicaid coverage, ODHS staff will periodically "redetermine" the person's eligibility to check if they should stay enrolled in Medicaid. During the disenrollment pause, these redeterminations still occur on the normal schedule using the ONE system. However, if the member 1) is enrolled in a type of Medicaid that has an income requirement and 2) reports an income level that would *normally* be too high to stay enrolled in that program, then the ONE system will send a *default* income value to MMIS. The default income value will be the normal upper limit for the program the person is enrolled in. For example, if a person is enrolled in a Medicaid program that usually has an upper income limit of 138% of the federal poverty level (FPL), but they reported an income that puts their household at 150% FPL, then ONE will send[4] a default income value of 138% FPL to MMIS. This eligible income must be provided so the updated eligibility can be successfully accepted and processed in MMIS, even though the provided value may be inaccurate (learn more in the box *"From eligibility to enrollment"* on the next page).

During the public health emergency, a person stayed enrolled in Medicaid even if they didn't respond to ODHS's request for updated income information during the redetermination process, or if the information they reported didn't match other income data the state had access to. For these reasons, **during the disenrollment pause, there is no way to know whether income information reported in ONE, or the information sent to MMIS, is a true reflection of a member's income.**

[4] While ONE and other eligibility systems **collect** income as a dollar value; they **send** the information to MMIS as a percentage of the federal poverty level (FPL)

When the disenrollment pause comes to an end in April 2023, OHA will begin redetermining the eligibility of all enrolled members using verified income information. It's expected to take 14 months (until summer 2024) to redetermine everyone's eligibility.

> **From eligibility to enrollment**
>
> The eligibility system (such as ONE) determines *whether* a person qualifies for Medicaid coverage (yes/no) and which specific program they should be in. Once the person is determined to be eligible, then their information is transferred to MMIS. MMIS processes the information and activates the person's coverage. If the information transferred from the eligibility system doesn't meet the program qualification criteria set up in MMIS, then MMIS will "reject" the enrollment.

Income information in MMIS may not be accurate for *some* members even during normal times (when there is not a temporary disenrollment pause)

The disenrollment pause described above is unique because it applies to *all* Medicaid members. But it should be noted that there are some occasions, even in normal (non-PHE) times, when the ONE system may send default income information to MMIS that doesn't match the person's reported income. This can occur when a person is enrolled in a Medicaid program that has "continuous enrollment" or "protected benefits" requirements. Continuous enrollment and protected benefits occur when people are allowed to stay enrolled in a program for a certain length of time, even if their income exceeds the normal income standard for that program. One example is people who are pregnant or have a newborn. Another example that's expected to begin in July 2023 are young children, who will be continuously enrolled until they turn six.

Just like in the example on the previous page, if people in these programs report an income change that exceeds the normal income limit, and they are still within the continuous enrollment window, then the ONE system will send a default FPL value to MMIS so that the system doesn't "reject" their continuous enrollment in the program. If your data request or analysis looks at these populations and considers income, be aware that some of the income information in MMIS may not reflect a person's actual reported income.

Medicaid data in the All Payer All Claims database

Oregon's All Payer All Claims database (APAC) contains administrative claims and enrollment data from all types of insurance, including Medicaid. OHA submits MMIS data to APAC from the DSSURS warehouse. The data fields in APAC are different than those stored in MMIS and DSSURS, so the process requires reformatting the data to "fit" into the APAC database. For that reason, **the Medicaid administrative data that are stored in MMIS may be different than the data stored in APAC.** If you are interested in analyzing *only* Medicaid data, you should use MMIS/DSSURS rather than APAC. However, if you want to *compare* Medicaid administrative data across different payers (for example Medicaid versus commercial) then it's best to use APAC.

Requesting MMIS data

When requesting MMIS data for policy or analysis, you don't need to specify which database the data come from (that is, DSSURS or HAL). The underlying data are the same: they both come

from MMIS. It's only how the data are formatted and grouped that's different. The analyst who helps you will know which source to use depending on the type of analysis you would like.

Internal data requests

To request Medicaid administrative data for policy and analysis, OHA staff should email their request to OHA.HealthAnalyticsRequest@odhsoha.oregon.gov to connect with a research analyst for assistance.

External data requests

External requests that are for research or evaluation should be submitted to OHA.HealthAnalyticsRequest@odhsoha.oregon.gov.

The general public or media can submit data requests through the public records request process. Typically, staff will only provide summary or aggregate level data to general public users. People can also request to see detailed administrative data *that's about them* through a public records request.

MMIS data in action

The Medicaid Management Information System has been an important source of information to inform policies and programs that have real impacts on peoples' lives. This section highlights just a few examples:

Monitoring the quality of Oregon's Medicaid program and holding CCOs accountable

Each year coordinated care organizations (CCOs) can earn bonus funds by showing that they have improved care for members. The program through which CCOs can earn these funds is called the CCO Quality Incentive Program. The program is one of Oregon's most effective tools for improving overall quality for Medicaid members.[5]

Over a billion dollars have been distributed to CCOs through the program since it began in 2013. To earn these funds, CCOs must improve on a set of health care quality measures selected by a public committee.

The majority of measures used in the Quality Incentive Program are calculated using Medicaid administrative data from MMIS. Just two examples for illustration include:

- ***Oral evaluation for adults with diabetes***: The percentage of adults with diabetes who received a comprehensive oral health evaluation during the measurement year. This measure is important because people with diabetes have higher rates of periodontal disease, and annual check-ups can help providers catch and treat disease early, resulting in better health outcomes. In addition, poor oral health can make a person's diabetes more difficult to manage.
- ***Postpartum care rate***: The percentage of people who have given birth and who received postpartum care between one and 12 weeks following the birth. This measure is

[5] https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf

important because postpartum care helps birthing parents address complications, like pain and incontinence, as well social-emotional health needs.

MMIS is an abundant source of detailed, timely, year-over-year data. Measuring and publicly reporting CCOs' progress on quality measures allows policymakers, researchers, and the public to understand and address the quality of care that Medicaid members are receiving.

Determining how much CCOs are paid to provide care to their members

A key part of Oregon's coordinated care model is the way coordinated care organizations (CCOs) are paid. Rather than paying providers for every specific service they provide (a model called *fee-for-service* or FFS), OHA pays CCOs a pre-determined budget based on the number and characteristics of their members. CCOs and their provider networks then have flexibility within that budget to address members' health needs. The budget is paid to CCOs on a monthly basis and is called a *capitation rate*.

OHA's Office of Actuarial and Financial Analytics (OAFA) constructs the capitation rates, which by law must be *actuarily sound*. That means the rates must be reasonable, attainable, and appropriate for the services covered under the CCO's contract. **MMIS data form the backbone of capitation rate construction**.

Capitation rates are typically developed by projecting CCO utilization and cost data from the recent past into the near future. For example, in 2022 OHA and its independent contracted actuary, Mercer, developed 2023 capitation rates based on 2021 encounter claim and enrollment data from MMIS.

Appendix: Oregon Eligibility (ONE) 101

What is the ONE Eligibility system?

The Oregon Eligibility (ONE) system is a single, integrated application portal where people can sign up for medical, food, cash, and childcare benefits. The ONE application asks people for demographic information such as their age, household income, whether they have any disabilities, and more. This information helps determine what types of benefits they are eligible to receive. The ONE application also asks for supplemental information such as a person's race, ethnicity, and gender identity. Read a paper version of Oregon's Medicaid application to understand which data fields collected in ONE transfer to MMIS.

When a person qualifies for Medicaid medical benefits, information from ONE is transferred to the Medicaid Management Information System (MMIS). MMIS is a computer system that helps OHA administer the Medicaid program. The Oregon Department of Human Services (ODHS) manages the ONE system, while OHA manages MMIS.

Requesting data from ONE

To request data directly from the ONE system, OHA staff should:

1. Coordinate with Vivian Levy. Vivian is OHA's "ONE Change Sponsor" and she sits within OHA's Health System Division
2. Email your request to one.changerequests@dhsoha.state.or.us. Include as much information as possible, such as what fields you are requesting and other criteria, the business need, and requested due date.

Then, ODHS staff will determine the best way to provide your data. They may either work with their contractor (Deloitte) to extract data directly from ONE; or they may choose to extract data from their own ONE reporting database, called Pioneer.

Appendix B: Understanding claims versus encounter data

How Oregon's *coordinated care* model impacts payment

The traditional health care is model is known as "fee-for-service" (or FFS). In the FFS model, health care providers are paid a certain amount for every service they provide to a Medicaid member. The more tests they run or surgeries they perform, the more they are paid.

In Oregon's coordinated care model, most Medicaid members (about 90 percent) receive care from one of many coordinated care organizations (CCOs). A CCO is a network of all types of health care providers who work together in their communities to serve people who receive Medicaid health coverage. In the CCO model, the state pays CCOs an annual budget based on the number and characteristics of their members. CCOs and their providers then have flexibility within that budget to address their members' health needs outside of traditional medical services.

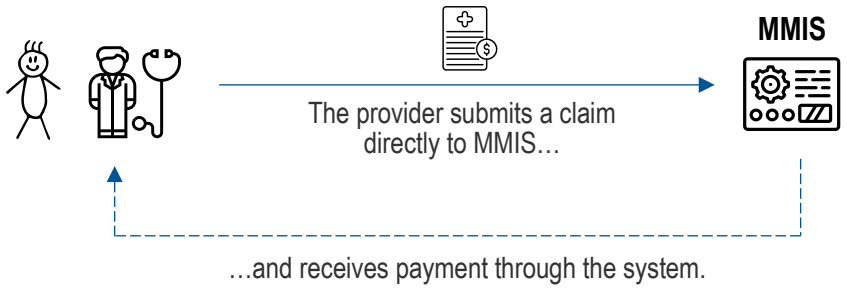
When a FFS Medicaid member receives a health service, the provider submits an invoice, or claims, directly to MMIS so they can get paid. The claims include the exact services that were provided, and the state makes sure the information is accurate before the provider is paid. The provider is even paid through MMIS.

When a CCO Medicaid member receives a health care service, the provider submits a claim for payment *to the CCO.* Later, the CCO will submit information about the services recorded in the claims to MMIS. This information is called "encounter data." CCOs must submit encounter data so that OHA can report it to the federal government, which oversees Medicaid. *See the figure on the next page for an illustration of claims versus encounter data.*

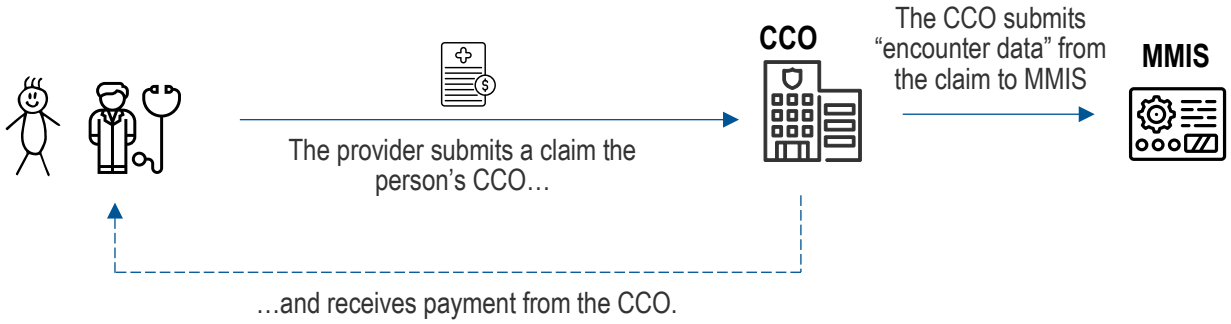
Encounter data submitted by CCOs may be incomplete or missing compared with claims data. Claims data submitted by FFS providers is usually more thorough and includes exactly what providers did, what the state paid for the services, and why. About 90 percent of the information about health care services in MMIS comes from encounter data, because most people in Oregon with Medicaid coverage are enrolled in a CCO.

Figure 2. Claims versus encounter data

When a person has FFS Medicaid, the provider submits an invoice (claim) directly to MMIS. Claims data in MMIS are very thorough and include the amount paid for the services provided.



When a person has CCO Medicaid, the provider submits an invoice (claim) to the person's CCO. The CCO then submits summary information from the claim to MMIS. This summary information is called "encounter data" and may be less complete than claims data. Encounter data do not include the exact amount that was paid for the services provided.



Quick Facts

Name	Medicaid Management Information System
Acronym	MMIS
Summary	A database that collects information about Oregon's Medicaid program, including enrollment and service utilization
Data type	Administrative
Populations	Medicaid members (all ages)
Frequency	MMIS is updated in real time, but the data are typically accessed through the Decision Support and Surveillance Utilization Review System (DSSURS), which is updated weekly or the Health Analytics Library (HAL), which is update monthly. Data are preliminary for three months before they are considered finalized.
Available since	MMIS data in the DSSURS warehouse is available back to 2002
Required?	Yes[6]
Regular reporting	Medicaid monthly report
Website	https://www.oregon.gov/oha/HSD/OHP/Pages/Reports.aspx
Lead staff	Chris Coon
Internal requests	Email OHA.HealthAnalyticsRequest@state.or.us with a detailed request and you will be connected with a research analyst to assist you.
External requests	For research or evaluation, email OHA.HealthAnalyticsRequest@state.or.us. All other inquiries, submit a public records request.
Security level[7]	Level 3 (restricted)
Data dictionary?	**HAL warehouse:** Yes | **DSSURS warehouse:** No
REALD/SOGI	MMIS has received REALD and SOGI demographic information about Medicaid members from the ONE eligibility system since June 2022. However, MMIS does not capture or store *free text* fields, so ONE is the better source for this information.
Suggested citation	Medicaid Management Information System (MMIS), Decision Support and Surveillance Utilization Review System (DSSURS) **or** Medicaid Management Information System (MMIS), Health Analytics Library (HAL)

[6] All states are required by section 1903 of the federal Social Security Act to maintain a "mechanized claims processing and information retrieval system" (i.e., MMIS)

[7] Learn more: https://www.oregon.gov/das/policies/107-004-050.pdf

Hospital and Emergency Department Discharge Data

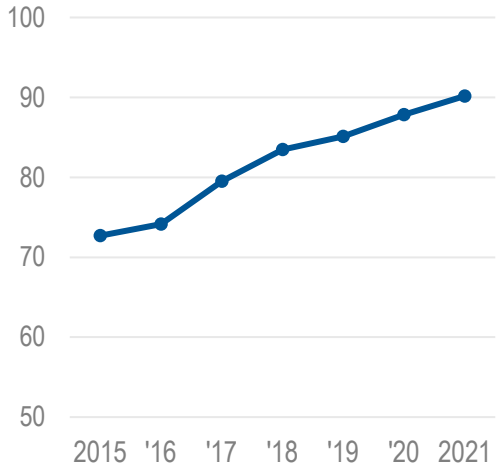
HPA Data Profile

Hospitals keep records every time a person is discharged (released) from an inpatient hospital or emergency department (ED). These records include important information such as the reason they were admitted, diagnoses that were made, and care that was delivered. Hospital and emergency department discharge data are used by researchers and policymakers to understand trends in hospital services and the health conditions experienced by people in Oregon.

Hospital and ED discharge data can tell us things like…

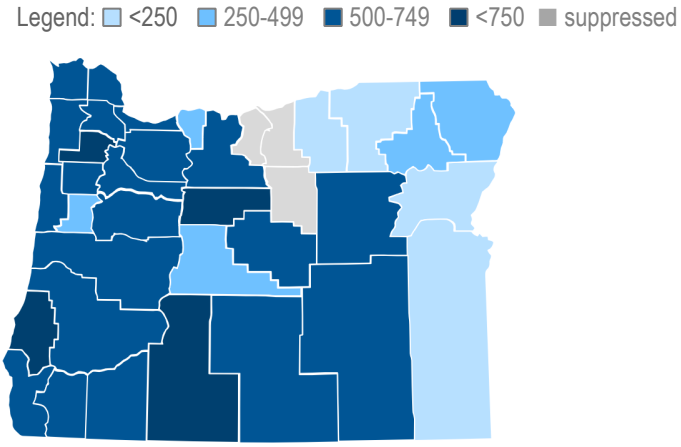
Hospitalizations for Sepsis have increased.

Age adjusted rates per 1,000 (2018-2020)



Emergency department visits for heart attack vary by county.

Age adjusted rates per 1,000 (2018-2020)



Regular reporting

OHA's Health Policy and Analytics Division does not maintain any regular reporting of hospital and ED discharge data. OHA's Public Health Division has published two interactive dashboards: one for hospital discharge data and one for ED discharge data. The dashboards show aggregated state- and county-level data related to visits for more than a dozen conditions such as asthma, diabetes, heart attack, and stroke. Users can:

- Compare hospitalizations and emergency department visits by race, ethnicity, gender, age, and geography
- View trends from 2016-2020
- See the amount of money that was billed to different insurance types for visits related to each condition

The dashboards can be accessed online at:
https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DATAREPORTS/Pages/Healthcare.aspx

About the data

Overview of data elements

Both hospital and ED discharge data include:

- **Who**[1] was discharged: Name, age, sex assigned at birth, ZIP code, race and ethnicity
- **What** happened during the visit: Procedures and services that were provided
- **Why** the visit occurred: Reason the person was admitted and diagnoses that were made
- **When** the visit occurred: Dates and times of admission and discharge
- **Where** the visit occurred: The name of the hospital or emergency department facility
- **How much** was billed for the visit, and the category of the payer (e.g., Medicaid, commercial insurance, etc.)

How the data are collected

Each of Oregon's 60 acute care inpatient hospitals[2] and one specialty psychiatric hospital (Unity Center for Behavioral Health) submit data quarterly to OHA's vendor, Apprise Health Insights. Apprise is the data subsidiary of Oregon's main hospital trade group, the Oregon Association of Hospitals and Health Systems. All but one hospital (Shriner's Hospital for Children) also has an emergency department.

Each hospital submits data for both their hospital inpatient discharges and emergency department discharges. The data are separated into two datasets (hospital inpatient and emergency department) by Apprise.

Timing and frequency

Hospitals submit the data within 60 days after the close of each quarter, and OHA purchases quarterly datasets from Apprise 120 days (about four months) after the close of each quarter. For example, data covering January-March 2022 become available to OHA around July 2022.

Hospital discharge data are readily available in electronic format going back to 2007. Emergency department discharge data are available only since 2020.

REALD and SOGI

What are REALD and SOGI?

REALD and SOGI are types of standardized demographic information. REALD stands for: **R**ace, **E**thnicity and **L**anguage, **D**isability. SOGI stands for: **S**exual **O**rientation and **G**ender **I**dentity.

Collecting data with REALD and SOGI[3] standards helps us identify and address health disparities, and support data justice in communities that are most affected by health disparities. Learn more on OHA's website.

[1] Certain information is de-identified to protect patient privacy. Learn more under "Requesting Data" on page 4.

[2] Hospitals that provide medical care and other related services for surgery, acute medical conditions or injuries

[3] As of this publication, only draft SOGI data collection standards have been released

Hospital and ED discharge demographics are not REALD and SOGI compliant

Hospitals do not yet have data systems in place to collect and report demographics according to REALD and SOGI standards. OHA's contract with Apprise requires Apprise to collect the data elements specified in OAR 409-022-0020. Those data elements include race and ethnicity but do not include all of the REALD elements.

As of this writing, discharge data only include the five race categories defined by the U.S. Office of Management and Budget (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, and White).

Things to remember when using hospital and ED discharge data

How hospital discharge data are similar to – and different than – billing claims data

Hospital and ED discharge data are submitted by hospitals. The reason hospitals record this type of information is for administrative billing purposes. When they send a bill to the patient's insurance company, the bill will include some of the same information that's part of the discharge dataset.

Administrative billing claims are another type of data used by health care researchers and policymakers. For example, Oregon's All Payer All Claims (APAC) database and the Medicaid Management Information System (MMIS) collect information directly from bills. However, billing claims data come from the payer (like an insurance company) who received the bill. Discharge data, on the other hand, come from the entities (i.e., hospitals) who provided the service and create the bill.

A key difference between billing claims and discharge data is that claims include details about how the bill was ultimately paid, while discharge data only include how much the hospital charged. And billing claims cover all different types of health care services (anything that was paid by insurance). Discharge data, on the other hand, are specific to inpatient hospitals and emergency department settings.

Purpose of administrative data

Although discharge data are slightly different than billing claims data (see above), both types of information are considered "administrative" data. It's important to remember that the *reason these data are collected* is ultimately to receive payment for the services provided. Information about a member's diagnosis, for example, is included to describe the reason why the hospital delivered a particular service, NOT to paint a complete picture of the person's health.

A visit is captured in the data upon *discharge* from a hospital or ED facility

Data are collected when a person is discharged (released) from a hospital or emergency department. An emergency department is part of a hospital. If a person is admitted to an emergency department, and then elevated to inpatient hospital care at the same hospital and eventually discharged from the hospital, then information about the emergency department visit will NOT be captured. Information about the inpatient hospital stay, however, will be captured in hospital discharge data.

However, if a person is transferred to inpatient hospital care at a *different* hospital, they will first be discharged from the emergency department at the first hospital (and thus captured in ED discharge data).

Events when a person dies after being admitted to the ED or hospital are also captured in the data.

Many diagnoses can be made during a hospital or ED stay

A single visit can have up to 25 diagnosis codes. Each hospital visit will have an **admitting diagnosis,** or the reason why a provider admitted the patient to hospital. An ED visit will have a **chief complaint,** or the reason the patient stated for seeking care. After admission, providers may make different or additional diagnoses.

Requesting data

Hospital and emergency department discharge public use datasets can be purchased from the OHA. The cost is $250 per year of data or $75 per quarter.

To ensure patient privacy in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule's Safe Harbor:

- There are no patient names or unique identifiers
- Ages above 90 are replaced with a category 90+
- Full ZIP codes are not provided (Learn more)

Instructions for requesting data can be found on the Hospital Reporting Program webpage.

Hospital and ED discharge data in action

Hospital and ED discharge data are core data systems for public health surveillance. Access to these data is required for some Centers for Disease Control and Prevention (CDC) funding opportunities. Hospital and ED discharge data are used to illustrate, track, and support prevention efforts for:

- chronic diseases such as asthma, cancer, diabetes, and heart disease
- suicide, firearm injury, and overdose
- general injury (both child and adult), transportation injury, and traumatic brain injury with children
- diseases linked to environmental exposures

In addition, hospital and ED discharge data are used as an integral part of the Birth Anomalies Surveillance System to identify Oregon-born children ages 0-6 with one of 50 birth anomalies, which include physical, chromosomal, or auditory abnormalities. The data are also shared with the public in interactive websites such as the Oregon Tracker Data Explorer and the Chronic Conditions and Chronic Conditions Risk Factors Data Portal.

Quick Facts

Name	Hospital Discharge Data, Emergency Department Discharge Data
Acronym	HDD (Hospital Discharge Data)
Summary	Records of every discharge from an inpatient hospital or emergency department. Data include diagnosis and procedure codes, how much was billed, and more.
Data type	Administrative
Populations	Any person who was admitted to an emergency department acute care inpatient hospital in Oregon
Frequency	Data are updated quarterly
Available since	Hospital discharge data available since 2007 Emergency Department discharge data available since 2020
Required?	Yes: Oregon Revised Statute 442.370 and Oregon Administrative Rule 409-022
Regular reporting	OHA's Public Health Department maintains two summary dashboards
Website	https://www.oregon.gov/oha/hpa/analytics/pages/hospital-reporting.aspx
Primary staff	Steven Ranzoni
Internal requests	State partners may request limited data sets by emailing hdd.admin@odhsoha.oregon.gov
External requests	Public use datasets are available for purchase (see program webpage). Researchers may request limited datasets by emailing hdd.admin@odhsoha.oregon.gov, subject to program approval.
Security level[4]	2 (Limited)
Data dictionary?	Yes, in FAQ document available on program webpage (see page 3)
REALD	No (only includes the five race categories defined by the U.S. Office of Management and Budget)
SOGI	No (only includes sex assigned at birth)
Suggested citation	Oregon Health Authority, Hospital Reporting Program [Year] Oregon Hospital Discharge Data [Revision #]

[4] Learn more: https://www.oregon.gov/das/policies/107-004-050.pdf

Hospital Community Benefit Spending Data

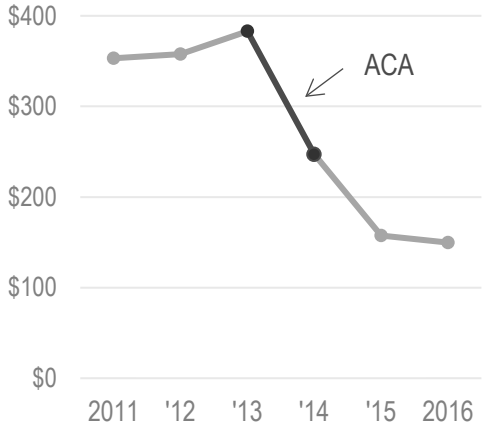
HPA Data Profile

Most hospitals in Oregon are designated as non-profit institutions. In return for their tax-exempt status, non-profit hospitals are expected to provide measurable benefits to the community. Every year, Oregon's 60 acute care inpatient hospitals[1] report the amount of money they contribute toward different categories of community benefit.[2]

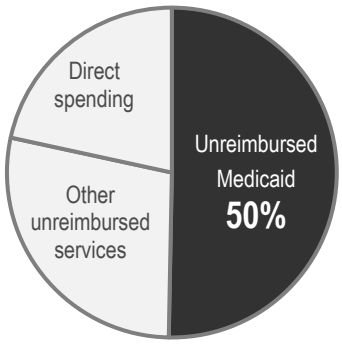
Hospital community benefit spending data can tell us things like:

Hospital charity care fell dramatically after the Affordable Care Act expanded insurance coverage.

Units are in $ billions

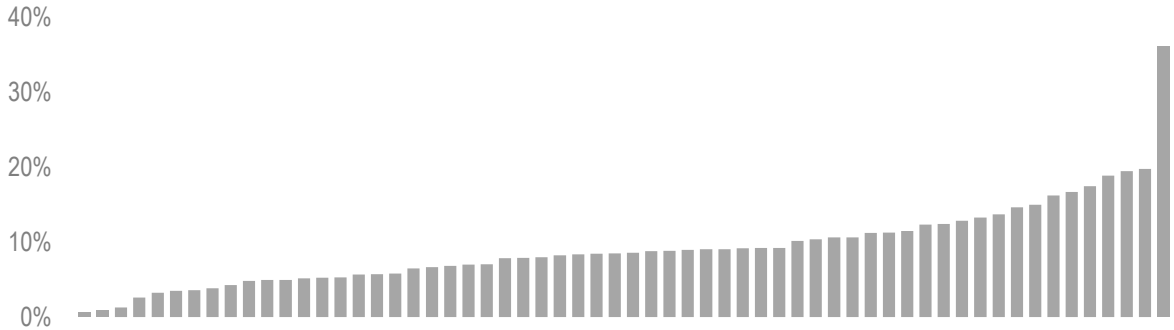


In 2020, the cost of providing *unreimbursed Medicaid* made up half of statewide community benefit spending.



Measured as a percentage of operating expense, total community benefit spending varied greatly across Oregon hospitals in 2019.

Operating expenses are from Audited Hospital Financial Data



[1] Hospitals that provide medical care and other related services for surgery, acute medical conditions or injuries

[2] Fifty-eight of Oregon's 60 hospitals are non-profit institutions. While all 60 are required by Oregon law to *report* community benefit spending, only the 58 non-profits are required to *provide* measurable community benefit. Learn more on page 6.

Regular reporting

Raw data are published annually (typically in late fall) in an Excel file on the Hospital Reporting Program webpage. The file includes data back to 2010. In addition to dollar spending in each of the ten community benefit categories, the file also includes supplemental information such as hospital type,[3] congressional district, and key financial measures[4] for the most recent year.

OHA also annually updates an interactive dashboard which allows users to visually explore trends over time and filter the data by different community benefit spending categories and hospital types. Along with each annual update, a short summary provides key takeaways and high-level policy analysis. These reports are published on the Hospital Reporting Program webpage under the "Community Benefit Reporting" dropdown menu.

Beginning with 2022 data, OHA will also publish a more in-depth, qualitative report each year. The 2022 report is expected to be published around spring 2024.

> ***Analyzing the data***
> When comparing across hospitals, community benefit data should be normalized against hospital financial measures. Learn more on pages 4-5 of this profile.

About the data

This section includes some helpful information about how hospital community benefit data are collected, and important things to remember when interpreting the data.

Overview of data elements

Broadly, community benefits are activities and services that improve the health of the community and social determinants of health. To be considered a community benefit, hospital spending must be provided at a loss to the hospital and in response to identified community needs; and must NOT be done for the primary purpose of advertising or marketing.

More specifically, community benefit spending is categorized into two main types: **1) unreimbursed care** and **2) direct community benefit spending**. Within each category are several sub-categories.

Unreimbursed care means services the hospital provided but didn't receive full payment to cover the cost of providing that care. Hospitals calculate the amount they spent toward unreimbursed care by 1) estimating the amount it costs to provide the care and 2) subtracting the amount they were reimbursed. Within the broader category of unreimbursed care are several sub-categories of spending. A few examples include:

- *Charity care:* The amount the hospital forgave from bills because patients were unable to pay
- *Unreimbursed Medicaid:* The difference between the amount the hospital estimates it cost to provide care to Medicaid members, and the amount that the Medicaid program paid for the care

[3] Hospital types: **DRG** hospitals are large and typically urban; **Type A** hospitals are small (fewer than 50 beds) and located more than 30 miles from another hospital; **Type B** hospitals are also small but located within 30 miles of another hospital.

[4] Financial measures come from hospital-reported Audited Financial Data

- *Subsidized health service:* Money the hospital lost for providing services that are needed by the community, and that otherwise wouldn't exist (or would be provided by government) if the hospital didn't provide the service. Examples include emergency and trauma services and newborn care.

Direct community benefit spending is when a hospital contributes money or activities toward certain causes. Within this category are several sub-categories. A few examples include:

- *Cash and in-kind contributions:* Direct donations toward programs or activities that are operated by a community partner and align with the mission and goals of the hospital
- *Community health improvement:* Costs incurred for providing programs or activities intended to improve community health
- *Health professional education:* Costs incurred for providing educational programs to the health care workforce

Full definitions of these and other sub-categories of unreimbursed care and direct community benefit spending can be found in the online dashboard. More detailed descriptions, including specific examples of what hospitals can and cannot count toward each category, are in Community Benefit Reporting Program documentation such as the CBR-1 form (available to download on the program webpage) and the accompanying form instructions.

How the data are collected

Each hospital submits a completed CBR-1 form, which itemizes spending amounts toward different community benefit categories during the hospital's most recent fiscal year.

Beginning with 2022 fiscal year reporting, hospitals are also required to submit the most recent version of their Community Health Assessment[5] (CHA) and Community Health Improvement Plan (CHIP), as well as a supplemental narrative describing how their community benefit spending addresses the needs and strategies identified in those documents. The narrative must also describe community partners the hospital partnered with, and how the spending addressed social determinants of health.

Timing and frequency

Hospitals submit their CBR-1 form and accompanying documents annually, within 240 days (about eight months) of their fiscal year ending. Hospitals in Oregon do not all follow the same fiscal year. Some end as early as March (beginning in April of the prior year) or as late as December (beginning in January).

OHA publishes annual data for all hospitals in late fall of each year. The data in each annual report are based on when the hospitals' fiscal years ended. For example, the 2021 data file and summary report (published in 2022) cover all fiscal year data that ended in 2021. Since hospitals use different

CHAs and CHIPs

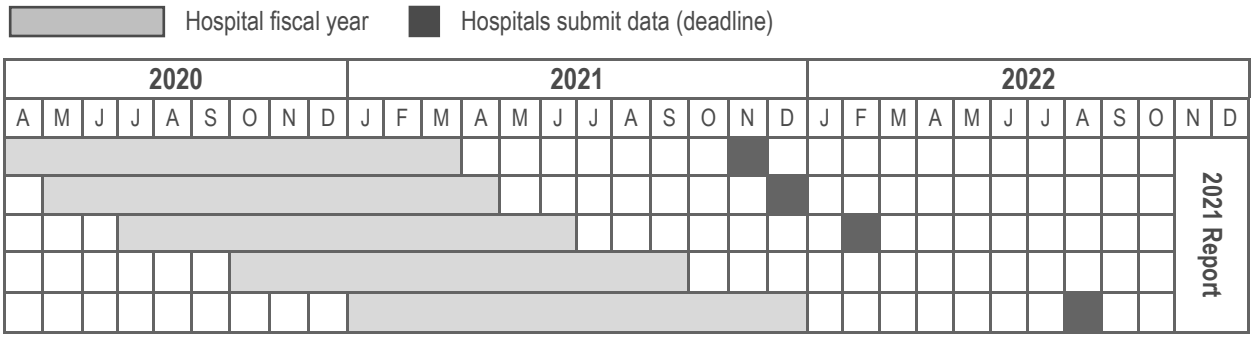
To maintain their tax-exempt status, non-profit hospitals are required by the federal government to prepare a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) every three years. CHAs identify the key health needs of a community. CHIPs are plans for how the hospitals will address the needs identified in the CHA.

Although hospital CHAs and CHIPs are a federal requirement, Oregon passed a law (HB 3076) in 2019 that includes additional reporting requirements.

[5] Also known as Community Health *Needs* Assessment, or CHNA

fiscal years, the time periods covered by the data will differ and include months from the prior calendar year. See Figure 1 below.

Figure 1. Oregon's 60 acute care hospitals follow different fiscal years, as shown by the gray bars below. Data are submitted by hospitals within 240 days of their fiscal year ending. Data for all hospitals are published annually, in late fall of the calendar year following the close of all fiscal years. The example below shows the range of fiscal year data included in the "2021" data report.



READ and SOGI

READ and SOGI[6] are types of standardized demographic information. READ stands for: Race, Ethnicity and Language, Disability. SOGI stands for: Sexual Orientation and Gender Identity.

Since hospital community benefit data do not include information about people, READ and SOGI do not apply.

Things to remember when interpreting hospital community benefit data

There are different types of community benefit spending

As described in the *Overview of data elements* section on page 2 of this profile, there are two main types of hospital community benefit spending: 1) unreimbursed care and 2) direct community benefit spending. When analyzing the data, it's important to remember the distinction between these two types of community benefit spending. **Unreimbursed care** is the amount of money that hospitals lost for providing care without being fully reimbursed for the cost of care. Rather than money going "out" the door, it's money that *didn't come in*. **Direct spending**, by contrast, is when hospitals donate or spend money toward community causes.

Some people in Oregon believe that non-profit hospitals should contribute more toward *direct* community benefit spending. Learn more in *Community benefit data in action* on page 6.

Hospitals vary greatly by size (and budgets)

Hospitals vary greatly by size and budgets. As a result, the dollar amounts that different hospitals spend on community benefits vary greatly – from a few thousand dollars, to a few hundred million. The reason OHA's reporting categorizes hospitals by type (DRG, Type A, and Type B) is that hospitals within each category share similar characteristics in terms of size and budgets.

However, there is still wide variation even within a single hospital type. When comparing spending between two or more hospitals, it's best to normalize the data by looking at percentage

[6] As of this publication, only draft SOGI data collection standards have been released

rates rather than raw dollar amounts. This is *especially* true if you want to compare hospitals that are different types (for example, a Type A and a DRG hospital).

Two ways to normalize community benefit spending are:

1. **Analyzing the *proportions* each hospital spends toward different categories of community benefit.** In the online dashboard, users can select to view how much individual hospitals spent on each category of community benefits *as a percentage of their total community benefit spending*.

2. **Calculating percentages using key financial metrics.** OHA includes supplemental financial information[7] about each hospital in the raw data files. That way, users can calculate the amount that hospitals spent toward community benefits *as a percentage* of their patient revenue or other financial metrics.

"Charity care" is reported in two other OHA datasets, but those are calculated differently than charity care in community benefit data

OHA also collects and publishes annual *audited hospital financial reporting* data and quarterly *hospital financial and utilization* data. Like community benefit data, both of those datasets include a field called "charity care." However, those two datasets use a different definition and way of calculating charity care than the way it's defined in community benefit data:

- In community benefit reporting, hospitals calculate their ultimate **cost** of charity care. For example, suppose a hospital fixed a patient's broken arm and forgave the bill as part of charity care. The hospital would calculate how much it actually cost them to fix that broken arm (in staff time, equipment/materials, and so on).

- In the two other datasets, on the other hand, hospitals report the amount they would have **charged** the patient and their insurance for fixing the broken arm (that is, the amount that would have appeared on the bill or invoice).

Since hospitals charge higher amounts than the actual cost for providing care, **charity care amounts reported in audited hospital financial data will be much higher than charity chare amounts reported in community benefit data.**

Learn more about *audited hospital financial reporting* data and *hospital financial and utilization data* on the Hospital Reporting Program webpage, or read their data profiles.

Because of an accounting adjustment, spending toward *subsidized health services* grew in 2020 onward

As described in the *Overview of data elements* section on page 2 of this profile, there are two main categories of community benefit spending: 1) unreimbursed care and 2) direct spending. One category of unreimbursed care is "unreimbursed Medicaid" spending. Before 2020, there was a similar category for unreimbursed **Medicare** spending.

House Bill 3076, passed by the Oregon Legislature in 2019, removed "unreimbursed Medicare" as a sub-category of unreimbursed care beginning in 2020. When OHA reported hospitals' 2020

[7] The source for this information is Hospital Audited Financial data. Learn more: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx

data, we removed the unreimbursed Medicare category of spending from historical data in the raw data files and online dashboard so that the overall unreimbursed care category can still be compared over time.

However, when unreimbursed Medicare was removed as a category, hospitals could begin reporting *some* of the amount of money they lost providing care to Medicare patients as a "subsidized health service" which is another category of unreimbursed service. As a result, the spending on subsidized health services appeared to grow in 2020 – but that was due mostly to the accounting change. **When looking at trends over time, spending toward unsubsidized health services from 2020 onward should not be directly compared to 2010-2019 results.**

Requesting data

Hospital community benefit spending data back to 2010 are available for download on the Hospital Reporting Program webpage. If users want assistance with analysis, email HDD.Admin@odhsoha.oregon.gov.

In addition to the summarized data, PDF copies of hospitals' CBR-1 forms are published on the Hospital Document Library webpage.

Hospital community benefit spending data in action

Helping policymakers understand the current landscape and establish new expectations

Fifty-eight of the 60 acute care inpatient hospitals in Oregon are considered non-profit institutions. As non-profits, these hospitals are exempt from paying state and federal taxes. The intent behind this tax exemption is that hospitals will invest their tax savings back into the community so everyone benefits.

In 2007, seeking better insight into the different ways – and amounts – that non-profit hospitals were giving back to their communities, the Oregon Legislature passed House Bill 3290 establishing requirements for hospital community benefit reporting.

Over the years, the data provided valuable insights. Just a few examples include:

- When insurance coverage increased in Oregon with the passage of the Affordable Care Act, the amount that hospitals spent toward charity care fell dramatically (see chart on page 1). Meanwhile, financial data showed that hospitals were earning higher profits.
- Every year between 2015 and 2019, hospitals categorized a greater share of total community benefit spending as *unreimbursed care*, while the share of *direct spending* fell. In 2019, direct spending made up less than a quarter of total spending.
- The amount that hospitals spent toward community benefits varied greatly. Measured as a percentage of operating expense, total community benefit spending in 2019 ranged from 0.6 to 36.2 percent (see chart on page 1).
- The quality of reporting was also inconsistent between hospitals, and the connection to identified community needs wasn't always clear.

The hospital community benefit reporting program established by HB 3290 provided new transparency. For the first time, policymakers and the public had a view into the investments that hospitals were obligated to make to improve the health and wellbeing of communities they serve in exchange for their tax-exempt status.

With this transparency, policymakers were able identify the ways hospitals were (or weren't) meeting community expectations. Advocates proposed ways that Oregon's Community Benefit Reporting could further improve transparency, increase accountability, and support genuine community priorities. To that end, in 2019 the Oregon Legislature passed House Bill 3076 which transforms hospital community benefit in important ways, such as:

- ✓ Establishing a target (minimum floor) for each hospital's annual community benefit spending; and
- ✓ Requiring hospitals to identify and describe how the programs and activities they are supporting will improve social determinants of health and other needs identified in their Community Health Assessment.

Minimum spending floors were introduced with hospitals' 2022 fiscal year reporting and will be reported on for the first time in early 2024.

Quick Facts

Name	Oregon Hospital Community Benefit Reporting
Acronym	None (occasionally "CBR")
Summary	Every year, hospitals report the amounts they spend toward different types of community benefits
Data type	Administrative
Populations	Level of analysis is hospitals in Oregon
Frequency	Annual
Available since	2010
Required?	Yes: Oregon Revised Statute 442.601 to 442.630 and Oregon Administrative Rule 409-023. Established by HB 3290 (2007) and HB 3076 (2019)
Regular reporting	Interactive dashboard and summary report, published annually
Website	https://www.oregon.gov/oha/hpa/analytics/pages/hospital-reporting.aspx
Lead staff	Steven Ranzoni
To request data	n/a (available online)
General contact	HDD.Admin@odhsoha.oregon.gov
Security level[8]	Level 1 "Published" (low-sensitive information)
Data dictionary?	Detailed definitions can be found in program documentation available on the Hospital Reporting Program webpage
REALD	n/a
SOGI	n/a
Suggested citation	Oregon Health Authority, Hospital Community Benefit Reporting [Year]

[8] Learn more: https://www.oregon.gov/das/policies/107-004-050.pdf

Hospital Financial and Utilization Data

(Also known as "Databank")

HPA Data Profile

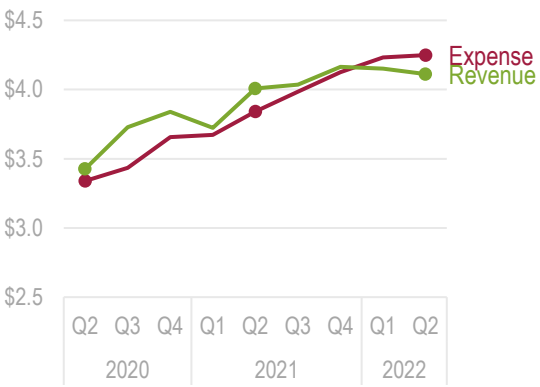
Hospitals play an important role in the health care system – both as institutions that provide medical, surgical, emergency, and nursing care; and as employers, research institutions, and centers to train the health care workforce. Hospital care also accounts for more than 30 percent of all health care spending in the United States each year.

Every month, Oregon's 60 acute care inpatient hospitals[1] self-report information about their finances and utilization. Timely and transparent reporting of these data helps researchers, policymakers, and the public identify and understand the impact of state and federal health reforms on hospital care and financial stability.

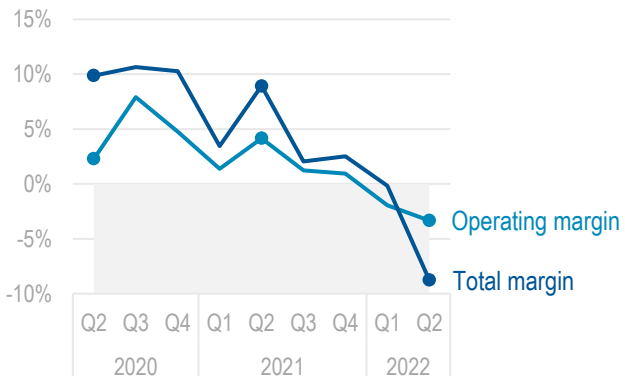
Did you know?
Hospitals also submit annual, audited financial data. Read the data profile.

A few examples of the things hospital financial and utilization data can tell us include:

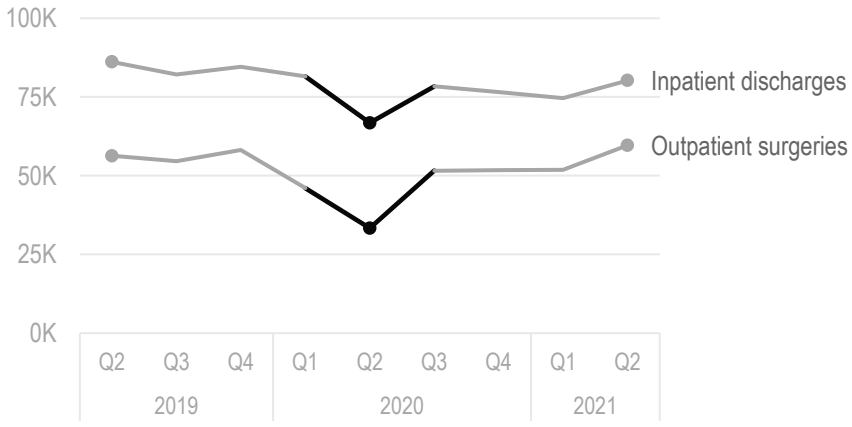
Hospitals are currently operating at a net loss, with operating expenses outpacing revenue.
Units are in billions. Note axis does not start at zero.



Operating margins (profits) are negative.
So are total profits, which include investments.



Hospital utilization fell sharply when the COVID-19 pandemic began but rebounded quickly.
Elective surgeries were banned in Oregon from March 23 to May 1.



Communicating the data

With hospital financial and utilization data, it's typically more meaningful to compare the same quarter across years. Learn more on page 3.

In these line charts, markers are used to emphasize the Q2 data points.

[1] Hospitals that provide medical care and other related services for surgery, acute medical conditions or injuries

Regular reporting

Quarterly Report and Dashboard

OHA publishes short quarterly reports that summarize recent trends and provide high-level policy analysis. These reports are available on the Hospital Reporting Program webpage under the "Hospital Financial and Utilization Quarterly" dropdown menu.

Along with each quarterly report, OHA updates an interactive dashboard. The dashboard allows users to visually explore trends over time on several key financial and utilization metrics. The dashboard shows data for all hospitals combined, as well as broken out by different hospital types.[2] Each quarterly update includes the most recent quarter's data and data from the last ten years.

A second dashboard shows data in table format for each of the 60 individual hospitals.

Raw data

Finally, users can download all available financial and utilization data back to 2007 in Excel format. This includes data by month at more granular levels of detail than what is shown in the quarterly report and dashboard. For example, while the dashboard shows "net patient revenue" the raw data include all the individual fields that are used to calculate net patient revenue. Raw data also show information by payer (e.g., Medicaid, Medicare, commercial insurance).

The raw data can be downloaded from the Hospital Reporting Program webpage under the "Datasets" dropdown menu.

About the data

Overview of data elements

Key financial measures available from hospital financial and utilization data include things like:

- **Revenues:** The amount of money a hospital received from different sources
- **Expenses:** The amount of money it cost the hospital to operate
- **Operating margin:** A comparison of revenues to expenses, which tells you whether the hospital is operating at a profit or loss
- **Charity care:** [3] The stated value of care that the hospital provided for free to low-income patients

Utilization measures include the number of visits to the Emergency Department, the number of outpatient visits and surgeries, and the number of people who were discharged from an inpatient hospital stay.

[2] Hospital types: **DRG** hospitals are large and typically urban; **Type A** hospitals are small (fewer than 50 beds) and located more than 30 miles from another hospital; **Type B** hospitals are also small, but located within 30 miles of another hospital.

[3] Note: "Charity care" is also an important field in Oregon's *hospital community benefit reporting* data. However, audited hospital financial data reports amounts **charged**, while community benefit data reports the **cost** hospitals incur for providing charity care.

For a full list of key metrics and definitions, read the *Hospital Financial and Utilization Trends Glossary*. A complete data dictionary can also be downloaded from the Hospital Reporting Program webpage (under "Datasets").

How the data are collected

Hospitals self-report monthly financial and utilization data to a database called Databank, which is managed by Oregon's main hospital trade group, the Oregon Association of Hospitals and Health Systems (OAHHS). Hospitals submit data covering the previous month by the 23rd day of the following month. For this reason, data are often incomplete upon initial submission and should be considered preliminary (learn more in *Things to remember when using hospital financial and utilization data* below).

Every three months, OAHHS makes these files available to OHA.

Databank is the name of the database where hospital financial and utilization data are collected and stored.

If you hear someone refer to "Databank" data, it means the same thing as *monthly Hospital Financial and Utilization data*.

Timing and frequency

OHA typically updates the dashboards and raw data files with a new quarter's worth of data about four months after the close of the quarter. For example, Quarter 1 data (January-March) are updated around July.

REALD and SOGI

REALD and SOGI[4] are types of standardized demographic information. REALD stands for: **R**ace, **E**thnicity and **L**anguage, **D**isability. SOGI stands for: **S**exual **O**rientation and **G**ender **I**dentity.

Since hospital financial and utilization data do not include person-level data, REALD and SOGI do not apply.

Things to remember when using hospital financial and utilization data

New data should be considered preliminary

Hospitals submit monthly data just three weeks after each month's end. Because this is a quick turnaround, data are usually incomplete, and the initial monthly submission is often adjusted in later months. While the information is still valuable to understand overall trends, it's important to understand that exact numbers will likely change slightly over the next few quarters.

Data grouped by quarter is usually more meaningful than looking at monthly trends

Data broken down by months can appear volatile with large month-to-month fluctuations, but these fluctuations typically smooth out when viewed by quarter. The Quarterly Report and Dashboard use quarters as the unit of analysis for this reason.

Hospitals experience seasonal patterns

Utilization (and corresponding financial impacts, like net patient revenue) usually follow seasonal patterns, so it's more meaningful to compare the same quarter across years rather than comparisons between successive quarters. For example, you should compare Q3 2019, Q3 2020, and Q3 2021, rather than Q1, Q2, and Q3 in 2021.

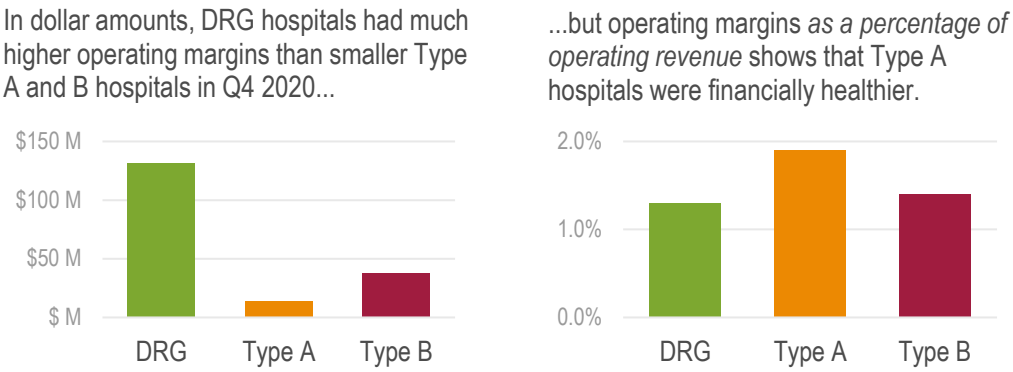
Hospitals vary greatly by size (and budget)

Revenues and other financial measures vary dramatically in dollar amounts across the 60 acute care inpatient hospitals that are reflected in hospital financial and utilization data. Some large DRG hospitals regularly have operating margins in the hundreds of millions of dollars, while smaller Type A and B hospitals have margins in the tens of millions. So, when comparing across hospitals or hospital types, it's better to look at percentage rates rather than raw dollar amounts.

Margins (also known as profits) means the difference between revenues and expenses.

The Quarterly Dashboard includes several measures calculated as rates. For example, you can look at operating margins *as a percentage of operating revenue*. That tells you what percentage of the money that the hospital earned through hospital services (operating revenue) it got to keep as profit (operating margin) and is a better measure of overall financial health than operating margins alone.

Figure 1. When comparing across hospital or hospital types, it's more meaningful to use percentage rates than dollar amounts.



Use caution when interpreting *total margin* and other non-operating financial measures

The raw hospital financial and utilization data (available for download in Excel) include financial measures that include money that's not accessible to the hospital. For example, total margin may include things like the value of employees' 401k retirement accounts and investments.

Requesting data

Full datasets are available for download on the Hospital Reporting Program webpage. For assistance with analysis, email HDD.Admin@odhsoha.oregon.gov.

Hospital financial and utilization data in action

Informing recommendations for Oregon's Sustainable Health Care Cost Growth Target Program

In 2019, the Oregon Legislature established the Sustainable Health Care Cost Growth Target Program, which aims to address the rising cost of health care by establishing shared goals and increasing transparency around total health care spending.

It took many years for the Legislature to arrive on this innovative policy solution. In 2017, the Oregon Legislature asked a Joint Task Force to explore whether Oregon should establish a rate-setting program focused exclusively on hospitals. The Task Force, which included researchers, policymakers, and health care industry representatives, spent almost a year studying the problem of rising health care costs and exploring whether a hospital rate-setting program was the right solution for Oregon.

To inform this work, OHA presented extensively using hospital financial and utilization data. These data helped the Task Force understand the overall financial landscape of Oregon's hospitals – including differences in how they are reimbursed, how they earn profits, and the types and volume of care they provide.

Ultimately, the Task Force recommended that a hospital rate-setting program was not the right solution for Oregon. Instead, they proposed that the Legislature establish a statewide health care cost growth target which applies not just to hospitals, but also to insurance companies and large health care provider organizations.

Having access to rich, timely, year-over-year hospital financial and utilization data helped policymakers understand and develop appropriate policy solutions for Oregon's unique health care landscape.

Timely financial data help legislators address a hospital crisis

Oregon's hospital financial and utilization data are the primary dataset the Legislature uses to understand current trends in hospital finances. A recent example demonstrating the value of these data occurred in September 2022, when the Joint Legislative Emergency Board convened to address a statewide crisis of hospital capacity and staffing. In addition to reviewing data related to staffing and available hospital beds, legislators were shown hospital financial data showing the widening gap between expenses and revenues.

As a result, the Emergency Board approved $35.4 million in funding to support increases in staffing and hospital capacity.

> **Based on data** published by OHA, the combined operating margin (profit) of Oregon's urban and rural acute care hospitals decreased by 85.5% in the fourth calendar year quarter of 2021. For the first quarter of 2022, the operating margin decreased another 302.7%, for a net loss of $103.5 million.
>
> *-Excerpt from 2022 E-Board presentation*

Quick Facts

Name	Hospital Financial and Utilization data
Acronym	None, although people sometimes refer to the data as "Databank" which is the database where the data are collected and stored
Summary	Every month, Oregon's 60 acute-care inpatient hospitals submit data about their finances and utilization
Data type	Administrative
Populations	Level of analysis is hospitals in Oregon
Frequency	Monthly
Available since	2007
Required?	Yes (Oregon Revised Statute 442.400 to 442.463; and Oregon Administrative Rule 409-015)
Regular reporting	Interactive dashboard and summary reports, both updated quarterly.
Website	https://www.oregon.gov/oha/hpa/analytics/pages/hospital-reporting.aspx
To request data	n/a (available online)
General contact	HDD.Admin@odhsoha.oregon.gov
Lead staff	Steven Ranzoni
Security level[5]	Level 1 "Published" (low-sensitive information)
Data dictionary?	Yes. Available on Hospital Reporting Program webpage (under "Datasets")
REALD	n/a
SOGI	n/a
Suggested citation	Oregon Health Authority, Hospital Financial and Utilization (Databank) [YEAR]

[5] Learn more: https://www.oregon.gov/das/policies/107-004-050.pdf

Audited Hospital Financial Data

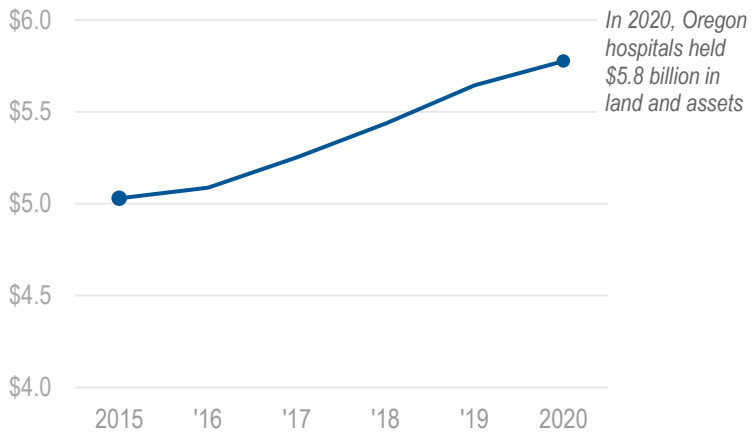
HPA Data Profile

Hospitals are a critical part of the health care system, and hospital care accounts for more than thirty percent of all health care spending in the United States each year. Every year, hospitals and health systems submit detailed audited financial records to the Oregon Health Authority for Oregon's 60 acute-care inpatient hospitals. Transparent reporting of these data is important to help researchers, policymakers, and the public understand hospitals' financial health, and their role in driving health care costs and meeting the needs of their communities.

A few examples of the things audited hospital financial data can tell us include:

The net value of land and assets that hospitals hold increased rapidly between 2015-2020.

Units are in billions. Note axis does not



Regular reporting

Once per year (typically in early summer), OHA publishes a raw data file and a summary table of audited hospital financial data. The summary table includes definitions, the most recent year's data, and comparisons on key metrics to the previous year. The raw data file shows more granular detail and includes data back to 2007.

Both files (Excel) can be downloaded from the Hospital Reporting Program webpage.

Hospital types

"Acute care inpatient hospitals" means hospitals that provide medical care and other related services for surgery, acute medical conditions or injuries (usually for a short-term illness or condition).

Acute care hospitals are further categorized by size and location:

DRG hospitals are large and typically urban. DRG stands for "diagnostic related group" and it refers to the way the hospital gets paid by Medicare. Almost half (27 of 60) hospitals in Oregon are DRGs.

Types A and B hospitals are both smaller (fewer than 50 beds). The difference is that Type A are located more than 30 miles from another hospital, while Type B have another hospital within 30 miles. Oregon has 12 Type A hospitals and 21 Type B hospitals.

About the data

How the data are collected

Hospitals and health systems submit 1) a financial statement with attached certification of audit and 2) a completed "FR-3" form, which itemizes certain financial measures and can be found on the Hospital Reporting Program webpage.

Timing and frequency

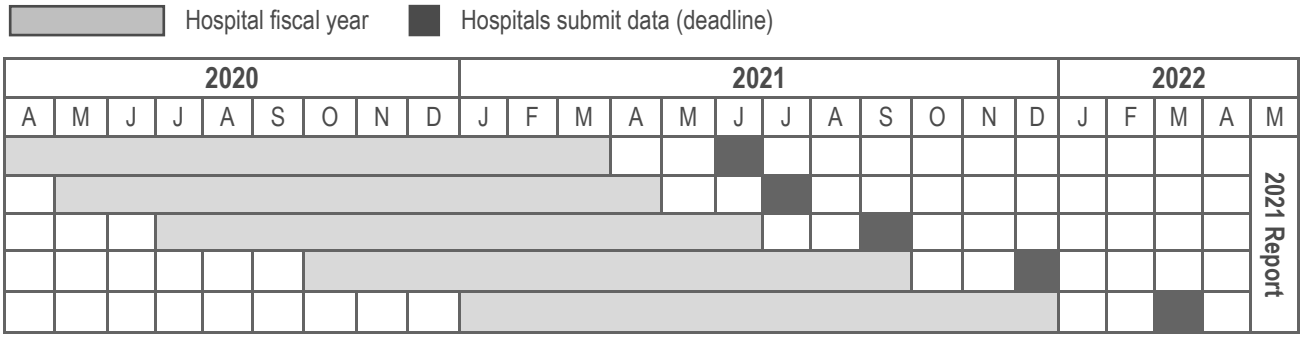
Hospitals and health systems must submit their audited financial statement and FR-3 within 120 days of their fiscal year ending. Hospitals and systems in Oregon do not all follow the same fiscal year. Some end as early as March (beginning in April of the prior year) or as late as December (beginning in January).

OHA publishes annual summary data for all hospitals in summer of each year. The data in each annual report are based on when the hospitals' fiscal years ended. For example, the 2021 data file and summary report (published in 2022) cover all fiscal year data that ended in 2021. Since hospitals use different fiscal years, the time periods covered by the data will differ and include months from the prior calendar year. See Figure 1 below.

Did you know?

Hospitals also submit monthly financial data. Read the Hospital Financial and Utilization data profile to learn more.

Figure 1. Oregon's 60 acute care hospitals follow different fiscal years, as shown in the gray bars below. Data for all hospitals are published annually, in late spring of the calendar year following the close of all fiscal years. The example below shows the range of fiscal year data included in the "2021" data report.



Overview of data elements

Audited hospital financial data provide a detailed picture of hospitals' financial health. Key metrics include things like:

- **Revenues:** The amount of money a hospital received from different sources, such as for providing patient care (net patient revenue)
- **Expenses:** The amount of money it cost the hospital to operate
- **Operating margin:** A comparison of revenues to expenses, which tells you whether the hospital is operating at a profit or loss

- **Charity care:**[1] The stated value of care that the hospital provided for free to low-income patients
- **Property plan and equipment:** The total value of all buildings, land, furniture, and other physical capital that a hospital owns.

The annual summary table also includes basic information about the reporting hospitals, such as hospital type (DRG, Type A, Type B).

REALD and SOGI

REALD and SOGI[2] are types of standardized demographic information. REALD stands for: Race, Ethnicity and Language, Disability. SOGI stands for: Sexual Orientation and Gender Identity.

Since audited hospital data do not include information about people, REALD and SOGI do not apply.

Things to remember when interpreting audited hospital financial data

Audited financial data differ from the financial data that hospitals submit monthly as part of their required hospital financial and utilization reporting

Audited hospital financial data appear similar in many ways to financial data that hospitals submit monthly through the *Hospital Financial and Utilization* reporting program, but are different in important ways:

- The types of information (data fields) are the same in both the annual audited and monthly data submissions, with the exception that **audited financial data include the value of a hospital's property, buildings, and equipment.** These types of assets are considered "non-liquid," meaning they can't quickly be turned into cash. They are important to understand a hospital's overall financial health.

- **Audited financial data are submitted annually, and there is long time lag**. Monthly financial and utilization data submissions, by contrast, are submitted each month just a few weeks after the close of the month.

- **Audited financial data are more definitive than monthly data submissions.** Since the monthly financial information is submitted by hospitals with a very quick turnaround (by the 23rd day of the following month) the initial data that's submitted is often incomplete and is adjusted in later months. While the monthly data are useful for quickly understanding developing trends in Oregon's hospital systems, audited financial data give a more detailed and conclusive picture of a hospital's total balance sheet.

Hospitals use different fiscal years

As described on page 2, hospitals use different fiscal years. That means direct comparisons can't be made across hospitals. If you want to compare across hospitals, it's better to use the monthly *Hospital Financial and Utilization* data.

[1] Note: "Charity care" is also an important field in Oregon's *hospital community benefit reporting* data. However, audited hospital financial data reports amounts **charged**, while community benefit data reports the **cost** hospitals incur for providing charity care.
[2] As of this publication, only draft SOGI data collection standards have been released

Systems submit a single audited report for all their affiliated hospitals

Forty-one of Oregon's 60 acute care hospitals are part of a larger system (for example, Legacy or Providence). Although an FR-3 form is submitted for each individual hospital, the audited financial statement is combined at the *system* level. That means the data on the FR-3 form cannot be verified with an audited financial statement for the 41 hospitals that are part of a larger system.

Hospitals vary greatly by size (and budget)

Revenues and other financial measures vary dramatically in dollar amounts across the 60 acute care inpatient hospitals that are reflected in hospital financial and utilization data. Some large DRG hospitals regularly have operating margins in the hundreds of millions of dollars, while smaller Type A and B hospitals have margins in the tens of millions. So, when comparing across hospitals or hospital types, it's better to look at percentage rates rather than raw dollar amounts.

Margins (also known as profits) means the difference between revenues and expenses.

For example, users can calculate operating margins *as a percent of operating revenue*. That tells you what percentage of the money that the hospital earned through hospital services (operating revenue) it got to keep as profit (operating margin) and is a better measure of overall financial health than the dollar amount of operating margins alone.

Requesting data

All audited hospital financial data are available for download on the Hospital Reporting Program webpage. For assistance with analysis, email HDD.Admin@odhsoha.oregon.gov.

In addition to the summarized data, PDF copies of hospitals' individual audited financial reports, as well as their completed FR-3 forms, are published back to 2013 on the Hospital Document Library webpage.

Audited hospital financial data in action

Using audited financial data to make meaningful comparisons across hospitals' community benefit spending

Another important type of information hospitals report to OHA is their **community benefit spending**. Fifty-eight of Oregon's 60 acute care hospitals are non-profit institutions, and thus are expected to provide measurable benefits to the communities they serve.

Read the Community Benefit data profile.

Since hospitals vary greatly by size and budgets, the dollar amounts different hospitals spend on community benefits vary greatly (from a few thousand dollars, to a few hundred thousand). By comparing hospitals' community benefit spending amounts to their audited financial data, the numbers can be normalized to show spending as a percentage of patient revenue or other financial metrics. Audited financials are an ideal pairing to community benefit data because both data sources are based on hospital fiscal years (as described on page 2).

Quick Facts

Name	Audited Hospital Financial Data
Acronym	n/a
Summary	Oregon's 60 acute care inpatient hospitals submit an audited financial statement for each fiscal year which includes information on things like revenues, expenses, margins, and the value of property and investments
Data type	Administrative (accounting/financial)
Populations	Level of analysis is acute care inpatient hospitals in Oregon
Frequency	Annual
Available since	All fields available back to 2007; partial data available since 2001
Required?	Yes: House Bill 2146 (1999), Oregon Revised Statute 442.400 to 442.463; and Oregon Administrative Rule division 409-015
Regular reporting	Dataset is updated once per year, usually around early summer
Website	https://www.oregon.gov/oha/hpa/analytics/pages/hospital-reporting.aspx
To request data	n/a (available online)
General contact	HDD.Admin@odhsoha.oregon.gov
Primary staff	Steven Ranzoni
Security level[3]	Level 1 "Published" (low-sensitive information)
Data dictionary?	No
REALD	n/a
SOGI	n/a
Suggested citation	Oregon Health Authority, Audited Hospital Financial Reporting [Year]

[3] Learn more: https://www.oregon.gov/das/policies/107-004-050.pdf

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

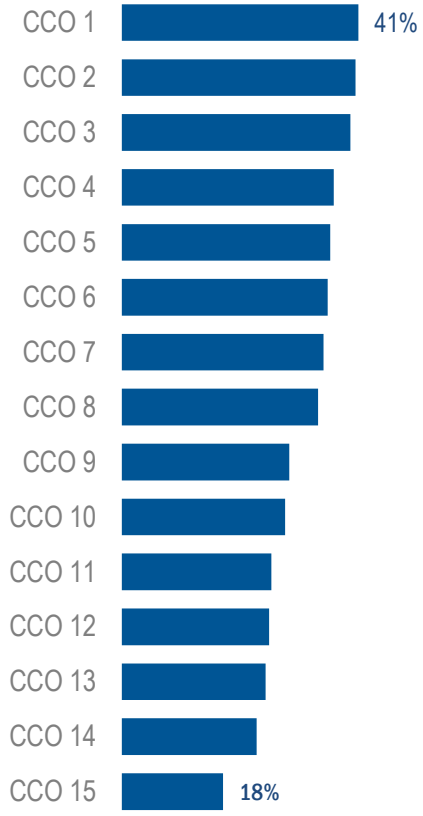
HPA Data Profile

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a survey of people in Oregon who have their main source of insurance coverage through Medicaid. It covers topics that are important to consumers and focuses on aspects of health care quality that consumers are best qualified to assess—such as the communication skills of providers and how easy it is to access services. The survey results help policymakers and researchers understand how Oregon's Medicaid system is (or isn't) working for people and evaluate the impacts of new policies to see if they are effective.

A few examples of the things CAHPS data can tell us include:

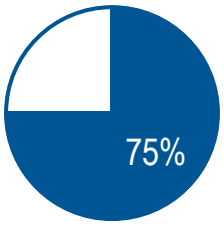
Access to dental care varied across CCOs in 2021.

Percentage of adult members who said they had a regular dentist and would go for checkups or when they had tooth pain.

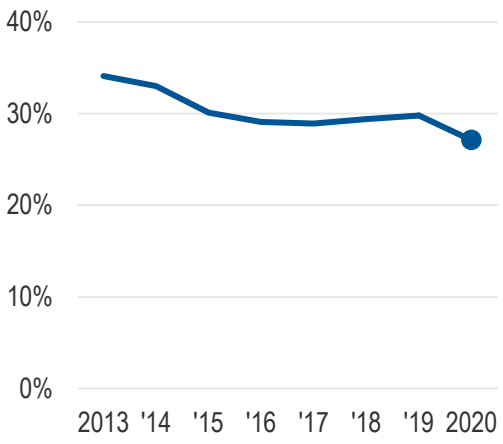


3 in 4 Medicaid members in Oregon reported getting an appointment with a specialist as soon as they needed.

Percentage reporting 'always' or 'usually' in 2021.



The percentage of Medicaid members who report using tobacco continues to decrease.



…and in 2020, 1 in 4 members who smoke said their doctor advised strategies to quit.

Did you know?
Standardized CAHPS surveys have been in use since the mid-1990s and are part of a national program overseen by the Agency for Healthcare Research and Quality (AHRQ).

Regular reporting

Banner Books provide detailed results and analysis at the CCO level

CAHPS survey results are published every summer on OHA's CAHPS webpage in a set of reports, called "Banner Books." Separate reports are published for each coordinated care organization[1] (CCO) and for fee-for-service (FFS), as well as combined statewide results. Statewide and CCO-level results are further stratified and published separately for adults and children.

CAHPS reports show summary results for many of the survey questions as well as composite measures (learn more about composite measures on the next page). Results also show:

- Trends over the last three years
- When a change from the prior year is statistically significant[2]
- Comparison to the statewide average and the highest- and lowest-performing CCOs

In addition to the survey results, the reports include helpful information like:

- *Key driver analyses* which recommend specific opportunities for improvement for each CCO (or FFS) based on their individual CAHPS results; and
- Detailed methodology and the survey questionnaire.

The CCO Metrics Dashboard allows users to view some summary measures across all CCOs at-a-glance

Summary results for eleven CAHPS measures (seven of which are reported separately for adults and children) are also published in Oregon's CCO Performance Metrics Dashboard. Through the dashboard, users can quickly compare trends over time across all of the state's CCOs. Two of the measures (*Access to care* and *Satisfaction with care*) were also previously part of Oregon's Quality Incentive Program, which rewards CCOs for improving their performance on a set of measures selected by a public committee.

Coming down the pike
OHA is working to develop an additional dashboard that will present CAHPS results disaggregated by race, ethnicity, language, and disability (READL).

About the data

This section provides an overview of CAHPS survey data and how they are collected. Detailed methodology and definitions can be found in the Banner Book reports on the CAHPS webpage.

Overview of data elements

The CAHPS survey includes dozens of questions designed to measure topics that consumers are best qualified to assess. Some examples[3] of the types of questions in the standardized CAHPS survey include:

"In the last 6 months, how often…"

- *did you get an appointment for routine care as soon as you needed?*
- *did your doctor explain things in a way that was easy to understand?*

[1] Coordinated care organizations (CCOs) are networks of all types of health care providers who work together in their local communities to serve people who receive health care coverage through the Oregon Health Plan (Medicaid)
[2] CAHPS survey results indicate when any change was statistically significant at the 95 percent confidence level. That means that we are very confident the difference was not due to chance.
[3] The complete questionnaire for each year can be found in the CAHPS reports online.

- *did your doctor show respect for what you had to say?*
- *did you get an appointment with a specialist as soon as you needed?*
- *did your health plan's customer service give you the information or help you needed?*
- *was it easy to get the medical equipment you needed through your health plan?*

In addition to the individual questions, standardized **composite** measures are also calculated. CAHPS composite measures combine results from multiple related survey questions into a single measure. For example, the *How well doctors communicate* composite measure summarizes responses to four questions: How often doctors explained things, listened carefully, showed respect, and spent enough time with the member. CAHPS has four composite measures: *Getting needed care*; *Getting care quickly*; *How well doctors communicate*; and *Customer service.*[4]

Finally, OHA sometimes adds additional questions beyond the standardized CAHPS survey questions to help inform Oregon's specific health policy priorities. For example, the 2022 survey included extra questions related to delayed dental care and the COVID-19 pandemic.

How the data are collected

OHA has a contractor that collects survey responses. The survey sample is drawn from people who live in Oregon and whose main source of insurance coverage is Medicaid. To be included, people must also be currently enrolled in Medicaid at the time of the survey, and continuously enrolled for 6 months prior to the sample being drawn. Usually only one member per household is selected to receive the survey.[5] There are two versions of the survey: one for adults, and one for children under 18. (The CAHPS survey administered to children ask*s legal guardians* to report *on behalf of* the child being surveyed.)

To identify the survey sample
OHA uses Medicaid administrative data from the Medicaid Management Information System (MMIS) database.

Read the MMIS data profile.

People who are selected for the survey have the option to participate online, by mail, or by phone. Members receive the survey in either English or Spanish, depending on their preferred language.

Statewide, between 45,000 and 48,000 people have historically been contacted for the CAHPS survey each year. **Beginning in 2023, the annual sample size will double to about 92,000**. This will improve the reliability of CAHPS results, especially at the CCO level and for smaller demographic groups. Sample sizes are evenly distributed among health plans (that is, among each CCO or FFS). The overall response rate for CAHPS surveys is typically 15-25 percent.

About survey response rates
The response rates for CAHPS are comparable to other survey research projects, which in recent years have experienced an overall decline in response rates. Response rates are impacted by many factors, such as changing methods of communication (social media, in-app messages, and cell phone-only households), potential survey fatigue for some groups, and lower engagement overall. OHA is working to increase response rates by using larger sample sizes, refining survey invitations and other communication materials, and using more efficient collection methods. Along with increasing the number of responses, OHA is prioritizing representation. A lower response rate with more diverse and representative respondents is more valuable statistically than a very high response rate with more homogenous or alike respondents.

[4] Note: In CCO metrics reporting (such as the metrics dashboard) Getting care quickly is referred to as "Access to care" and Customer service is referred to "Satisfaction with care."
[5] An exception to this rule might occur if the surveyor is having a hard time meeting the desired sample size for an individual CCO; then more than one member per household might be selected.

Timing and frequency

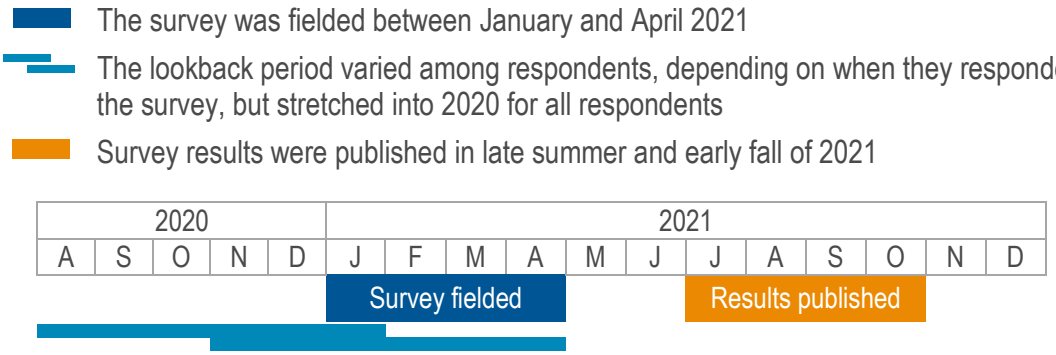
CAHPS surveys are fielded early each calendar year—usually from January through April. Respondents are asked about their experiences with health care **during the previous six months.**

Depending on when individuals respond during the survey period, the lookback period might stretch as far back as August of the previous year, or as late as November. See Figure 1 below for an illustrated example using the 2021 survey.

Survey results are published within a few months after the survey closes. CCO and state-level Banner Books are published online in the summer, and CAHPS measures that are part of the CCO metrics reporting program are usually published by early fall (learn more on page 2).

CAHPS results are readily available online back to 2013.

Figure 1. A timeline of the 2021 CAHPS survey



An important note about how CAHPS results are labeled

In OHA's CCO metrics reporting, CAHPS results are labeled by the year prior to the survey being fielded because the six-month "lookback period" for respondents stretches into the previous calendar year (as shown in Figure 1 above). CAHPS Banner Book reports, on the other hand, label results based on the year the survey was administered. For simplicity, **the remainder of this profile will refer to results by the year the survey was fielded** (that is, consistent with CAHPS Banner Book reporting).

REALD and SOGI

What are REALD and SOGI?

REALD and SOGI[6] are types of standardized demographic information. REALD stands for: **R**ace, **E**thnicity **a**nd **L**anguage, **D**isability. SOGI stands for: **S**exual **O**rientation and **G**ender **I**dentity.

Collecting and analyzing data aligned with REALD and SOGI standards helps us identify and address health disparities, and support data justice in communities that are most affected by health disparities. Learn more on OHA's website.

REALD and SOGI in the CAHPS survey

The CAHPS survey has asked the full suite of REALD demographic questions since the 2021 fielding of the survey. A partial list of questions had been included for three years prior to 2021.

[6] As of this publication, only draft SOGI data collection standards have been released.

Beginning with surveys fielded 2023, the CAHPS survey will include SOGI questions according to the current draft standards. Previous iterations of the survey have included some gender identity questions.

For some questions, particularly at the CCO level, small numbers of respondents mean the results aren't very reliable. OHA suppresses these results from public reporting. As described on page 3, the overall sample size will almost double beginning with the 2023 survey fielding. Therefore, more results should become publishable when stratified by REALD and SOGI group levels.

Things to remember when interpreting CAHPS data

Oversampling by race and ethnicity

To make sure the survey results do a good job of representing all people in Oregon, OHA oversamples the statewide survey by race and ethnicity. Oversampling means reaching out to a larger proportion of people in certain groups than there are in the population. Oversampling helps make survey results more reliable for groups with smaller representation in Oregon. For example, suppose XX percent of people in Oregon are Native Hawaiian and Pacific Islander. The surveyors will contact enough people who are Native Hawaiian and Pacific Islander so that enough people among the XX percent so that valid conclusions can be drawn for the population from their responses.

Data for members in the "oversample" are only included in the aggregated statewide results (and not the individual CCO results).

Changes over the years

There have been some important changes to the CAHPS survey—and the way the results are reported in the CCO metrics dashboard—in recent years:

Children with chronic conditions

To understand the experience of care for children with chronic conditions, OHA has always stratified CAHPS results for this population. However, the methodology used for surveying children with- and without chronic conditions changed in 2021, and **results for children from 2021[7] onward cannot be directly compared to earlier years.**

Prior to fielding the 2021 survey, OHA administered separate surveys to two mutually exclusive samples of children: Children **with-** and **without chronic conditions**. The children "with chronic conditions"[8] received an extra set of questions relevant to the specific needs of that population—such as access to specialized services and coordination of care. Children "without chronic conditions" received the CAHPS survey without these extra questions. Results from these two samples were **combined** in the CCO metrics dashboard for child-level CAHPS measures. In other words, children with chronic conditions were previously *overrepresented* in the child-level CAHPS results presented in the dashboard.

[7] Remember results from the 2021 survey are labeled as "2020" in CCO metrics reporting. See the box on page 4 for more information.

[8] Children who are likely to have chronic conditions are identified using Medicaid administrative data (for example through diagnosis and procedure codes).

Beginning in 2021, OHA continues to field the chronic questionnaire to a sample of children *with* chronic conditions in a comparable manner as before. However, instead of specifically surveying children *without* chronic conditions, a random sample of children—which may include some children with chronic conditions—receives the standard survey. That means the general children's sample now includes some children with chronic conditions and is more representative of the overall population. It also means that results reported through the CCO metrics reporting program for **"children" overall from 2021 onward should not be directly compared to earlier years.**

Race and ethnicity oversample

As described in the previous section, OHA oversamples the CAHPS survey by race and ethnicity at the statewide level. Prior to 2022, OHA excluded the oversample from CAHPS results presented in the CCO metrics dashboard. Beginning in 2022, the oversample is included. **That means statewide results in the CCO metrics dashboard from 2022 onward should not be directly compared to earlier years.**

In the CAHPS Banner Book reports published on the CAHPS webpage, however, the oversample results have always been included in statewide results. As such, statewide results presented in the Banner Book will differ from results presented in the CCO metrics dashboard prior to 2021.

Finally, the oversample methodology changed with the survey fielded in 2022 to include oversampling of Native Hawaiian and Pacific Islanders.

Composite measures

As described on page 3, CAHPS composite measures combine results from related survey questions into a single measure. **The calculation used by OHA to calculate composite measures has changed, so results from 2021 onward should not be directly compared to earlier years**. The methodology now used aligns with National Committee on Quality Assurance.

Statistical significance

As described on page 2, the reports on the CAHPS webpage use a * symbol when the change was statistically significant at the 95 percent confidence level. That means that we are very confident the difference was not due to chance.

Requesting data

Complete deidentified individual-level survey results can be requested by emailing Metrics.Questions@oha.oregon.gov or submitting a general data request form (available on the Health Analytics webpage).

CAHPS survey data in action

Evaluating Oregon's unique Medicaid program

CAHPS survey data were a key part of Oregon's 2017-2022 Medicaid waiver evaluation. The evaluation focused on areas the waiver was designed to address, including the use of health-related services, or HRS. (Learn more about waivers and HRS in the side bar on the next page.)

Specifically, the evaluation included four CAHPS measures to help assess how people in Oregon experienced HRS, as well as the impact of HRS on quality and costs:

- ***Member Rating of Health Status***
  Percentage of members who rated their overall health as good, very good, or excellent
- ***Getting Care Quickly*** (composite)
  Percentage of members who said they usually or always got 1) care for illness or injury as soon as needed, and 2) non-urgent/routine care appointments as soon as needed within the last six months
- ***Getting Needed Care*** (composite)
  Percentage of members who said it was usually or always easy to get 1) needed care, tests, or treatments, and 2) appointments with specialists as soon as needed within the last six months
- ***Rating of All Health Care***
  Percentage of members who rated all of their health care in the last six months an 8, 9, or 10 (on a scale of 0 to 10)

The evaluators compared results *during* waiver implementation (2019) against a baseline (2016). Results were mixed: *Ratings of All Health Care*, *Getting Care Quickly* and *Getting Needed Care* increased, but **only the increase in *Ratings of All Health Care was* statistically significant**. Finally, *Member Rating of Health Status* decreased slightly, although this change was not statistically significant.

What's a waiver?

Medicaid is a federal program that is administered by each state. The federal government helps pay for the program and sets standards for how it works. However, a state can ask for **flexibility** to experiment with different approaches to administering its Medicaid program by applying for an 1115 Medicaid demonstration waiver.

Oregon has had such a waiver for its Medicaid program (which is called the Oregon Health Plan) since 1994. Each waiver is typically approved for a period of five years and **must be formally evaluated to see if the state's methods are working.**

Health-Related Services (HRS)

Through Oregon's Medicaid waiver, provider networks have the option to address patients' health needs outside of traditional health services. For example, HRS might support access to things like housing, transportation, or health food.

Quick Facts

Name	Consumer Assessment of Healthcare Providers and Systems Survey
Acronym	CAHPS Survey
Summary	A survey of people in Oregon who have their main source of insurance coverage through Medicaid. Covers topics that are important to consumers and that consumers are best qualified to assess.
Data type	Survey
Populations	Medicaid adults and children
Frequency	Annual
Available since	2013
Required?	Oregon is required to implement the child-level CAHPS survey to comply with federal reporting requirements. Although the adult-level survey is not required by any regulation, it is important for quality improvement efforts.
Regular reporting	Statewide and CCO-level (including FFS) results are published on the CAHPS webpage. Many results are also reported in the CCO Performance Metrics Dashboard.
Website	https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CAHPS.aspx
Primary/Lead staff	Jen Davis
Data requests	Email Metrics.Questions@dhsoha.state.or.us or submit a general data request form (available on the Health Analytics webpage)
Security level[9]	Deidentified data sets: Level 1 "Published" (low-sensitive information) Raw data files: Level 3 "Restricted" (sensitive information)
Data dictionary?	Yes – available within in the reports published on the CAHPS webpage
REALD	Fully implemented since 2021
SOGI	2022 results will include SOGI questions according to the current draft standards. Previous years included some gender identity questions.
Suggested citation	Oregon Health Authority, Oregon Consumer Assessment of Healthcare Providers and System (CAHPS) Survey [YEAR]

[9] Learn more: https://www.oregon.gov/das/policies/107-004-050.pdf

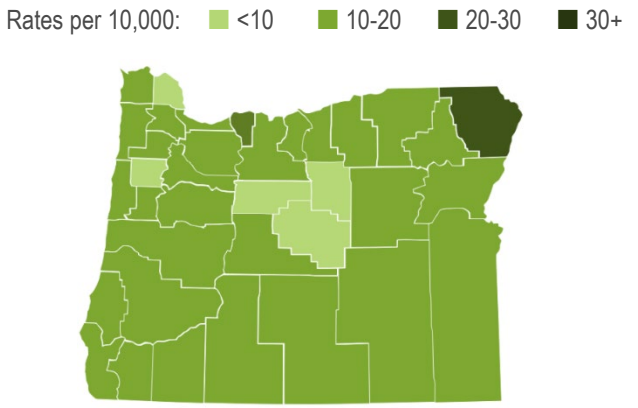
Health Care Workforce Reporting Program Data

HPA Data Profile

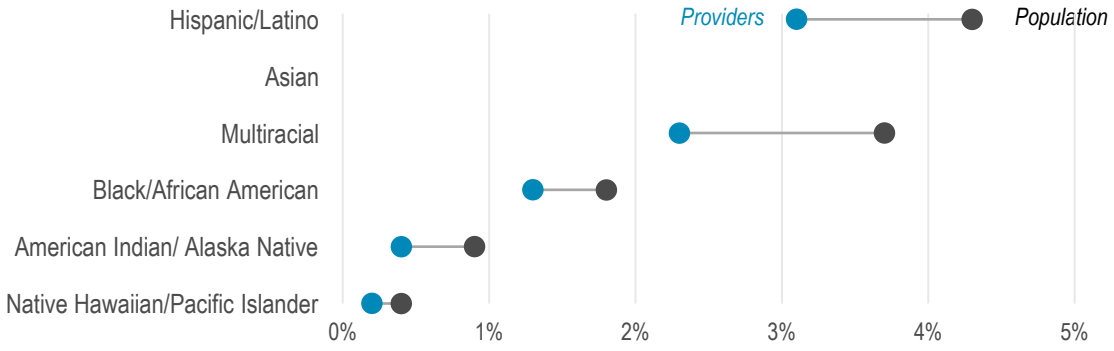
The Health Care Workforce Reporting Program (HWRP) collects survey data from health care professionals licensed in Oregon every time they renew their licenses. The survey asks questions about providers' demographics, the care they provide, their plans for the future, and more. As of 2023, there are over 35 health care occupations licensed by 17 health licensing boards that are required to participate in the survey. Policymakers and researchers use this information to understand and improve the health care workforce so that people in Oregon can get the care they need.

Health Care Workforce Reporting Program data can tell us things like…

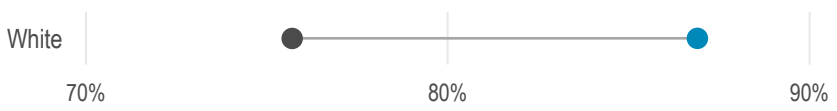
Some counties in Central Oregon have fewer primary care professionals per resident than other areas of the state.



Compared with the **general population in Oregon**, there are fewer **behavioral health providers** who identify as people of color.



Behavioral health providers who identify as white, on the other hand, are overrepresented.



Regular reporting

The Health Care Workforce Reporting Program publishes several regular reports:

Data are updated annually in an interactive dashboard

Oregon's Licensed Health Care Workforce is an interactive (Tableau) dashboard that allows users to explore data for each of the health care professions that take the workforce survey. Key measures include:

- The total number of health care professionals licensed in Oregon
- The number of professionals actively practicing in Oregon
- The estimated "full-time equivalency" of professionals providing direct patient care
- Trends over time
- Geographic (county) distribution
- Provider demographics
- Practice characteristics, such as how the workforce spends their time, top practice specialties, and more

The *Licensed Health Care Workforce* dashboard is updated annually with data that were collected through the previous calendar year.

Two biennial reports provide analysis and key insights

Every January of odd-numbered years, the Health Care Workforce Reporting Program publishes:

1. ***Oregon's Licensed Health Care Workforce Supply***, which includes analysis, key insights, and deeper dives into the data that are published in the annual dashboard. *Oregon's Licensed Health Care Workforce Supply* is an important source of information for the *Health Care Workforce Needs Assessment*, which is a biennial report to the Legislature.

   Read the most recent Workforce Supply Report.

2. ***Diversity of Oregon's Health Care Workforce***, which explores the race, ethnicity, gender, and language makeup of licensed health care professionals, and examines whether the workforce is representative of communities in Oregon. This report is a requirement of the Health Care Workforce Committee.[1]

   Read the most recent Diversity Report.

While the dashboard shows only data about individual occupations (that is, license types), the biennial reports also analyze supply and diversity of the broader workforce categories such as primary care or maternal health. These categories are based on providers' self-reported specialty areas of practice. Learn more on page 7 in the section called *Broader workforce categories.*

The dashboard and reports, as well as other historical reports back to 2011, can be accessed on the Health Care Workforce Reporting Program webpage.

[1] The Health Care Workforce Committee is a subcommittee of the Oregon Health Policy Board. It coordinates the state's efforts to achieve a dynamic health care workforce that helps all people in Oregon reach their full health potential.

About the data

This section includes some helpful information about where Health Care Workforce Reporting Program data come from, what types of information are available, and important things to keep in mind when using these data.

How the data are collected

The Health Care Workforce Reporting Program collaborates with 17 health professional licensing boards to collect data from providers through an online survey when they renew their licenses every 1-2 years. Providers are **required** to complete the online survey as part of the renewal process. Learn more about licensing boards in the box below.

> **Licensing Boards 101**
>
> To practice in Oregon, health care providers must be licensed by a state health licensing board. There are 17 boards focusing on different areas of the workforce that are part of the program.
>
> Providers must get a license to begin practicing in Oregon, and they must **renew** their license every 1-2 years (different boards have different timelines). HWRP Survey data are collected each time a provider **renews** their license.
>
> Read the full list of participating boards, licensed professions, and their renewal timelines.

Every year, each licensing board submits a file containing data about all of their licensed providers to the Health Care Workforce Reporting Program. The survey data that were collected during providers' license renewals are then merged with these files to create an annual database.

Data elements

While the surveys differ slightly between license types, they generally include provider demographics, education, languages spoken, practice locations, number of hours worked at each location, future practice plans, and information about specialty area of practice. For selected occupations[2] the survey also includes whether the provider sees Medicaid clients.

Who is represented in the survey?

- The Health Care Workforce Reporting Program collects data from **all** renewing licensees, making it a "full count" survey (as opposed to a sample survey).
- Because the survey is taken when providers **renew** their license, new providers who are being licensed for the first time are not included in the survey. However, new providers are **counted** in the overall workforce supply estimates because they are included in the boards' file about **all** active licensees – they just don't have survey data.
- Survey data are collected from 17 boards, as required by Oregon law. In 2022, these 17 boards covered about 35 license types. While some licensing boards administer only one license type, many administer two or three (for example, the Board of Pharmacy administers licenses for pharmacists and certified pharmacy assistants). Oregon's nursing

[2] Medical professions, naturopathic physicians, chiropractic physicians, dentists, nurse practitioners, counselors and therapists, social workers, and psychologists

workforce includes six distinct occupations, such as registered nurses, certified nursing assistants, nurse practitioners, and more. Boards sometimes add new license types, so the exact occupations covered by these 17 boards may change over time.

Timing and frequency

Different boards renew licenses (and thus collect data) on different timelines. Some renew every year (annually) while others renew every two years (biennially).

In about January of each year, the Health Care Workforce Reporting Program creates a new annual database. For boards that renew annually, the annual database includes data collected in the prior year. For boards that renew biennially, the annual database contains survey data collected in the prior two years.

This means that the **2022 database** includes the **number of all providers licensed as of January 2022** and it includes **survey data collected during all license renewals that occurred during the previous 1-2 years** (depending on the board). Similarly, the 2023 database includes the number of all providers licensed as of January 2023 and survey data collected during the previous 1-2 years. **Learn more about time lag, comparing trends over time, and how license renewal schedules can impact the data on page 5.**

Comparable annual data are available as far back as 2016 for some occupations; others are available only back to 2018 or 2019. Learn more in the box below.

> **Health Care Workforce Program History**
>
> The Health Care Workforce Reporting Program was established in 2009 by House Bill 2009 and required data collection for just seven licensing boards, covering 17 occupations. The first data were published in 2011.
>
> In 2015, the Oregon Legislature added ten more licensing boards to the program with Senate Bill 230 – more than doubling the total number of occupations included in the data.
>
> With these major changes, the Health Care Workforce Reporting Program took the opportunity to make improvements to data collection methods. For that reason, **most data reported before 2016 are not comparable to later years.**

READLD and SOGI

What are READLD and SOGI?

READLD and SOGI[3] are types of standardized demographic information. READLD stands for: **R**ace, **E**thnicity and **L**anguage, **D**isability. SOGI stands for: **S**exual **O**rientation and **G**ender **I**dentity.

Collecting data with READLD and SOGI standards helps us identify and address health disparities, and support data justice in communities that are most affected by health disparities. Learn more on OHA's website.

[3] As of this publication, only draft SOGI data collection standards have been released

REALD and SOGI in Health Care Workforce Reporting Program data

REALD data collection has been implemented by the Health Care Workforce Reporting Program since 2021 with two exceptions:

- One of the disability questions is not included: *Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?*
- All disability questions are excluded from the four license types administered by the Oregon Medical Board.

The reason for these omissions is concern among licensing boards about unintended harm of these questions if shared with licensing boards or others outside OHA. It should also be noted that the Oregon Medical Board is the only board that administers their own survey (in close collaboration with the Health Care Workforce Reporting Program).

Things to remember when using Health Care Workforce Reporting Program data

Who is and is not included

Only health care providers that are required to report by Oregon law are included in the survey. Additional licensed types (for example, some allied health professionals) and non-licensed health care professionals – such as Traditional Health Care Workers and Health Care Interpreters – are not included.

Not all licensees are actively working in Oregon

The number of providers licensed in the state is reported directly by each of the licensing boards in January of each year. But it's important to remember that **not all providers who hold a license are actively working in their fields in Oregon.** Furthermore, not all providers who *are* actively are working work full time. For that reason, the Health Care Workforce Reporting Program produces two estimates:

1. The number of providers who are **actively practicing** in Oregon; and
2. The "full-time equivalency" of practicing professionals in direct patient care.

These two measures provide a more nuanced picture of the actual supply of health care professionals in Oregon. The interactive Tableau dashboard, *Oregon's Licensed Health Care Workforce*, allows users to toggle between each of the measures.

New licensees don't take the survey

The workforce survey is completed only by providers who are **renewing** their licenses. Providers who are being licensed for the first time do not take the survey. Supply estimates account for these licenses, however the annual survey results such as demographics and practice characteristics do not reflect providers who are new to the field.

Time lag

Because survey data are only collected at renewal, the data reported during a calendar year may be up to two years old. For example, the 2023 database includes the **number** of all licensees that held a current license in January 2023, but it contains **survey data** from those providers' most recent renewal – which could be up to two years prior. Learn more in the Timing and Frequency section on the previous page.

Comparing trends over time

As described in the box on page 4, data from 2016 onward should not be compared with earlier years. In addition to that, **questions are sometimes modified or added** to make sure the survey provides relevant information for policymakers and researchers. For example, when telehealth became an important policy topic during the COVID-19 pandemic, questions about the practice were added to the survey. Users who want to do their own analysis of raw workforce data should consult with program staff to understand nuances that may impact trends over time.

License renewal schedules can create noise in the data for some occupations

Different boards renew licenses (and thus collect data) on different schedules. There are two components:

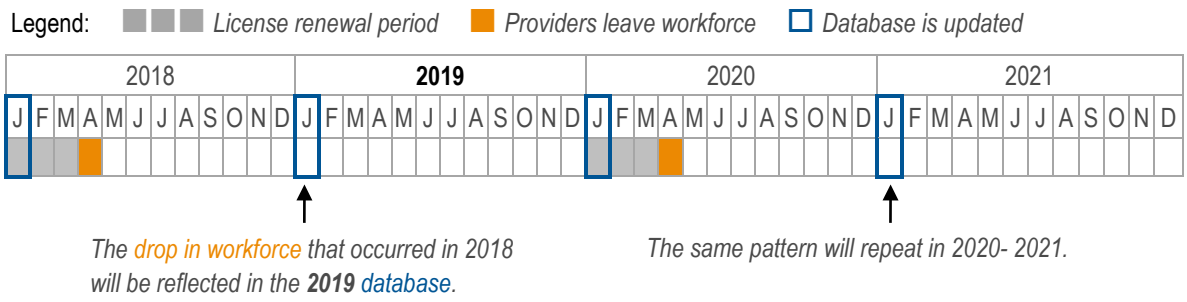
1) The renewal **cycle:** *how often* licensees are required to renew their license (either annually or biennially); and
2) The renewal **period:** *when during the year* licensees can renew (either ongoing, or during a specific window).

Occupations that renew on a biennial cycle[4] and during a specific period will often show a cyclical drop in the number of licensees during years when no renewals take place. That's because most licensees who decide to **leave** the workforce will simply forgo renewing their license during the renewal period. As a result, there will be a **drop** in the total number of licenses at timepoints following the renewal period.

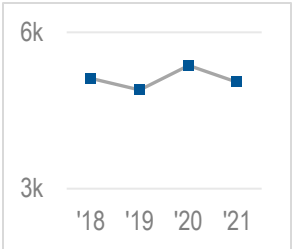
Figure 2. on the next page illustrates an example with the Physical Therapy Licensing Board, which renews licenses on a biennial cycle from January to March.

Figure 2. The example below shows how a biennial renewal cycle impacts trends over time.

The total count of providers dropped slightly in spring 2018 ■ after providers who decided to leave the workforce didn't renew their licenses during the renewal period ■■■. That drop will be reflected when data are collected for the database ☐ the following year (2019). The same pattern will repeat every odd year, following the license renewal period.



As a result, the number of licensed physical therapists appears to fall in odd years, as shown in the line chart at right:



[4] pharmacy, occupational therapy, physical therapy, and speech-language pathology and audiology occupations

Specialty areas of practice

As described earlier, the survey collects data about providers' *specialty* areas of practice. **Specialty areas of practice are loosely defined and subjective.** Two providers may do the exact same thing, and one judges (and reports) that YES they provide primary care; while the other judges (and reports) that NO they don't really provide primary care. Therefore, this element of the data has more uncertainty – or is a rougher estimate – than other elements such as practice location or education. Furthermore, the specialty areas included as options in the survey varies by board.

Broad workforce categories

As described on page 2, the Health Care Workforce Reporting Program sometimes calculates and reports estimates for broad workforce categories such as primary care, pediatrics, oral health, behavioral health, or maternal health care. These categories typically include multiple occupations (that is, license types) as well as multiple self-reported specialty areas. For example, Table 1. below shows how "behavioral health professional" was defined in the 2021 Workforce Supply Report. **There are many different ways these broad workforce categories could be defined.** Therefore, estimates from the Health Care Workforce Reporting Program may differ from other sources.

Table 1. Licenses and specialty areas of practice included in the *behavioral health professionals* category (2021).

Occupations (license types)	Self-reported specialty areas of practice
– All psychologists – All counselors and therapists – All licensed clinical social workers and clinical social work associates	– physicians and physician assistants who specialize in psychiatry (addiction, neurology, child, adolescent, geriatric, or forensic) or psychoanalysis – nurse practitioners who specialize in psychiatry or mental health – naturopathic physicians who specialize in mental health

Impacts of the COVID-19 pandemic

In response to the COVID-19 emergency declaration, many boards adopted permanent or temporary rules relaxing certain requirements in an effort to expand workforce capacity. For example, some boards allowed providers who were licensed in another state to practice in Oregon during an emergency; or automatically extended all licenses that were set to expire. Rules like these will impact Health Care Workforce data in subtle and varied ways. At the same time, the pandemic has had many impacts on both the supply of, and demand for, Oregon's health care workforce.

Requesting data

The Health Care Workforce Reporting Program makes de-identified public-use health care workforce datasets available for a variety of purposes including research, program evaluation, or other activities that support OHA's mission. Instructions to request data are on the Health Care Workforce Reporting Program webpage under "Data Requests."

Health Care Workforce Reporting Program data in action

HWRP data are a vital source of information for many policies and programs. A few examples include:

Allocating resources to underserved communities

State and national policymakers have established many programs to improve access to health care in underserved areas. Eligibility for these programs usually depends on special "health care needs designations" which are based on specific, measurable criteria – **including population-to-provider ratios that are calculated using Health Care Workforce Reporting Program data.**

Based on these designations, clinics and providers can apply for enhanced resources. There are four types of designations that determine eligibility for almost a dozen different programs. For example, physicians who provide services in designated *Health Professional Shortage Areas* (HPSAs) can apply for special bonus payments. Such bonus payments serve as an incentive to bring more providers to underserved parts of Oregon.

Health care need designations bring in more than $50 million in federal dollars to Oregon communities, clinics and providers to help address the health care workforce shortages experienced by people in Oregon.

Providing transparency to the public during the COVID-19 pandemic

During the COVID-19 pandemic, OHA created a dashboard that allowed the public to explore the percentage of providers vaccinated against COVID-19. Data were shown by occupation and race/ethnicity as well as by county. To create this dataset, analysts combined HWRP data with records from Oregon's ALERT Immunization Information System.

Quick Facts

Name	Health Care Workforce Reporting Program data
Acronym	HWRP data
Summary	A survey of all renewing health care licensees. Information is self-reported by licensees on demographics and practice details, such as hours worked each week, specialties, and future plans. The program also annually reports the total number of licensees and several supply estimates.
Data type	Full-count survey
Populations	Licensed health care providers
Frequency	Annual
Available since	2010, however due to method changes beginning in 2016, data from 2010-2015 are not comparable to later years
Required?	Yes: House Bill 2009 (2009), Senate Bill 230 (2015), and Oregon Revised Statute 676.410
Regular reporting	*Oregon's Licensed Health Care Workforce* (interactive dashboard, updated annually) and two biennial reports: *Oregon's Licensed Health Care Workforce Supply*; and *Diversity of Oregon's Health Care Workforce*
Website	www.oregon.gov/oha/HPA/ANALYTICS/Pages/Health-Care-Workforce-Reporting.aspx
Lead staff	Andy Davis
Internal requests	email Andy.Davis@dhsoha.state.or.us
External requests	Complete the Health Care Workforce Program's data request process. Instructions and forms available on the Health Care Workforce Reporting Program webpage under "Data Requests."
General contact	wkfc.admin@odhsoha.oregon.gov
Security level[5]	Level 3 (restricted)
Data dictionary?	Yes: Available on the Health Care Workforce Reporting Program webpage under "Data Requests"
REALD	REALD data collection has been implemented in health care workforce survey since 2021. See page 4 for details.
SOGI	Surveys include 'Male,' 'Female,' 'Prefer to self-describe' (with open field), and the option to decline to answer
Suggested citation	Oregon Health Authority, Health Care Workforce Reporting Program

[5] Learn more: https://www.oregon.gov/das/policies/107-004-050.pdf

Mental Health Statistics Improvement Program (MHSIP) Surveys

HPA Data Profile

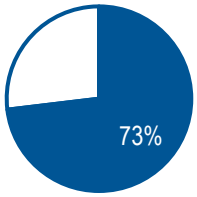
Oregon administers surveys that ask people about mental health care services they receive through the state's Medicaid program. The surveys ask adults, youth, and parents or guardians of children about their experiences across several domains including access to services, quality of care, and treatment outcomes. These questions are standardized by the Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by states and territories nationwide.

A few examples of the things MHSIP survey data can tell us include:

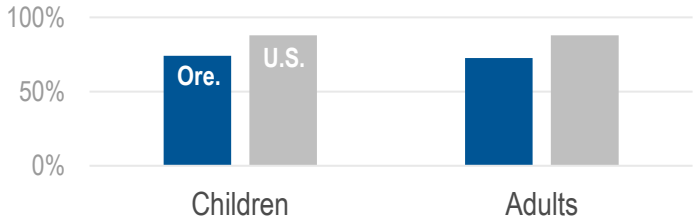
The percentage of adults who positively rated their mental health care in 2020, by domain of care.

In 2020, more than 1 in 3 caregivers of youth (ages 0-17) reported that their child had been **prescribed psychotropic medications**…

…and when asked if they felt the **medication had helped** their child, 73% felt that it had.



Both children and adults in Oregon are less likely to report positively about **access to mental health care** *compared with the US average*.



National comparisons to Oregon's MHSIP survey results can be found in federal reporting.

Learn more on pages 4-5.

The 2020 MHSIP survey found that most people preferred seeing a mental health provider in person, but also acknowledged the **convenience of seeing a provider virtually**.
These insights were presented at the 2021 Oregon Public Health Association conference.

Regular reporting

MHSIP survey results are published annually (typically in January) on OHA's MHSIP webpage. Comprehensive results are presented in two separate reports for 1) adults and 2) youth. The reports present statewide results, five-year trends, and brief analyses for each survey question; as well as summary results stratified by each coordinated care organization (CCO) and certified community behavioral health clinic (CCBHC) in the state.

Additional brief reports are published for each CCO. These reports compare a CCO's scores to all other CCOs combined as well as the CCO's five-year trends for different domains of care.

About the data

This section provides an overview of the MHSIP surveys data and how the data are collected. Detailed methodology and definitions can be found in the statewide reports on the program webpage.

Overview of data elements

The MHSIP surveys include dozens of questions designed to measure Medicaid clients' experiences with the mental health care services they received under both residential and outpatient settings. The standardized MHSIP questions ask people how strongly they agree (or disagree) with statements such as:

"As a direct result of services received from my provider… "
- *I do better in social situations*
- *My symptoms are not bothering me as much*
- *I am better able to handle things when they go wrong*

"Based on my experience with my most recent mental health provider… "
- *Services were available at times that were good for me*
- *Staff were sensitive to my cultural background*
- *Staff here believed my health can improve and I can recover*

In addition to the standardized MHSIP questions, OHA includes additional questions that are important to Oregon's specific health care goals. A few examples include questions about expectations versus outcomes of treatment; whether people had primary care providers; trauma screening; and whether mental health providers offered help finding housing or employment.

How the data are collected

OHA has a contractor that collects survey responses. People who are selected for the survey receive the questionnaire in either English or Spanish, depending on their preferred language, and have the option to participate by mail, phone, or online.

Timing and frequency

MHSIP surveys are fielded annually, typically from spring through summer. People are asked to rate the care they received since January 1 of the previous calendar year.

Who is represented in the survey

The surveys are sent to a sample of people who live in Oregon and received mental health service(s) during the previous year that were paid for by Medicaid. Specifically, there are four different populations surveyed:

1. **Adults** (18+) who received **outpatient** mental health services
2. **Adults** (18+) who received **residential** treatment services
3. *Parents or guardians* of **youth ages 0-17** who received any mental health services
4. **Youth ages 14-17** who received any mental health services

To identify the survey sample
OHA uses Medicaid administrative data from the Medicaid Management Information System (MMIS) database.

Read the MMIS data profile.

Sample sizes and response rate

The number of people who are randomly selected to receive the survey (sample size) varies by the four populations listed above, as does the percentage of people who respond to the survey (response rate). See the table below:

Population	**Sample size** *Approximate in 2021*	**Response rate** *Range between 2017 and 2021*
Adults who received outpatient care	13,000	17% - 24%
Adults who received residential care	Less than 2,000*	15% - 20%
Guardians of youth ages 0-17	13,000	17% - 23%
Youth ages 14-17	4,500	16% - 23%

Note: The residential adult sample included **all adults who were identified as receiving at least one day of treatment in a residential or adult foster care facility.*

OHA tries to include at least 500 people from each CCO in each sample, and at least 300 adults from each CCBHC. For CCOs or CCBHCs that did not serve enough people, 100 percent of their member populations are included in the sample.

REALD and SOGI

What are REALD and SOGI?

REALD and SOGI[1] are types of standardized demographic information. REALD stands for: **R**ace, **E**thnicity **a**nd **L**anguage, **D**isability. SOGI stands for: **S**exual **O**rientation and **G**ender **I**dentity.

Collecting and analyzing data aligned with REALD and SOGI standards helps us identify and address health disparities, and support data justice in communities that are most affected by health disparities. Learn more on OHA's website.

REALD and SOGI in MHSIP surveys

Oregon's MHSIP surveys have always included race and ethnicity questions. Language and disability questions were added in 2023 to make the surveys fully compliant with REALD data collection standards. SOGI questions were also added in 2023 (results for which will be published early 2024).

[1] As of this publication, only draft SOGI data collection standards have been released

However, because MHSIP has relatively small sample sizes, results stratified by REALD and SOGI categories often aren't reliable. OHA suppresses these results from public reporting.

Things to remember when interpreting MHSIP survey data

Positive response rates

All the standardized MHSIP survey questions are asked on a five-point scale from "strongly agree" to "strongly disagree." Results are presented as a single number which is the percentage of survey respondents who chose "agree" or "strongly agree" for that question.

Statistical significance

MHSIP survey results also indicate when any change was statistically significant at the 95 percent confidence level. That means that we are very confident the difference was not due to chance.

Weighting and trend over time

Beginning in 2018 MHSIP results have been ***weighted***, which means calculations are applied to the survey response results to make them more representative of Oregon's actual population.

MHSIP reports analyze and display survey results in many ways, including five-year trends. Between 2018 and 2022, trends are shown using ***unweighted* results**, since there weren't yet five years of weighted data available. However, *weighted* results are used for reporting of single years. As a result, the numbers displayed in trend charts may differ from the numbers in single-year reporting. The differences are usually very small. Beginning in 2023, there will be five years of weighted results available, so all charts and analysis (including trend reporting) will use the same weighted results.

Oversampling by race and ethnicity

To make sure the MHSIP survey results do a good job representing all Medicaid members in Oregon who receive mental health, OHA oversamples by race, ethnicity, and language. Oversampling means reaching out to a larger proportion of people in certain groups. Oversampling helps make survey results more reliable for groups with smaller representation in Oregon. For example, suppose XX percent of people in Oregon are Native Hawaiian and Pacific Islander. The surveyors will contact enough people who are Native Hawaiian and Pacific Islander so that enough people among the XX percent so that valid conclusions can be drawn for the population from their responses.

Requesting data

Deidentified individual-level survey results can be requested by emailing Metrics.Questions@dhsoha.state.or.us or by submitting a general data request form (available on the Health Analytics webpage).

MHSIP survey data in action

Oregon is one of eight states to receive special block grants from the federal government to help pay for community mental health services. These funds fill identified gaps in Oregon's mental health care system by paying for services that otherwise aren't covered by Medicaid or other commercial insurers (the funds are also used to provide services to people who don't have any insurance coverage). A few examples of programs that these funds help support include:

- Comprehensive treatment and support services for people diagnosed with severe and persistent mental illness (SPMI)
- Special services and treatment for children who are experiencing their first episode of psychosis
- Services for priority populations, such as people who have substance use disorders and are pregnant or have young children

To be eligible for these grants, OHA must annually report MHSIP results to the federal block grant program.

Quick Facts

Name	Mental Health Statistics Improvement Program Surveys
Acronym	MHSIP Surveys
Summary	Surveys that ask adults and youth about mental health care services they receive through Oregon's Medicaid program
Data type	Survey
Populations	Adults and children who received mental health services in the previous year that were paid by Medicaid
Frequency	Annual
Available since	2005 (adult surveys) and 2011 (youth surveys)
Required?	Yes: OHA is required to report data elements annually to the federal government in support of Oregon's Mental Health Block Grant (MHBG)
Regular reporting	Annual summary results and CCO reports are published on the MHSIP webpage
Website	https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Mental-Health-Statistics-Improvement-Program-Survey.aspx
Primary staff	Rebekah Gould
Internal requests	Email Rebekah.Gould@oha.oregon.gov
External requests	Email Metrics.Questions@dhsoha.state.or.us or submit a general data request form (available on the Health Analytics webpage)
Security level[2]	Deidentified data sets: Level 1 "Published" (low-sensitive information) Raw data files: Level 3 "Restricted" (sensitive information)
Data dictionary?	Yes: Available in annual statewide reports online and by request from program
REALD	Yes: Race and ethnicity since 2019: Language and Disability since 2023
SOGI	Yes: Since 2023
Suggested citation	Oregon Health Authority: Mental Health Statistics Improvement Program Survey [Year]

[2] Learn more: https://www.oregon.gov/das/policies/107-004-050.pdf

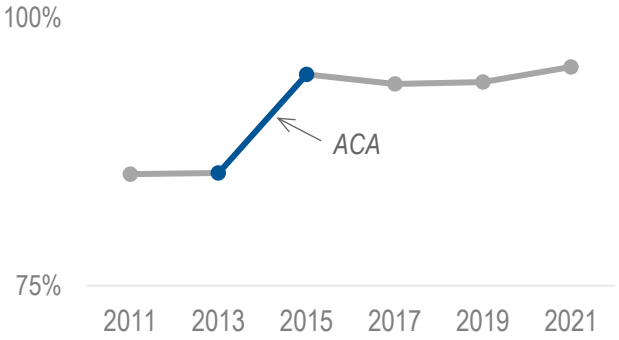
Oregon Health Insurance Survey

HPA Data Profile

The Oregon Health Insurance Survey ("OHIS") is a survey of people in Oregon. It asks questions that help us understand how well the health care system is (or isn't) working for people – from how many people have health insurance, to how much they pay in medical bills, to their ability to get care when they need it. The survey happens every two years.

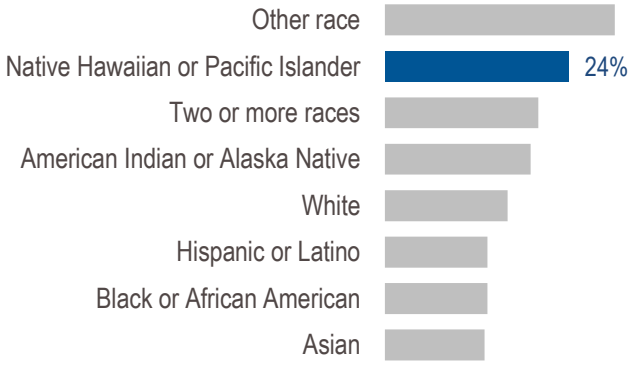
A few examples of the things OHIS can tell us about people in Oregon include:

The percentage of people with health insurance increased dramatically when the Affordable Care Act took effect in 2014.



More than 1 in 4 people who didn't have health insurance in 2021 were eligible for free coverage through the Oregon Health Plan (Medicaid).

Native Hawaiian or Pacific Islanders were more likely to report delaying care due to medical cost in 2019.



Regular reporting

OHIS data are published in several interactive dashboards

1. The **Insurance Coverage** dashboard shows data about how many people have health insurance, what types of insurance they have (for example Medicaid, Medicare, or commercial), and more. Data go back to 2011.

2. The **Uninsured** dashboard shows data about people who said they didn't have health insurance. It includes data about reasons why people were uninsured, and whether they could have received coverage through Medicaid or the Marketplace. Data go back to 2011.

3. *Coming very soon!* A **Cost and Affordability** dashboard will show data related to how much people said they spent on health care, and the impact that spending had on their financial well-being. It will also show data about whether people delayed different types of care because of cost. Data go back to 2017.

4. *Coming soon!* Two smaller dashboards focused on **access** and **utilization** will show data about what types of care people used, whether they had an easy or hard time getting the type of care they needed, and reasons why people delayed care. Data go back to 2017.

All the dashboards can be filtered by different demographic variables, like race, ethnicity, age, income, employment status, and geographic region. You can also make requests for data not shown in the dashboards. See *Requesting OHIS data* on page to learn more.

About the data

This section includes some helpful information about how OHIS is collected, and important things to remember when you are interpreting the data. You can find more information, like detailed methodology, the complete questionnaire, and a data dictionary, on the OHIS website.

How the data are collected

Timing and frequency

The survey happens every two years. It was conducted in **odd-numbered** years from 2011 to 2023. Starting in 2024, it will be conducted in **even-numbered** years. This means that the survey will be done in both 2023 *and* 2024.

OHA has a contractor that gathers survey responses, usually starting around January, and OHA gets the data in early fall. Later that winter (usually January or February of the next calendar year) OHA publishes the data in online dashboards that allow users to explore the data.

Who is represented in the survey

- OHIS is a household survey, meaning that each respondent answers questions for everyone who lives in their household.
- The survey sample is created to represent all people living in Oregon, except people who live in group quarters or institutions like nursing homes, dormitories, prisons, or jails.
- The survey questions are asked in English or Spanish.

- OHIS does not ask about citizenship. That means the sample may include non-citizens. It does ask where the respondent was born, and how long they have lived in Oregon.

Sample size

OHIS collects information from at least 8,000 households (this is called the "sample size"). The sample size is set so that OHIS results can be generalized to broader populations in Oregon.

Oversampling

To make sure the survey results do a good job representing all people in Oregon, we *oversample* by geographic region and by race and ethnicity. Oversampling means reaching out to a larger proportion of people in certain groups than there are in the state. Oversampling helps make survey results more reliable for groups with smaller representation in Oregon. For example, suppose six percent of people in Oregon are Asian. The surveyors will make sure that *more* than six percent of people who respond to the survey are Asian to increase survey reliability for that group.

Changes to the survey over the years

Questions have been modified over the years.

- In 2017, the survey was expanded to include many new questions about cost, affordability, access, and utilization.
- For that reason, some data points only have historical data back to 2017 instead of all the way back to 2011 (when OHIS began).

The **way people are contacted** for the survey has shifted over the years:

- The first three years (2011, 2013, and 2015) the survey was done by phone (landline), personalized web link, and paper mail.
- Since 2017, the survey has been done just by phone (both cell and landlines). People tend to give more accurate responses when the interview is conversational because the respondent and interviewer can ask clarifying questions.

REALD and SOGI

What are REALD and SOGI?

REALD and SOGI are types of standardized demographic information. REALD stands for: **R**ace, **E**thnicity and **L**anguage, **D**isability. SOGI stands for: **S**exual **O**rientation and **G**ender **I**dentity.

Collecting data with REALD and SOGI[1] standards helps us identify and address health disparities, and support data justice in communities that are most affected by health disparities. Learn more on OHA's website.

Beginning in 2023, OHIS will meet all REALD standards

OHIS has asked basic questions about race and ethnicity since 2011 and added more detailed questions in 2017 and 2021. The survey asked some questions about disability from 2011-2015,

[1] As of this publication, only draft SOGI data collection standards have been released

but the number of questions was reduced between 2017-2021. Beginning in 2023, OHIS will meet all REALD standards.

OHIS has used a version of SOGI questions since 2017 and will revise the questions to meet OHA standards when they become available.[1]

Things to remember when interpreting OHIS data

Like all surveys, OHIS produces **estimates.** Estimates will always have some uncertainty, but we set *sample sizes* and use *oversampling* to make the estimates more reliable (learn more on page 3.)

Statistical significance

The *Insurance Coverage* dashboard shows data over time and uses a * symbol when the change was statistically significant. That means that we are very confident the change was not due to chance.

"Interpret with caution"

Sometimes, OHIS results are *suppressed* (not shown) because the sample was too small to be reliable. Other times, results are shown, but a † symbol is used to tell you to interpret the results "with caution" because of small sample size. These estimates are less reliable than others, and it's important that you also include these warnings in any reporting that you do with OHIS data.

Learn more about reporting small numbers in Health Analytics' Small Numbers Reporting Guidelines.

How do these estimates compare to others?

There are some other national surveys, like the American Community Survey (ACS), that ask people whether they have health insurance. But the results from those surveys may be different than OHIS because the data are collected differently. Therefore, data from OHIS and other surveys aren't directly comparable. *Learn more about other data sources that provide health insurance rates and how they differ from OHIS.*

Communicating OHIS data

When people talk about health insurance, they use many different words such as *coverage, insurance,* or *insurance coverage.* All these words mean the same thing, but it can be confusing to readers. Try to be consistent – and remember that in other contexts, "covered" has an entirely different meaning (i.e., the types of services that insurance pays for).

There are also two main ways of looking at the data:

1. How many people DO have insurance? (Higher is better)
2. How many people DON'T have insurance? (Lower is better)

You may have reasons for focusing on one or the other, but you should be thoughtful about the differences. Again, try to be consistent: When possible, avoid switching between the two in your analysis or writing.

Additional considerations

Some questions in the survey ask about the timing of when something occurred. Since big surveys like OHIS are asked over a period of many months, the exact timeframes that different respondents are referring to will vary slightly.

In OHIS, a few of the questions about whether people have health insurance ask if they had insurance at a "point in time" (that is, the day when the question was asked) or "any time in the past year" or "all of the past year." The "past year" refers to the 12 months leading up to when the question was asked, and not a specific calendar year.

Requesting OHIS data

Although the OHIS dashboards have been recently expanded to reflect almost all of the questions that are asked in the survey, there are many ways of interpreting the data – and not every view is readily available in our public reporting. The good news is that if you want to see data in a way that isn't shown in the dashboards, OHA staff can probably provide that for you.

Here's an example of something you could request:

> The dashboards show four age groups: 18 and under; 19-34; 35-64; and 65 and older. They also show three different income levels: Less than 138 percent of the federal poverty level (FPL); 138-400% FPL; and more than 400% FPL. But maybe YOU want to see results for different or combined demographics, like people ages 25-40 who also earn less than 200% FPL.

To request data that are not in the dashboards, you can submit a general data request (available on the Health Analytics webpage) or email ohis.admin@odhsoha.oregon.gov.

Sometimes a request can't be fulfilled because the numbers are too small to be reliable, but OHA staff will help you understand what's available.

OHIS in action

The Oregon Health Insurance Survey has been an important source of information to inform policies that have real impacts on peoples' lives. This section highlights one recent example: when OHIS helped policymakers better understand and address the systemic barriers that have been preventing people from getting and staying insured.

Helping policymakers understand and address systemic barriers to coverage

OHIS has shown that whether people have health insurance differs significantly by race and ethnicity. For example, in 2019 people some in communities of color and tribal communities were twice as likely to be uninsured than the statewide average. Such inequities reflect that health and social systems are structured to benefit dominant racial groups. To reach our goal of eliminating health inequities by 2030, Oregon must remove the structural barriers that are causing unequal access to coverage – and exploring OHIS data suggests some ways to get there.

For example, OHIS shows that many people of color who are uninsured *could get free insurance coverage* through Oregon's Medicaid program, which is called the Oregon Health Plan. In 2019,

more than 40 percent of people who identified as Hispanic, Latinx, and/or a race other than White were eligible for OHP because of their incomes.

Why would people who are eligible for free health insurance still be uninsured? Policymakers know that one common reason people are uninsured at any given time is because of "churn," which means temporarily losing insurance and then re-signing up. Churn happens for many different reasons. Administrative barriers (like paperwork and deadlines) may cause people to lose insurance even though they are still eligible. Or peoples' incomes may fluctuate so that they briefly make too much money to be eligible for OHP… but then fall back below the income limit within a short time. Churn can be disruptive to people's lives and bad for their health.[2] It's also expensive for taxpayers and the health system.[3]

OHP enrollment data show that in 2019, about one third of enrollees were returning to OHP after less than a year. OHIS illustrates the problem further: In 2017 and 2019, about a third of people in Oregon who didn't have insurance said that "losing OHP coverage" was a reason they were uninsured. That number was true even among people who earned less than 138 percent of the federal poverty level – which means they should have been eligible for OHP.

Recently, a temporary federal policy was created that put a pause on disenrolling people from OHP.[4] It's no surprise that during this pause in disenrollment, the number of people insured by OHP increased dramatically. However, thanks to OHIS, Oregon has been able to gain valuable insights about the impact this policy has had on churn. For example, 2021 OHIS data showed that during the pause in disenrollment:

- The overall percentage of people in Oregon without insurance fell to the lowest level ever: 4.6 percent. And it declined most significantly among people who identify as Black or African American – suggesting that pausing OHP disenrollment is an important strategy to achieve health equity.
- The percentage of people who said that "losing OHP" was a reason for being uninsured fell dramatically. Among people within the OHP eligibility income bracket (< 138%), the number fell by half.
- The uninsurance rate fell most dramatically among people who earn between 138 and 200% of the federal poverty level. That's the population that earns just a little too much to qualify for OHP in normal times – and is thus likely to experience churn if their income fluctuates just a little.
- The percentage of people reporting that they delayed care because of cost and the percentage of people reporting that they had trouble paying medical bills over the past year both decreased in 2021.

Having rich, timely, year-over-year data from OHIS helped reveal the impact of the continuous insurance coverage policy. As a result, in 2022 the Oregon Legislature passed HB 4035, which directs resources toward preserving health insurance for people when the temporary policy ends.

[2] https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0455
[3] https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204
[4] The Family First Coronavirus Recovery Act was passed in March 2020 and was still in effect as of this writing

A Task Force is developing a proposal for a 'bridge health plan' which would help eliminate churn by providing insurance to those who earn slightly too much to qualify for OHP. As they design the program, OHIS data are helping the Task Force understand the population that the program is meant to serve. OHIS results will also be one important way to measure whether the Bridge Program is working as intended. OHA is working with the Task Force to consider whether questions should be added or modified in future surveys to continue informing the program.

Oregon recently received approval from the federal government to keep people enrolled in OHP for two years before requiring them to re-enroll; and to guarantee continuous enrollment for young children through their sixth birthday. Normally, people are enrolled for just one year at a time, which (as described earlier) can make "churn" more likely. OHIS was a critical source of data to demonstrate to the federal government that keeping people continuously enrolled for longer is an effective policy and will help improve the lives of people in Oregon.

OHIS and the Cost Growth Target Program

Another example of OHIS informing health policy is the use of data about cost and affordability in the development of Oregon's new Sustainable Health Care Cost Growth Target program. A report, *Impact of Health Care Costs on People in Oregon, 2019,* includes OHIS data that reveal how people in Oregon are delaying care and struggling with medical bills and debt.

In future years, the Cost Growth Target program will continue to use OHIS data to maintain a focus on affordability and drive additional policy development.

Quick Facts

Name	Oregon Health Insurance Survey
Acronym	OHIS
Summary	Information about health insurance coverage, access to care, and affordability
Data type	Survey
Populations	All people in Oregon
Frequency	Every two years
Available since	2011
Required?	No legislative requirement
Regular reporting	Interactive dashboards
Website	https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Insurance-Data.aspx
Primary staff	Rebekah Gould
Internal requests	email Rebekah.Gould@dhsoha.state.or.us
External requests	Email ohis.admin@odhsoha.oregon.gov or submit a general data request form (available on the Health Analytics webpage)
Security level[5]	Level 1 “Published” (Low-sensitive information)
Data dictionary?	Yes (available online)
REALD	Partially implemented since 2011; fully compliant beginning in 2023
SOGI	Versions of SOGI questions have been included since 2017; questions will be revised to meet OHA standards when they become available
Suggested citation	Oregon Health Authority, Oregon Health Insurance Survey [Year]

[5] Learn more: https://www.oregon.gov/das/policies/107-004-050.pdf