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MEMORANDUM

TO: The Honorable Sen. Elizabeth Steiner Hayward, Senate Co-Chair
The Honorable Rep. Dan Rayfield, House Co-Chair
Subcommittee on Human Services

FROM: Janell Evans, Budget Director, Oregon Health Authority

DATE: February 13, 2017

SUBJECT: Responses to February 9 Public Hearing Questions

During OHA's presentation before your committee on Thursday, February 9, committee members asked question that required additional follow-up. Here are those questions and our responses:

Rep. Buehler: Can you outline the metrics we have for the CCOs for impacting social determinants?

Attached is *Oregon's Health System Transformation: CCO Metrics 2016 Mid-Year Report* published in January 2017. As Director Saxton stated, there has been keen interest on the part of the Metrics and Scoring Committee to tackle "Kindergarten Readiness". A subcommittee was formed to identify opportunities for a shared metrics set across CCOs and Early Learning Hubs, but this work has not moved into implementation at this time. There is also work underway to work on a measure of "food insecurity". The Metrics and Scoring Committee has attempted to establish stabilities in metrics while identifying some stretch measures such as tobacco cessation. Beginning in 2017, a new Metrics Committee will be formed as directed by SB 440. Commercial payers, PEBB and OEBB carriers along with other key stakeholders will work to establish and align metrics across the system.

This committee is being appointed by the Governor and its work will be overseen by the Oregon Health Policy Board (OHPB).

Rep. Buehler (29 min): how many call center employees do you have? And what's that total budget?

Member Services of the Health Systems Division is responsible for processing OHP applications and renewals. Member Services consists of a call center team, an eligibility unit, the community partner program and administrative staff. The 2015-17 budget as of December Rebalance for Members Services is $119,739,073 Total Funds ($48,811,869 General Fund).

As of January 31, 2017, Member Services employed 480 staff, excluding contracted staff to support call center activities.

Sen. Gelser: In your strategy to close JC in 2018, what happens with the maintenance budget? Does that go to DAS or are we spending OHA dollars to maintain an empty building?

The budget anticipates that the hospital will be fully closed by July 2018 and does not include funding for building maintenance. Depending on disposition of the facility when closed as a hospital, if the vacated facility is "mothballed," we anticipate a cost of approximately $390,000 per year (minimal utilities, security, pest control, etc. for minimal maintenance of the building and grounds). Funding for mothballing is not specifically included in either the OHA or DAS budgets for 2017-19.

Note that, if CMS and hospital accreditation of the facility were desired to be retained, costs would increase significantly in order to maintain service and inspection of facility systems.

Sen. Gelser: I'm alarmed by the idea that DHS would people in an institution (in reference to DHS putting kids in hospital cottages), can you expand? Do we have any outstanding responsibility to the municipality around the Junction City hospital?

The cottages on the Junction City campus have not been used for any purpose. Executives from both DHS and OHA have toured the cottages to explore potential uses; however, the process has not progressed any further.

The hospital is currently obligated to Lane Fire Authority (LFA) for $15,000 per year to provide response to medical emergency treatment, personnel, and transportation, including responding to the site of the emergency. LFA responds to Junction City campus fire emergencies, HAZ-MAT incidents, and it may invoke a

mutual aid agreement between agencies if and when emergency events are beyond LFA capabilities. LFA also provides OSH staff with training re: fire detection systems operation, emergency preparedness and practice exercises, hazardous materials incident exercises, and fire-life-safety best practices.

If the facility were to be vacated, the contract would have to be renegotiated to only cover fire and HAZ-MAT response.

Sen. Winters: What percent of the contracting that is done by OHA that's private (not including CCOs)? What percent are minority and women?

From the Office of Contracts and Procurement, the following 2015-17 data are provided:

- Total OHA contracts (excluding CCOs and nonprofits): 1,122
- Total face value of these 1,122 contract agreements: $619,600,000
- Number COBID certified vendors: 34
  - Certification Office for Business Inclusion & Diversity (COBID): Certification for minority, women, and emerging small businesses
- Total face value of COBID* certified vendors: $27,700,000
- Percentage that are COBID certified vendors: 4.47%

Sen. Steiner Hayward: When people are incarcerated they're not eligible for Medicaid, but who pays for the 370 population pre-adjucation? **Sen. Winters**: It would be helpful for staff to get the overarching federal policy for institutional healthcare.

Patients in the GEI and .370 populations do not meet the federal definitions of inmates; therefore, they are eligible for Medicare. Medicaid funding is severely limited by the federal Institution for Mental Disease (IMD) exclusion, which denies federal funding for patients in psychiatric institutions over 21 and under 65.

County jail funding is used for people under .370 orders before they come to OSH. When they come to OSH, funding is General Fund and Medicare for those eligible.

Sen. Winters: It would be helpful for staff to get the overarching federal policy for institutional healthcare. Could you provide us with the donut for 2015 back to 2013 to show how budget funding has changed (shift in state-federal funds)?

Attached is the *OHA Overview Budget Chart* that displays the OHA Total Fund budget for 2013-15 actual expenditures, 2015-17 Legislatively Approved Budget, and 2017-19 Governor's Budget.

Sen. Steiner Hayward: Why has the number of open card almost doubled since last year?

Leslie Clement committed to researching the root cause of this issue and we will be glad to report back once that analysis is complete.

Rep. Rayfield: What's the average cost difference between maintaining an open card use for a biennium versus a CCO user? Can we dig down in terms of the populations?

There is a fundamental issue in attempting to compare costs between those who are enrolled in CCOs and those who are on open card fee-for-service. For example:

- Individuals with third-party insurance coverage are exempt for CCO enrollment and remain on open card fee-for-service.
- Much of their health care costs are covered by their third party-insurance, greatly reducing their cost impact to the Oregon Health Plan.
- This results in an apples-to-oranges comparison. The individuals on open card have dramatically different cost characteristics than those enrolled in CCOs, even within the same eligibility categories.

One other additional complexity in comparing populations is that there are some services, such as mental health drugs and adult mental health residential treatment, that are not provided under CCO contracts and are paid entirely on a fee-for-service basis, even if they are a member of a CCO.

Other issues driven by the policies that exempt individuals from CCO enrollment also create difficulties for comparing costs.

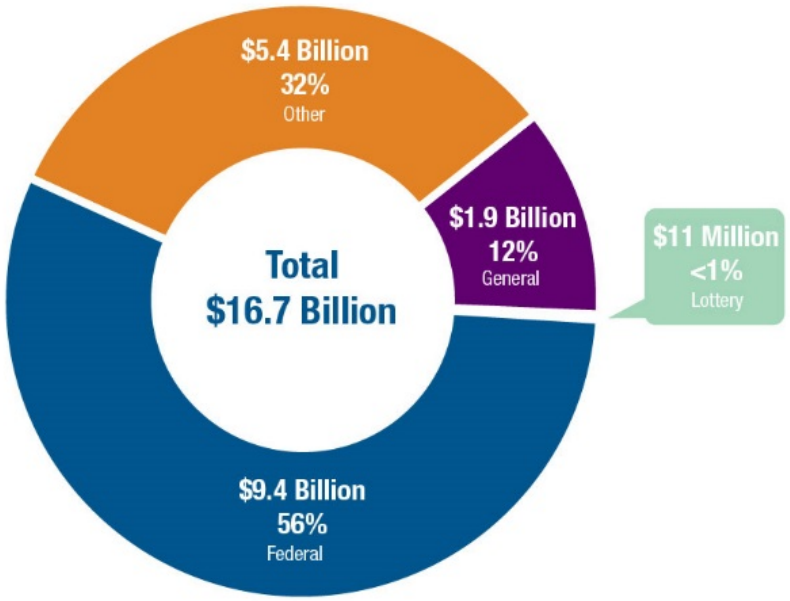
We would be glad to meet with you to discuss this issue further.

Rep. Hayden: Why the drop off for pregnant women in that poverty level just because they're signed up with a different category (CAWEM)?

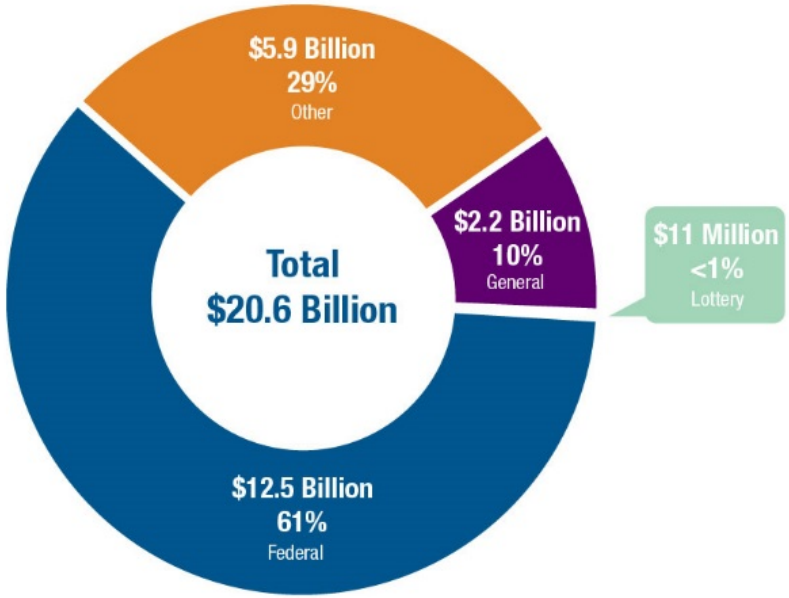
More research into the underlying issues is needed. OHA is evaluating the population needs, network, fee schedules, and other contributing factors in order to recommend necessary policy and/or operational changes. In a couple of weeks, for example, OHA will be hosting a webinar with dentists—some who provide dental services to OHP clients on fee-for-service and some who do not—to discuss why they participate or do not, identify barriers, and find out what might encourage dentists to participate in the program. OHA is also specifically evaluating fee-for-service rates for dental preventive care and oral surgery treatment—two areas that are especially important for pregnant women.

Oregon Health Authority Total Agency Budget
Total Fund by Fund Type

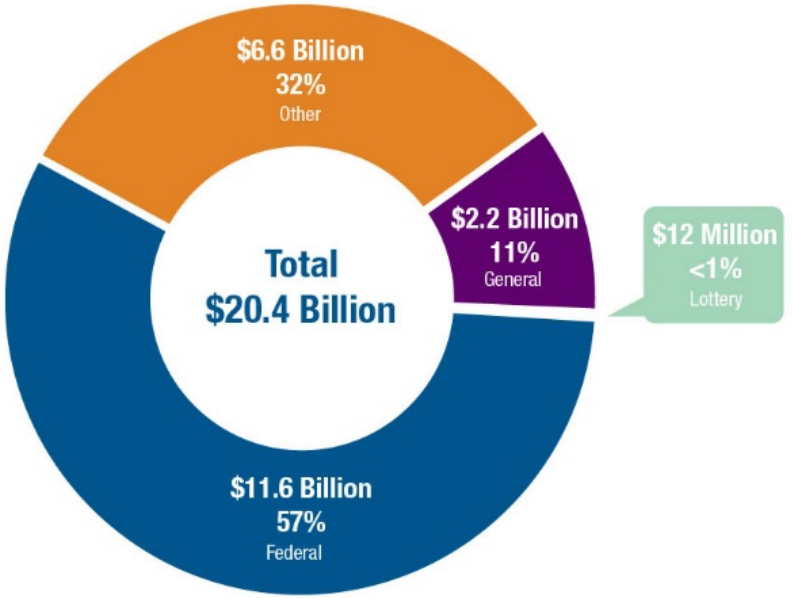
2013-15 Actuals



2015-17 Legislatively Approved Budget



2017-19 Governor's Budget



Oregon's Health System Transformation: CCO Metrics 2016 Mid-Year Report

January 2017

Oregon Health Authority

MEASUREMENT PERIOD:
July 2015 - June 2016
Version 1.0
January 2017

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METRIC QUICK GUIDE

CCO incentive metrics

State performance metrics

METRIC QUICK GUIDE

State performance metrics, continued.

Core metrics

EXECUTIVE SUMMARY

This mid-year report lays out the progress of Oregon's coordinated care organizations (CCOs) on quality measures from July 1, 2015 through June 30, 2016. Measuring quality and access to care are key to moving health system transformation forward, to ensure high quality care for Oregon Health Plan members.

The report indicates that through the coordinated care model, improvements continue in a number of areas, such as reductions in hospital admissions and avoidable emergency department utilization, and increases in developmental screening and enrollment in patient-centered primary care homes.

Key findings include:

- **Decreased hospital admissions for asthma and chronic obstructive pulmonary disease (COPD)**. The rate of adult patients (ages 18 and older) who had a hospital stay because of COPD or asthma dropped 4.4 percent in mid-2016 compared with calendar year 2015, and by more than 60 percent since 2011 baseline data. In addition, the rate of younger adult members (ages 18-39) who had a hospital stay because of asthma dropped 13.6 percent since 2015, and by more than fifty percent since 2011 baseline data.
- **Patient-Centered Primary Care Home (PCPCH) enrollment continues to increase.** Coordinated care organizations continue to increase the proportion of members enrolled in patient-centered primary care homes. This increase suggests support for the PCPCH model. PCPCH enrollment has increased 60 percent since 2011.
- **Rate of developmental screening for young children continues to increas**e. Fifty-eight percent of young children were screened for risks of developmental, behavioral, or social delays as of June 2016, indicating continuing improvement since 2011 baseline when only 1 in 5 children received the recommended screening.
- **Rate of dental sealants on permanent molars for children continues to increase.** Statewide, the percentage of children receiving dental sealants has increased 77 percent since 2014 baseline. Dental sealants was added to the CCO incentive program in 2015.

There are also areas where CCOs are making strides but room for improvement remains:

- CCOs continue to demonstrate improvements in providing timely health assessments for children in DHS custody (foster care), but all sixteen CCOs remain far below the benchmark.
- The percentage of adolescents and young adults (ages 12-21) receiving at least one well care visit during the measurement year (as recommended by clinical guidelines) continues to improve, but fewer than forty percent had a visit.

EXECUTIVE SUMMARY

Measures that require observation or improvement:

- For the first time since CCOs were established, there is a slight increase in emergency department visits by people served by CCOs. However, the rate of avoidable emergency department utilization (for conditions that could have been more appropriately managed in a primary care setting) continues to improve. OHA will continue to monitor and explore this trend as data become available.
- Effective contraceptive use among adult women at risk of unintended pregnancy declined slightly (2 percent) in mid-year compared with 2015, and has improved only modestly (6 percent) since 2014 baseline. Introduced to the CCO incentive program in 2015, CCOs are encountering barriers such as provider knowledge, access to care, and cultural views.

This is the third report to show statewide performance on selected measures for members with disabilities, and members with mental health conditions and severe and persistent mental illness, and the first to report trend over time (calendar year 2015 compared with mid-2016). Key findings include:

- Children and adolescents with disability or with mental health conditions have higher rates of adolescent well-care visits, developmental screenings, and well-child visits than children and adolescents statewide. These higher rates might indicate that conditions are being identified during the visits and screenings.
- Children in foster care with disability or with mental health conditions are less likely to receive health assessments than other children in foster care.
- Members with mental health diagnoses or severe and persistent mental illness use the emergency department at much higher rates than other members. Members with disability also use the emergency department more frequently; and the increase in ED utilization among members with disability was higher in the first six months of 2016 than statewide (10 percent compared with 5.8 percent, respectively).

A hallmark of Oregon's health system transformation continues to be a commitment to transparency and accountability. By measuring Oregon's progress and identifying both successes and challenges, the state can identify how we can continue to push for greater health transformation and ways that we can create better health outcomes for Oregon Health Plan members.

2016 Mid-Year Incentive Measure Summary

	2011 baseline	2013	2014	2015	2015 revised	mid-2016	2016 benchmark	% change since 2015	# of CCOs currently meeting benchmark or improvement target (as of mid-year)
Adolescent well care visits	27.1%	29.2%	32.0%	37.5%	-	38.7%	61.9%	⇧ 3.2%	2
Alcohol and drug misuse screening (SBIRT) 12+	0.1%	2.0%	6.4%	12.7%	-	16.3%	12.0%	⇧ 28.3%	14
Ambulatory care - ED utilization	61.0	50.5	47.3	43.1	-	45.6	39.8 (lower is better)	⇧ 5.8%	6
Assessments for children in DHS custody	53.6%	63.5%	27.9%	58.4%	-	67.5%	90.0%	⇧ 15.6%	11
Childhood immunization status	-	-	-	70.7%	67.7%	67.7%	82.0%	– 0.0%	7
Dental sealants for children	-	-	11.2%	18.5%	-	20.1%	20.0%	⇧ 8.6%	8
Developmental screening	20.9%	33.1%	42.6%	54.7%	-	58.9%	50.0%	⇧ 7.7%	15
Effective contraceptive use (ages 18-50)	-	-	33.4%	36.3%	-	35.5%	50.0%	⇩ -2.2%	0
Follow up after hospitalization for mental illness	65.2%	67.6%	70.7%	75.3%	76.6%	76.0%	79.9%	⇩ -0.8%	9
Patient-centered primary care home (PCPCH) enrollment	51.8%	78.6%	81.0%	87.5%	-	90.6%	60.0%	⇧ 3.5%	16

This "dashboard" shows statewide results over time for the ten incentive measures for which mid-year data are available. The blue columns show the number of CCOs that are achieving the statewide benchmark or individual improvement target *as of mid-year repor ing*. Incentive payments are based on final calendar year results; this snapshot is shown only to help illustrate mid-year progress. The right-most columns show the percent change at the statewide level compared with calendar year 2015. **Green** arrows indicate positive improvement, while **red** indicates change in the wrong direction.

The light grey column titled "2015 revised" shows updated results for measures that have been recalculated since 2015 final reporting. These revised results are the baseline against which 2016 performance is compared. Revised results should not be compared to earlier years.

REPORT NOTES and ONLINE INFORMATION

A note about ICD-10:

In October 2015, the medical classification list of billing codes was revised. While this may have had a small effect on any measures in this report that are determined using administrative billing claims, Alcohol or other drug misuse screening (SBIRT) was particularly affected; calendar year 2015 and mid-2016 are not directly comparable for this measure, and trends should be interpreted with caution.

A note about missing race and ethnicity data:

Race and ethnicity data are missing for a large percentage of the population in this report (as high as 30 percent for some measures) due to changing enrollment information systems. This percentage is expected to decrease in future reports.

Mid-year data are not available for the following metrics:

- Access to care (CAHPS)*
- All-cause readmissions
- Colorectal cancer screening*
- Depression screening and follow-up plan*
- Diabetes HbA1c poor control*
- Early elective delivery
- Electronic health record adoption
- Health status (CAHPS)
- Medical assistance with smoking and tobacco use cessation (CAHPS)
- Obesity prevalence
- Prenatal and postpartum care: Timeliness of prenatal care*
- Prenatal and postpartum care: Postpartum care rate
- Provider access questions from the Physician Workforce Survey
- Satisfaction with care (CAHPS)*
- Tobacco use prevalence*
- Well-child visits in the first 15 months of life

**denotes CCO incentive measure*

CY 2016 results for these measures will be published in June 2017

For more information and technical measure specifications, visit:

www.oregon.gov/oha/analytics/pages/CCO-Baseline-Data.aspx

To view this report and previous metrics reports online, visit:

www.oregon.gov/oha/metrics

For more information and coordinated care organizations, visit:

www.health.oregon.gov

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OREGON HEALTH PLAN POPULATION

Medicaid demographics

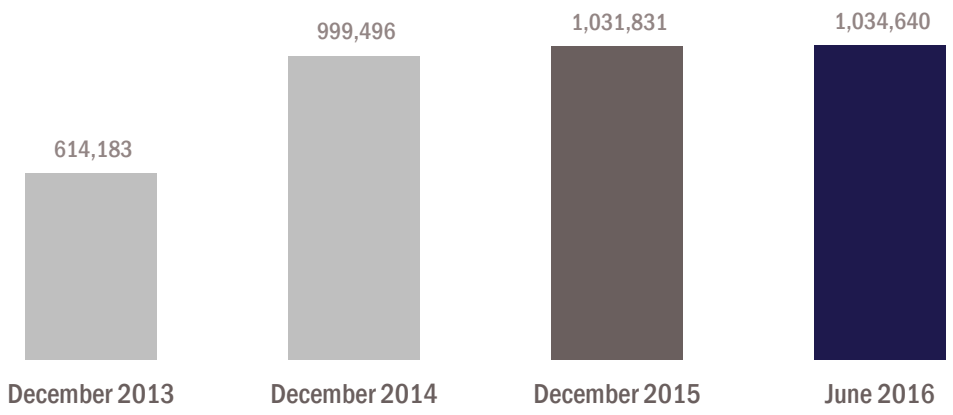
With the Affordable Care Act (ACA) coverage expansion, 1 in 4 Oregonians receives health insurance through the Oregon Health Plan (Medicaid).

The racial and ethnic makeup of the Medicaid population has remained largely consistent. The age distribution has shifted: in 2013 and earlier, the majority of the population were children and adolescents; with the enrollment expansion in 2014, more adults were eligible for Medicaid and the proportion of members ages 19-64 increased, with the greatest increase being members ages 19-35.

This section of the report also includes racial/ethnic and age distribution at the CCO level, as well as enrollment stratified by members with disability.

Total Medicaid enrollment has increased 68 percent since 2013.

Counts exclude other medical assistance programs.

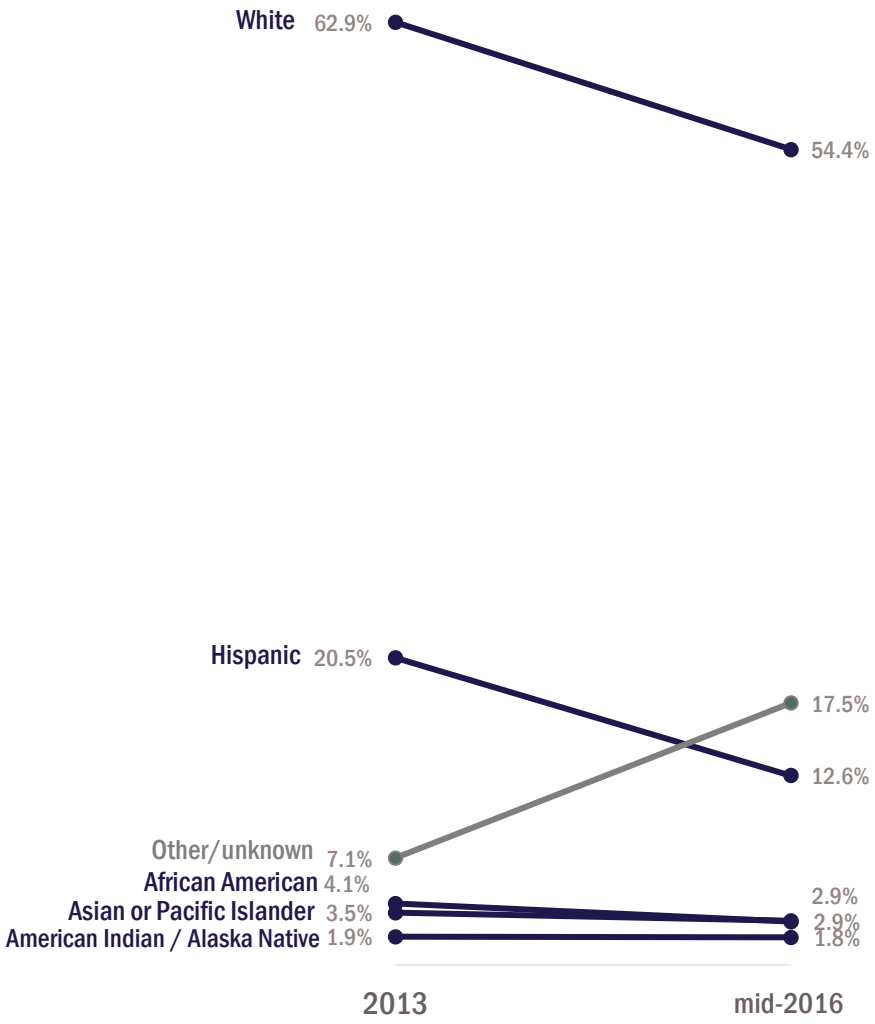


OREGON HEALTH PLAN POPULATION

Racial and ethnic distribution of Oregon's Medicaid population between 2013 and mid-2016

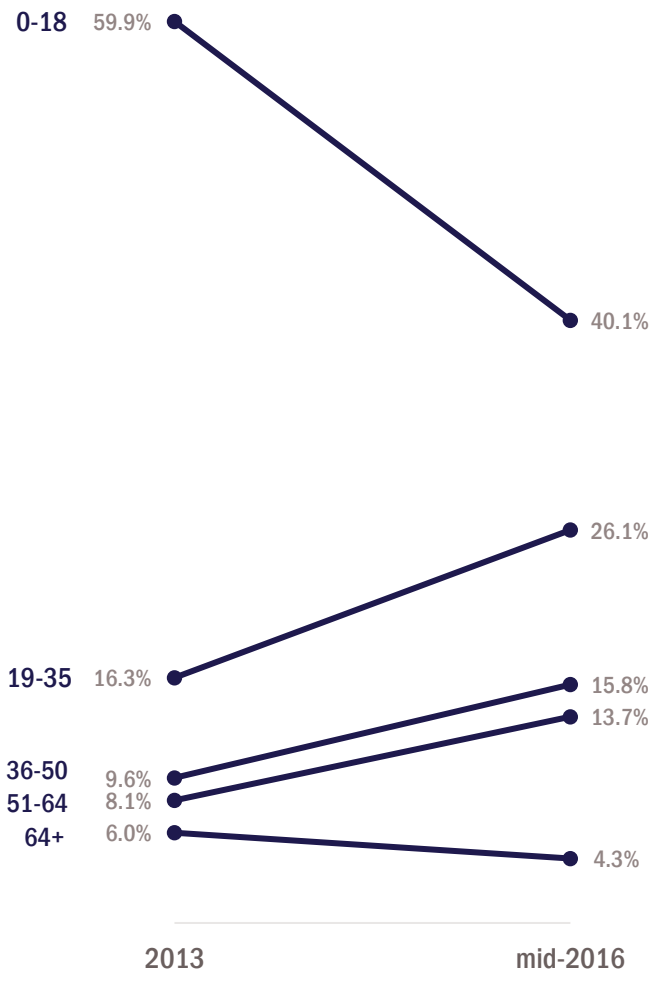
More members are categorized as "other/unknown" today.

Data missing for 8% of respondents in both 2013 and mid-2016

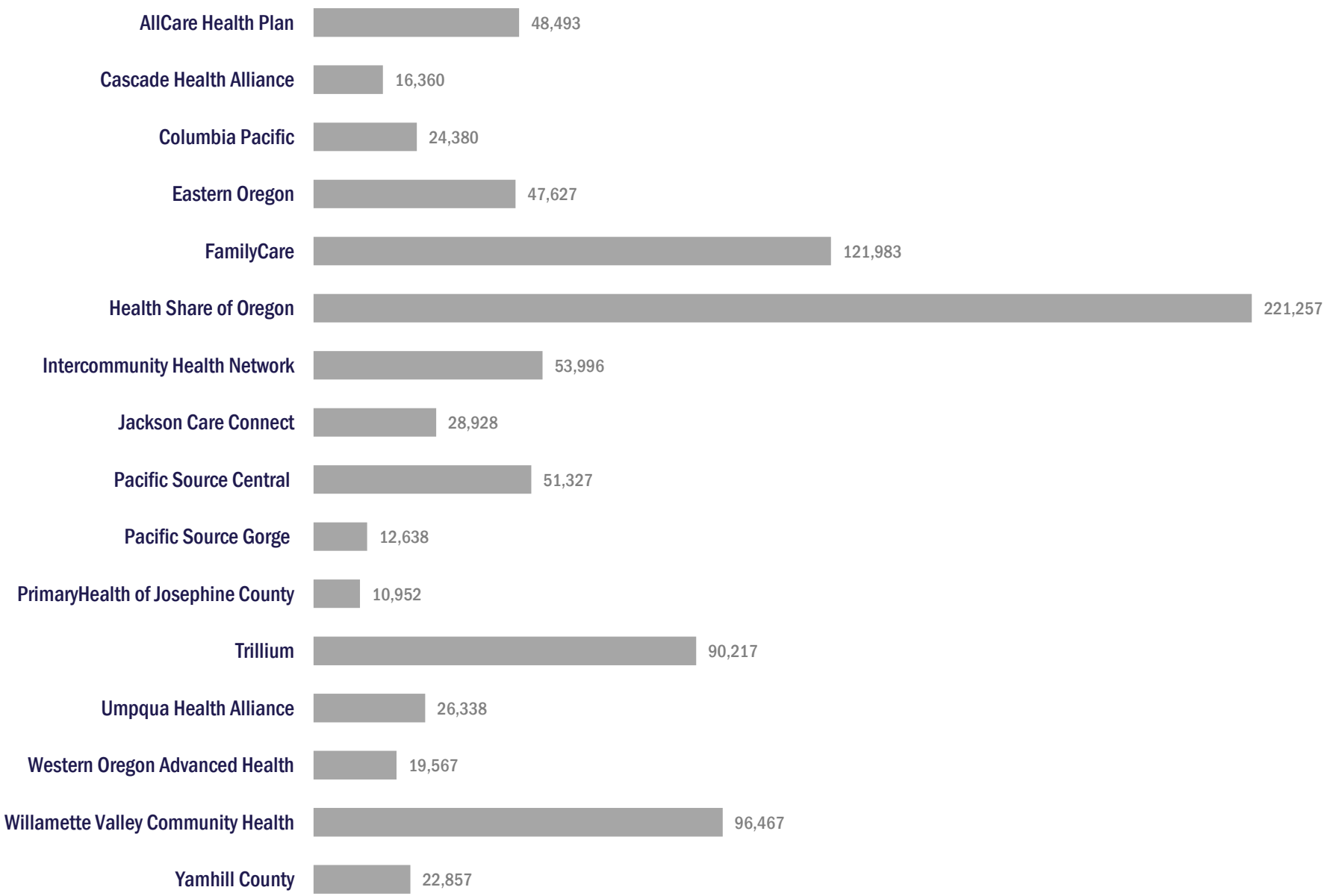


Age distribution of Oregon's Medicaid population between 2013 and mid-2016.

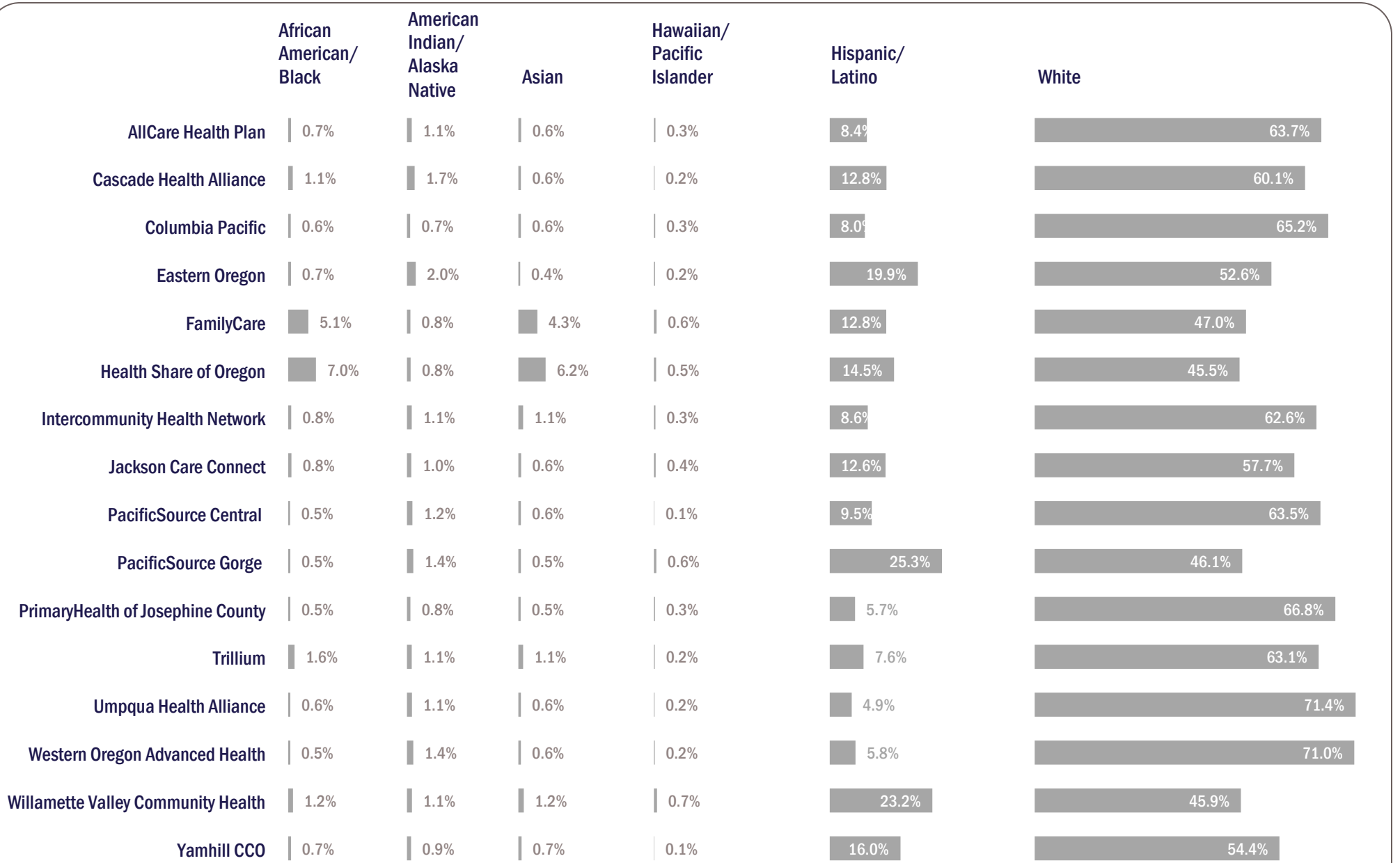
Children make up a smaller share of Medicaid members in mid-2016



TOTAL CCO ENROLLMENT (JUNE 2016)

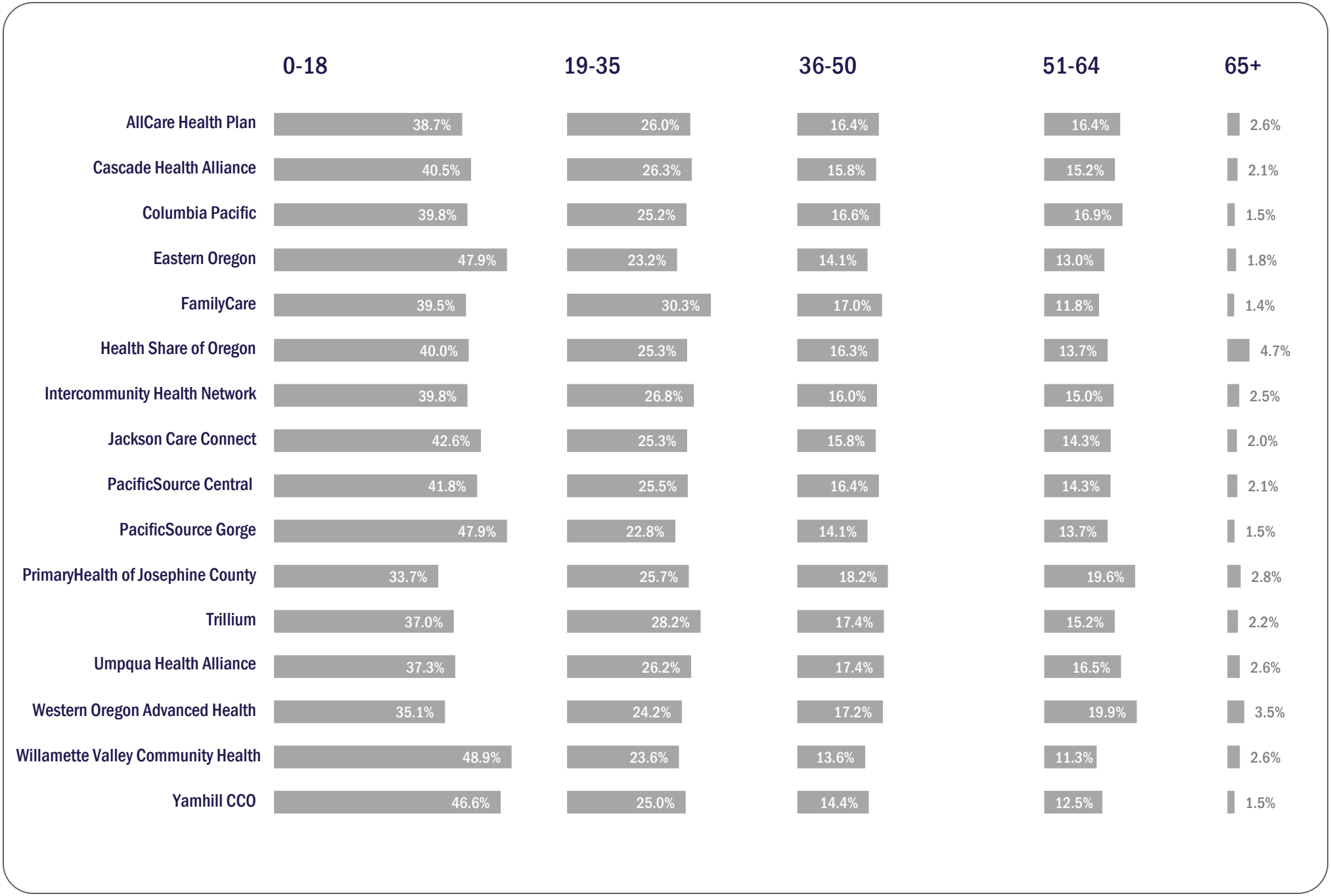


RACE AND ETHNICITY DISTRIBUTION BY CCO (JUNE 2016)



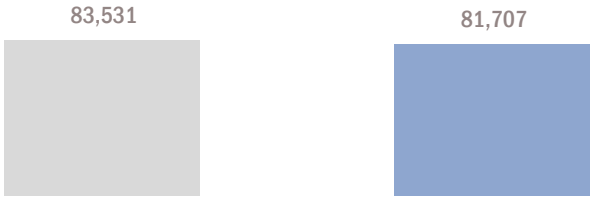
Values do not add to 100% because race and ethnicity data are missing for some members.

AGE DISTRIBUTION BY CCO (JUNE 2016)



OREGON HEALTH PLAN POPULATION WITH DISABILITY

Although the total number of members with disability has remained fairly steady since 2013....

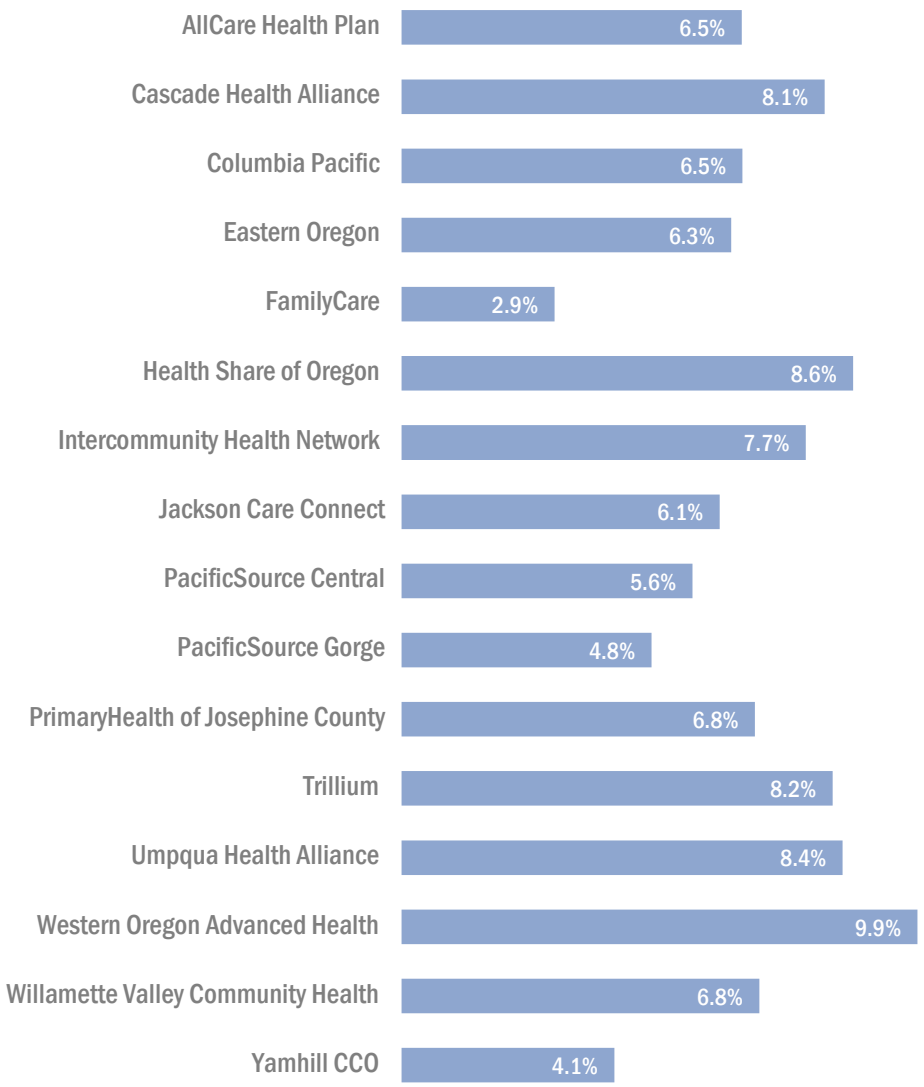


...members with disability now make up a smaller share of total enrollment.

With disability means people who qualify for Medicaid based on an impairment that has prevented them from performing substantial gainful activity for at least one year, or is expected to prevent them from performing substantial gainful activity for at least one year. This may include physical, mental, emotional, learning, developmental or other disabilities. These individuals may or may not also be qualified for Medicare. Eligibility codes include: 3, 4, B3, and D4.

See page 95 for a subset of incentive metrics stratified by members with disability.

Percent of members with disability in June 2016 by CCO.



HOW TO READ THESE GRAPHS

Icons

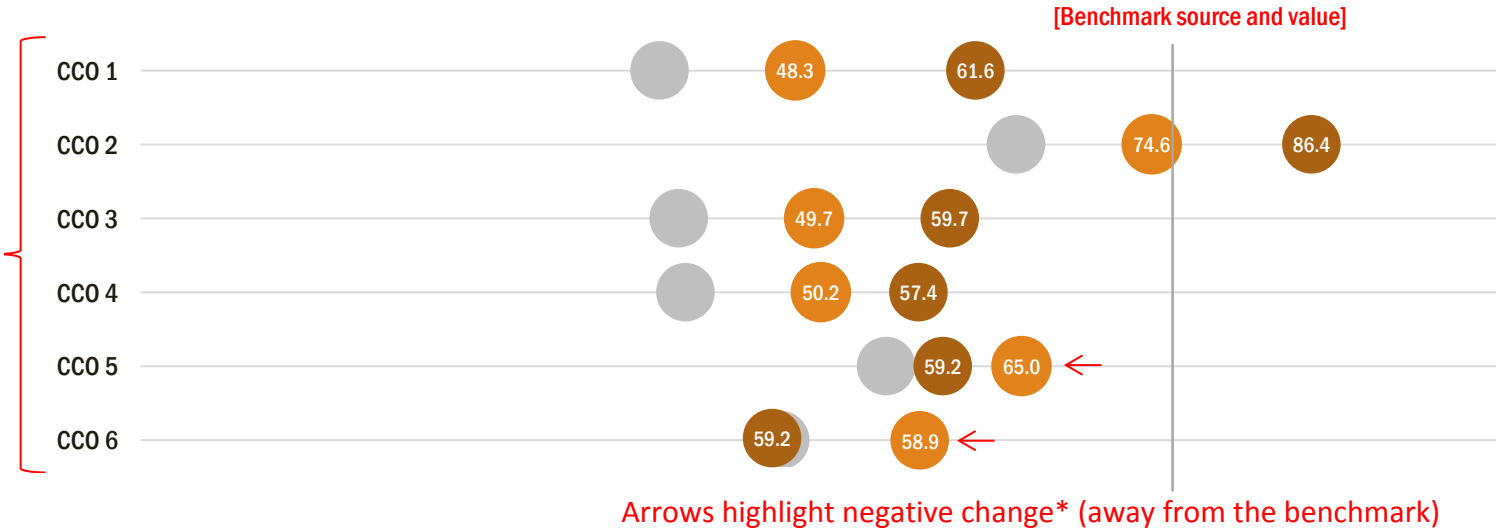
To help readers identify which metrics belong in which measure set, each metric is accompanied by up to three icons that denote the measure set:

This icon indicates the measure is one of the 18 CCO incentive metrics. CCOs will earn quality pool funding in June 2017 based on their CY 2016 performance on these measures.

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

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

[Measure name] between 2015 & mid-2016.



*Please note that changes between years have not been tested for statistical significance.

ADOLESCENT WELL CARE VISITS

Adolescent well-care visits

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

mid-2016 data (n=111,696)

Statewide change since 2015: **+3.2%**

Number of CCOs that improved: **11**

See page 96 for results stratified by member with disability and mental health diagnoses.

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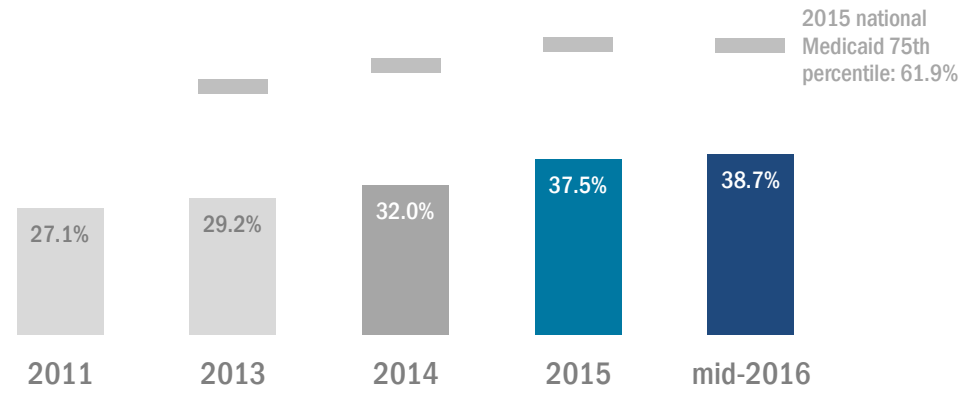
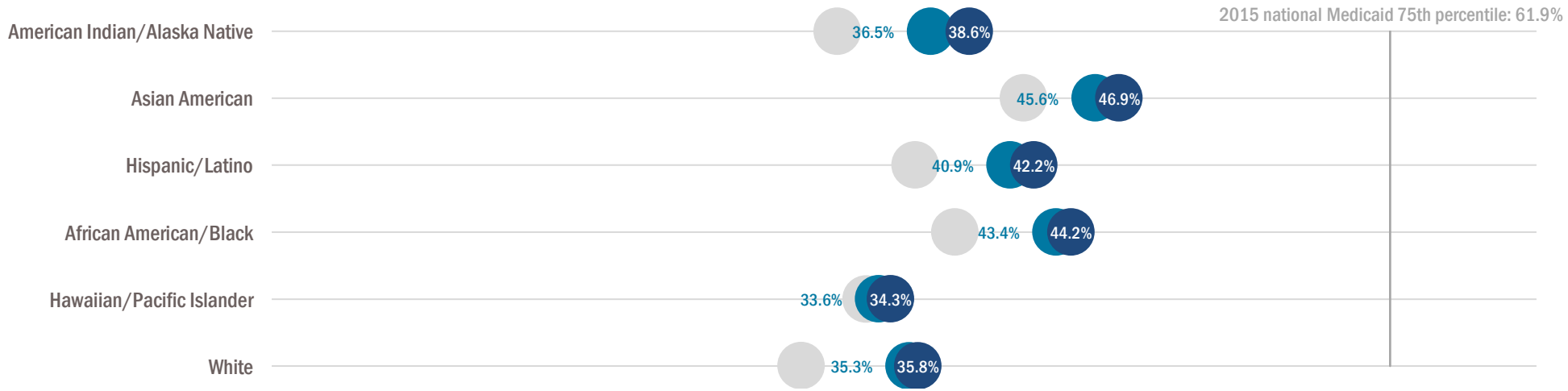
Adolescent well-care visits, statewide.

Data source: Administrative (billing) claims



Adolescent well-care visits in 2015 & mid-2016, by race and ethnicity.

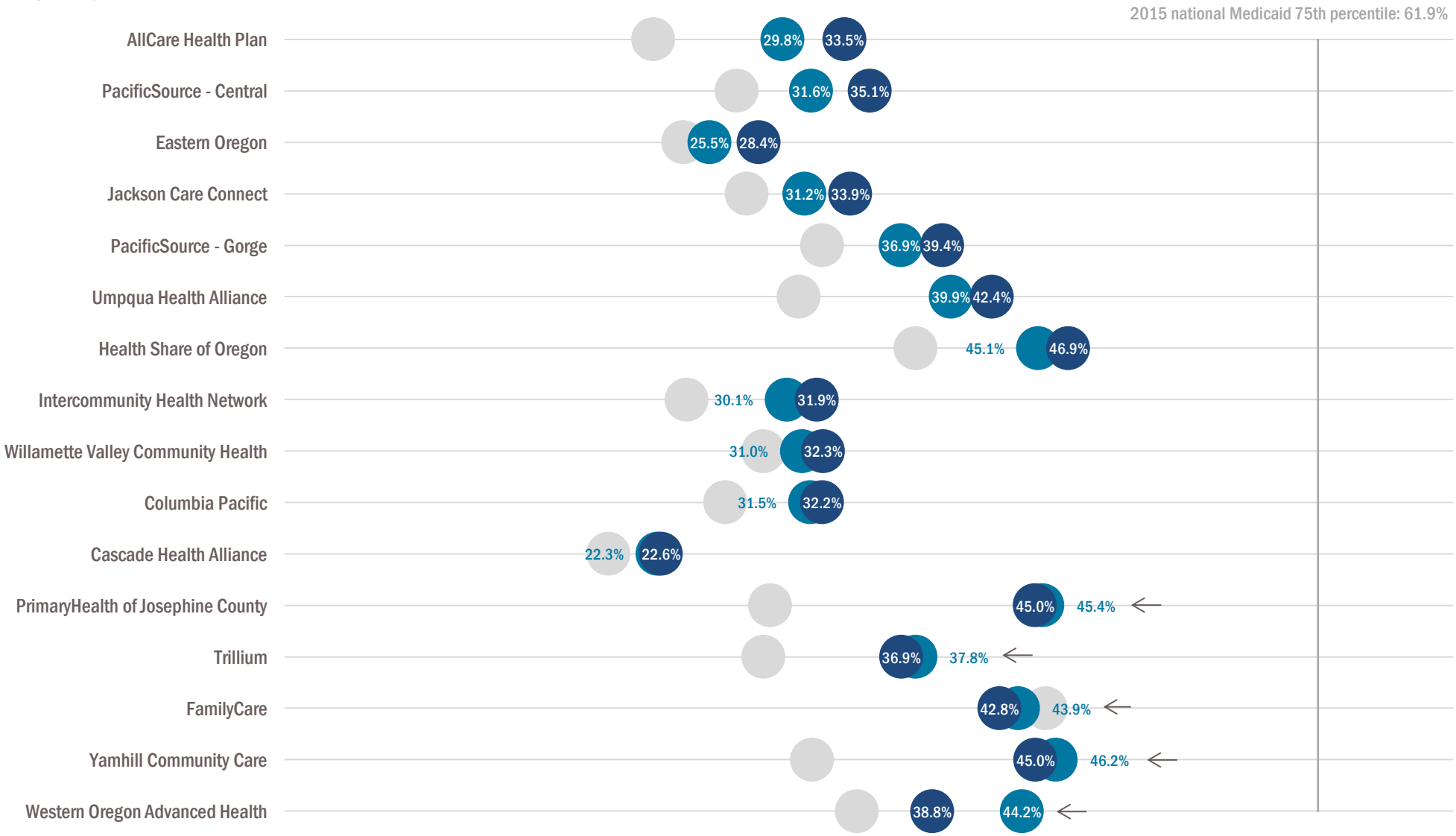
Grey dots represent 2014 / Race and ethnicity data missing for 28.1% of respondents / Each race category excludes Hispanic/Latino



ADOLESCENT WELL CARE VISITS

Adolescent well-care visits in 2015 & mid-2016, by CCO.

Grey dots represent 2014



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (all ages)

Alcohol or other substance misuse screening (SBIRT) (all ages)

The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of members (ages 12 and older) who had appropriate screening and intervention for alcohol or other substance abuse.

mid-2016 data (n=510,953)

Statewide change since 2015: **+28.3%**

Number of CCOs that improved: **15**

Calendar year 2015 and mid-2016 results for this measure are not directly comparable due to changes in the data source (ICD-10) which occurred in October 2015 (see page 9 for more information). Part of the increase that occurred in mid-2016 can be attributed to this code change and not actual performance. Specifically, the change to ICD-10 resulted in codes that are less specific to SBIRT. Thus, additional screening services (not just SBIRT) are likely being counted, artificially inflating performance.

See page 97 for results stratified by member with disability and mental health diagnoses.

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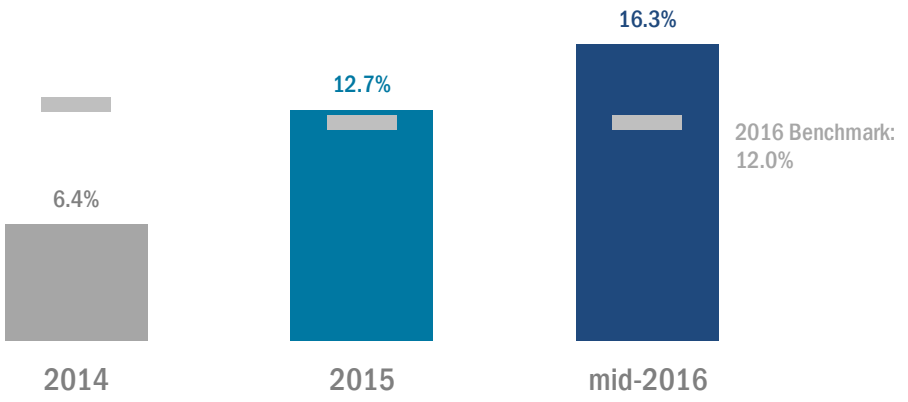
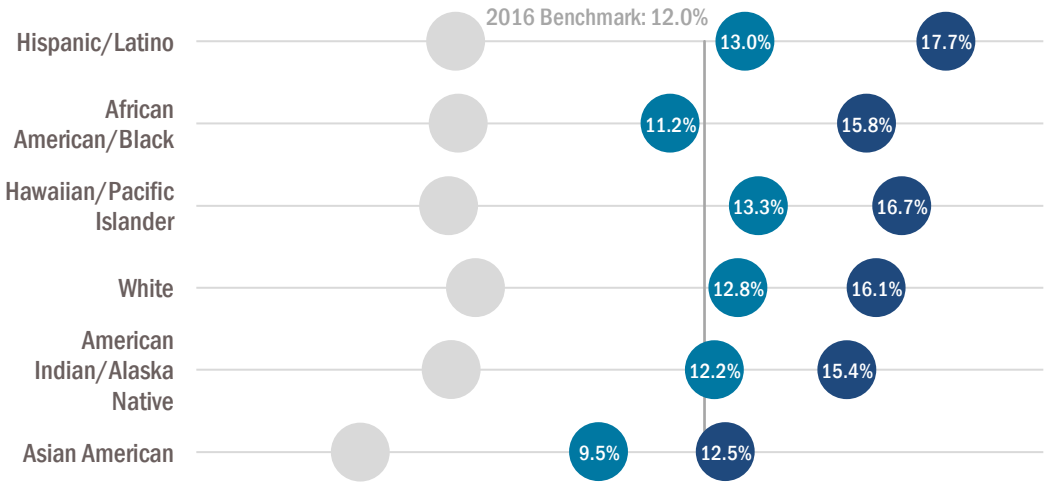
Alcohol or other substance misuse screening (ages 12+), statewide.

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



Alcohol or other substance misuse screening (ages 12+) in 2015 & mid-2016, by race and ethnicity.

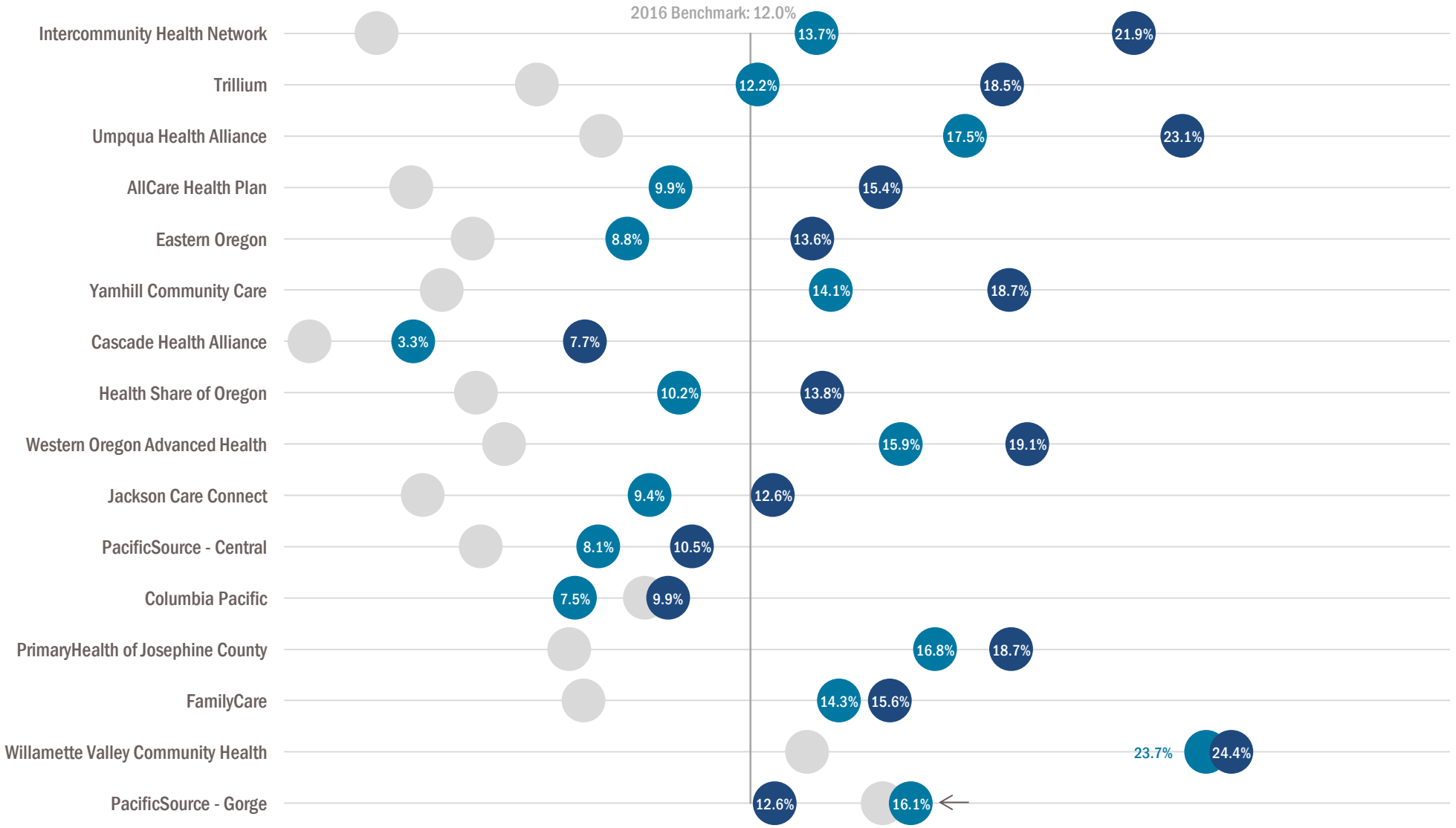
Grey dots represent 2014 / Race and ethnicity data missing for 23.6% of respondents / Each race category excludes Hispanic/Latino



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (all ages)

Alcohol or other substance misuse screening (ages 12+) in 2015 & mid-2016, by CCO.

Grey dots represent 2014



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ages 12-17)

Alcohol or other substance misuse screening (SBIRT) (ages 12-17)

The SBIRT measure, or Screening, Brief Intervention, and Referral to Treatment, measures the percentage of members (ages 12-17) who had appropriate screening and intervention for alcohol or other substance abuse.

mid-2016 data (n=81,384)

Statewide change since 2015: **+60.6%**

Number of CCOs that improved: **all 16**

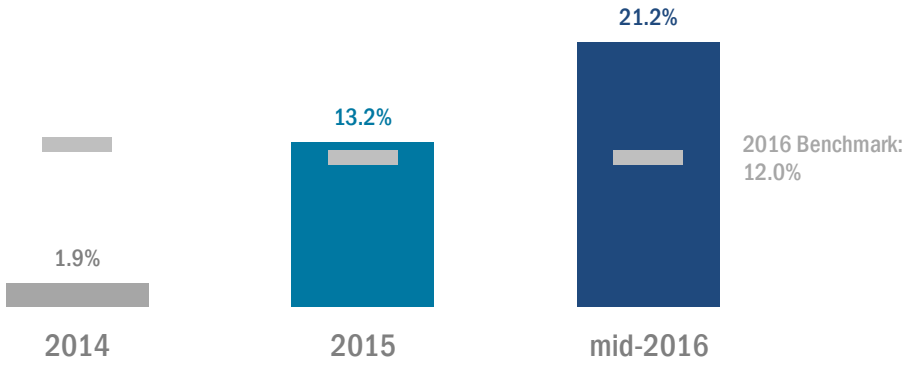
Calendar year 2015 and mid-2016 results for this measure are not directly comparable due to changes in the data source (ICD-10) which occurred in October 2015 (see page 9 for more information). Part of the increase that occurred in mid-2016 can be attributed to this code change and not actual performance. Specifically, the change to ICD-10 resulted in codes that are less specific to SBIRT. Thus, additional screening services (not just SBIRT) are likely being counted, artificially inflating performance.

See page 97 for results stratified by member with disability and mental health diagnoses.

Back to table of contents.

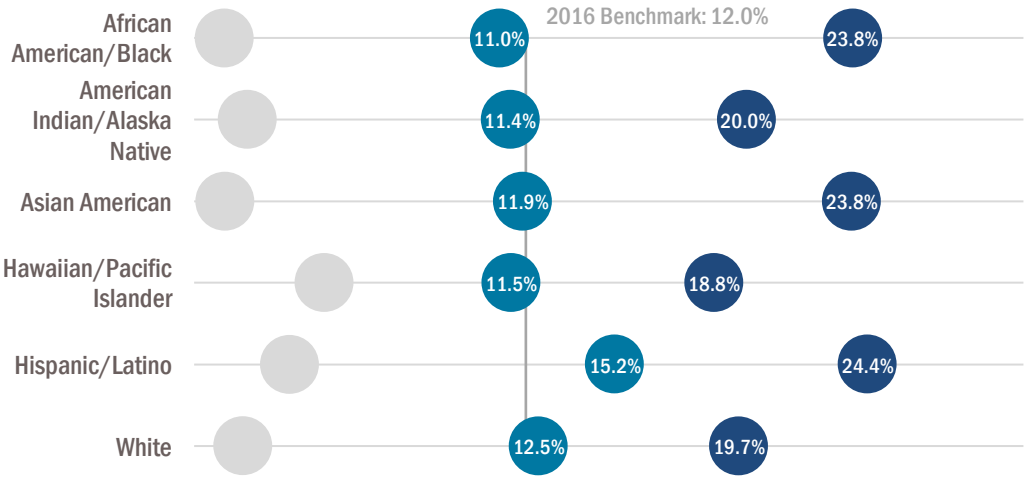
Alcohol or other substance misuse screening (ages 12-17), statewide.

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



Alcohol or other substance misuse screening (ages 12-17) in 2015 & mid-2016, by race and ethnicity.

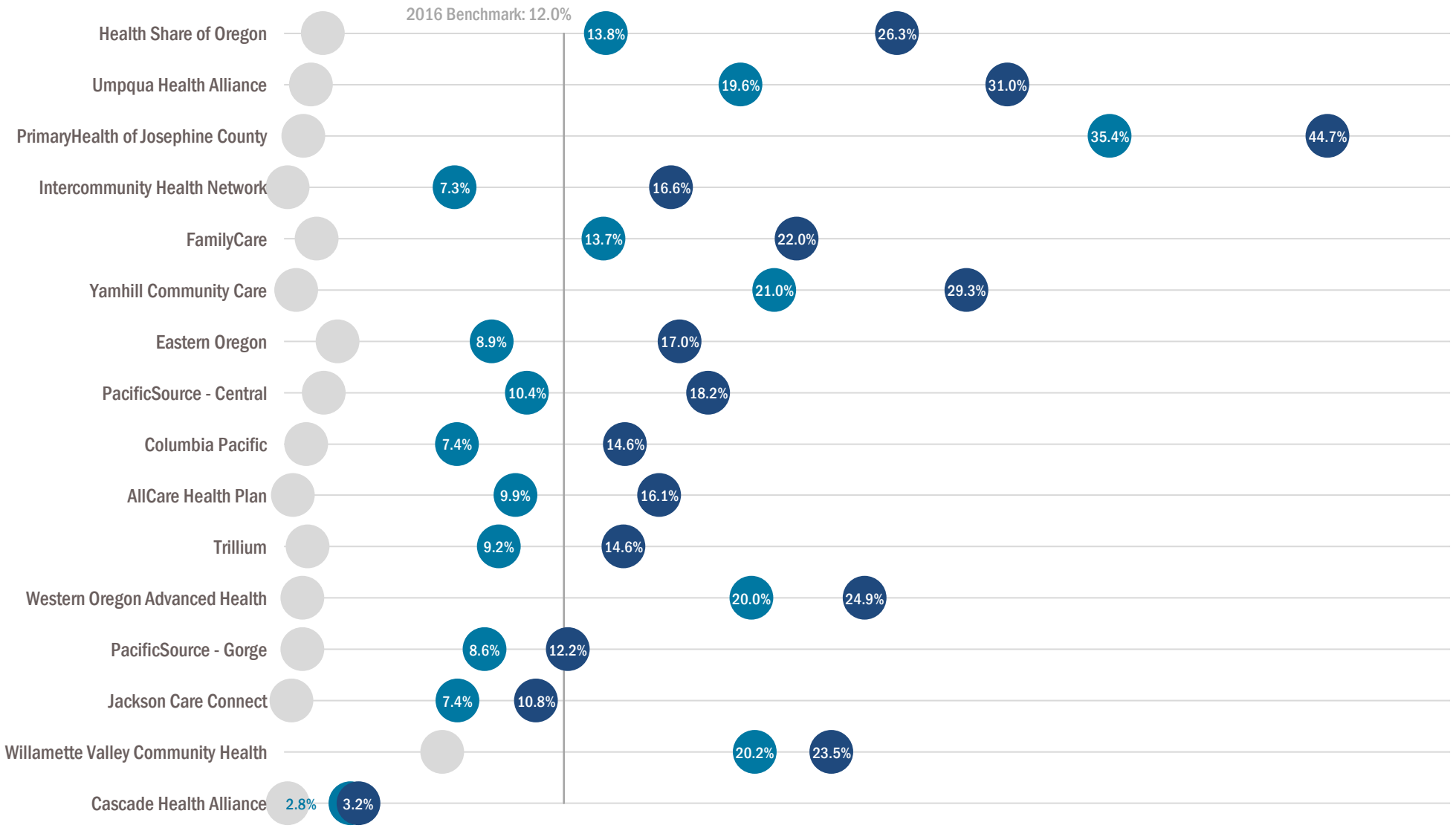
Grey dots represent 2014 / Race and ethnicity data missing for 29.7% of respondents / Each race category excludes Hispanic/Latino



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ages 12-17)

Alcohol or other substance misuse screening (ages 12-17) in 2015 & mid-2016, by CCO.

Grey dots represent 2014



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ages 18+)

Alcohol or other substance misuse screening (SBIRT) (ages 18+)

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

mid-2016 data (n=429,569)

Statewide change since 2015: +**22.2%**

Number of CCOs that improved: **14**

Calendar year 2015 and mid-2016 results for this measure are not directly comparable due to changes in the data source (ICD-10) which occurred in October 2015 (see page 9 for more information). Part of the increase that occurred in mid-2016 can be attributed to this code change and not actual performance. Specifically, the change to ICD-10 resulted in codes that are less specific to SBIRT. Thus, additional screening services (not just SBIRT) are likely being counted, artificially inflating performance.

See page 97 for results stratified by member with disability, mental health diagnoses, and severe and persistent mental illness.

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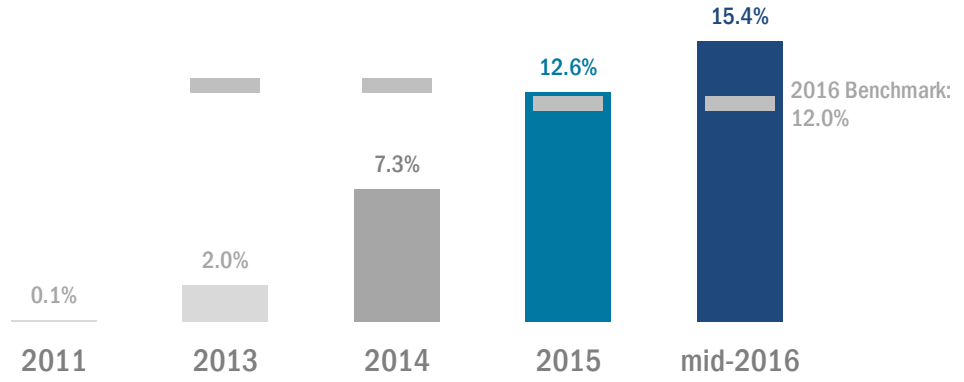
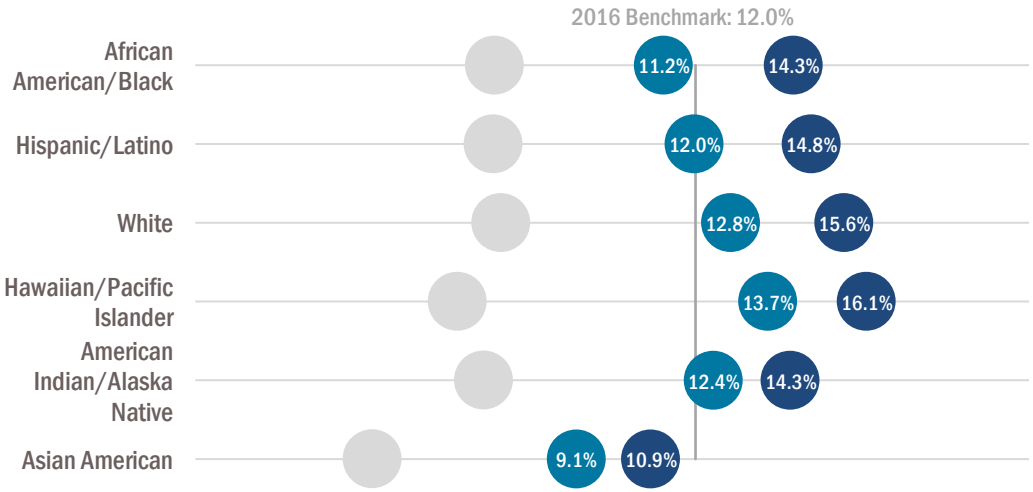
Alcohol or other substance misuse screening (ages 18+), statewide.

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



Alcohol or other substance misuse screening (ages 18+) in 2015 & mid-2016, by race and ethnicity.

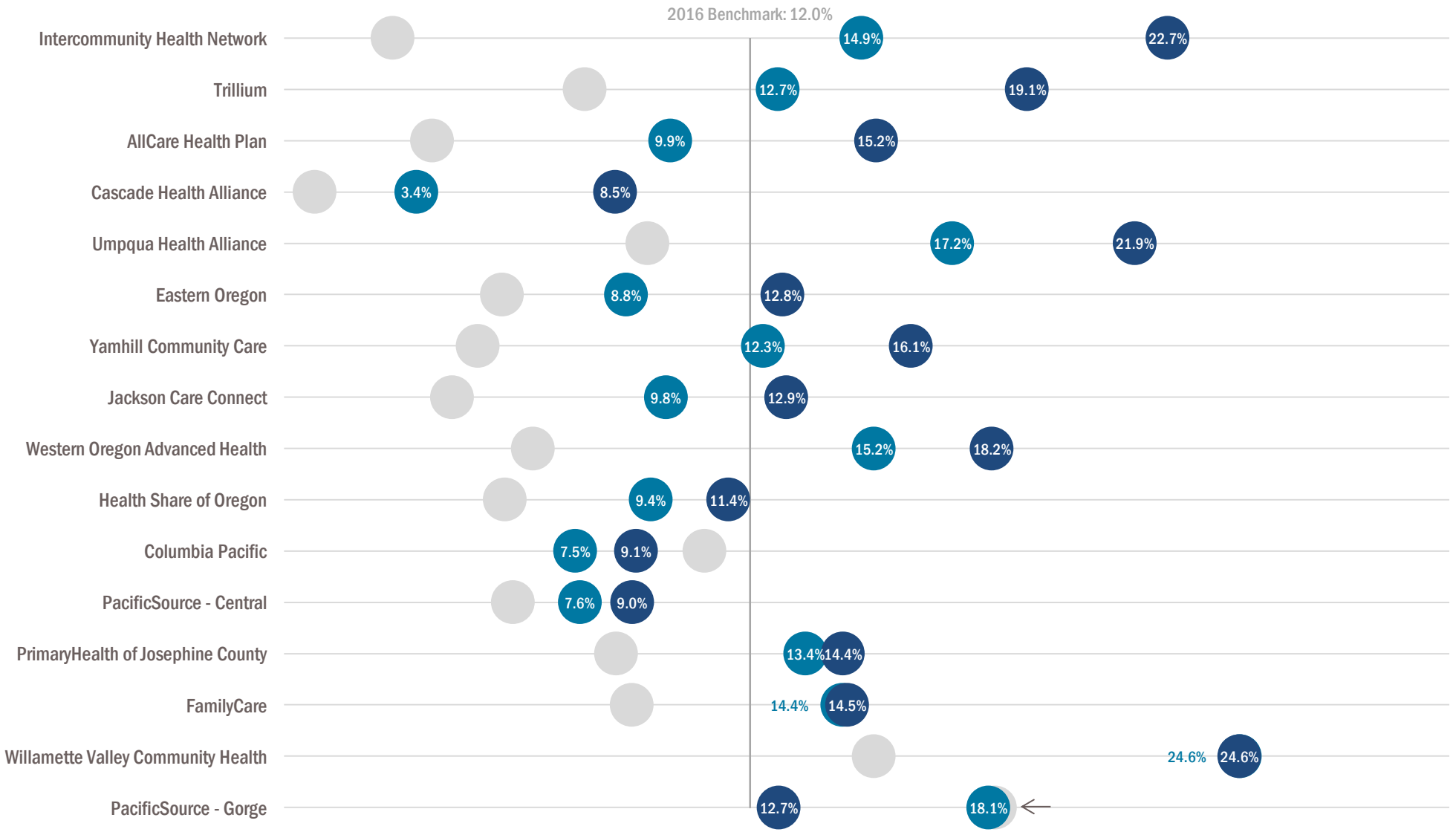
Grey dots represent 2014 / Race and ethnicity data missing for 22.5% of respondents / Each race category excludes Hispanic/Latino



ALCOHOL OR OTHER SUBSTANCE MISUSE SCREENING (SBIRT) (ages 18+)

Alcohol or other substance misuse screening (ages 18+) in 2015 & mid-2016, by CCO.

Grey dots represent 2014



AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Ambulatory care: Emergency department utilization

Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of care. (Per 1,000 member months means that in one month, XX visits occur per 1,000 members).

mid-2016 data (n=10,885,196 member months)

Statewide change since 2015: **+5.8%** (lower is better)

Number of CCOs that improved: **2**

See page 98 for results stratified by member with disability and mental health diagnoses.

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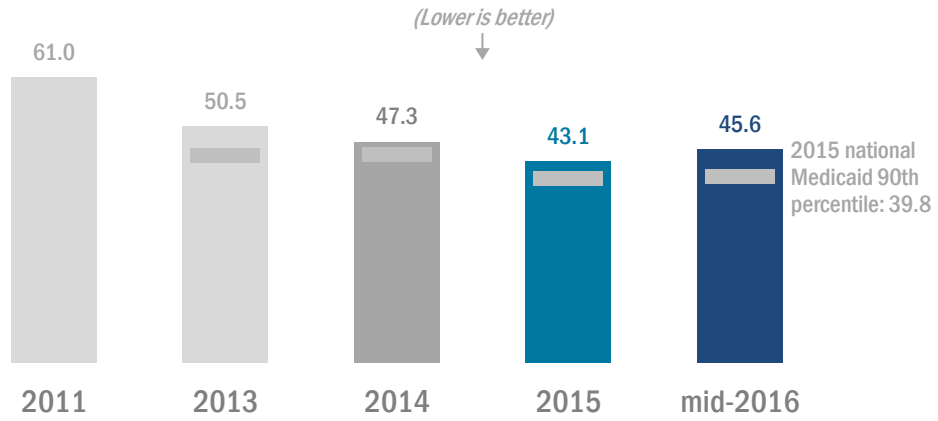
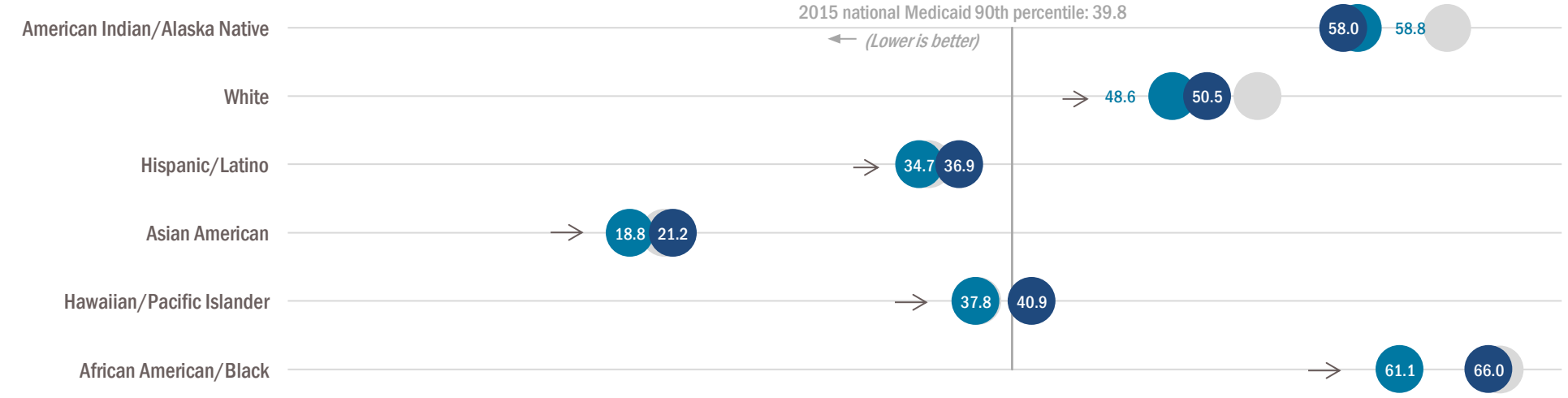
Emergency department utilization, statewide.

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



Emergency department utilization in 2015 & mid-2016, by race and ethnicity.

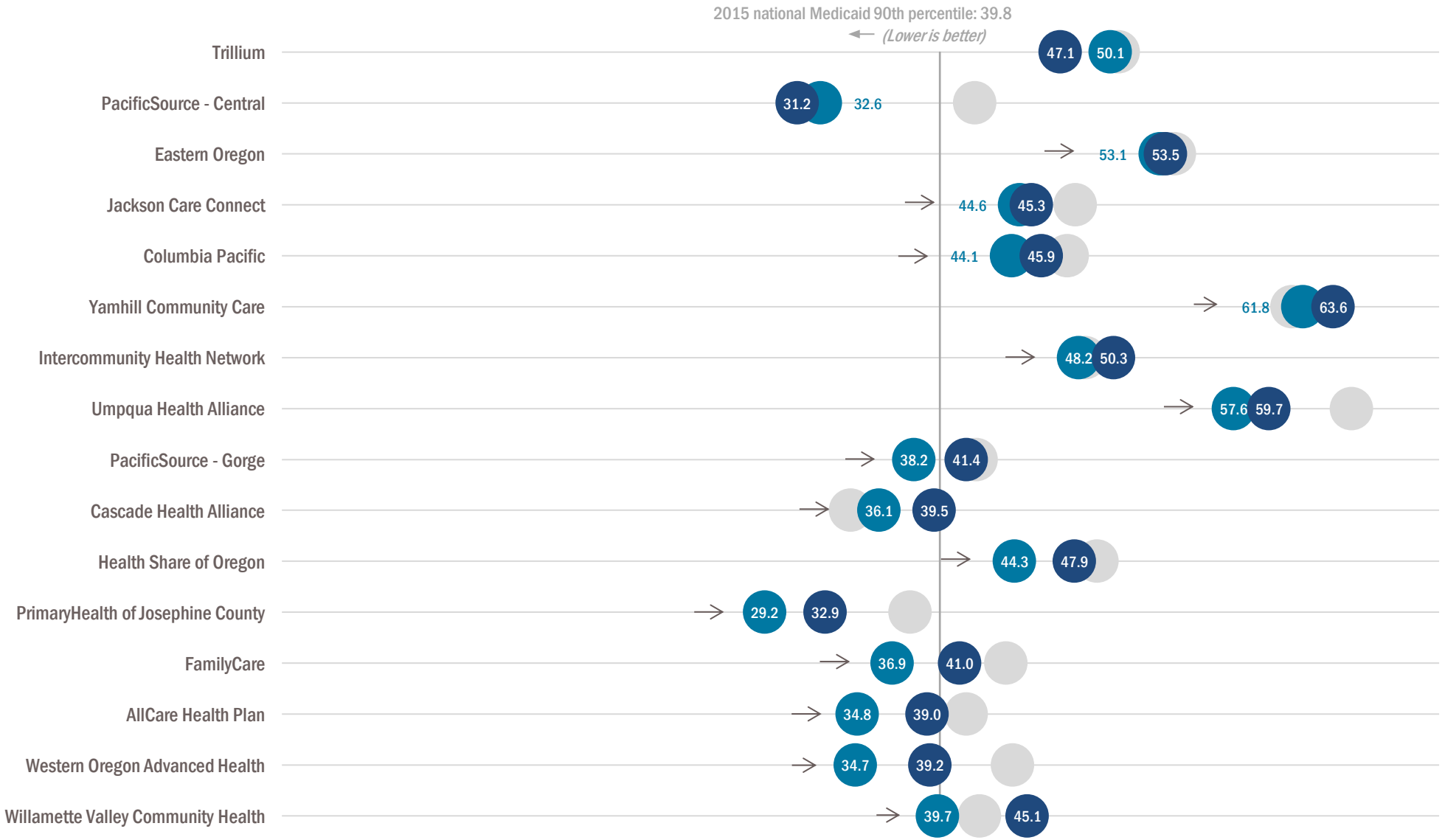
Rates are per 1,000 member months / Grey dots represent 2014 / Race and ethnicity data missing for 26.9% of respondents / Each race category excludes Hispanic/Latino



AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Emergency department utilization in 2015 & mid-2016, by CCO.

Rates are per 1,000 member months / Grey dots represent 2014



AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization

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

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

mid-2016 data (n=10,880,603 member months)

Statewide change since 2015: **-5.6%** (lower is better)

Number of CCOs that improved: **15**

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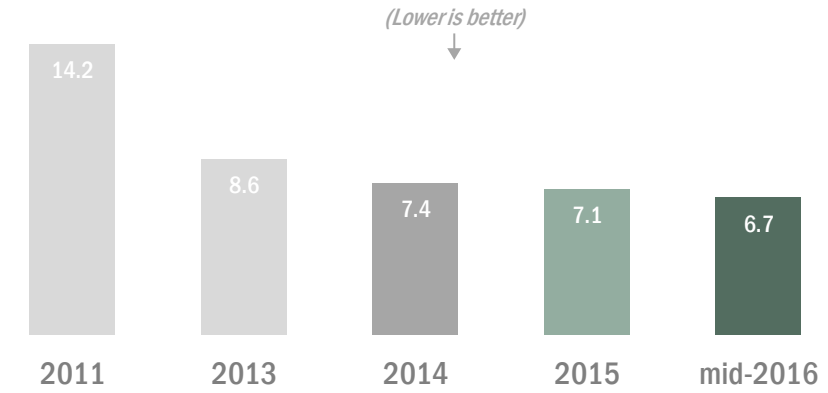
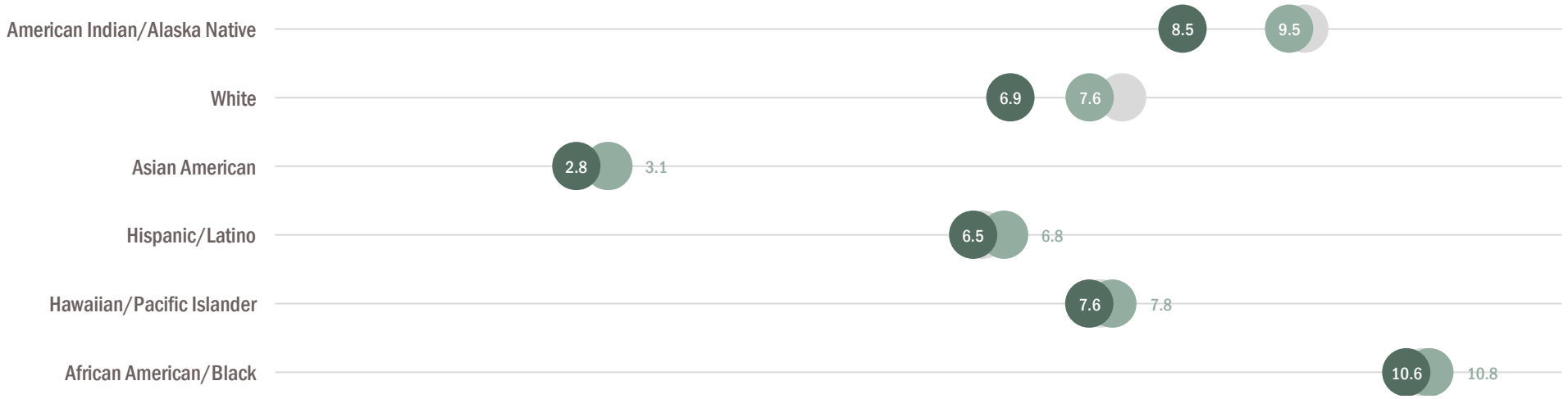
Avoidable emergency department utilization, statewide.

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



Avoidable emergency department utilization in 2015 & mid-2016, by race and ethnicity.

Rates are per 1,000 member months / Grey dots represent 2014 / Race and ethnicity data missing for 26.2% of respondents / Each race category excludes Hispanic/Latino



AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization in 2015 & mid-2016, by CCO.

Rates are per 1,000 member months / Grey dots represent 2014

AMBULATORY CARE: OUTPATIENT UTILIZATION

Outpatient utilization

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

mid-2016 data (n=10,885,196 member months)

Statewide change since 2015: **-0.4%**

Number of CCOs that increased: **11**

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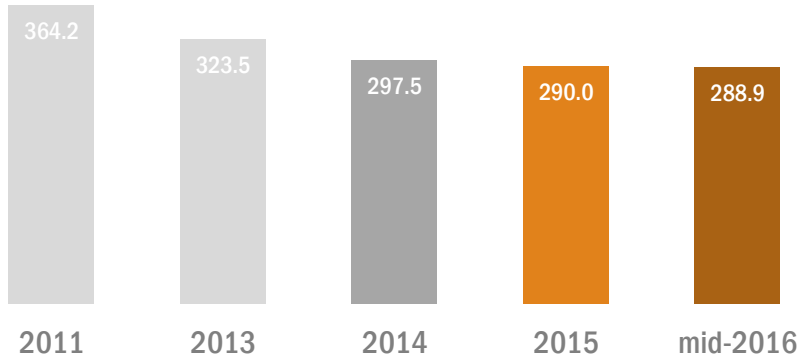
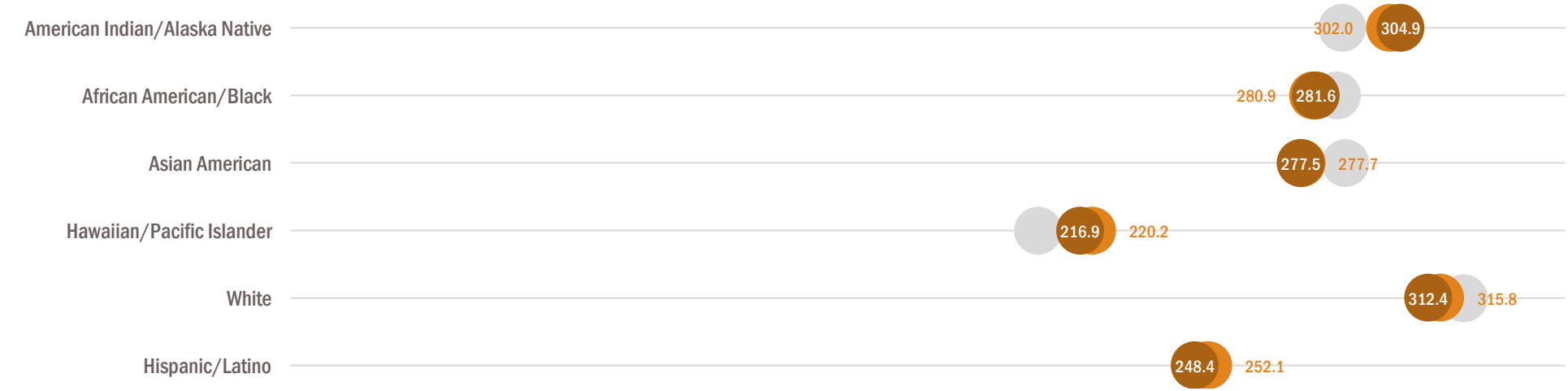
Outpatient utilization, statewide.

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



Outpatient utilization in 2015 & mid-2016, by race and ethnicity.

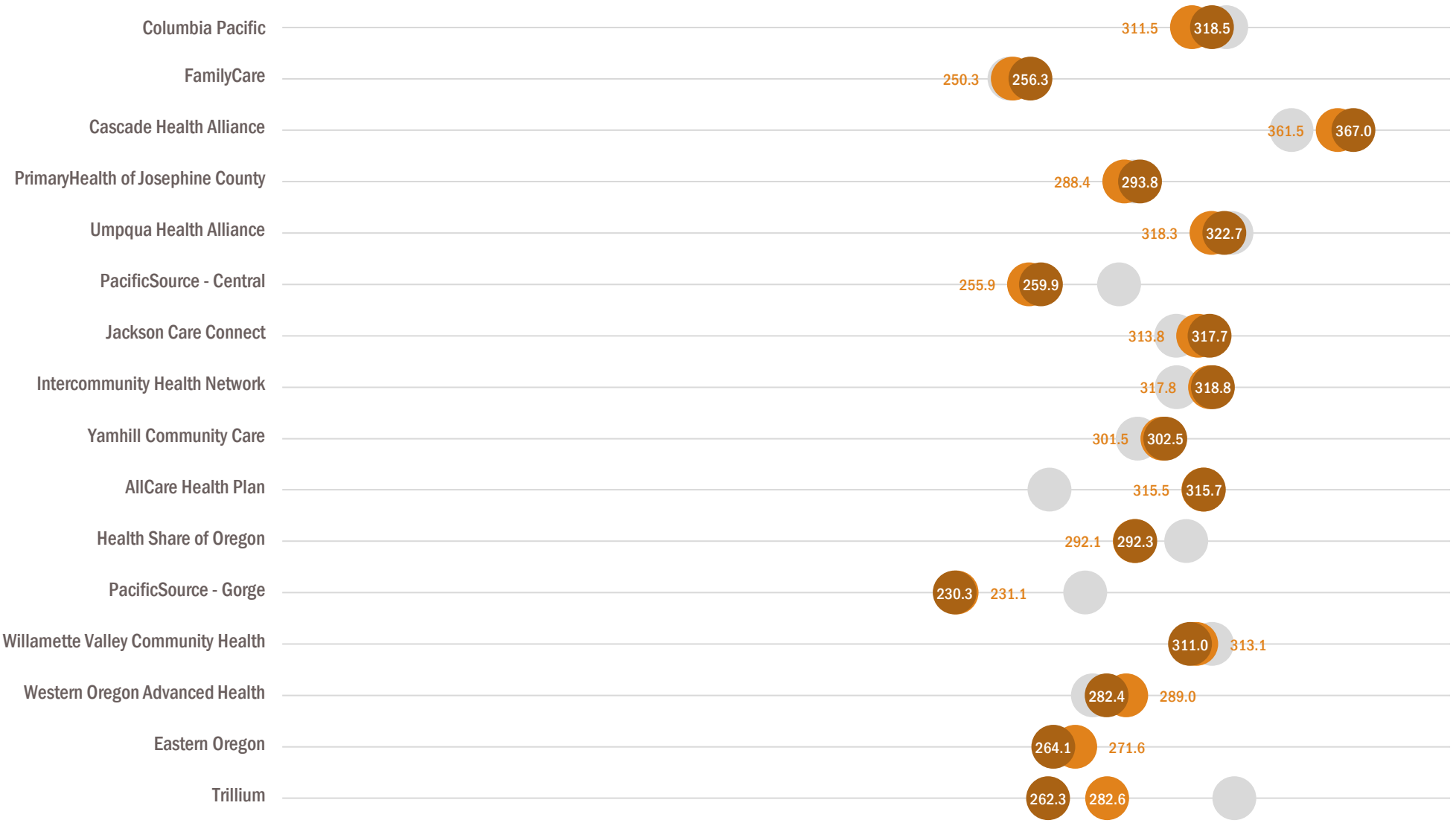
Rates are per 1,000 member months / Grey dots represent 2014 / Race and ethnicity data missing for 25.9% of respondents / Each race category excludes Hispanic/Latino



AMBULATORY CARE: OUTPATIENT UTILIZATION

Outpatient utilization in 2015 & mid-2016, by CCO.

Rates are per 1,000 member months / Grey dots represent 2014



APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Appropriate testing for children with pharyngitis

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

mid-2016 data (n=8,859)

Statewide change since 2015: **+0.9%**

Number of CCOs that improved: **11**

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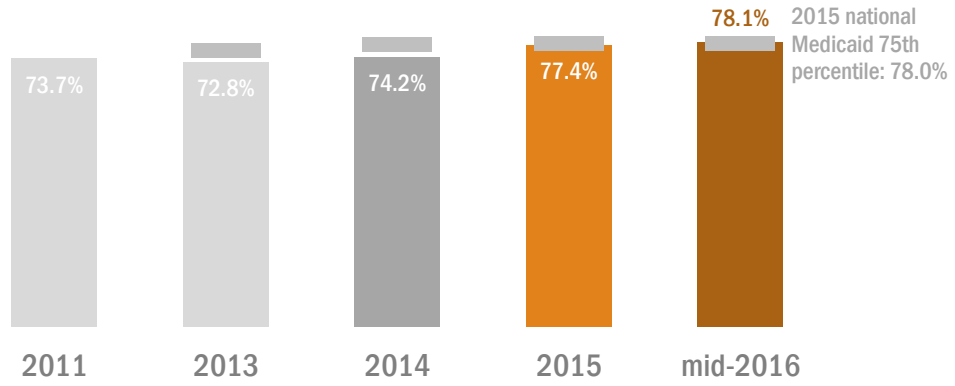
Appropriate testing for children with pharyngitis, statewide.

Data source: Administrative (billing) claims



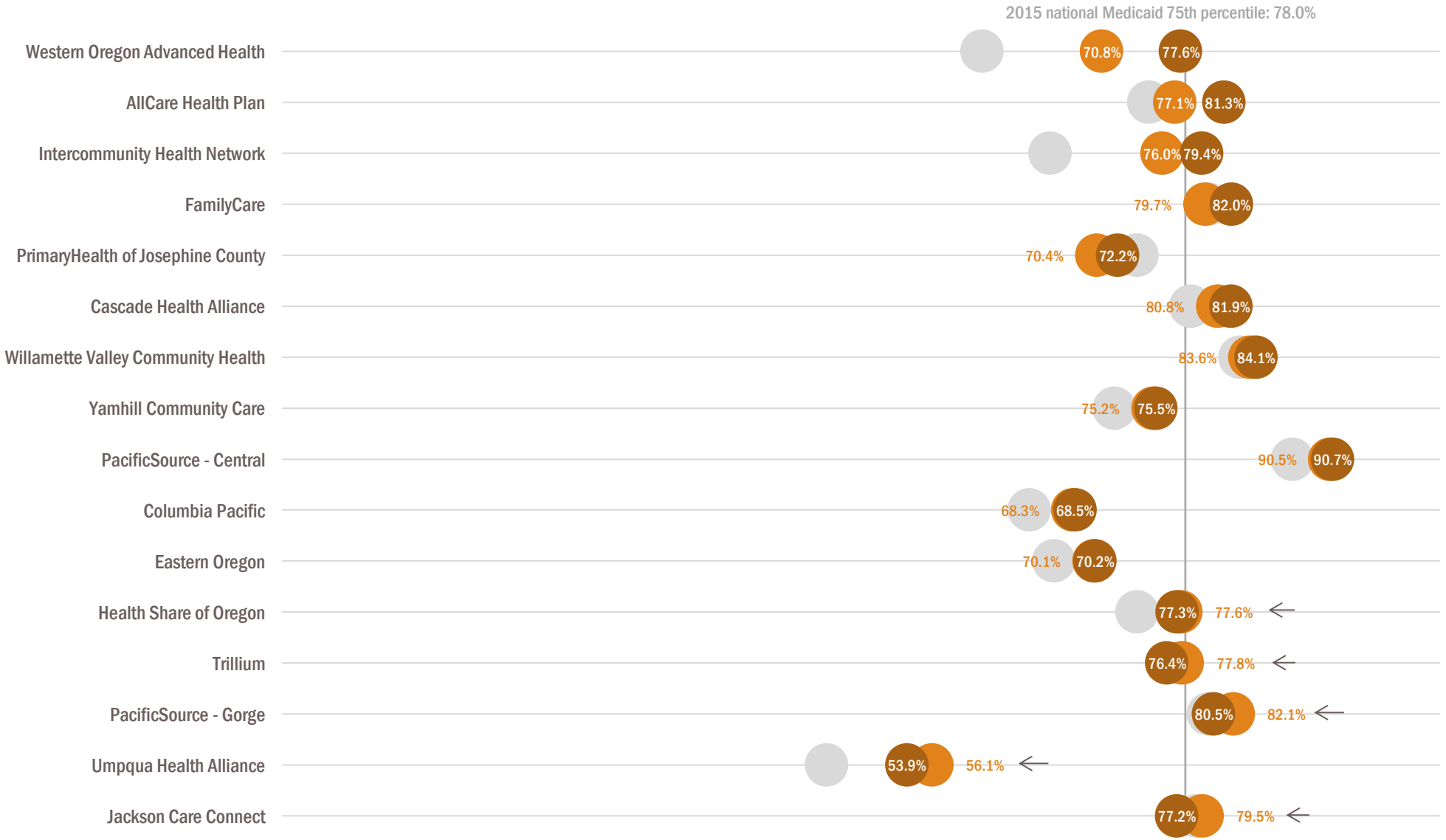
Appropriate testing for children with pharyngitis in 2015 & mid-2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 30.2% of respondents / Each race category excludes Hispanic/Latino
~ Data suppressed (n<30)

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Appropriate testing for children with pharyngitis in 2015 & mid-2016, by CCO.

Grey dots represent 2014



ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Assessments for children in DHS custody

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

mid-2016 data (n=1,639)

Statewide change since 2015: **+15.6%**

Number of CCOs that improved: **13**

See page 101 for results stratified by member with disability and mental health diagnoses.

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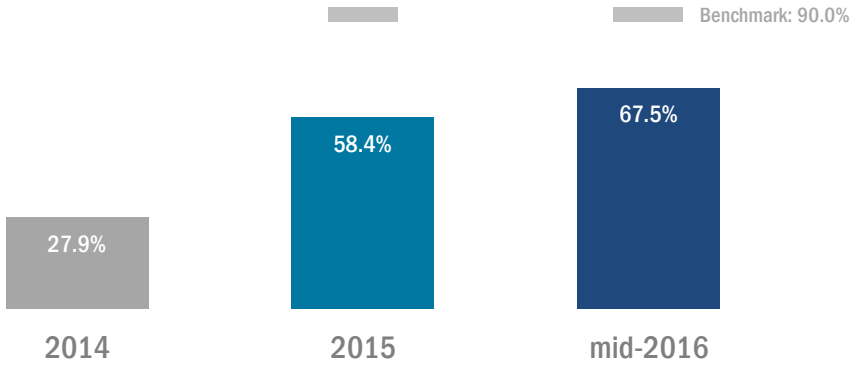
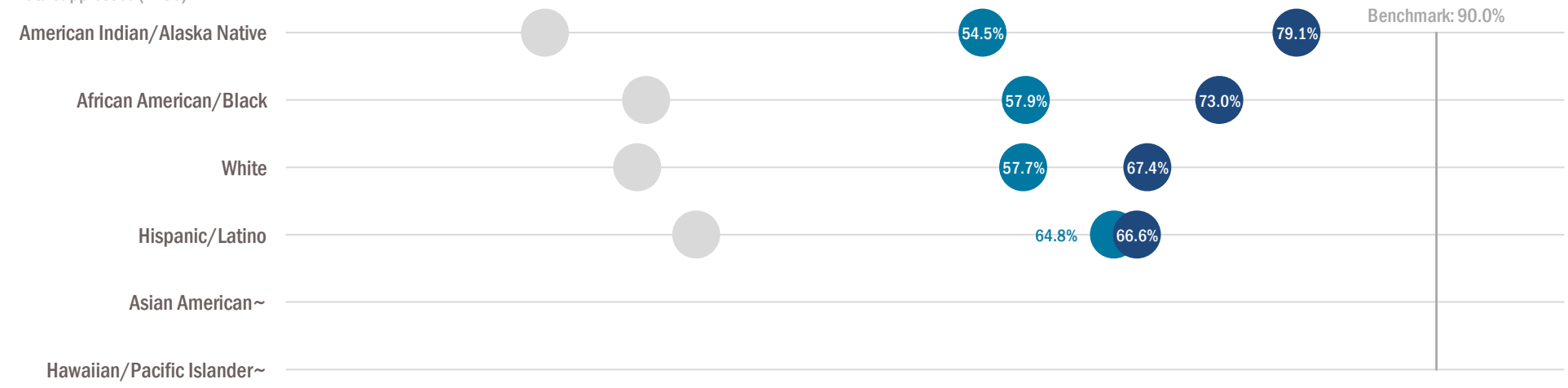
Percentage of children in DHS custody who received health assessments, statewide.

Data source: Administrative (billing) claims + ORKids



Percentage of children in DHS custody who received health assessments in 2015 & mid-2016, by race and ethnicity.

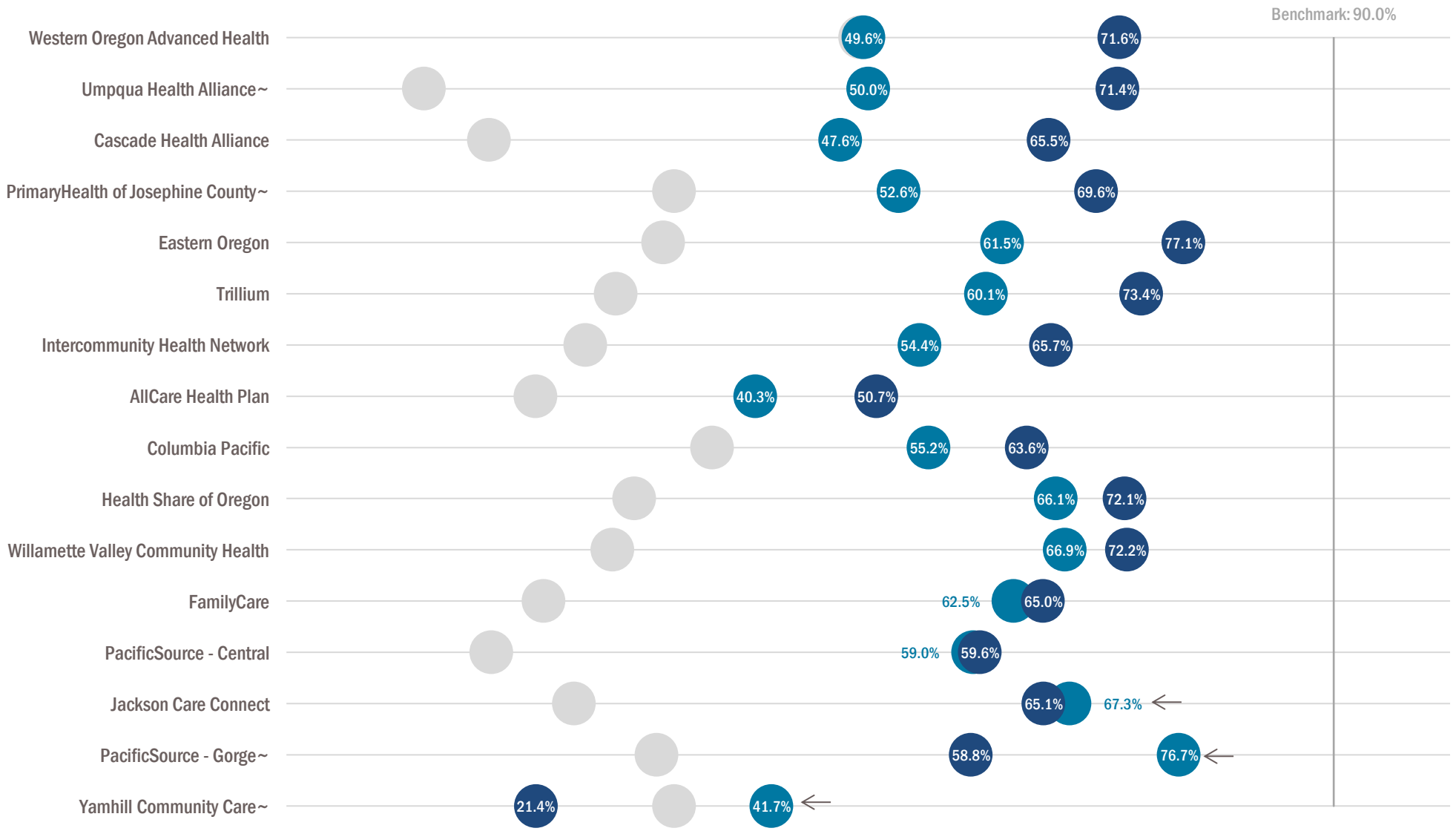
Grey dots represent 2014 / Race and ethnicity data missing for 7.1% of respondents / Each race category excludes Hispanic/Latino
~ Data suppressed (n<30)



ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Percentage of children in DHS custody who received health assessments in 2015 & mid-2016, by CCO.

Grey dots represent 2014
~ Note small denominator (n<30)



CERVICAL CANCER SCREENING

Cervical cancer screening

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

mid-2016 data (n=163,129)

Statewide change since 2015: **+4.4%**

Number of CCOs that improved: **all 16**

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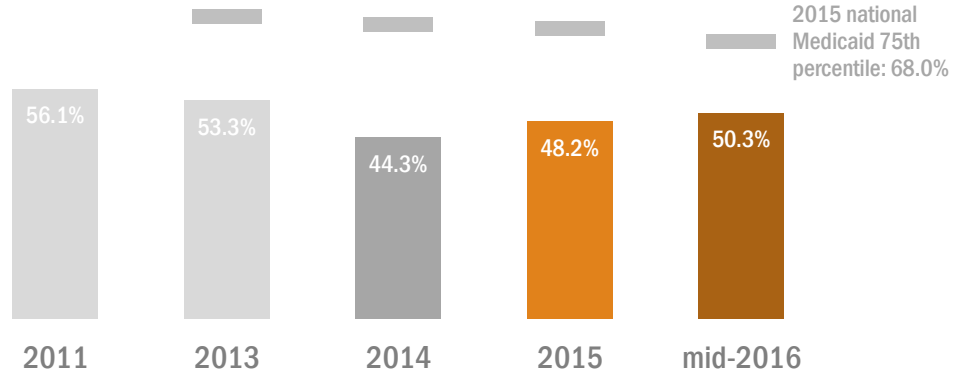
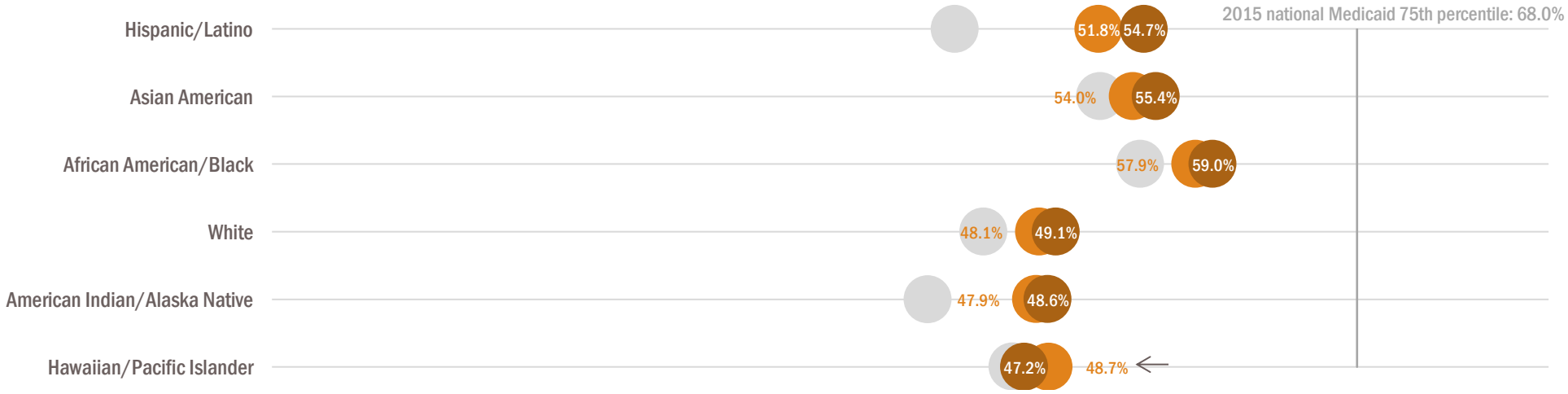
Cervical cancer screening, statewide.

Data source: Administrative (billing) claims



Cervical cancer screening in 2015 & mid-2016, by race and ethnicity.

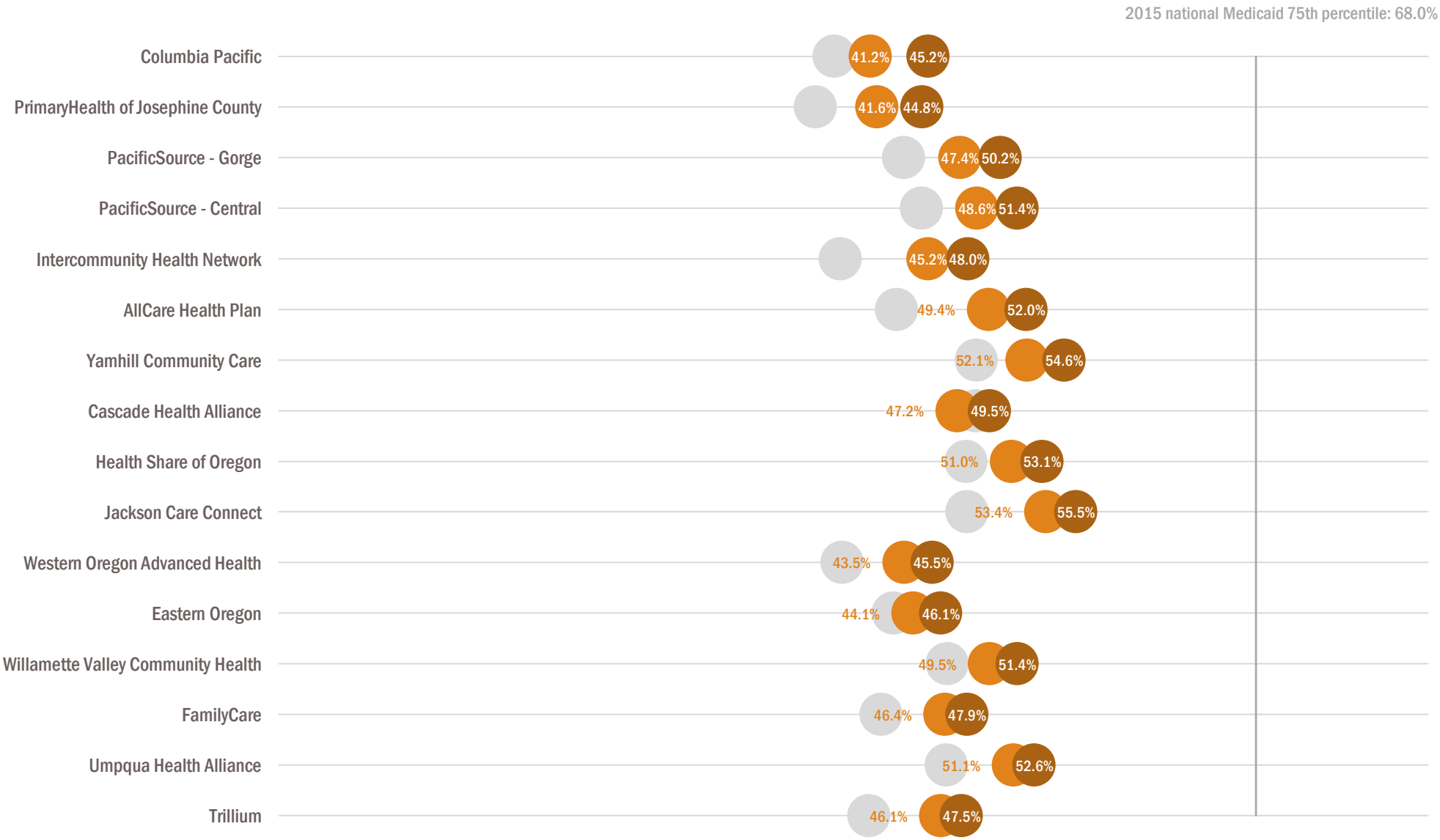
Grey dots represent 2014 / Race and ethnicity data missing for 23.8% of respondents / Each race category excludes Hispanic/Latino



CERVICAL CANCER SCREENING

Cervical cancer screening in 2015 & mid-2016, by CCO.

Grey dots represent 2014



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

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

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

mid-2016 data (n=223,696)

Statewide change since 2015: **-0.4%**

Number of CCOs that improved: **3**

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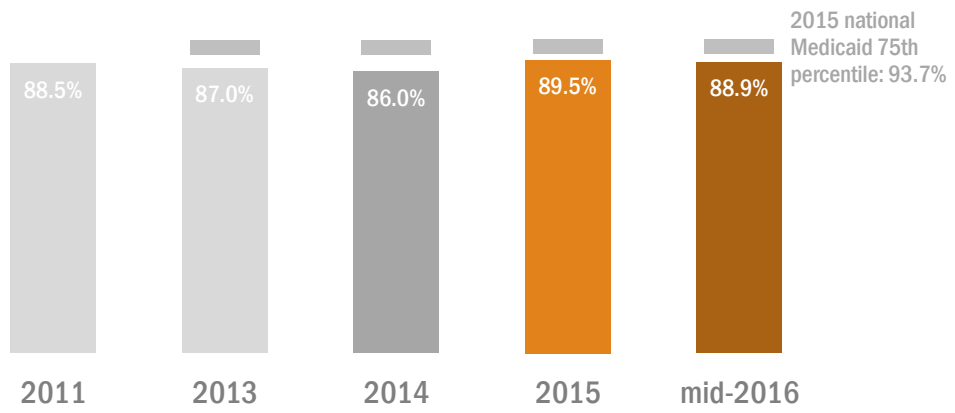
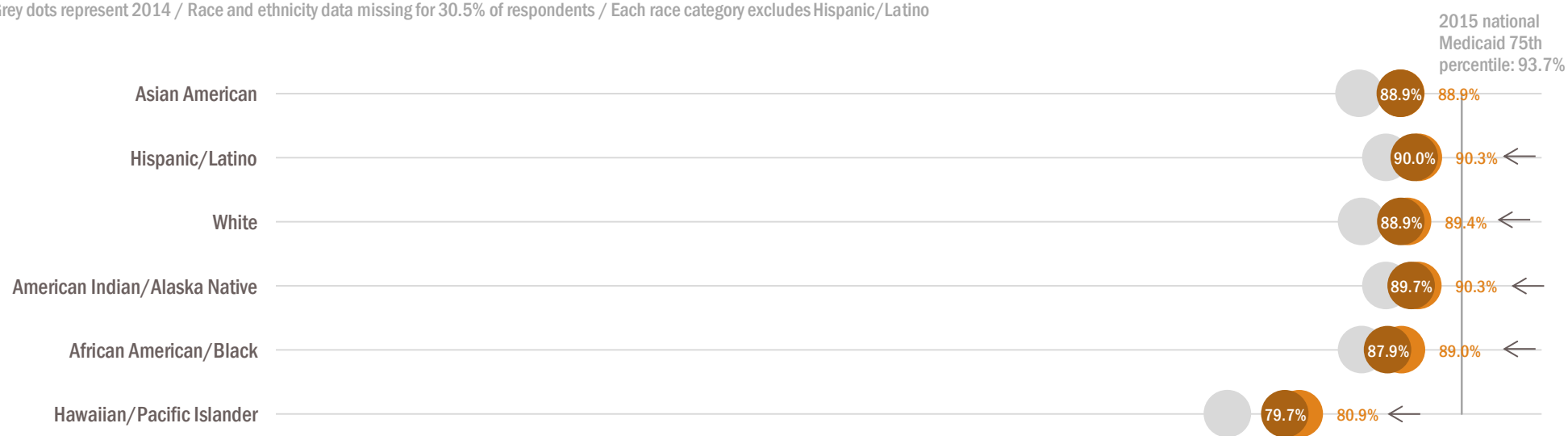
Percentage of children and adolescents (all ages) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children and adolescents (all ages) who had a visit with a primary care provider in 2015 & mid-2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 30.5% of respondents / Each race category excludes Hispanic/Latino



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

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

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

mid-2016 data (n=18,772)

Statewide change since 2015: **-0.8%**

Number of CCOs that improved: **4**

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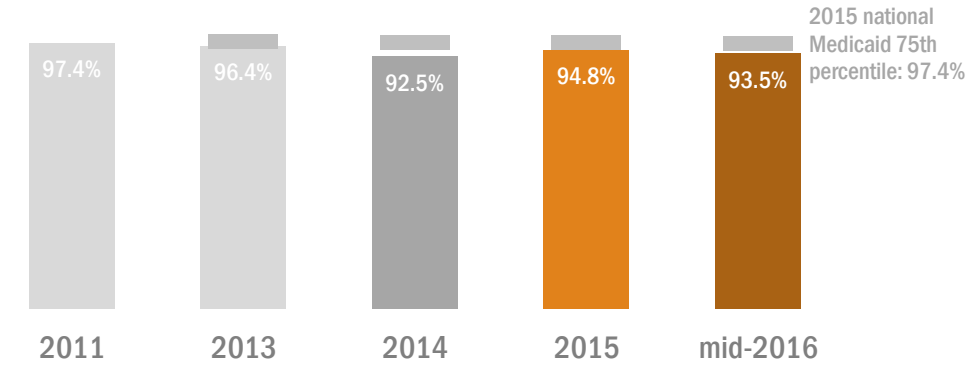
Percentage of children (ages 12-24 months) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children (ages 12-24 months) who had a visit with a primary care provider between 2015 & mid-2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 32.4% of respondents / Each race category excludes Hispanic/Latino

CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (25 months-6 years)

Childhood and adolescent access to primary care providers (24 months - 6 years)

Percentage of children and adolescents (ages 24 months - 6 years) who had a visit with a primary care provider.

mid-2016 data (n=71,393)

Statewide change since 2015: **-1.6%**

Number of CCOs that improved: **2**

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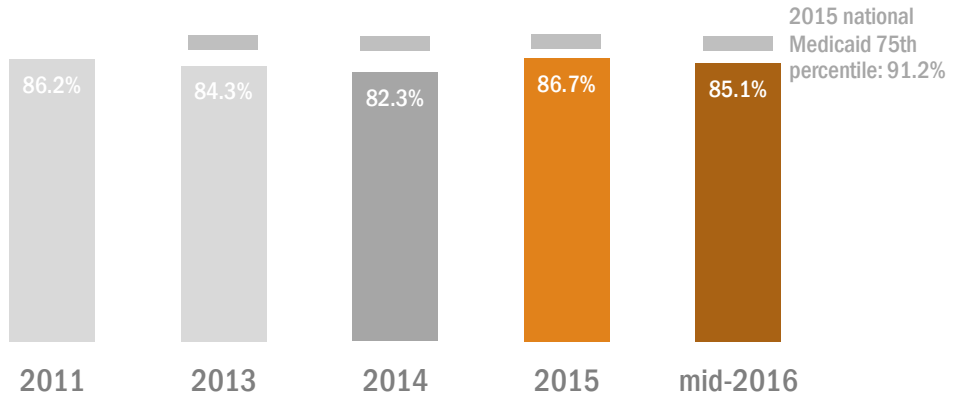
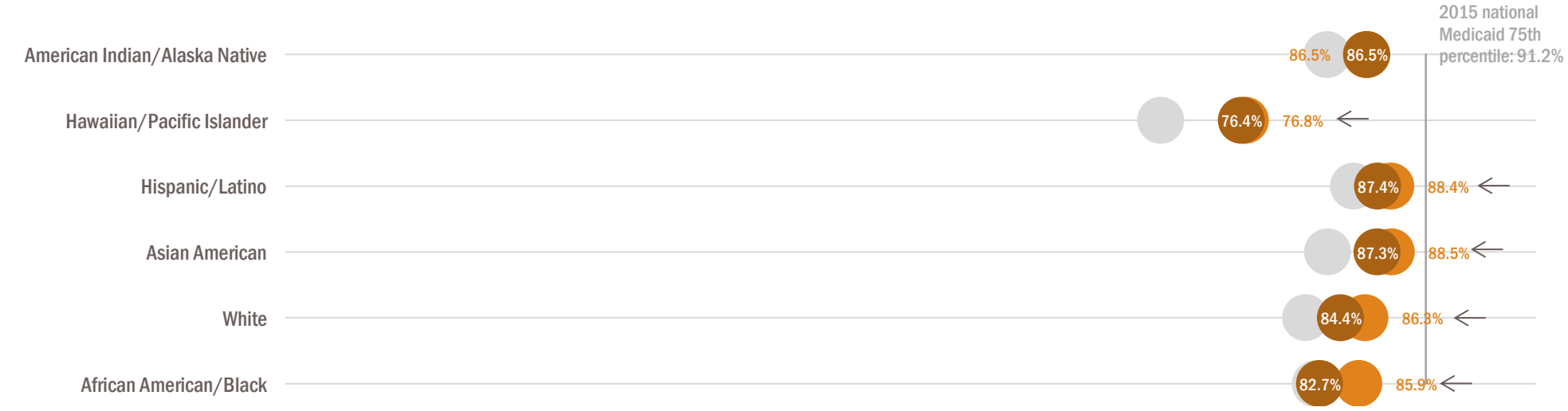
Percentage of children (ages 25 months - 6 years) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children (ages 25 months - 6 years) who had a visit with a primary care provider in 2015 & mid-2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 31.1% of respondents / Each race category excludes Hispanic/Latino



CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS (7—11 years)

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

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

mid-2016 data (n=58,316)

Statewide change since 2015: **0.4%**

Number of CCOs that improved: **11**

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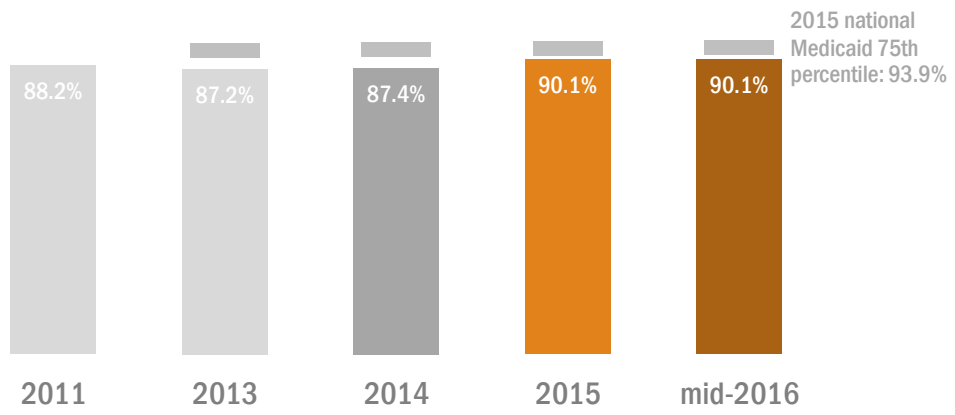
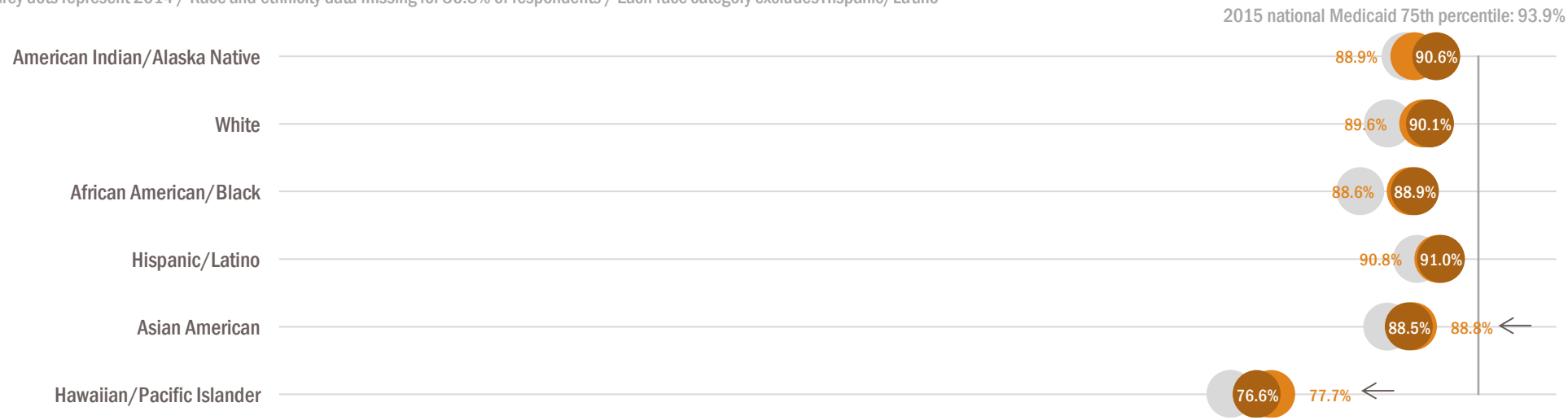
Percentage of children (ages 7-11 years) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of children (ages 7-11 years) who had a visit with a primary care provider in 2015 & mid-2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 30.8% of respondents / Each race category excludes Hispanic/Latino



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

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

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

mid-2016 data (n=75,215)

Statewide change since 2015: **0.1%**

Number of CCOs that improved: **10**

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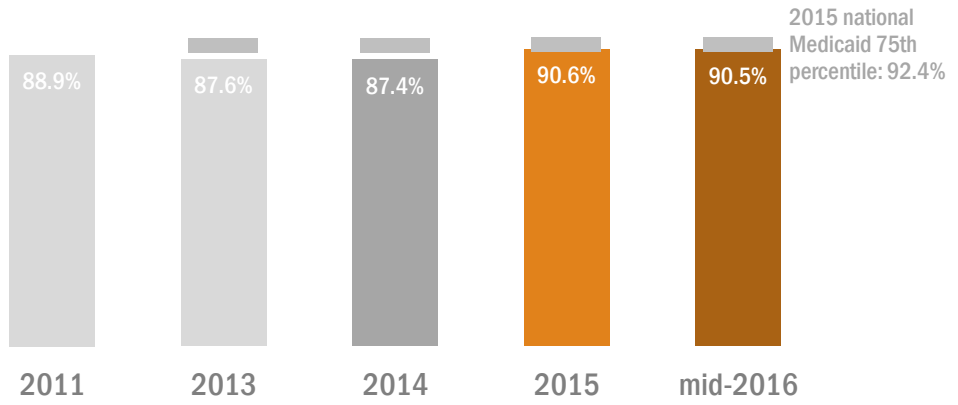
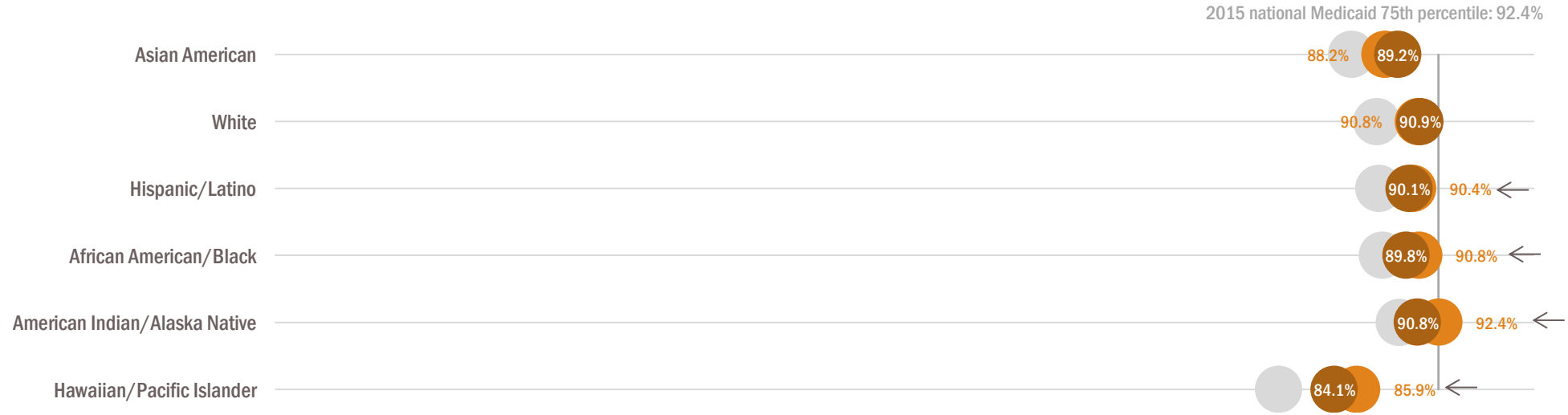
Percentage of adolescents (ages 12-19 years) who had a visit with a primary care provider, statewide.

Data source: Administrative (billing) claims



Percentage of adolescents (ages 12-19 years) who had a visit with a primary care provider in 2015 & mid-2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 29.1% of respondents / Each race category excludes Hispanic/Latino



CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS - by CCO

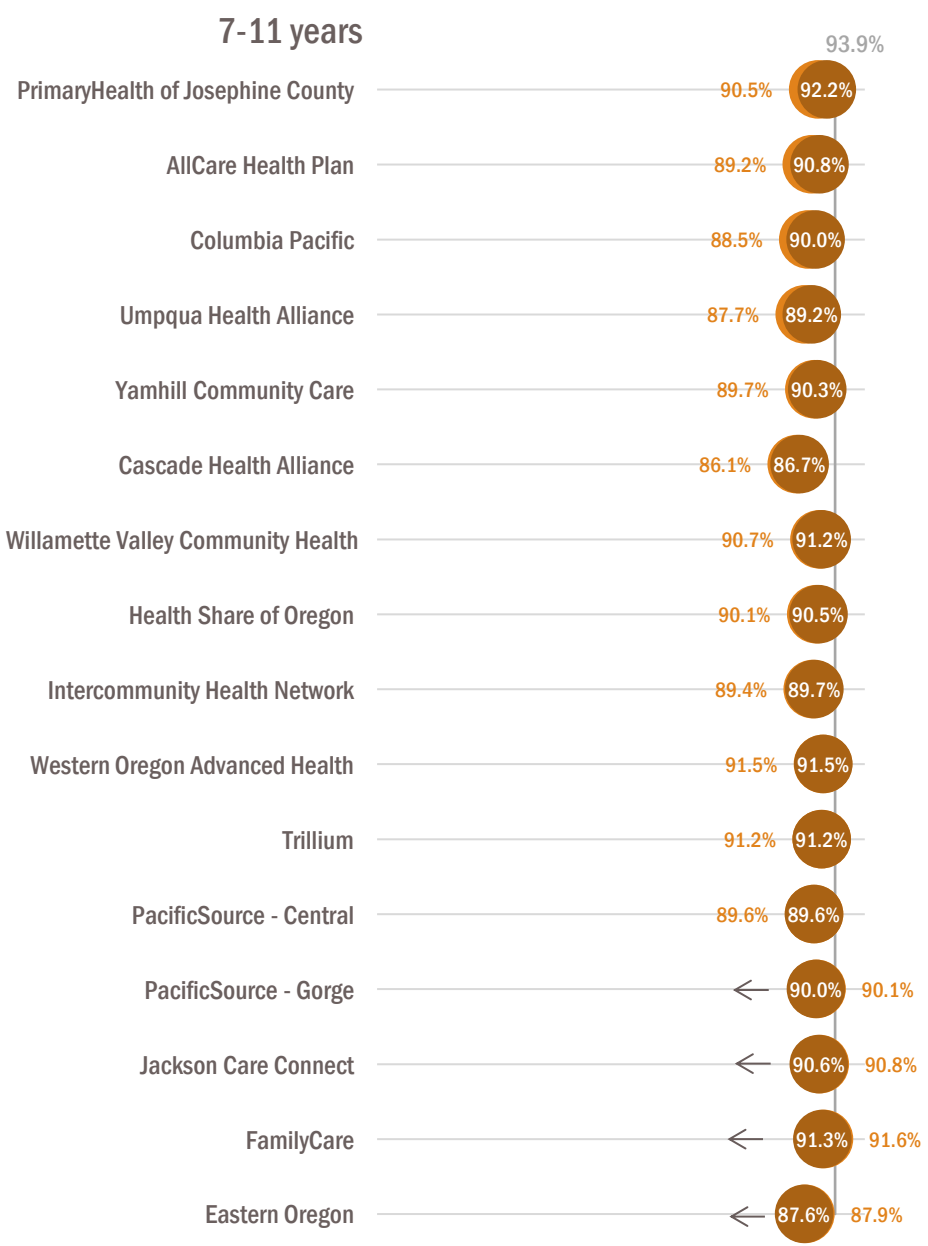
Percentage of children and adolescents (all ages) who had a visit with a primary care provider in 2015 & mid-2016, by CCO.

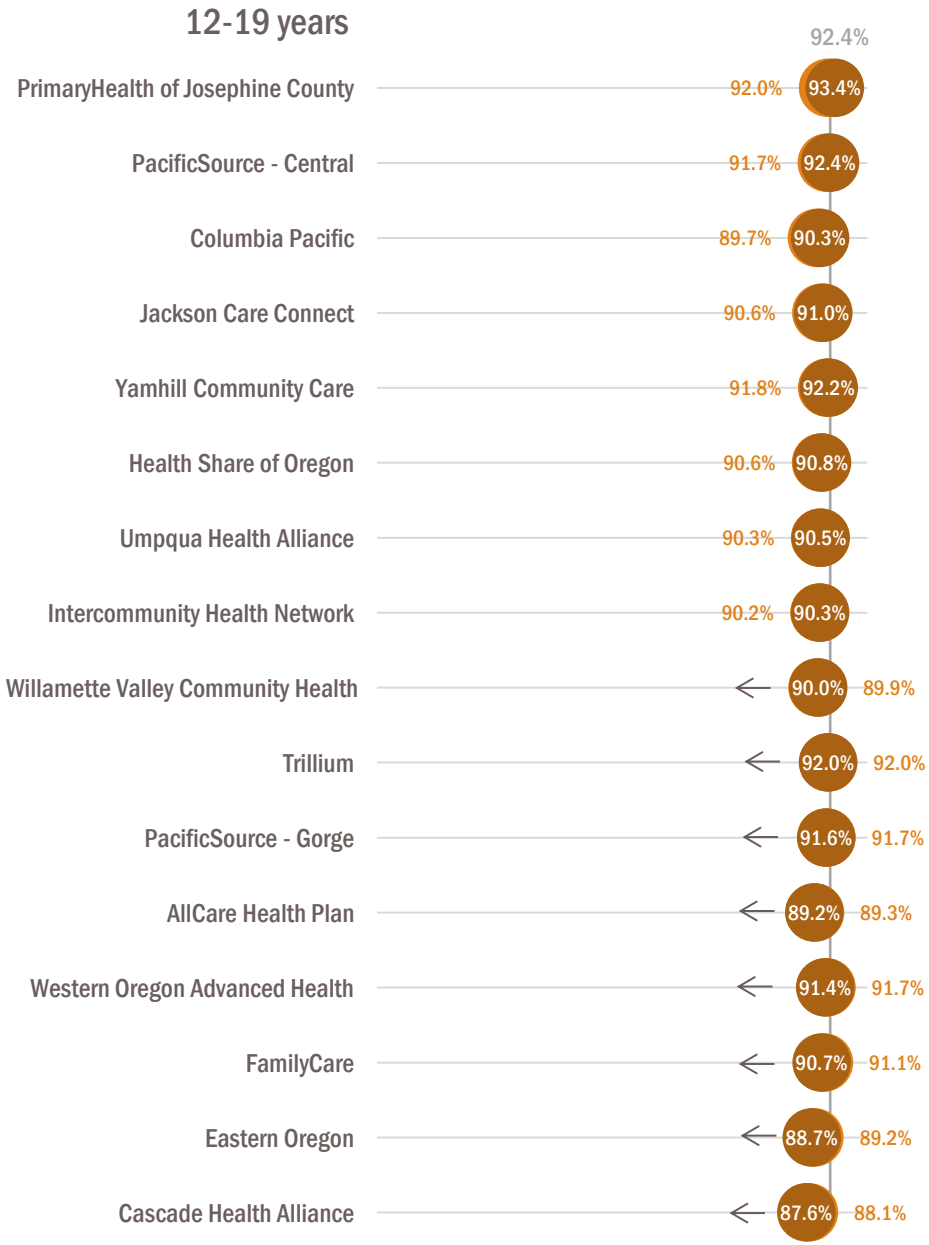
CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS - by CCO

Percentage of adolescents who had a visit with a primary care provider in 2015 & mid-2016, by CCO.

CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS - by CCO

Percentage of children who had a visit with a primary care provider in 2015 & mid-2016, by CCO.





CHILDHOOD IMMUNIZATION STATUS

Childhood immunization status

Percentage of children who received recommended vaccines (DTaP, IPV, MMR, HiB, Hepatitis B, VZV) before their second birthday.

mid-2016 data (n=14,481)

Statewide change since 2015: **0.0%**

Number of CCOs that improved: **8**

Childhood immunization status is a new incentive measure beginning in 2016.

Calendar year 2015 and mid-2016 results for this measure are not directly comparable due to changes in the data source (administrative billing claims) which occurred in October 2015. See page 9 for more information.

See page 103 for results stratified by member with disability and mental health diagnoses.

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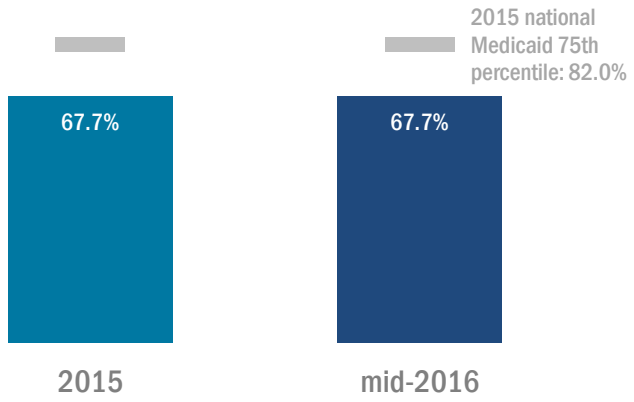
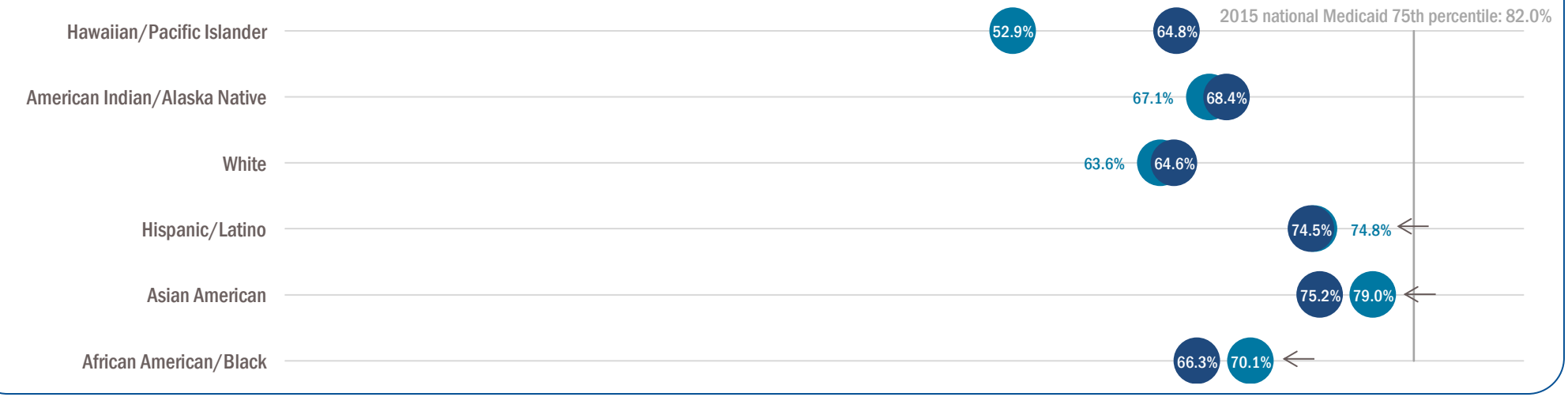
Percentage of children who received recommended vaccines before their second birthday, statewide.

Data source: Administrative (billing) claims and ALERT immunization data



Percentage of children who received recommended vaccines before their second birthday in 2015 & mid-2016, by race and ethnicity.

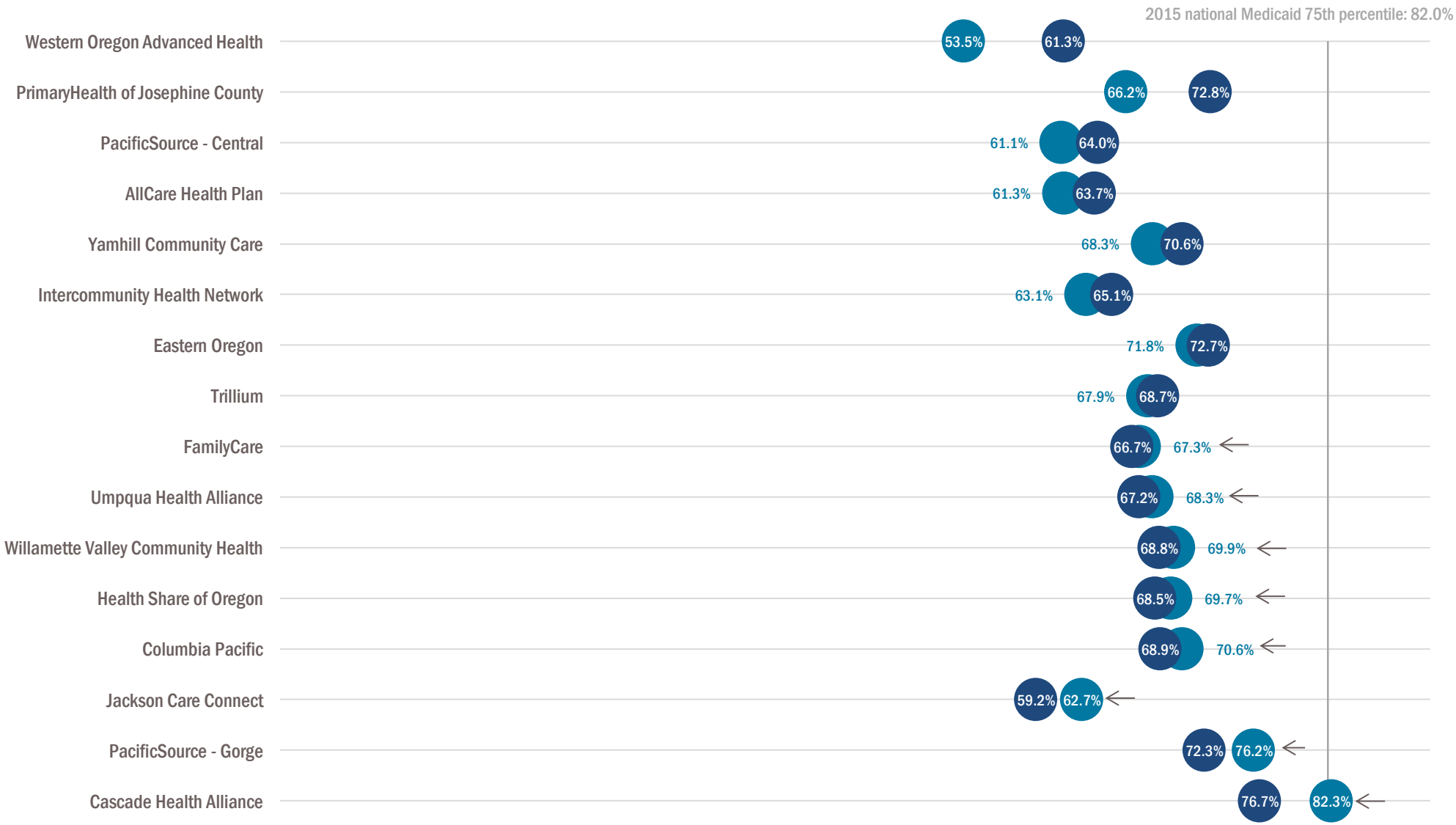
These data should not be compared to previously-published reports / 2015 results have been updated / Race and ethnicity data missing for 32.6% of respondents / Each race category excludes Hispanic/Latino



CHILDHOOD IMMUNIZATION STATUS

Percentage of children who received recommended vaccines before their second birthday in 2015 & mid-2016, by CCO.

These data should not be compared to previously-published reports / 2015 results have been updated



CHLAMYDIA SCREENING

Chlamydia screening

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

mid-2016 data (n=25,291)

Statewide change since 2015: **-2.0%**

Number of CCOs that improved: **7**

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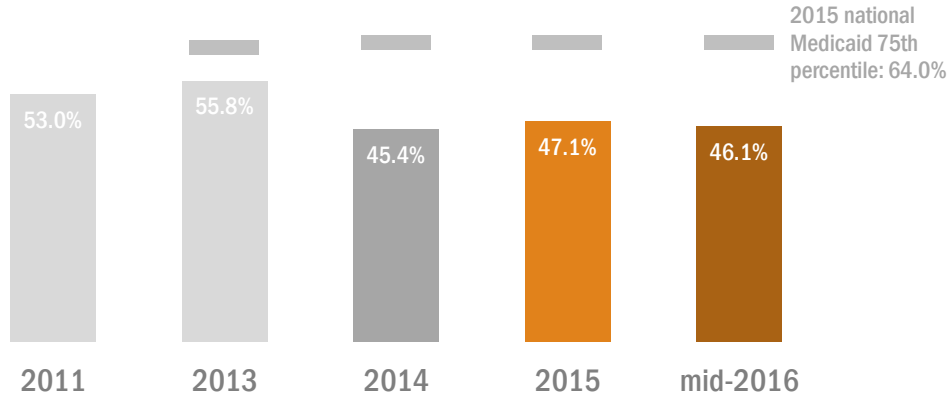
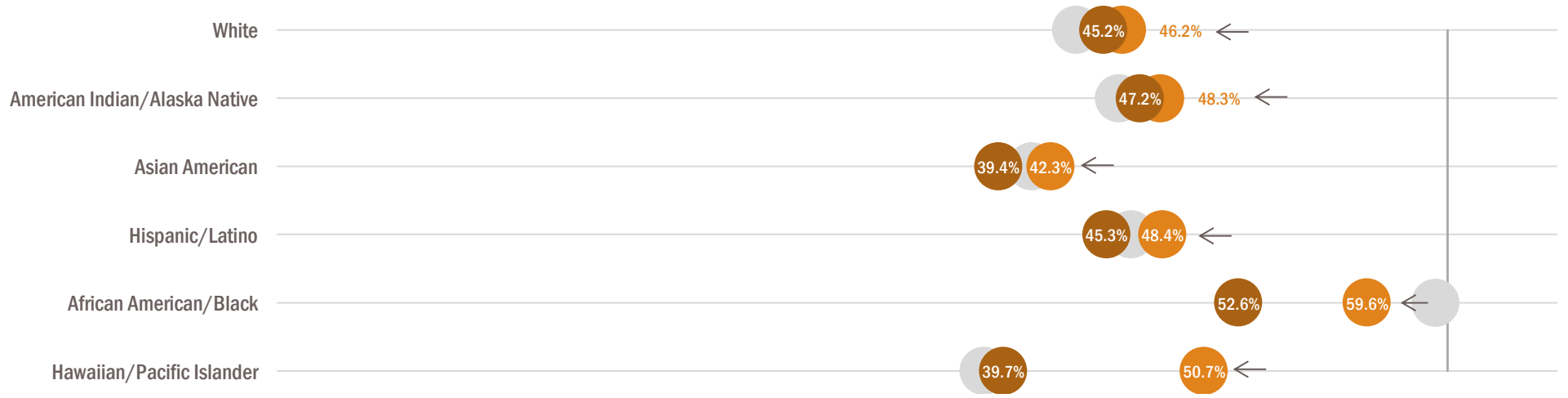
Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection, statewide.

Data source: Administrative (billing) claims



Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection in 2015 & mid-2016, by race and ethnicity.

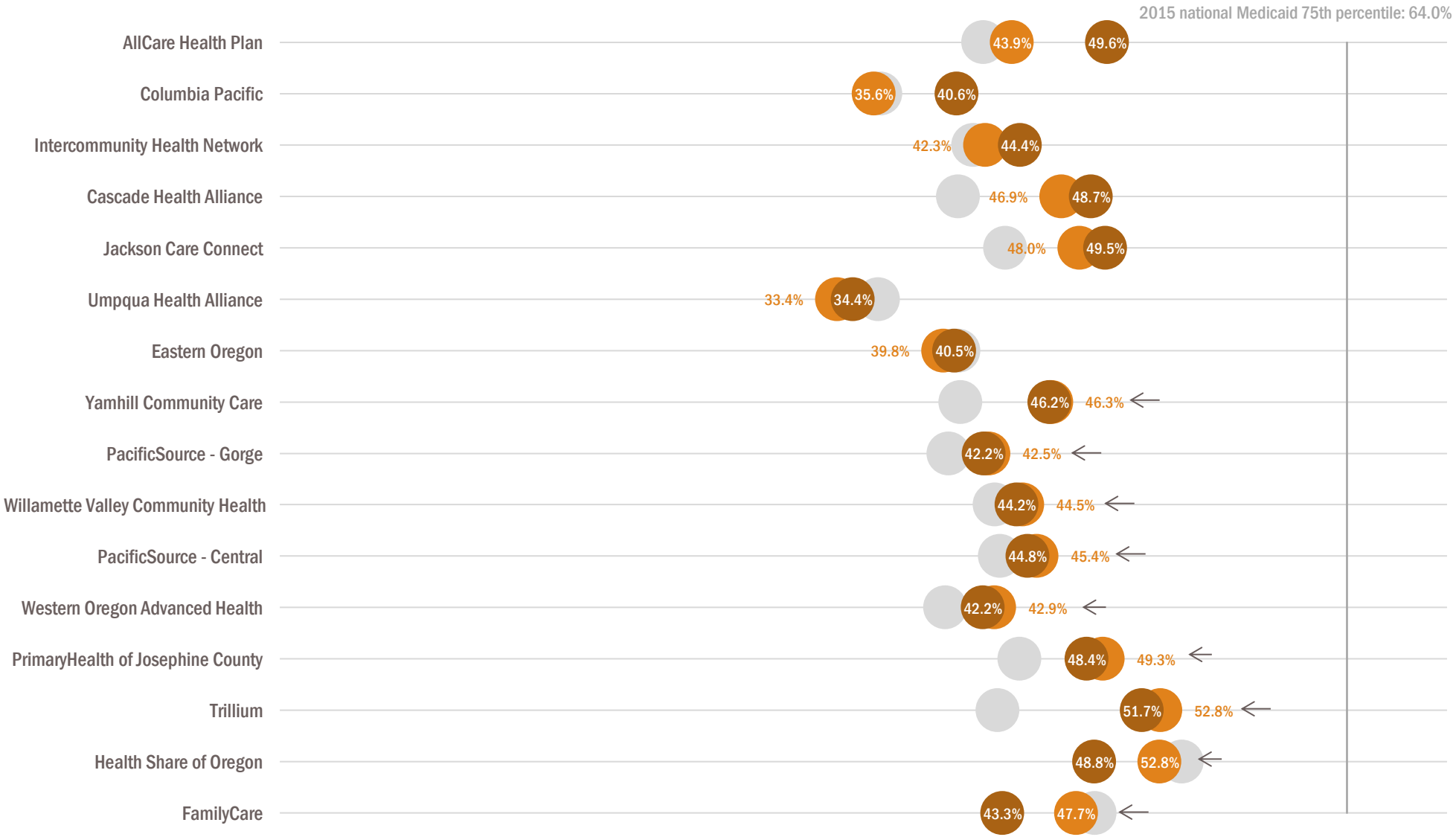
Grey dots represent 2014 / Race and ethnicity data missing for 25.7% of respondents / Each race category excludes Hispanic/Latino



CHLAMYDIA SCREENING

Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection in 2015 & mid-2016, by CCO.

Grey dots represent 2014



COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

Comprehensive diabetes care: HbA1c testing

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

mid-2016 data (n=34,222)

Statewide change since 2015: **-0.7%**

Number of CCOs that improved: **4**

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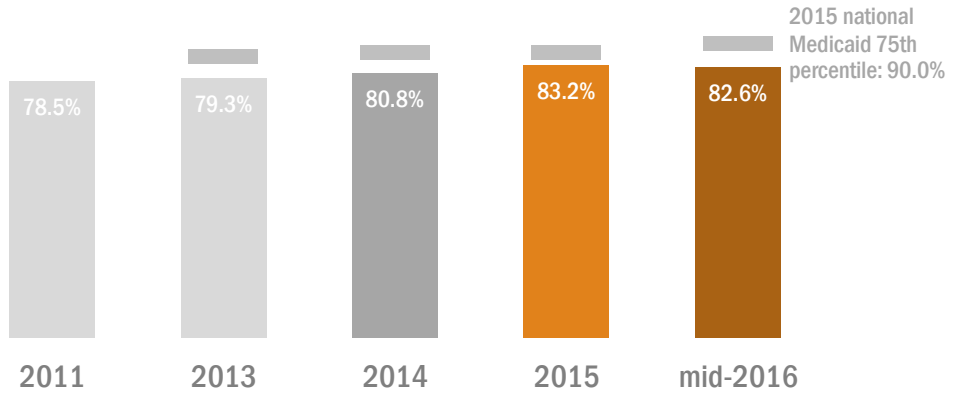
Percentage of adults with diabetes who received an A1c blood sugar test, statewide.

Data source: Administrative (billing) claims



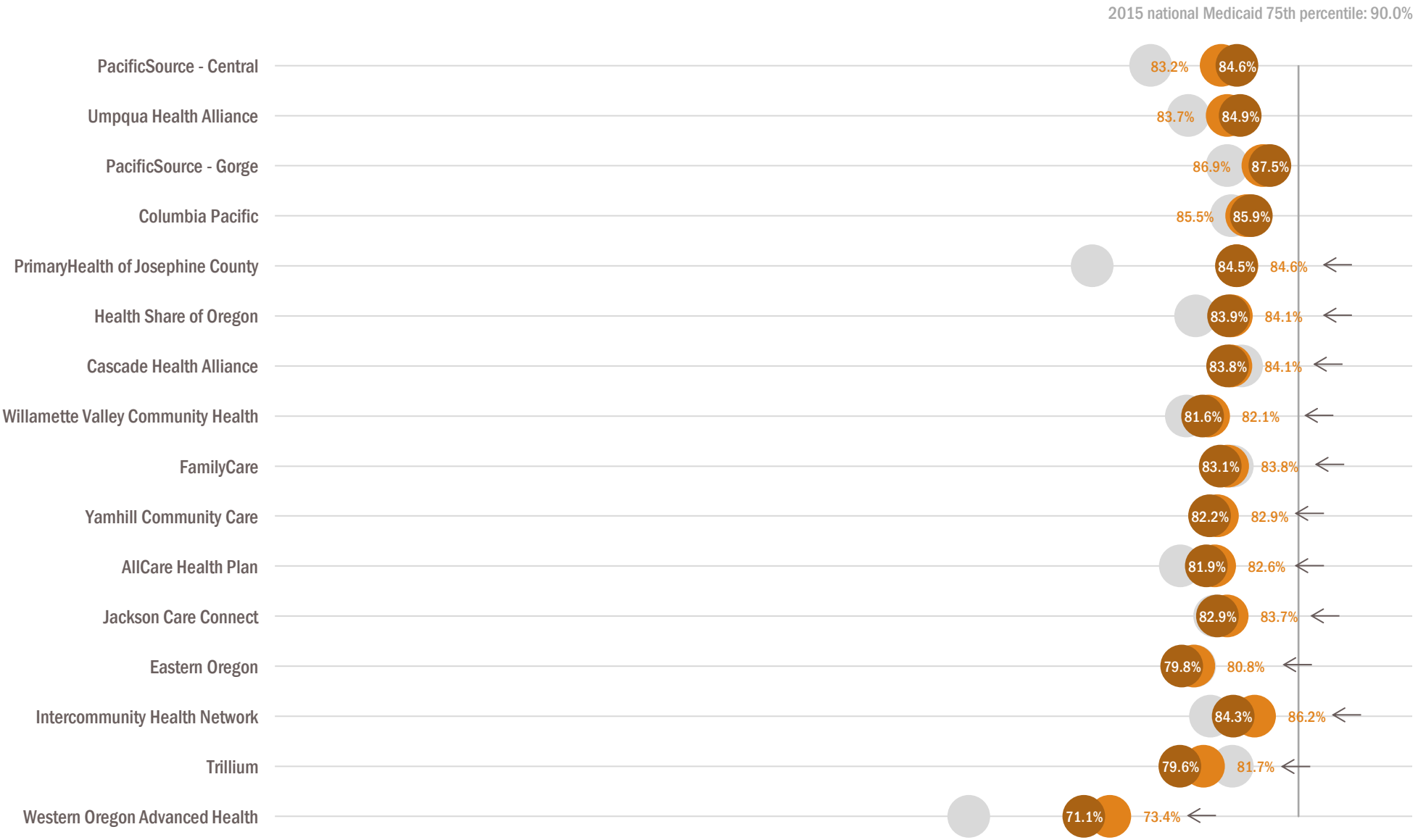
Percentage of adults with diabetes who received an A1c blood sugar test in 2015 & mid-2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 16.8% of respondents / Each race category excludes Hispanic/Latino

COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

Percentage of adults with diabetes who received an A1c blood sugar test in 2015 & mid-2016, by CCO.

Grey dots represent 2014



COMPHREHENSIVE DIABETES CARE: LDL-C SCREENING

Comprehensive diabetes care: LDL-C screening

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

mid-2016 data (n=34,222)

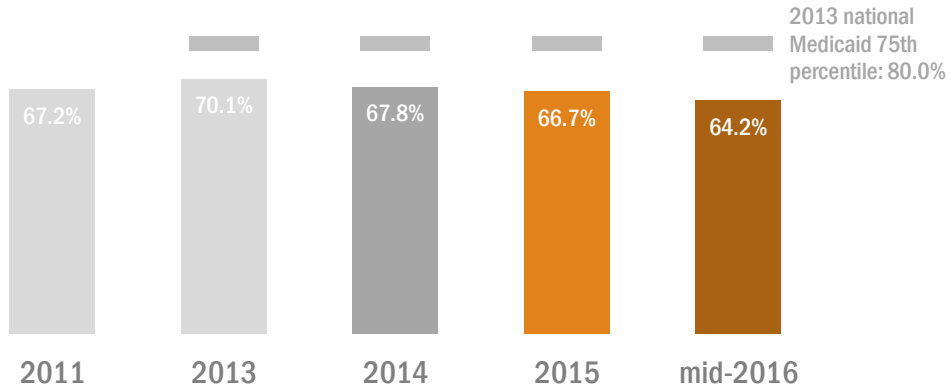
Statewide change since 2015: **-3.7%**

Number of CCOs that improved: **5**

LDL-C (cholesterol) testing among members with diabetes has declined each year since 2013, while HbA1c blood sugar testing among the same population increased. This may be because the American College of Cardiology / American Heart Association released updated guidelines in 2013 which removed treatment targets for LDL-C for primary or secondary prevention of arteriosclerotic cardiovascular disease and recommended statin therapy instead. LDL-C screening and control measures were removed from the healthcare effectiveness data and information set (HEDIS) measures in 2015.

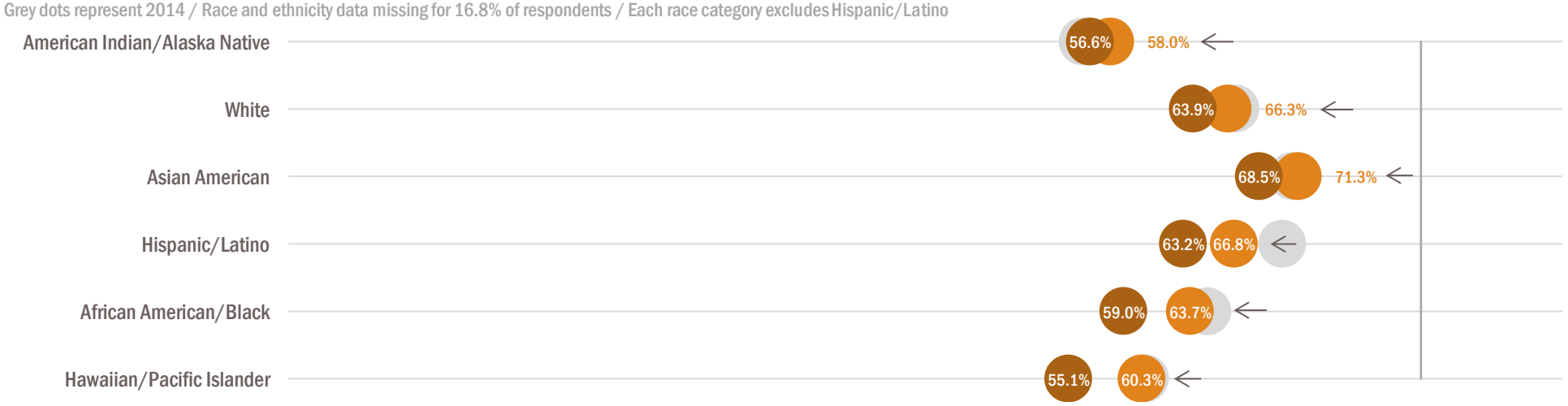
Percentage of adults with diabetes who received an LDL-C (cholesterol) test, statewide.

Data source: Administrative (billing) claims



Percentage of adults with diabetes who received an LDL-C (cholesterol) test in 2015 & mid-2016, by race and ethnicity.

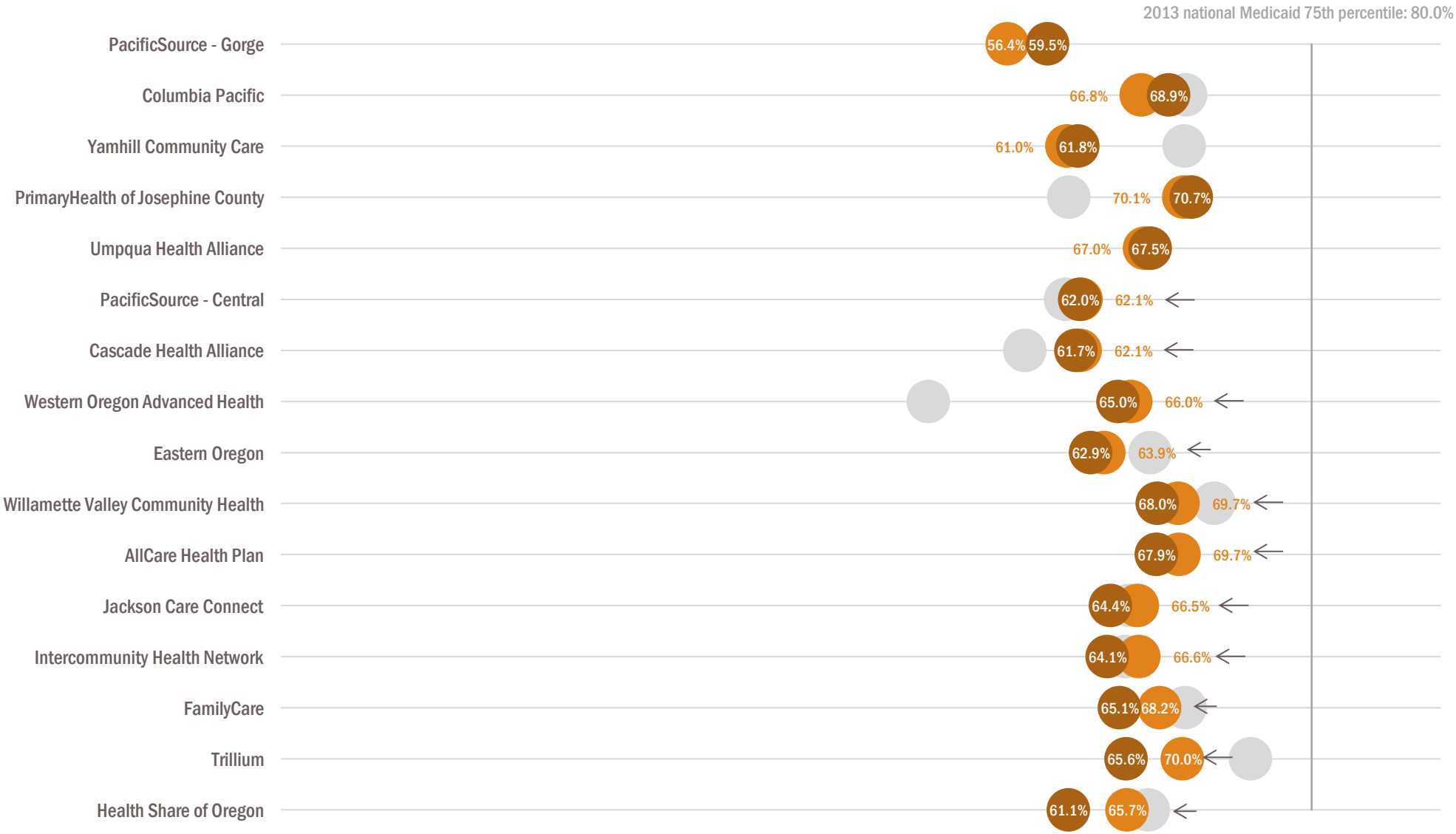
Grey dots represent 2014 / Race and ethnicity data missing for 16.8% of respondents / Each race category excludes Hispanic/Latino



COMPHREHENSIVE DIABETES CARE: LDL-C SCREENING

Percentage of adults with diabetes who received an LDL-C (cholesterol) test in 2015 & mid-2016, by CCO.

Grey dots represent 2014



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

Dental sealants on permanent molars for children (all ages)

Percentage of children ages 6-14 who received a dental sealant during the measurement year.

mid-2016 data (n=127,455)

Statewide change since 2015: **+8.6%**

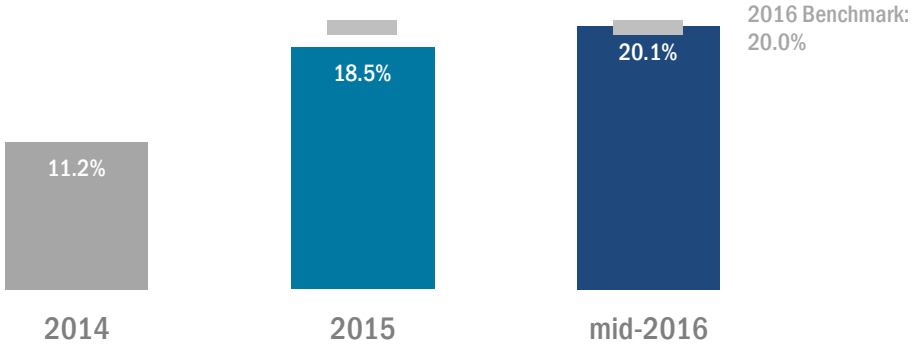
Number of CCOs that improved: **14**

See page 99 for results stratified by member with disability and mental health diagnoses.

Back to table of contents.

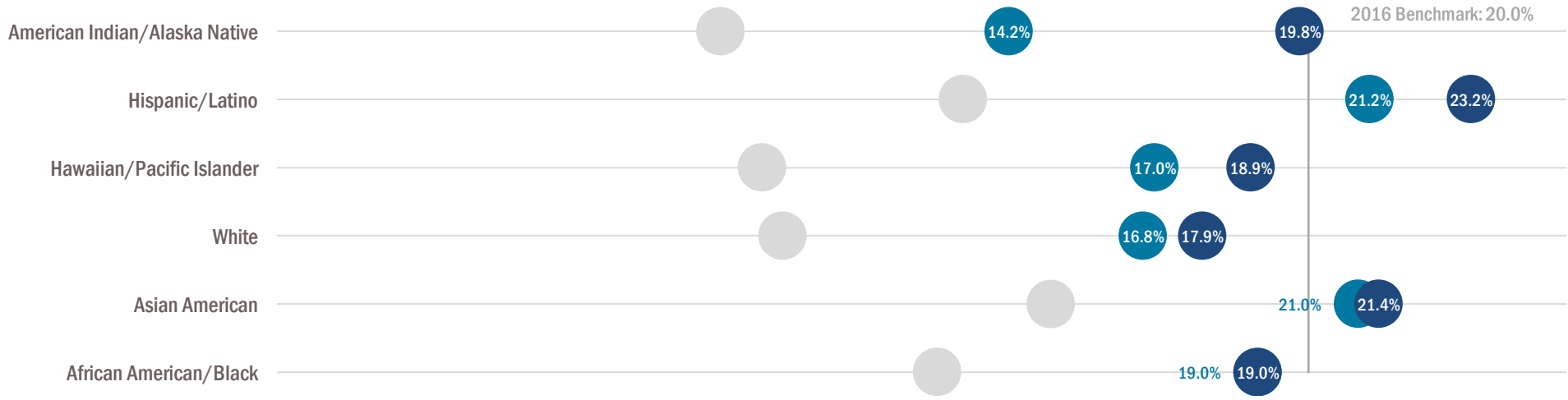
Dental sealants for children ages 6-14, statewide.

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



Dental sealants for children ages 6-14 in 2015 & mid-2016, by race and ethnicity.

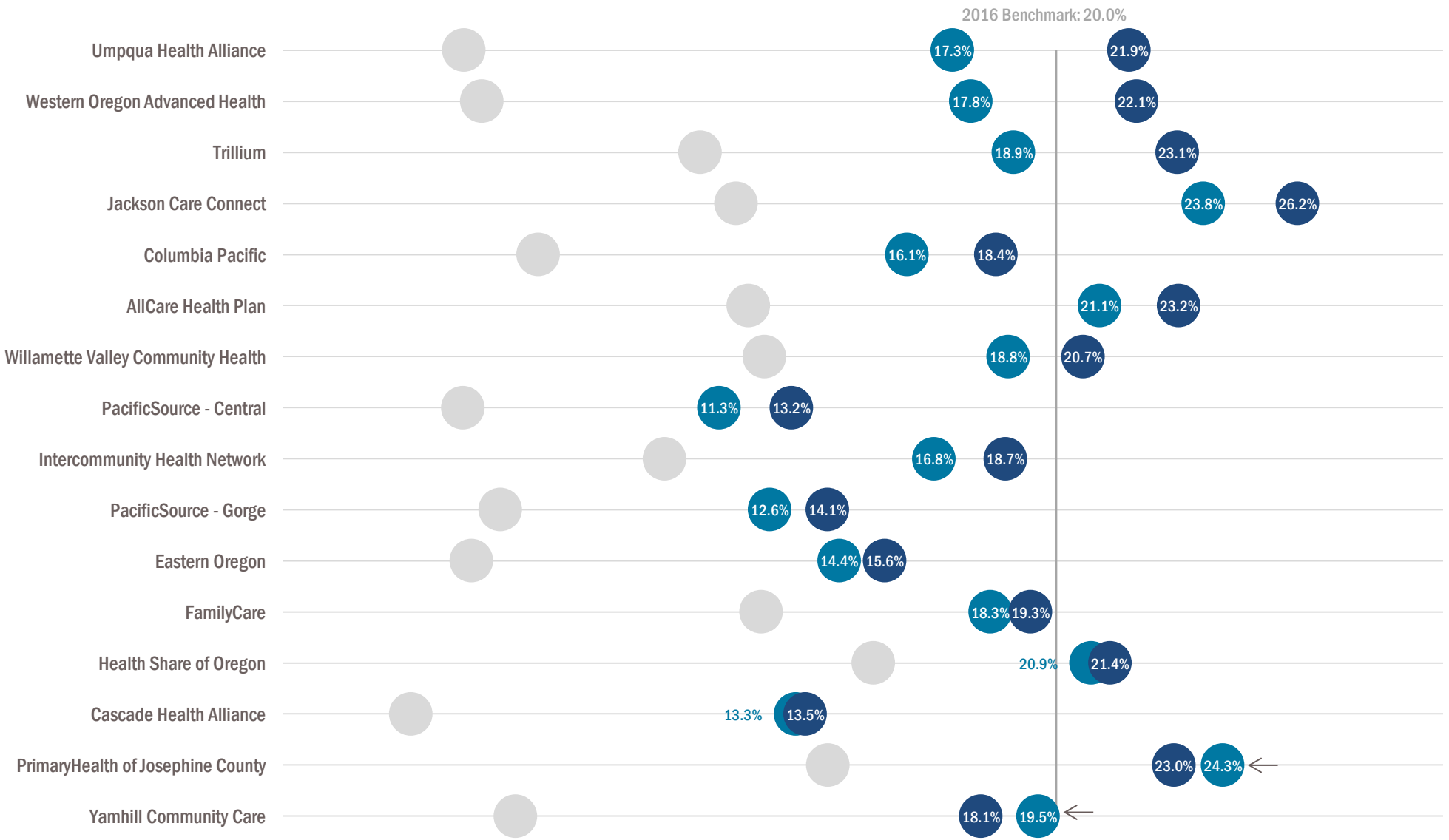
Grey dots represent 2014 / Race and ethnicity data missing for 30.3% of respondents / Each race category excludes Hispanic/Latino



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

Dental sealants for children ages 6-14 in 2015 & mid-2016, by CCO.

Grey dots represent 2014



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 6-9)

Dental sealants on permanent molars for children (ages 6-9)

Percentage of children ages 6-9 who received a dental sealant during the measurement year.

mid-2016 data (n=60,571)

Statewide change since 2015: **+8.2%**

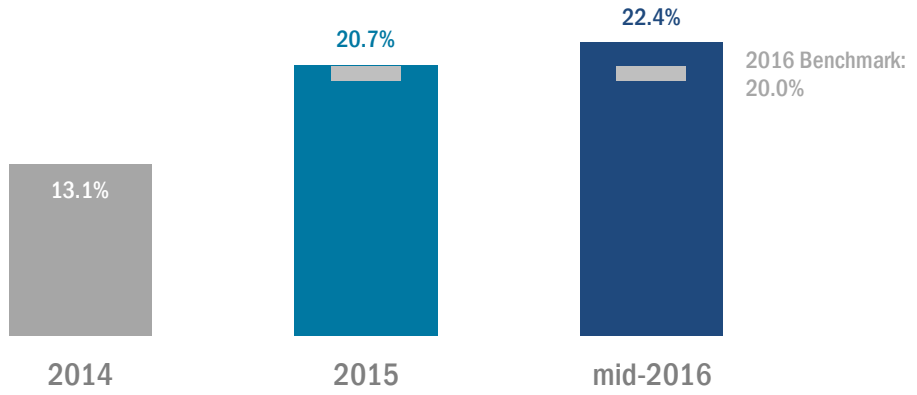
Number of CCOs that improved: **14**

See page 99 for results stratified by member with disability and mental health diagnoses.

Back to table of contents.

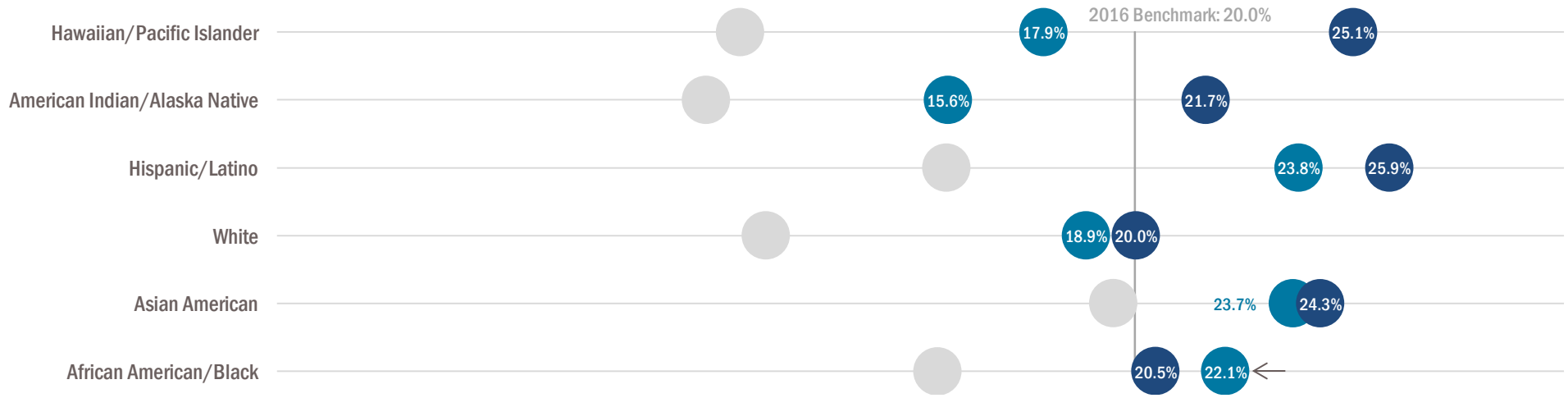
Dental sealants for children ages 6-9, statewide.

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

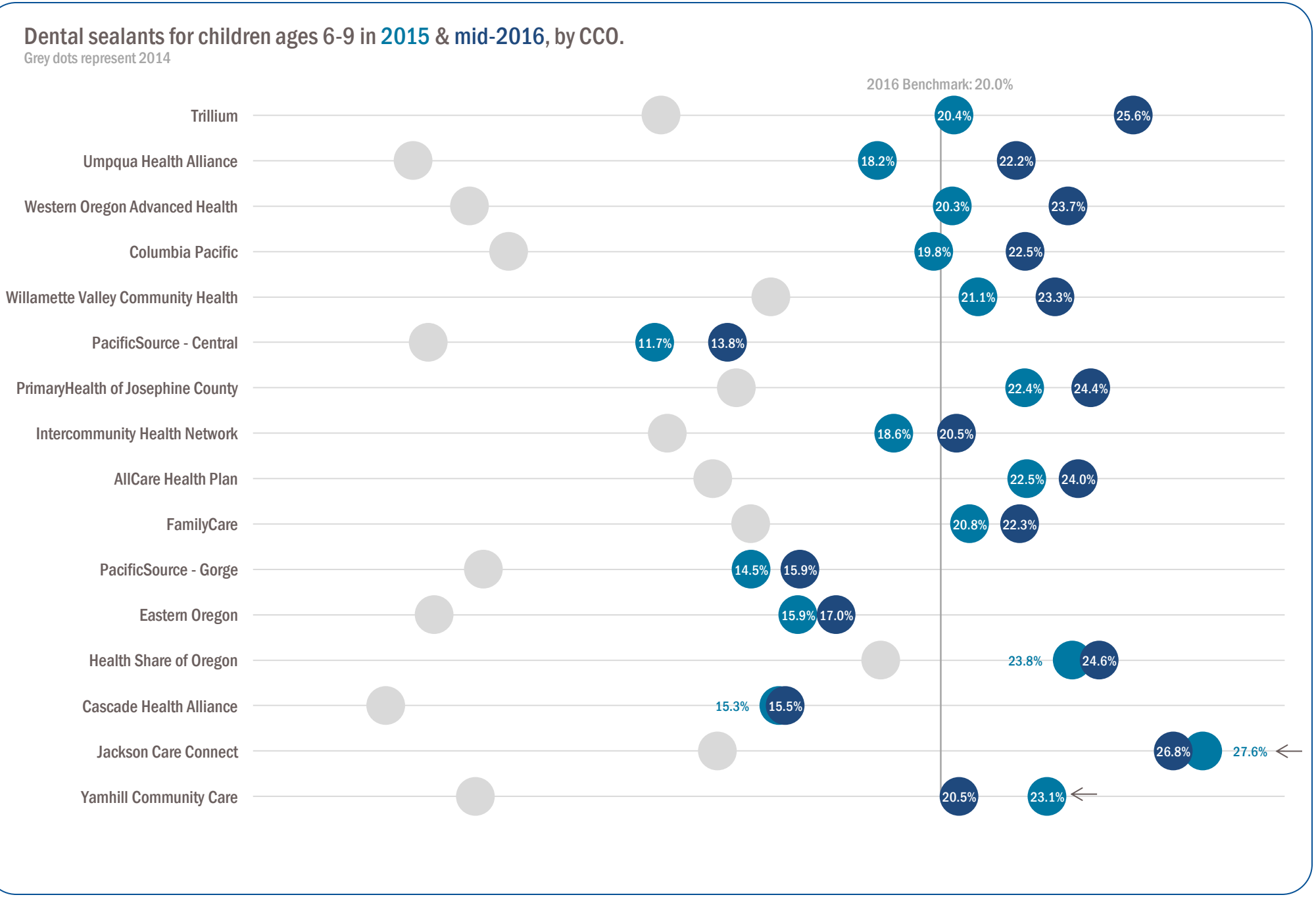


Dental sealants for children ages 6-9 in 2015 & mid-2016, by race and ethnicity.

Grey dots represent 2014 / Race and ethnicity data missing for 30.7% of respondents / Each race category excludes Hispanic/Latino



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 6-9)



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 10-14)

Dental sealants on permanent molars for children (ages 10-14)

Percentage of children ages 10-14 who received a dental sealant during the measurement year.

mid-2016 data (n=66,884)

Statewide change since 2015: **+9.1%**

Number of CCOs that improved: **14**

See page 99 for results stratified by member with disability and mental health diagnoses.

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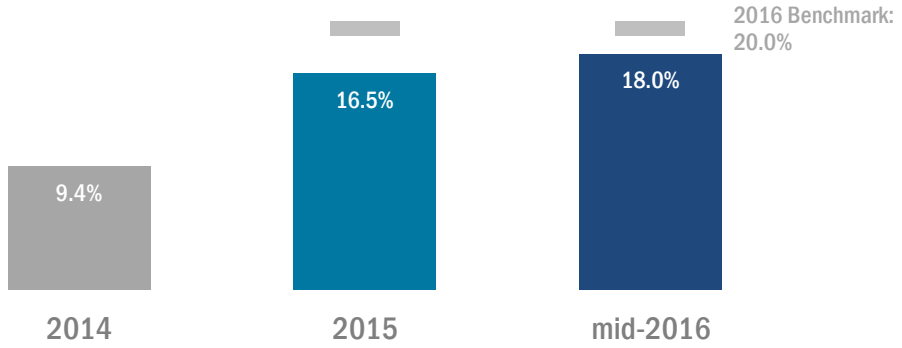
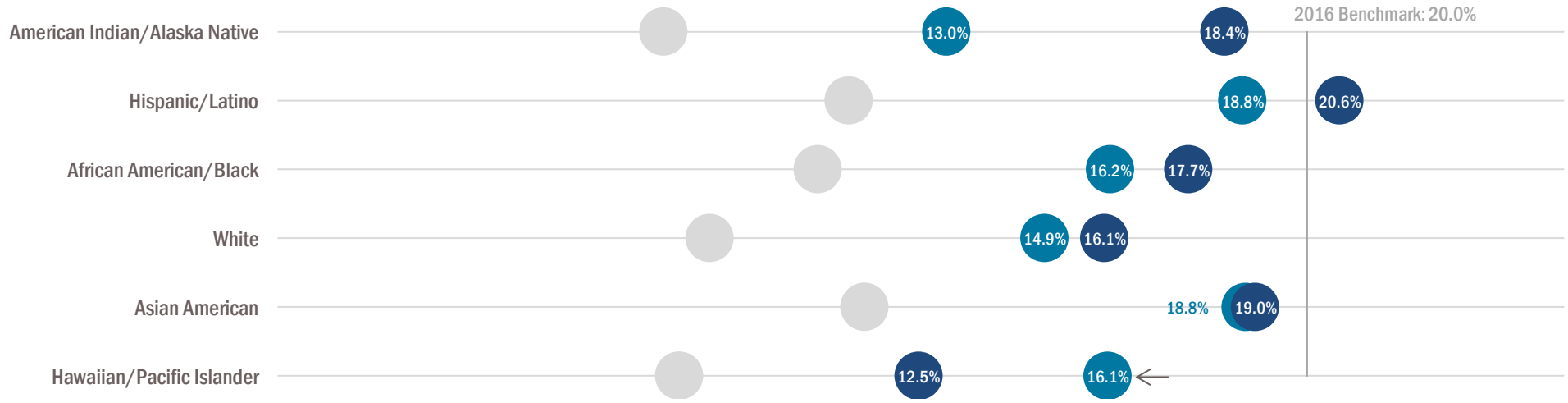
Dental sealants for children ages 10-14, statewide.

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



Dental sealants for children ages 10-14 in 2015 & mid-2016, by race and ethnicity.

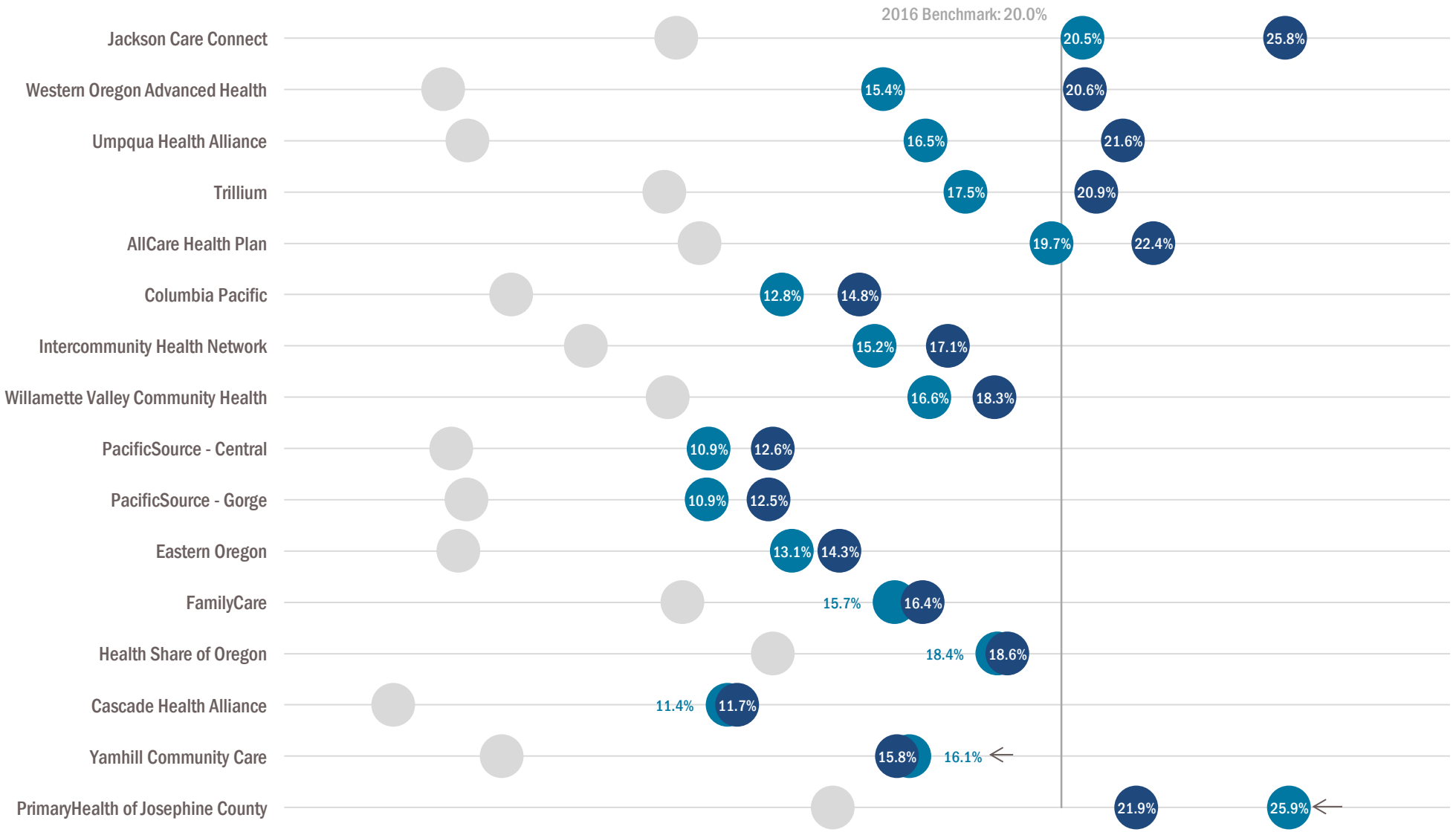
Grey dots represent 2014 / Race and ethnicity data missing for 29.9% of respondents / Each race category excludes Hispanic/Latino



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 10-14)

Dental sealants for children ages 10-14 between 2015 & mid-2016, by CCO.

Grey dots represent 2014



DEVELOPMENTAL SCREENING IN THE FIRST 36 MONTHS OF LIFE

Developmental screening in the first 36 months of life

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

mid-2016 data (n=48,229)

Statewide change since 2015: **+7.7%**

Number of CCOs that improved: **15**

See page 96 for results stratified by member with disability and mental health diagnoses.

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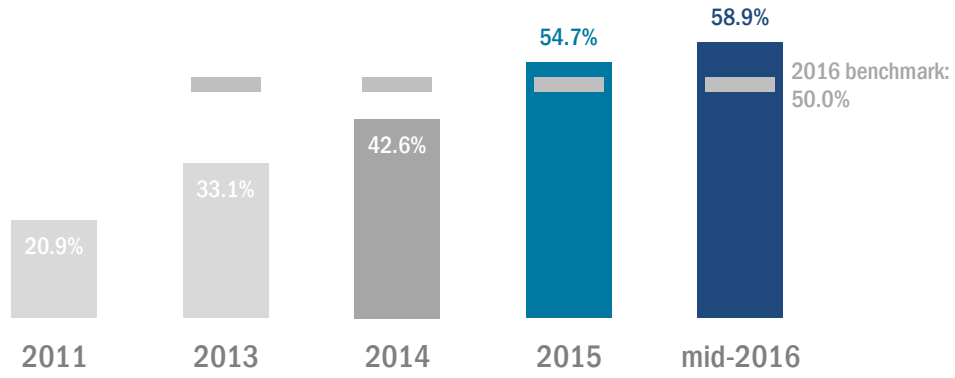
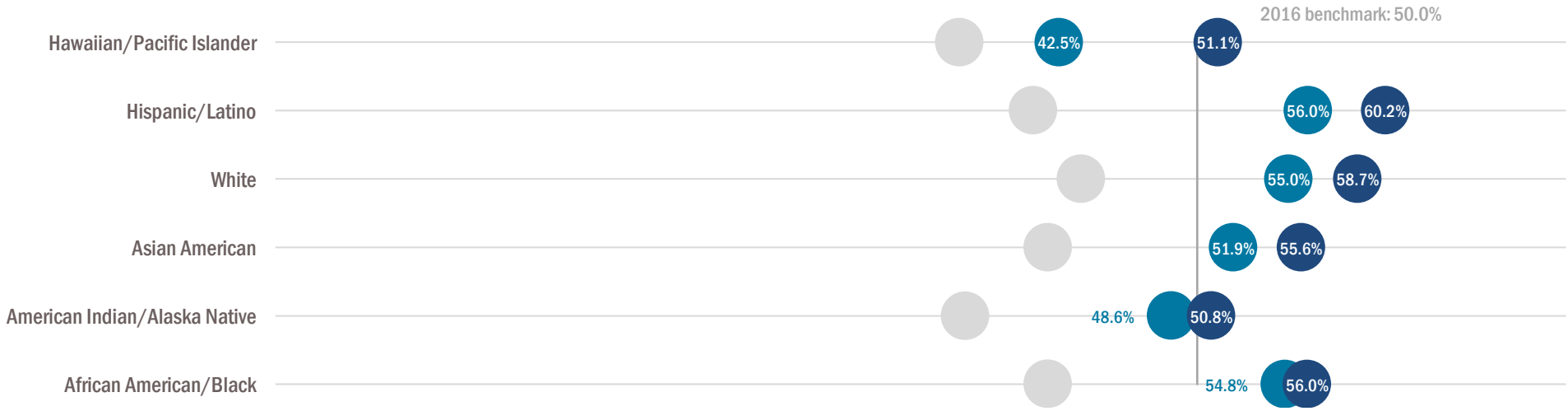
Developmental screening, statewide.

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



Developmental screening in 2015 & mid-2016, by race and ethnicity.

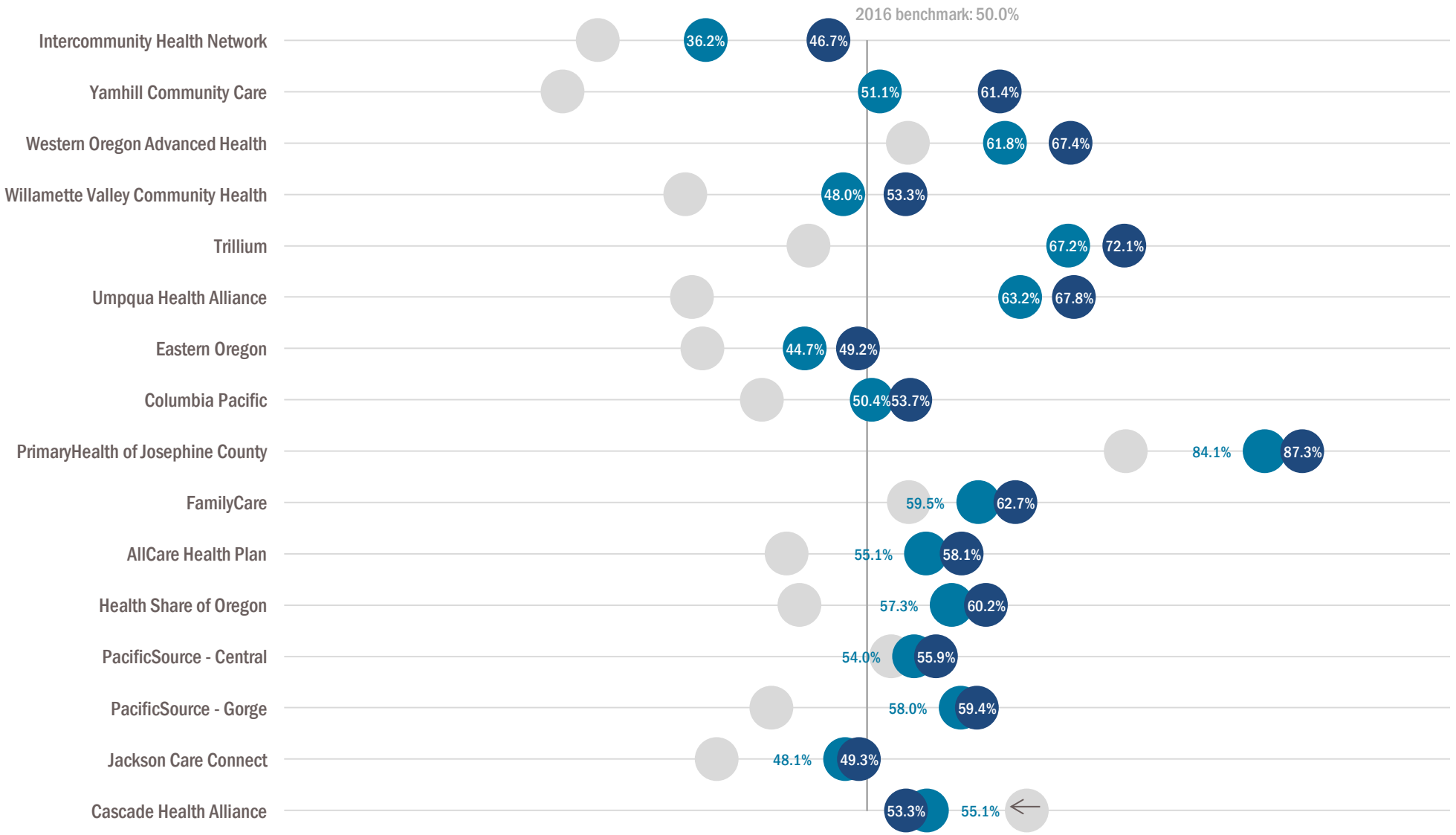
Grey dots represent 2014 / Race and ethnicity data missing for 31.9% of respondents / Each race category excludes Hispanic/Latino



DEVELOPMENTAL SCREENING IN THE FIRST 36 MONTHS OF LIFE

Developmental screening in 2015 & mid-2016, by CCO.

Grey dots represent 2014



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 18-50)

Effective contraceptive use among women at risk of unintended pregnancy (ages 18-50)

Percentage of adult women (ages 18-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

mid-2016 data (n=131,421)

Statewide change since 2015: **-2.2%**

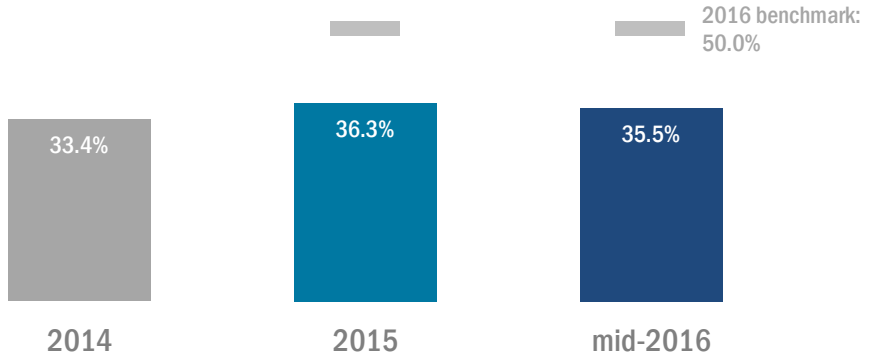
Number of CCOs that improved: **5**

See page 100 for results stratified by member with disability, mental health diagnoses, and severe and persistent mental illness.

Back to table of contents.

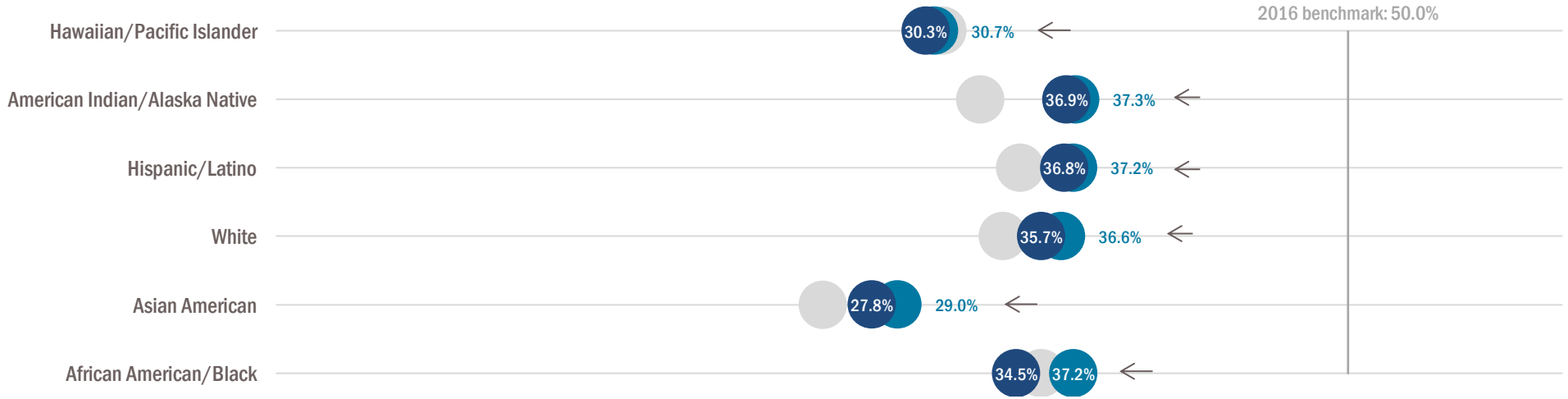
Effective contraceptive use among adults, statewide.

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



Effective contraceptive use among adults in 2015 & mid-2016, by race and ethnicity.

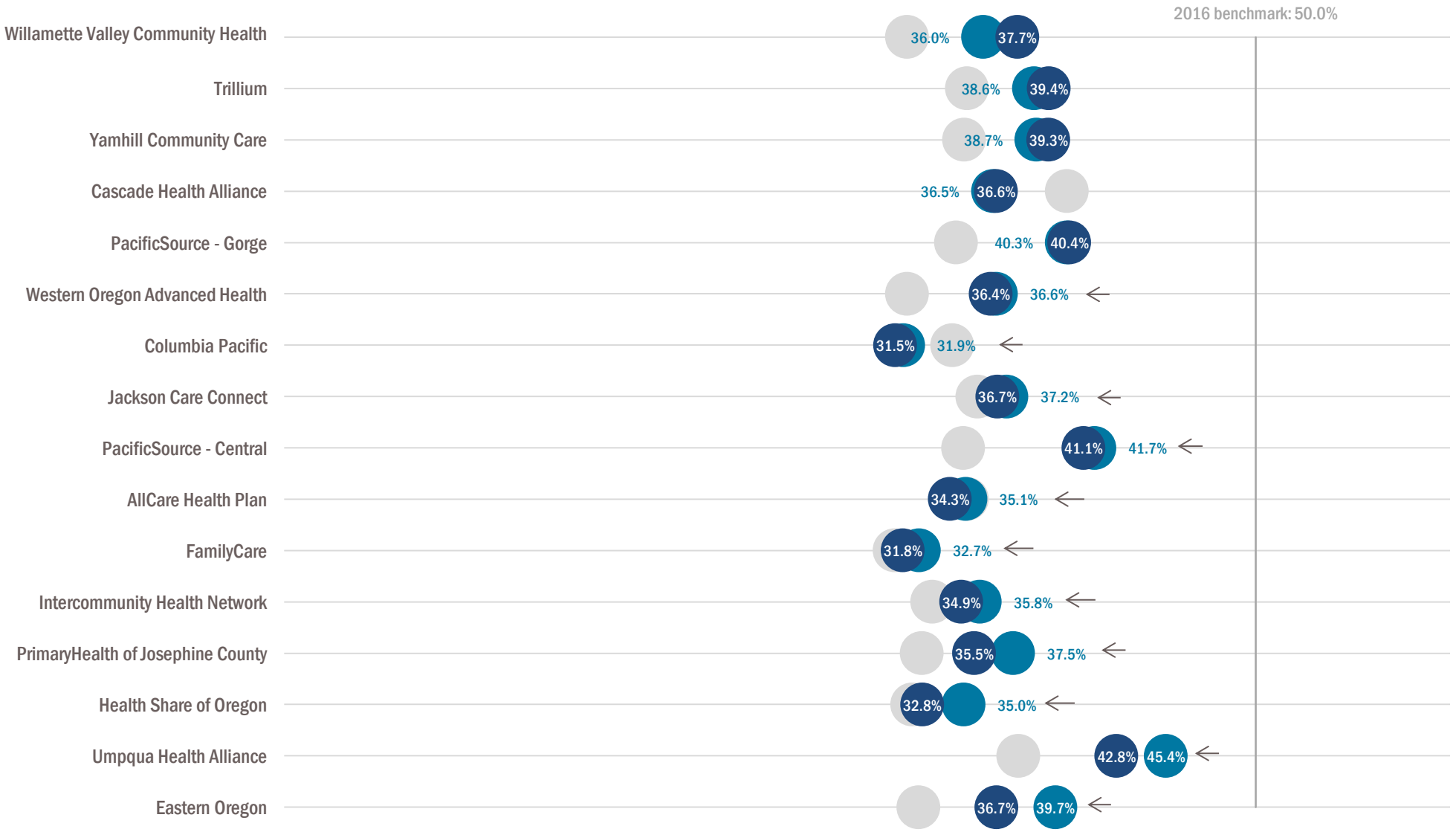
Grey dots represent 2014 / Race and ethnicity data missing for 24.8% of respondents / Each race category excludes Hispanic/Latino



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 18-50)

Effective contraceptive use among adults in 2015 & mid-2016, by CCO.

Grey dots represent 2014



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 15-17)

Effective contraceptive use among women at risk of unintended pregnancy (ages 15-17).

Percentage of adult women (ages 15-17) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

mid-2016 data (n=17,653)

Statewide change since 2015: **0.0%**

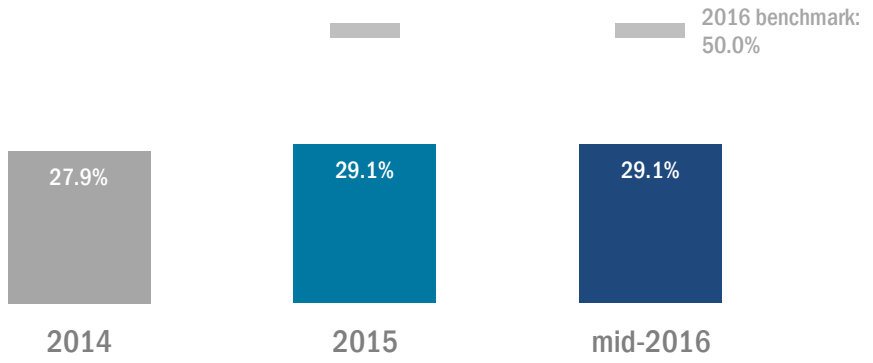
Number of CCOs that improved: **7**

See page 100 for results stratified by member with disability and mental health diagnoses.

Back to table of contents.

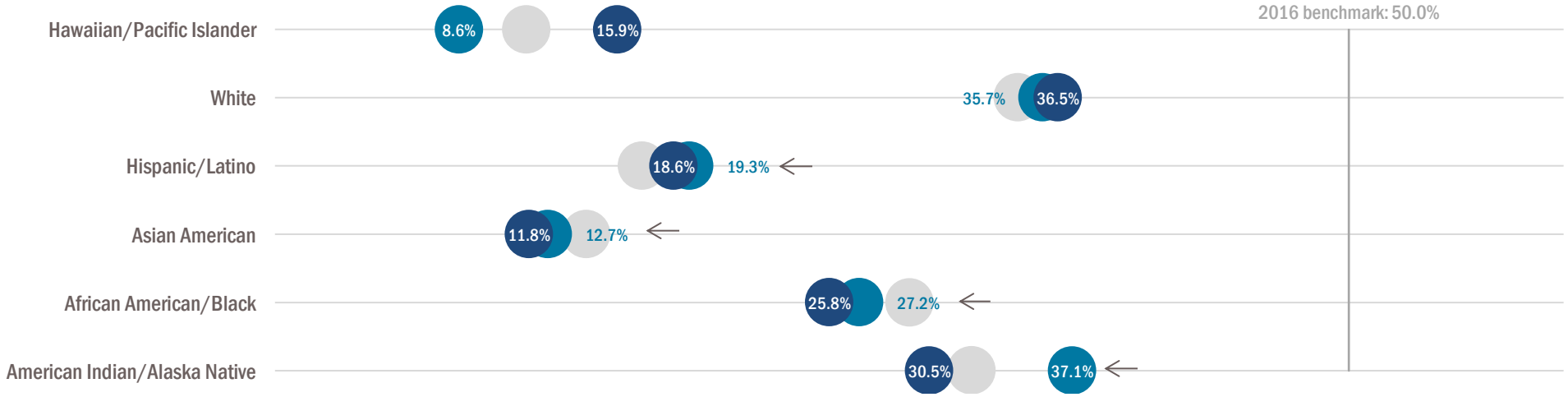
Effective contraceptive use among adolescents, statewide.

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



Effective contraceptive use among adolescents in 2015 & mid-2016, by race and ethnicity.

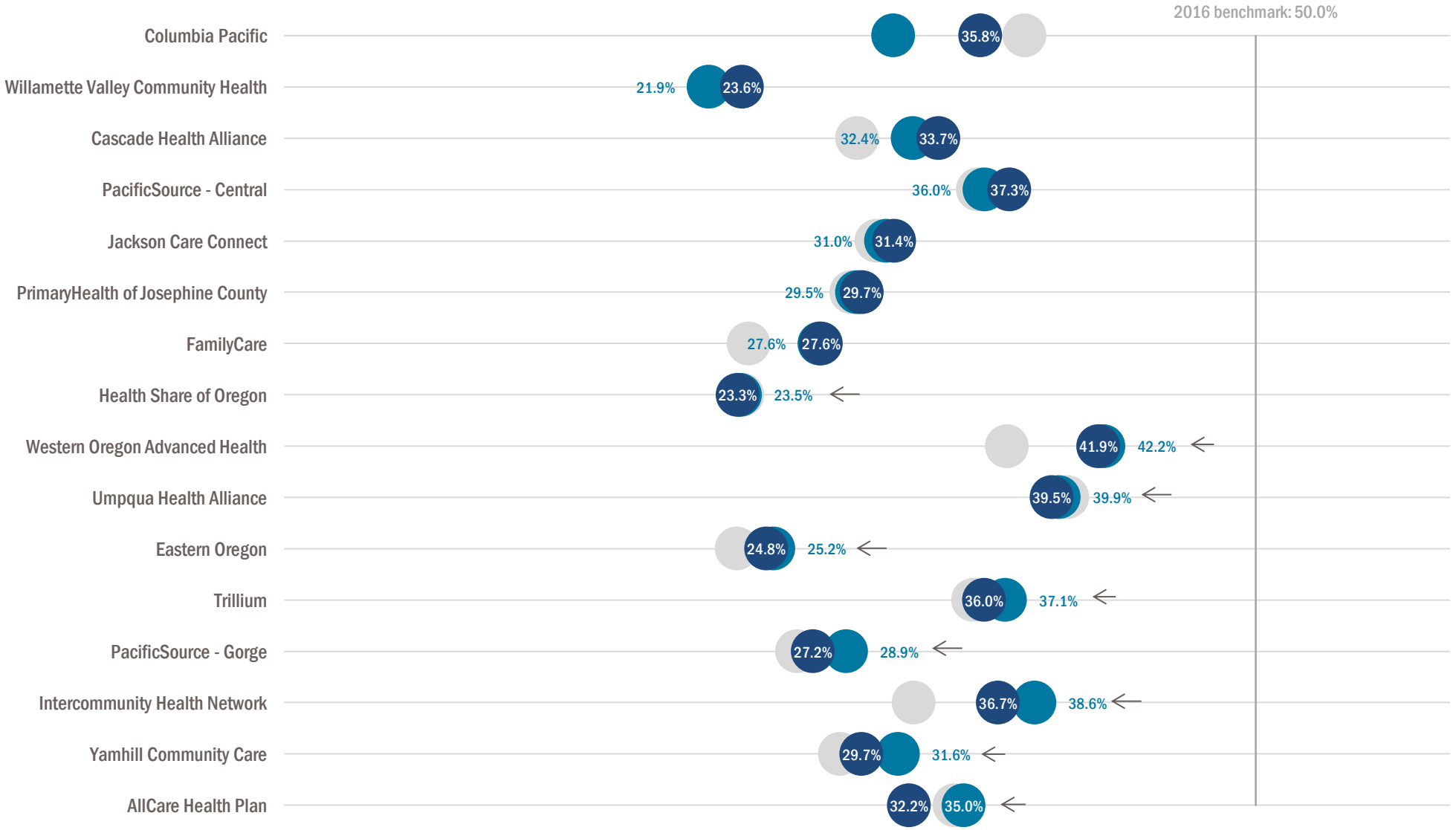
Grey dots represent 2014 / Race and ethnicity data missing for 29.3% of respondents / Each race category excludes Hispanic/Latino



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 15-17)

Effective contraceptive use among adolescents in 2015 & mid-2016, by CCO.

Grey dots represent 2014



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (all ages 15-50)

Effective contraceptive use among women at risk of unintended pregnancy (ages 15-50).

Percentage of adult women (ages 18-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

mid-2016 data (n=149,074)

Statewide change since 2015: **-2.0%**

Number of CCOs that improved: **5**

See page 100 for results stratified by member with disability and mental health diagnoses.

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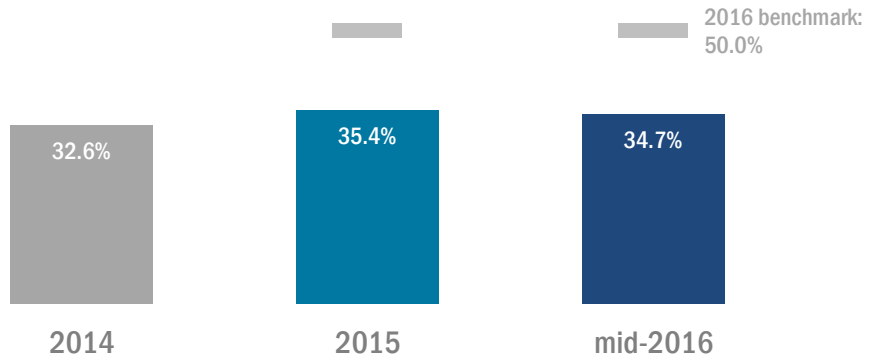
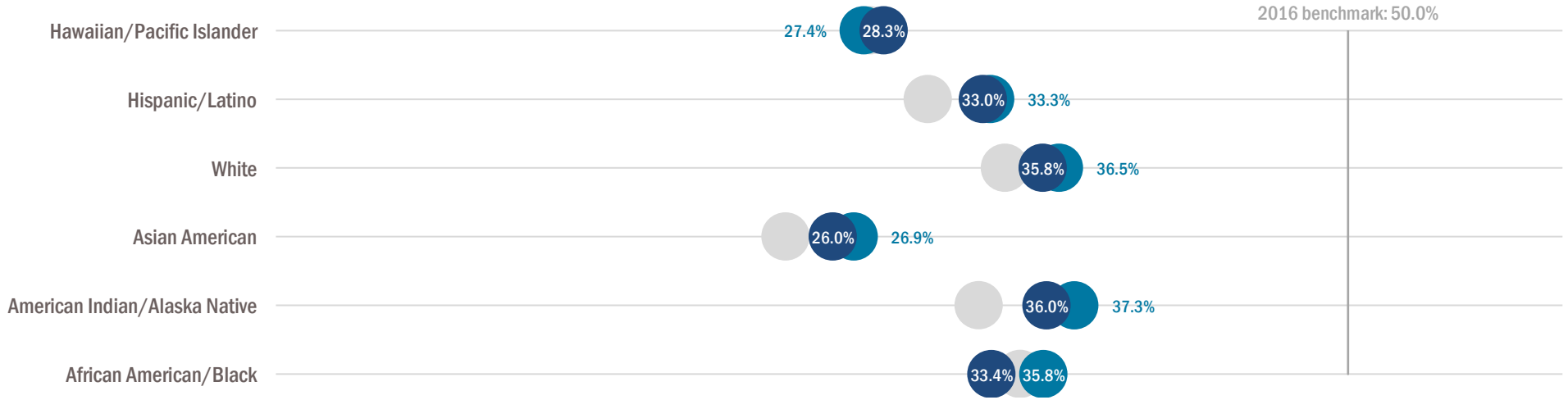
Effective contraceptive use (all ages 15-50), statewide.

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



Effective contraceptive use (all ages 15-50) in 2015 & mid-2016, by race and ethnicity.

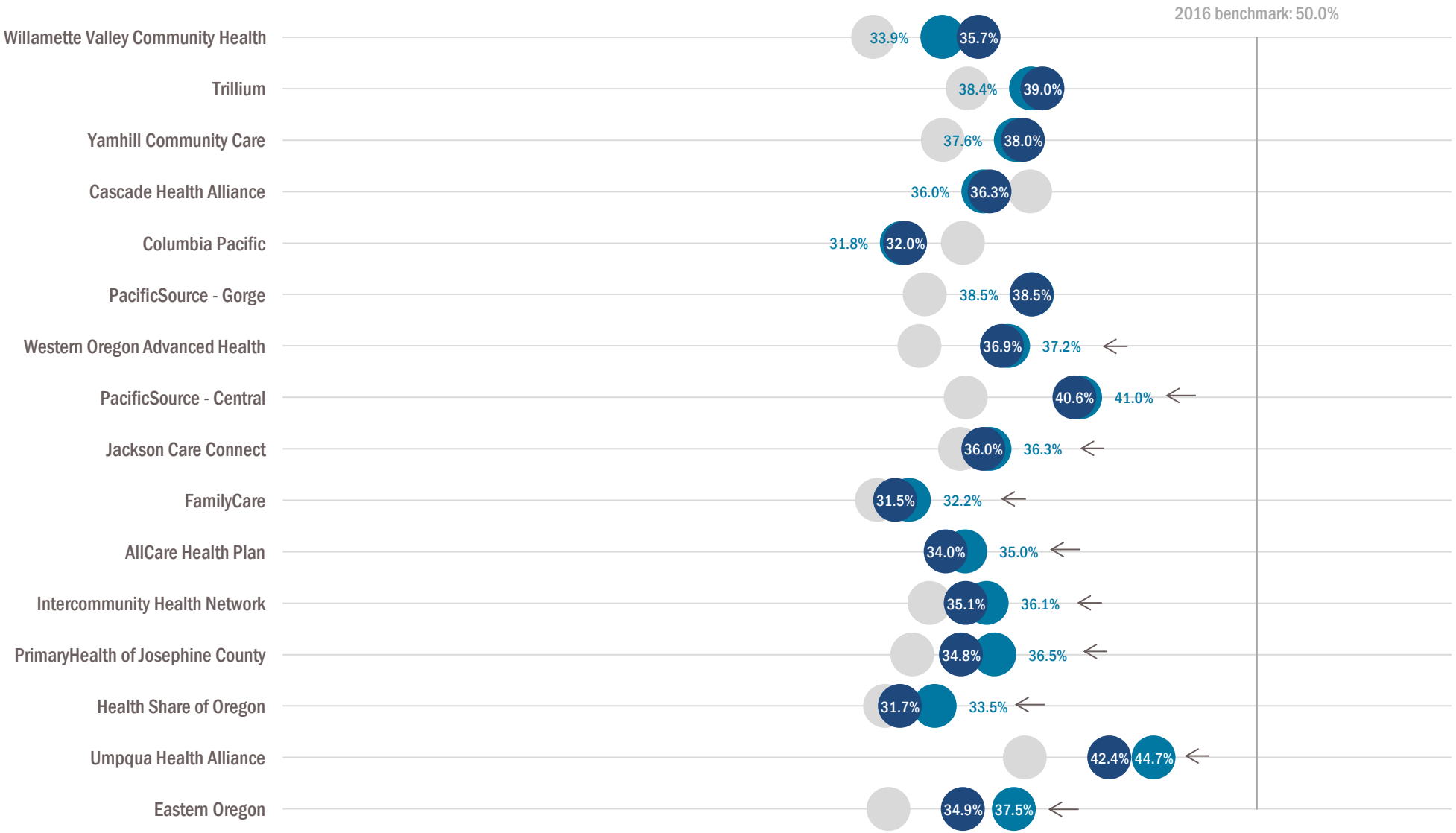
Grey dots represent 2014 / Race and ethnicity data missing for 25.4% of respondents / Each race category excludes Hispanic/Latino



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (all ages 15-50)

Effective contraceptive use (all ages 15-50) between 2015 & mid-2016, by CCO.

Grey dots represent 2014



FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-up after hospitalization for mental illness

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

mid-2016 data (n=3,276)

Statewide change since 2015: **-0.9%**

Number of CCOs that improved: **7**

See page 102 for results stratified by member with disability and mental health diagnoses.

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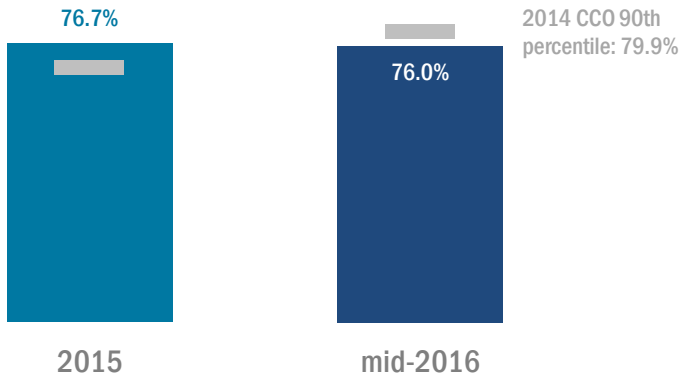
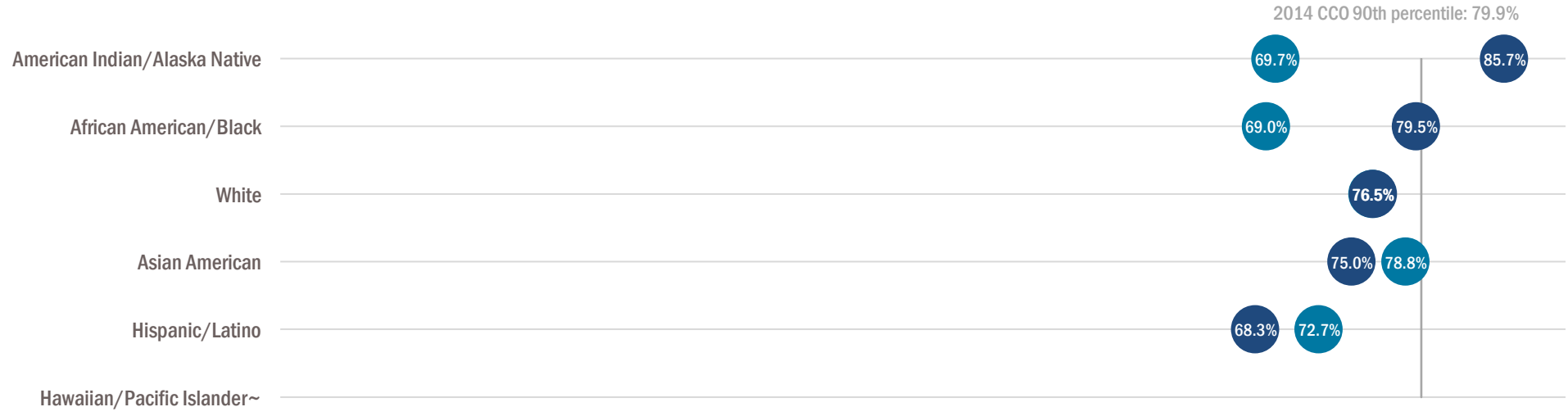
Follow-up after hospitalization for mental illness, statewide.

Data source: Administrative (billing) claims
2015 results have been recalculated according to updated measure specifications and differ from previously-published reports; these results are not directly comparable to earlier reports.



Follow-up after hospitalization for mental illness in 2015 & mid-2016, by race and ethnicity.

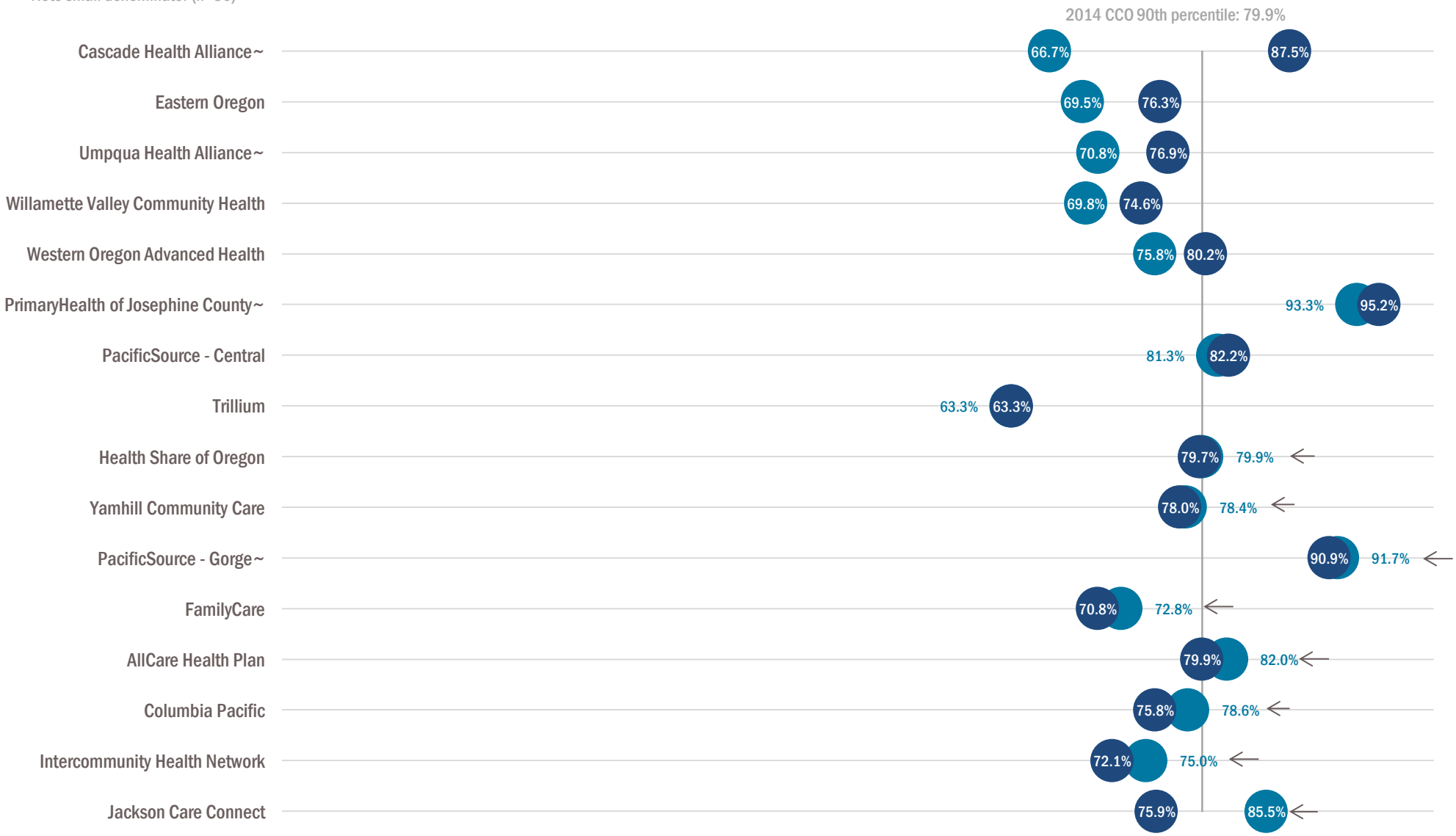
2015 results have been recalculated according to updated measure specifcations and differ from previously published reports; these results are not directly comparable to earlier years / Race and ethnicity data missing for 18.3% of respondents / Each race category excludes Hispanic/Latino



FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-up after hospitalization for mental illness in 2015 & mid-2016, by CCO.

2015 results have been recalculated according to updated measure specifcations and differ from previously published reports; these results are not directly comparable to earlier years.
~ Note small denominator (n<30)



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

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

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

mid-2016 data (n=2,365)

Statewide change since 2015: **+3.6%**

Number of CCOs that improved: **9**

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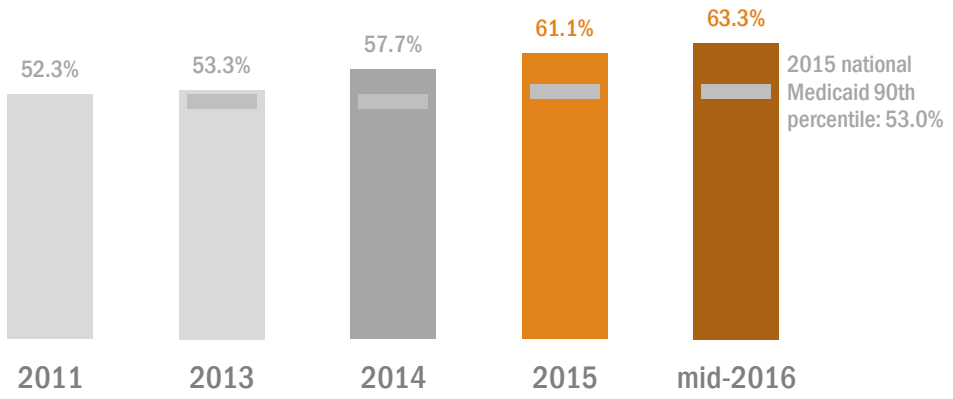
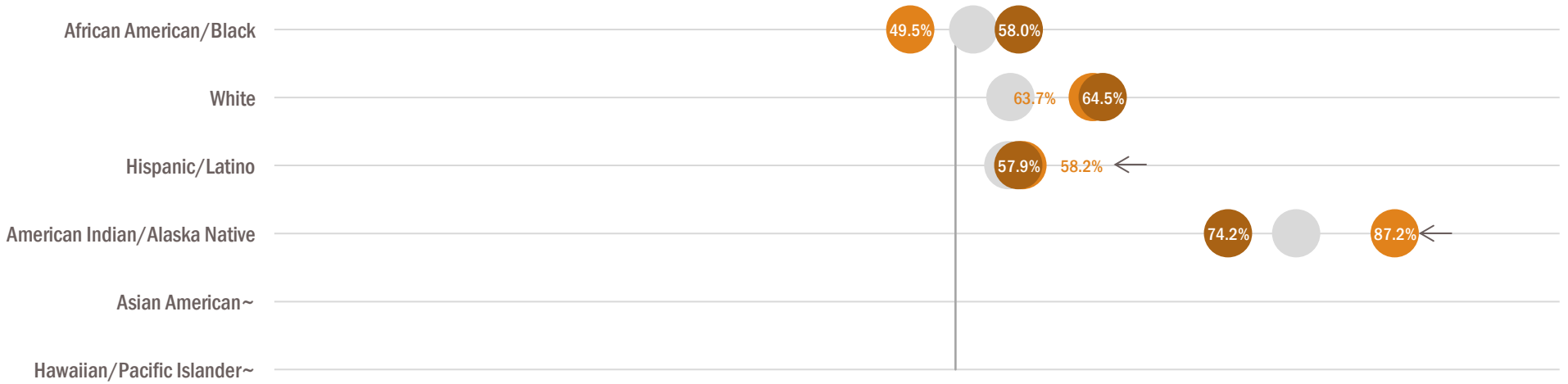
Initiation of follow-up care for children prescribed ADHD medication, statewide.

Data source: Administrative (billing) claims



Initiation of follow-up care for children prescribed ADHD medication in 2015 & mid-2016, by race and ethnicity.

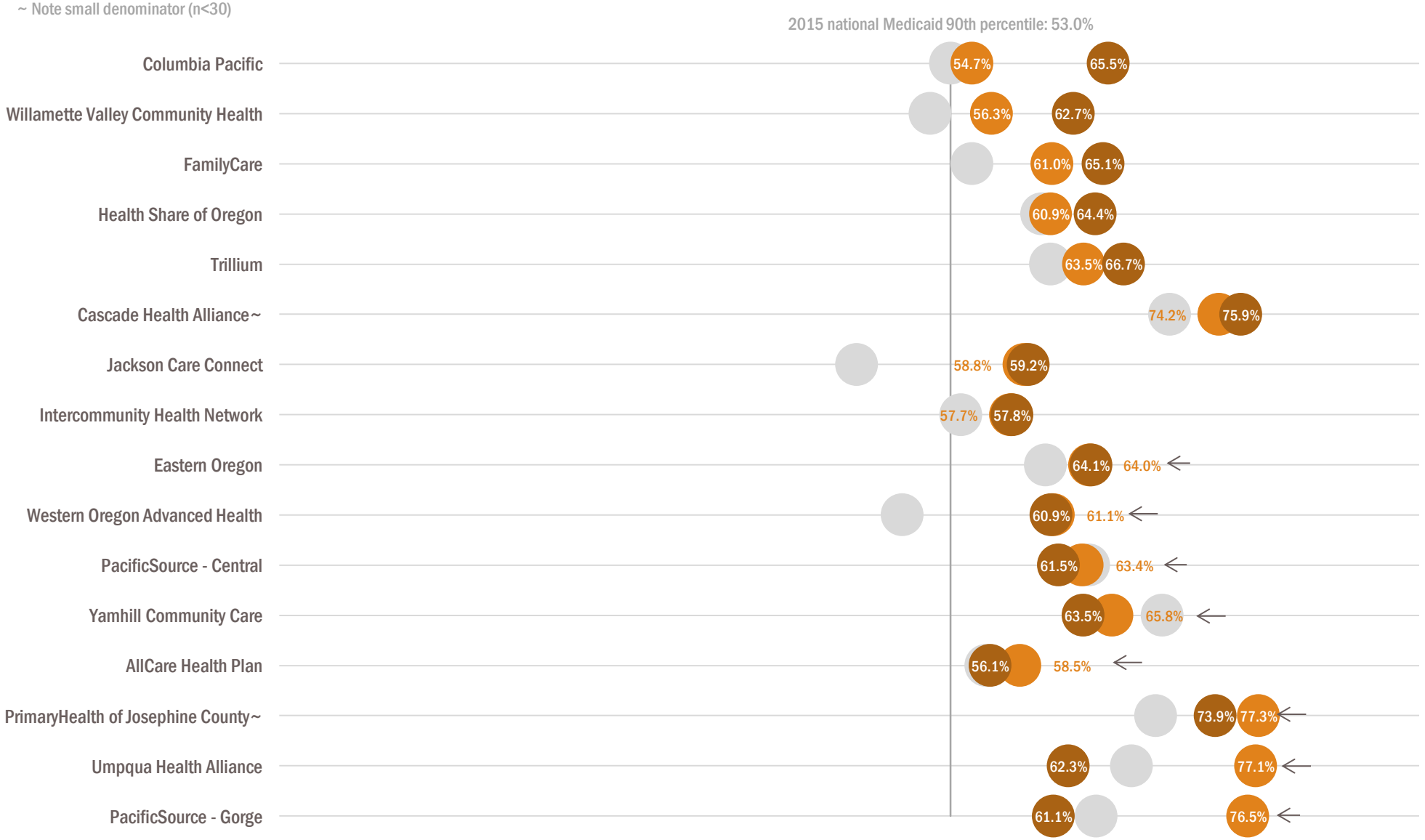
Grey dots represent 2014 / Race and ethnicity data missing for 26.4% of respondents / Each race category excludes Hispanic/Latino
~ Data suppressed (n<30)



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

Initiation of follow-up care for children prescribed ADHD medication in 2015 & mid-2016, by CCO.

Grey dots represent 2014
~ Note small denominator (n<30)



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

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

Percentage of children (ages 6-12) who remained on attention deficit hyperactivity disorder (ADHD) medication for 210 days after receiving a new prescription and who had at least two follow-up visits with a provider within 270 days after the initiation phase (see page 69).

mid-2016 data (n=719)

Statewide change since 2015: **-2.0%**

Number of CCOs that improved: **7**

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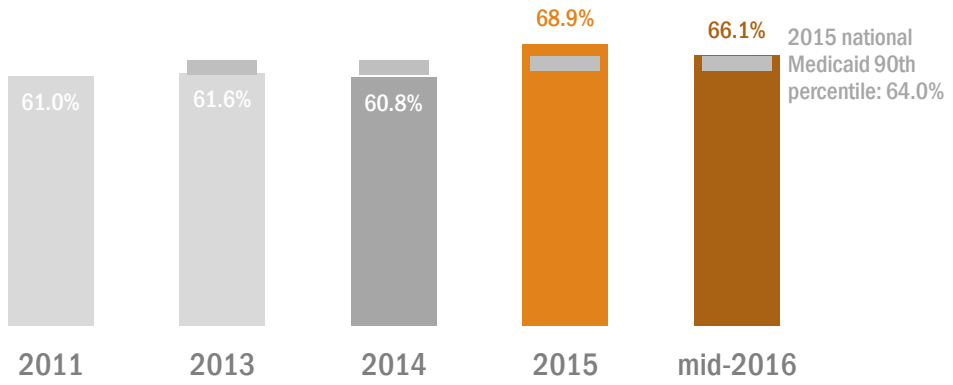
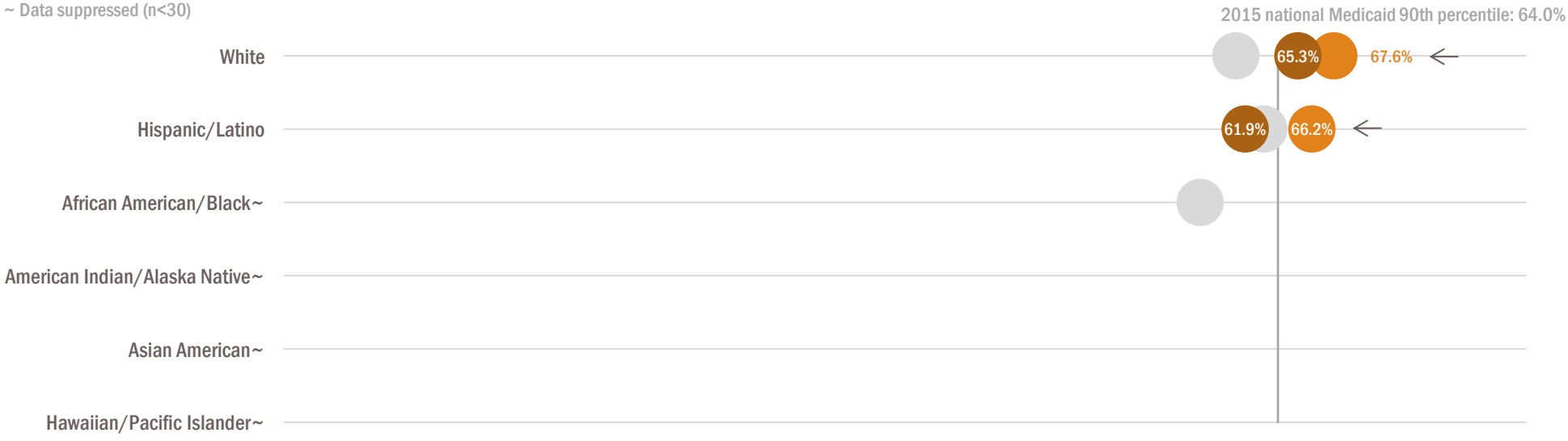
Ongoing follow-up care for children prescribed ADHD medication, statewide.

Data source: Administrative (billing) claims



Ongoing follow-up care for children prescribed ADHD medication in 2015 & mid-2016, by race and ethnicity.

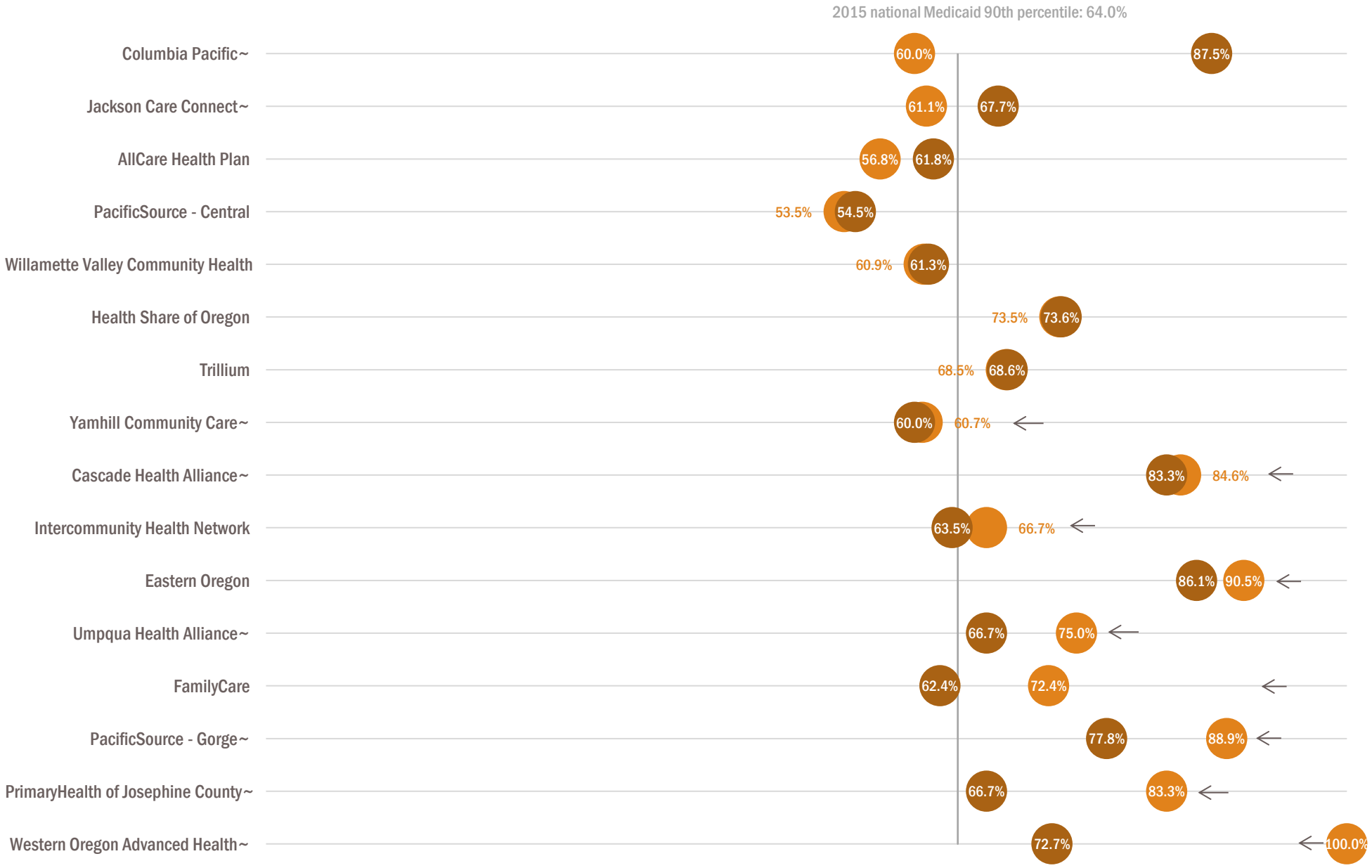
Grey dots represent 2014 / Race and ethnicity data missing for 24.6% of respondents / Each race category excludes Hispanic/Latino
~ Data suppressed (n<30)



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

Ongoing follow-up care for children prescribed ADHD medication in 2015 & mid-2016, by CCO.

~ Note small denominator (n<30)



IMMUNIZATION FOR ADOLESCENTS

Immunization for adolescents

Percentage of adolescents who received recommended vaccines (Meningococcal and Tdap/TD) before their 13th birthday.

mid-2016 data (n=13,686)

Statewide change since 2015: **+4.5%**

Number of CCOs that improved: **13**

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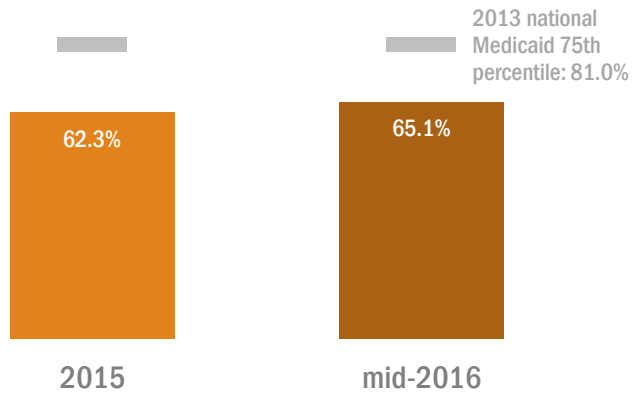
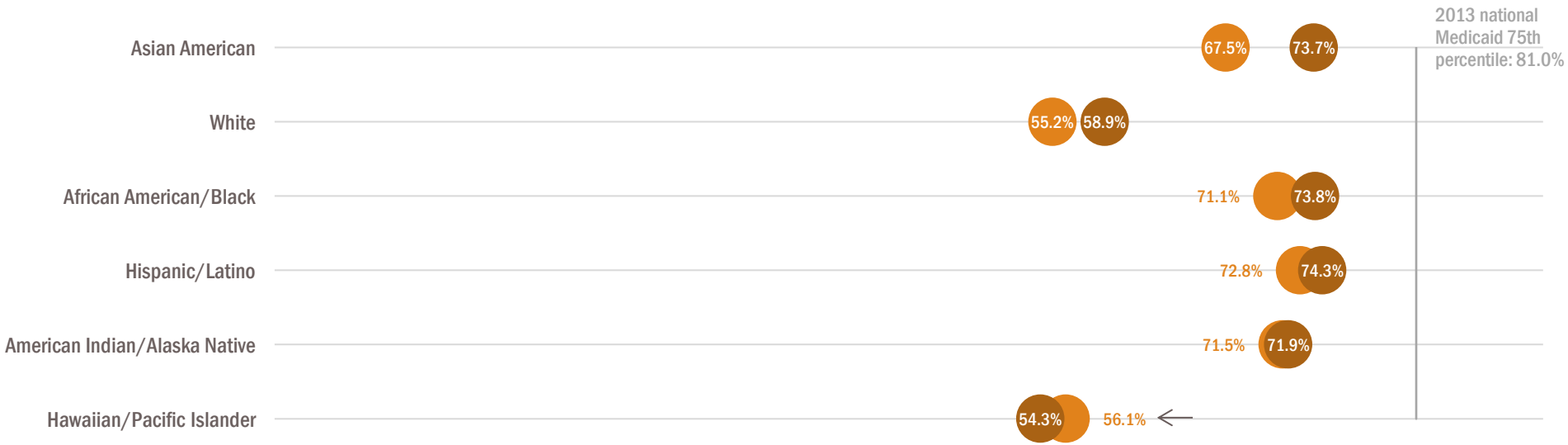
Percentage of children who received recommended vaccines, statewide.

Data source: Administrative (billing) claims and ALERT immunization data.
These data should not be compared to previously-published reports.



Percentage of adolescents who received recommended vaccines in 2015 & mid-2016, by race and ethnicity.

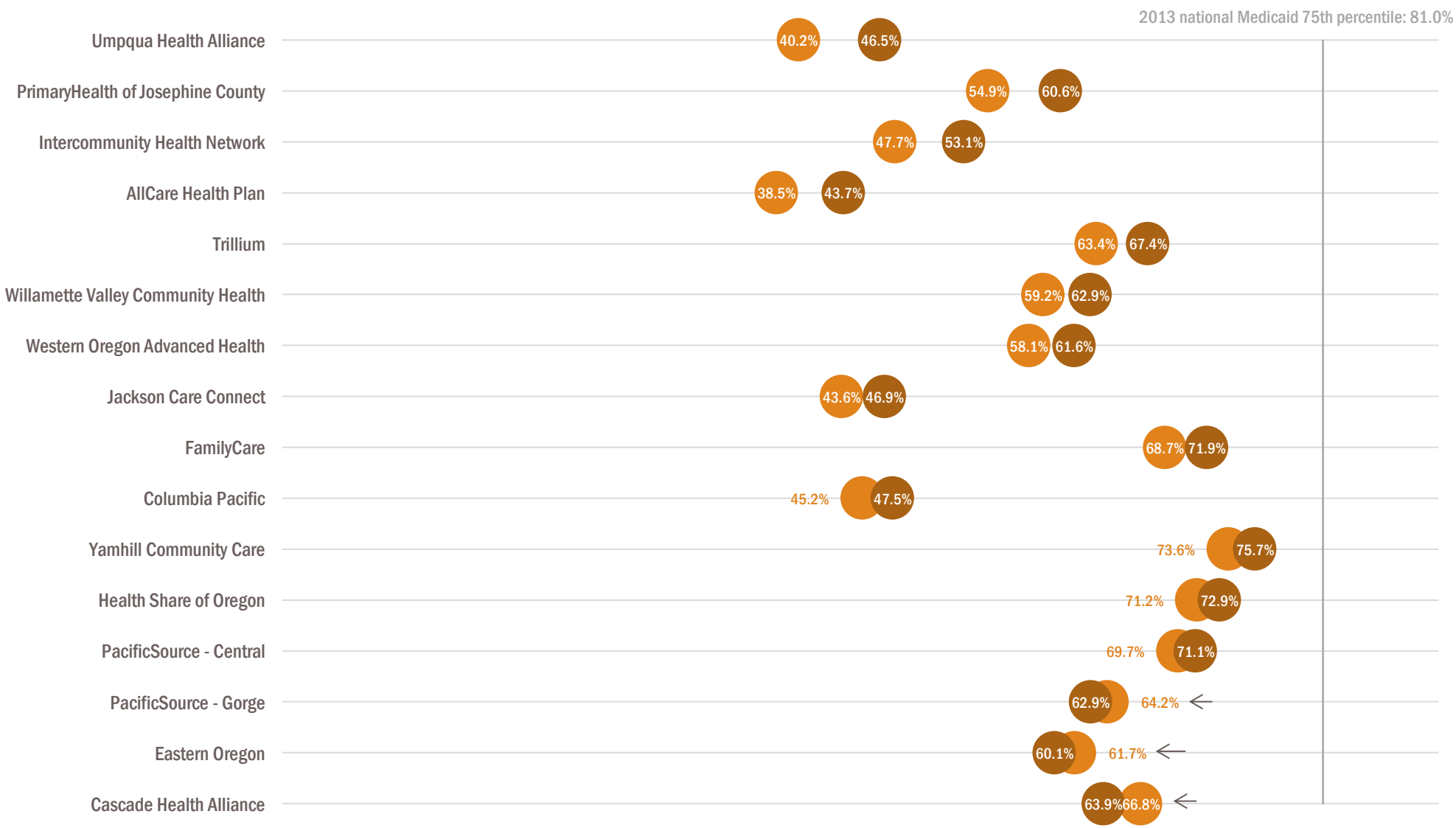
These data should not be compared to previously-published reports / 2015 results have been updated / Race and ethnicity data missing for 29.6% of respondents / Each race category excludes Hispanic/Latino



IMMUNIZATION FOR ADOLESCENTS

Percentage of adolescents who received recommended vaccines in 2015 & mid-2016, by CCO.

These data should not be compared to previously-published reports / 2015 results have been updated



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

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

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

mid-2016 data (n=1,919)

Statewide change since 2015: **-1.3%**

Number of CCOs that improved: **7**

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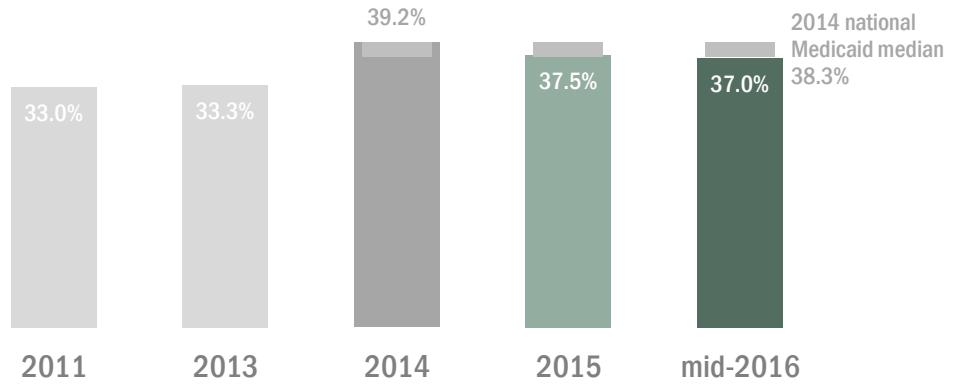
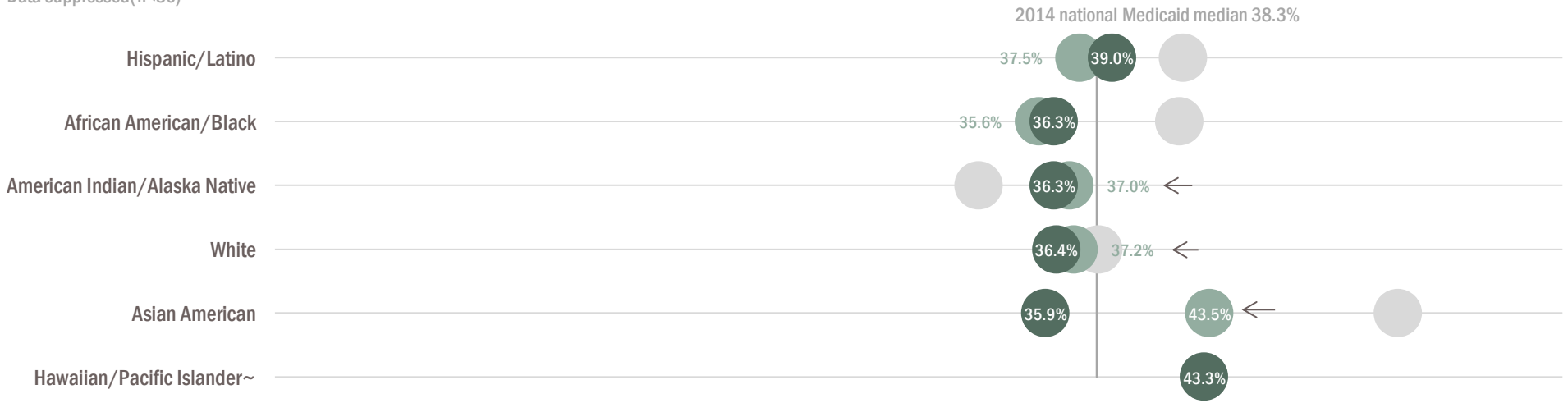
Initiation of treatment for members diagnosed with alcohol or other drug dependence, statewide.

Data source: Administrative (billing) claims



Initiation of treatment for members diagnosed with alcohol or other drug dependence in 2015 & mid-2016, by race and ethnicity.

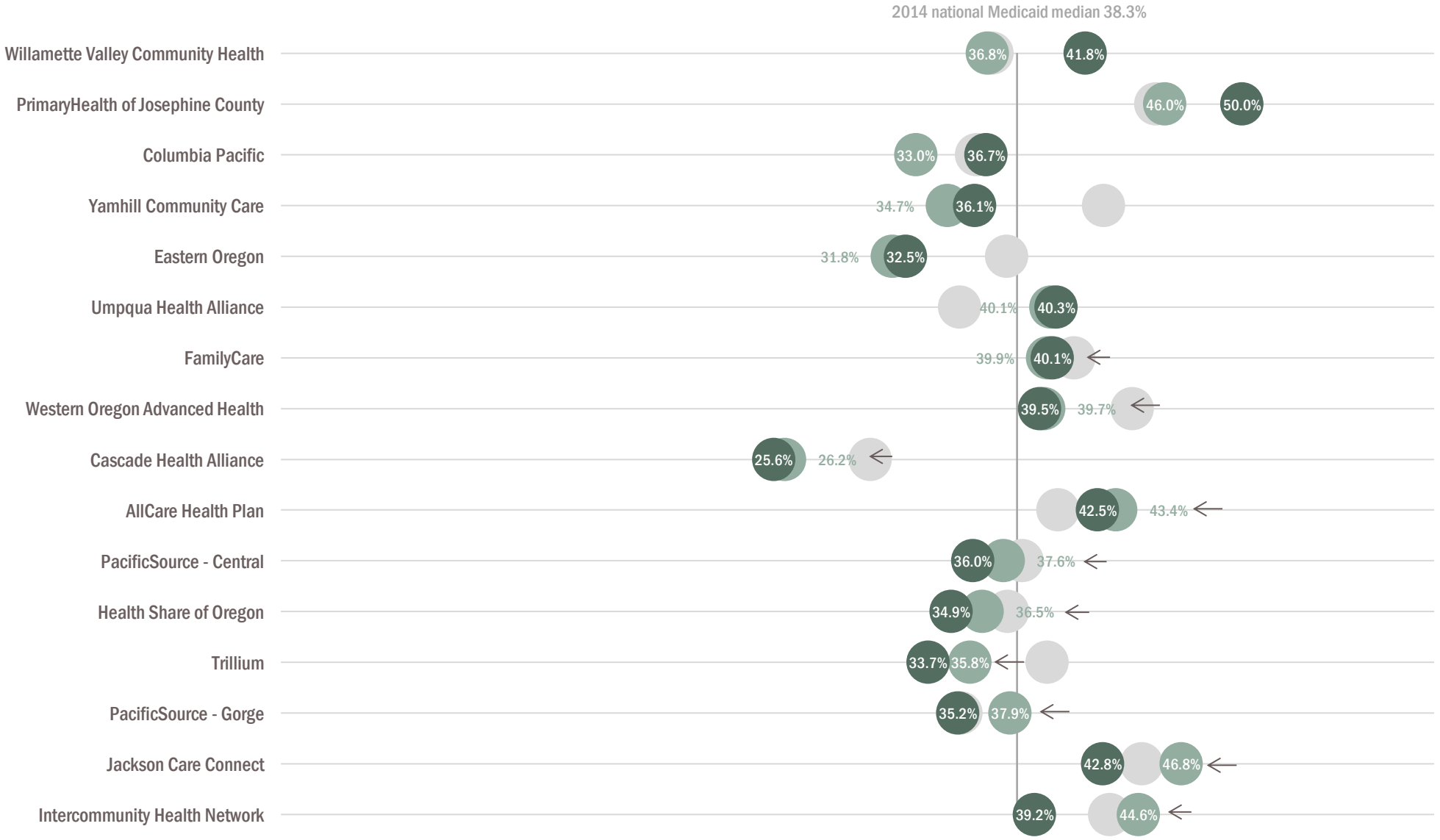
Grey dots represent 2014 / Race and ethnicity data missing for 11.4% of respondents / Each race category excludes Hispanic/Latino
~Data suppressed(n<30)



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

Initiation of treatment for members diagnosed with alcohol or other drug dependence in 2015 & mid-2016, by CCO.

Grey dots represent 2014



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

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

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

mid-2016 data (n=1,919)

Statewide change since 2015: **-4.0%**

Number of CCOs that improved: **2**

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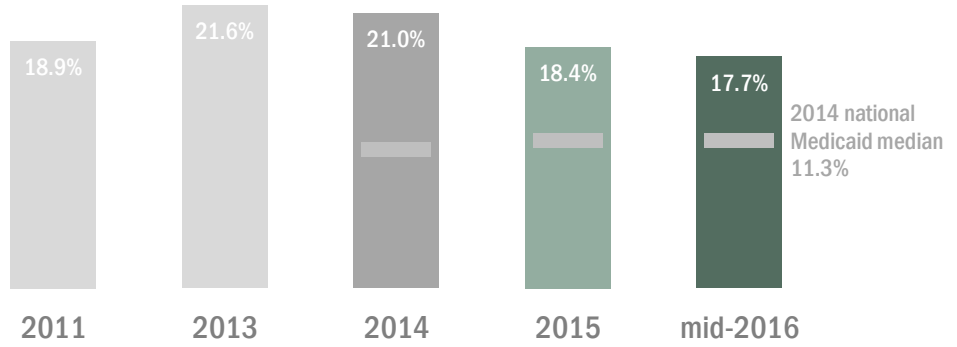
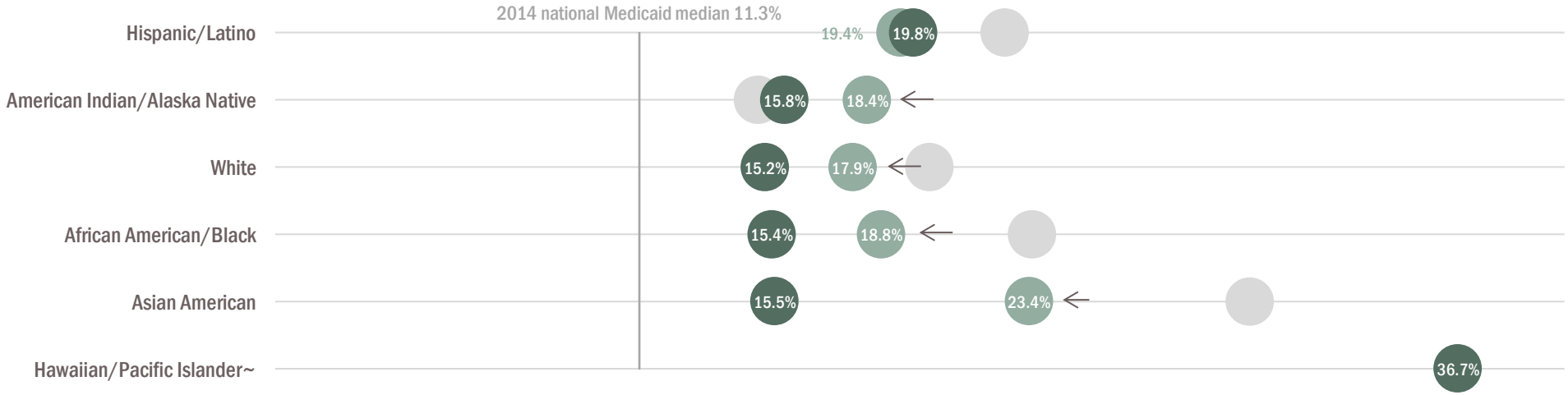
Engagement of alcohol or other drug treatment, statewide.

Data source: Administrative (billing) claims



Engagement of alcohol or other drug treatment in 2015 & mid-2016, by race and ethnicity.

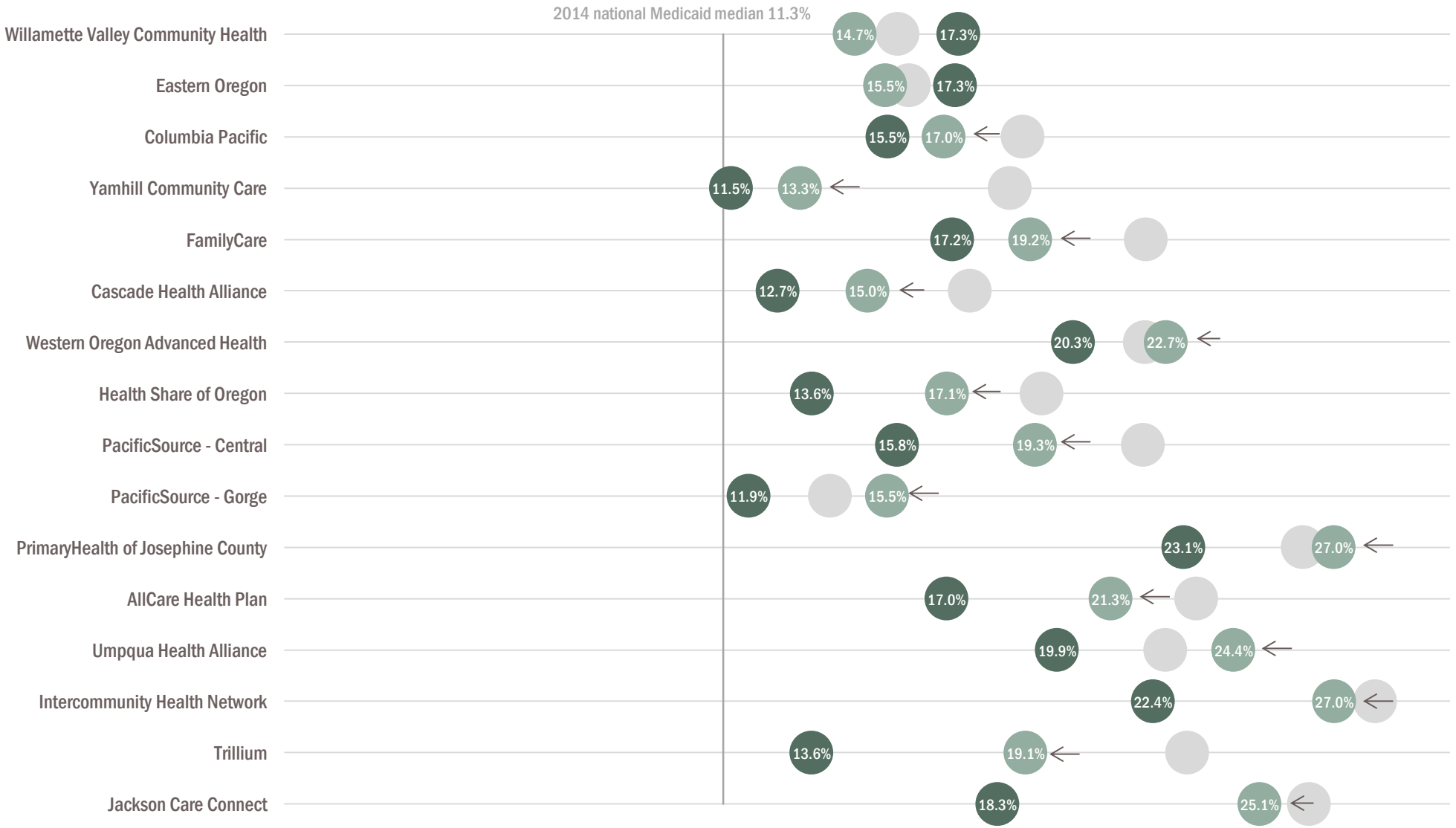
Grey dots represent 2014 / Race and ethnicity data missing for 11.4% of respondents / Each race category excludes Hispanic/Latino
~ Data suppressed (n<30)



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

Engagement of alcohol or other drug treatment in 2015 & mid-2016, by CCO.

Grey dots represent 2014



PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Patient-centered primary care home enrollment

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

mid-2016 data (n=840,880)

Statewide change since 2015: **+3.5%**

Number of CCOs that improved: **14**

Enrollment in patient-centered primary care homes increased by 75 percent since 2012. This improvement is impressive considering that CCO enrollment has increased almost 60 percent due to Medicaid expansion (see graph at right).

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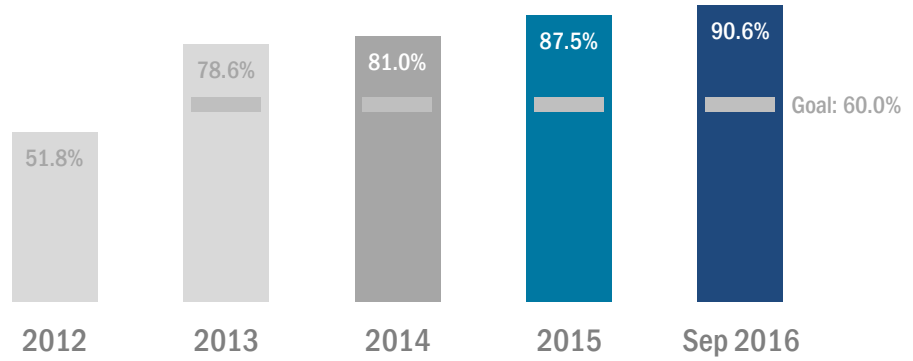
Race and ethnicity data are not available for this measure.

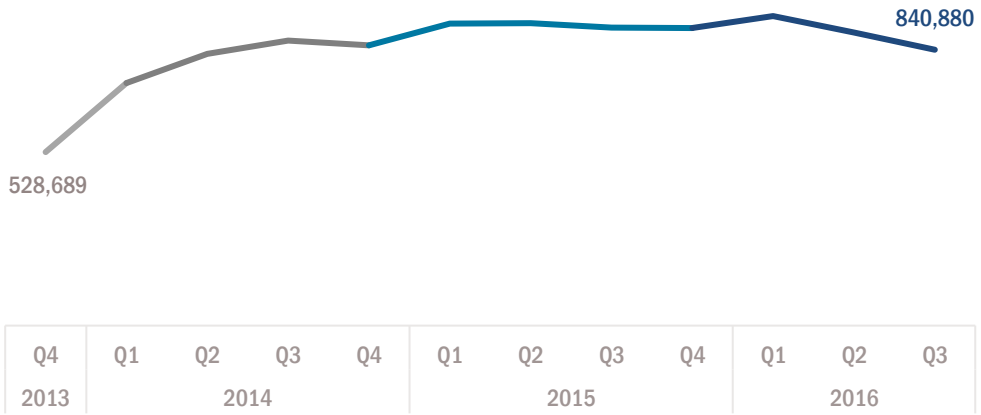
Percentage of members enrolled in a patient-centered primary care home, statewide.

Data source: CCO quaterly reporting



Total CCO enrollment has increased almost 60 percent since 2013.

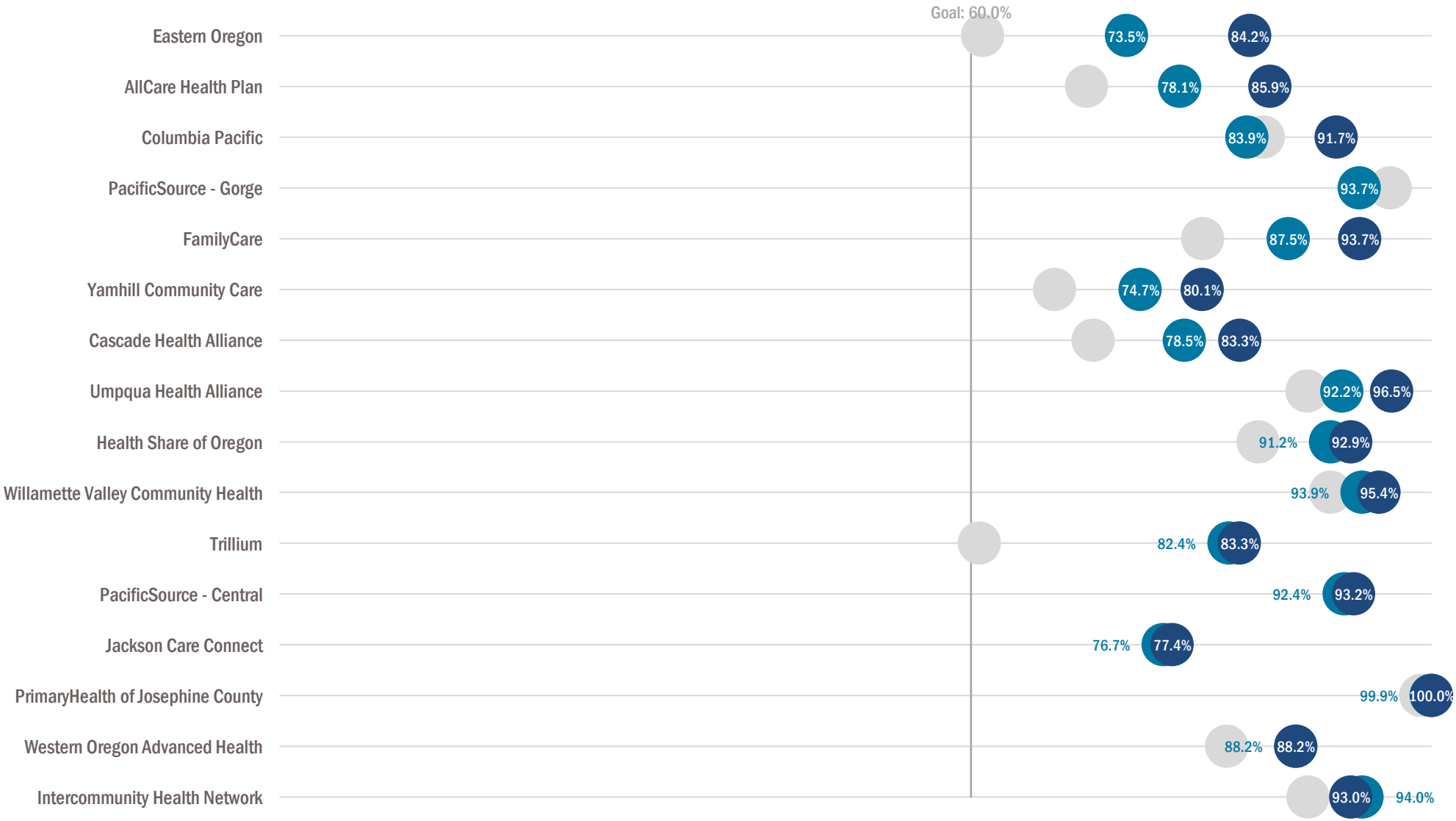
84.9% of Medicaid recipients were enrolled in a CCO in September 2016.



PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Percentage of members enrolled in a patient-centered primary care home in 2015 & September 2016, by CCO.

Grey dots represent 2014



PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

Diabetes short-term complications admission rate

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

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

mid-2016 data (n=6,674,167 member months)

Statewide change since 2015: **+3.5%** (lower is better)

Number of CCOs that improved: **9**

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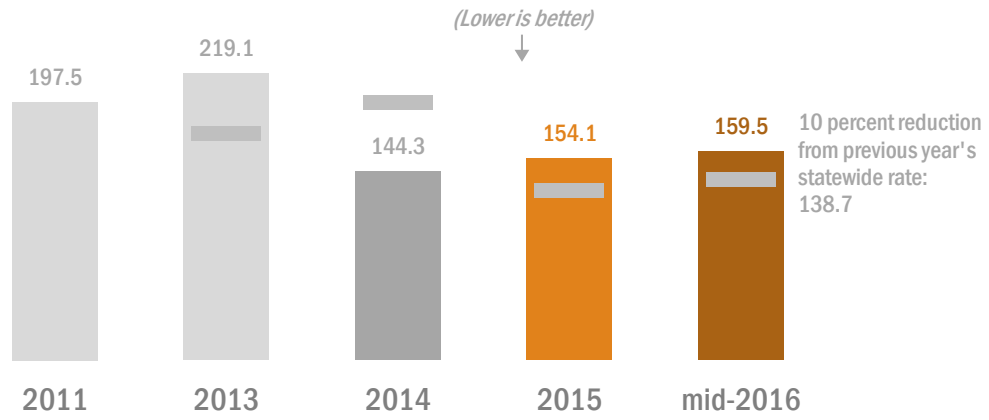
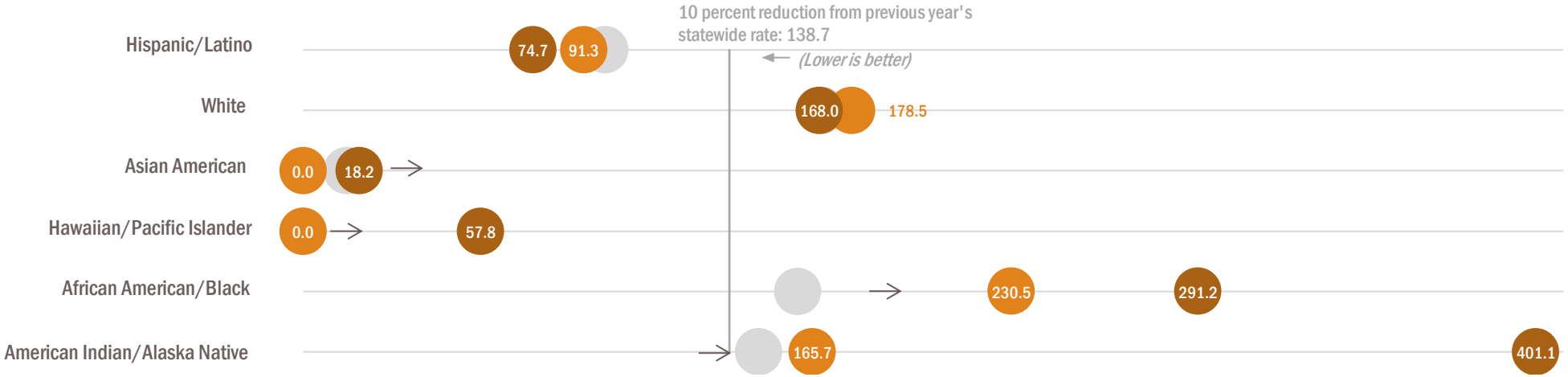
Admissions for diabetes short-term complications, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Admissions for diabetes short-term complications in 2015 & mid-2016, by race and ethnicity.

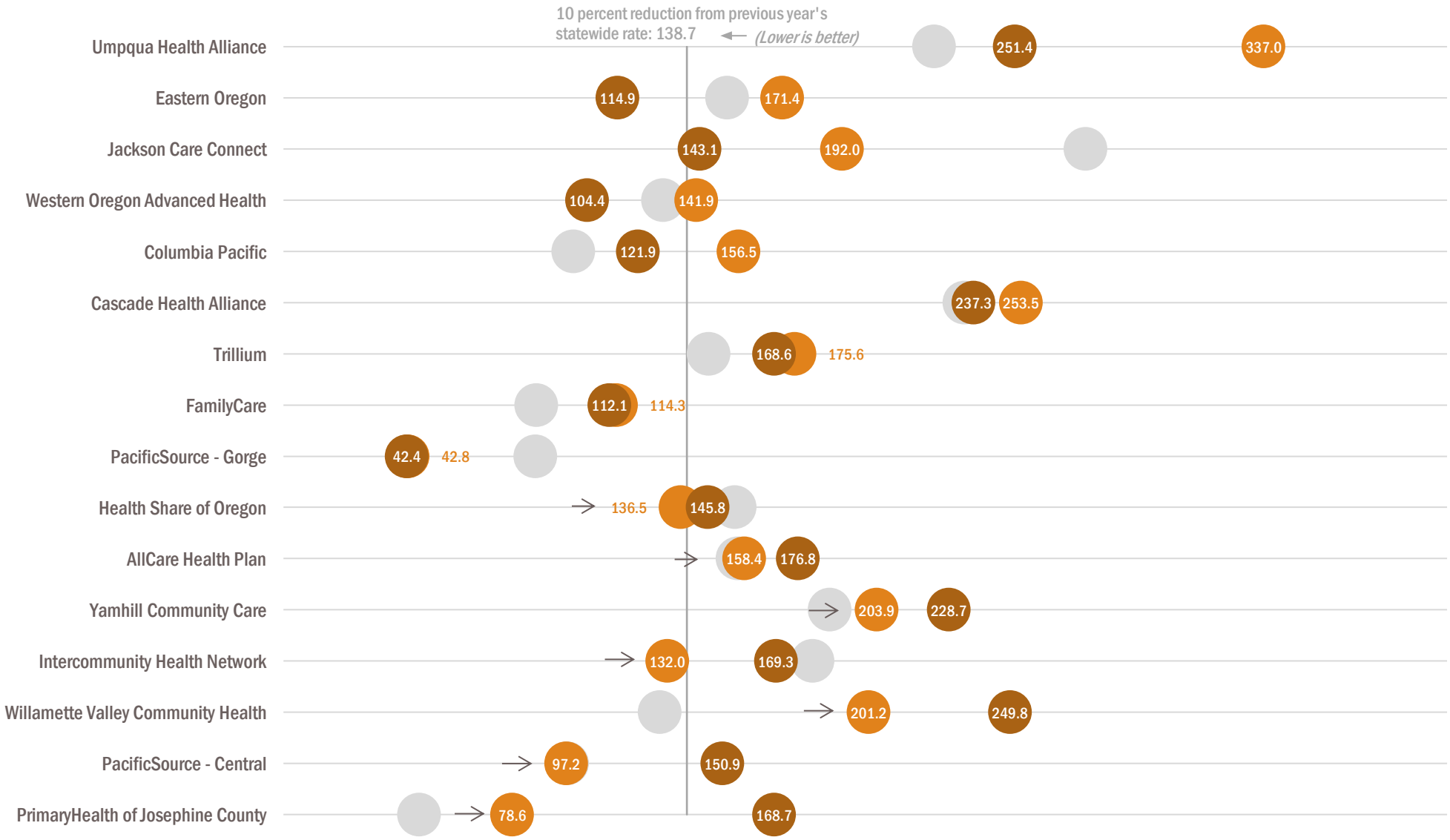
Rates are reported per 100,000 member years / Grey dots represent 2014 / Race and ethnicity data missing for 22.8% of respondents / Each race category excludes Hispanic/Latino



PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

Admissions for diabetes short-term complications in 2015 & mid-2016, by CCO.

Rates are reported per 100,000 member years / Grey dots represent 2014



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

COPD or asthma in older adults admission rate

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

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

mid-2016 data (n=3,093,900 member months)

Statewide change since 2015: **-4.4%** (lower is better)

Number of CCOs that improved: **7**

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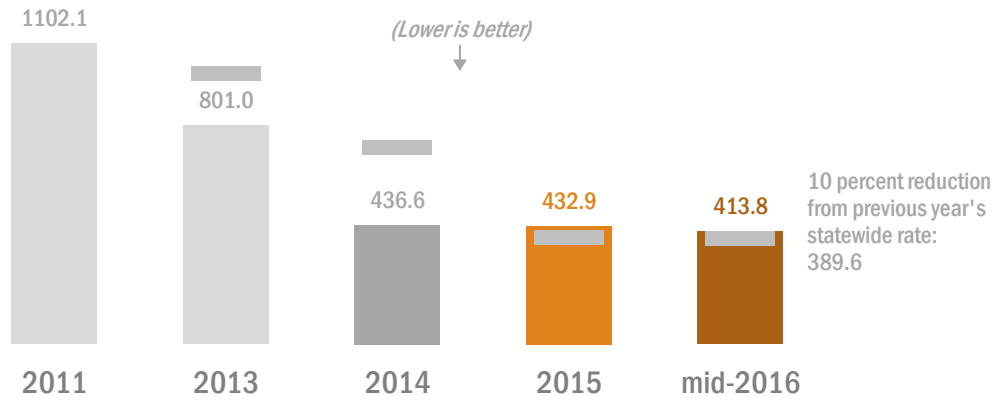
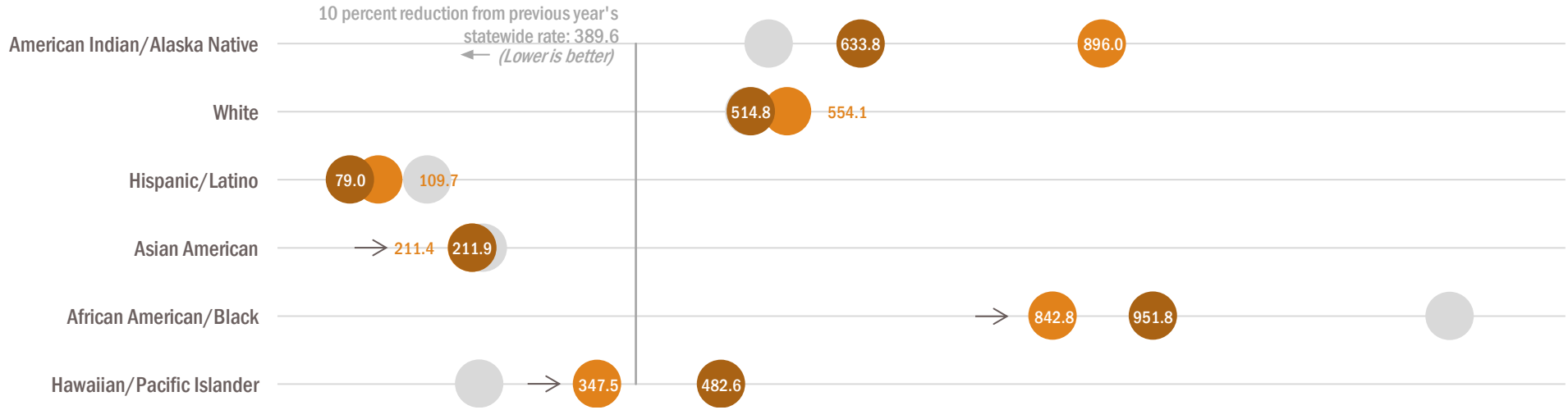
Admissions for COPD or asthma in older adults, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Admissions for COPD or asthma in older adults in 2015 & mid-2016, by race and ethnicity.

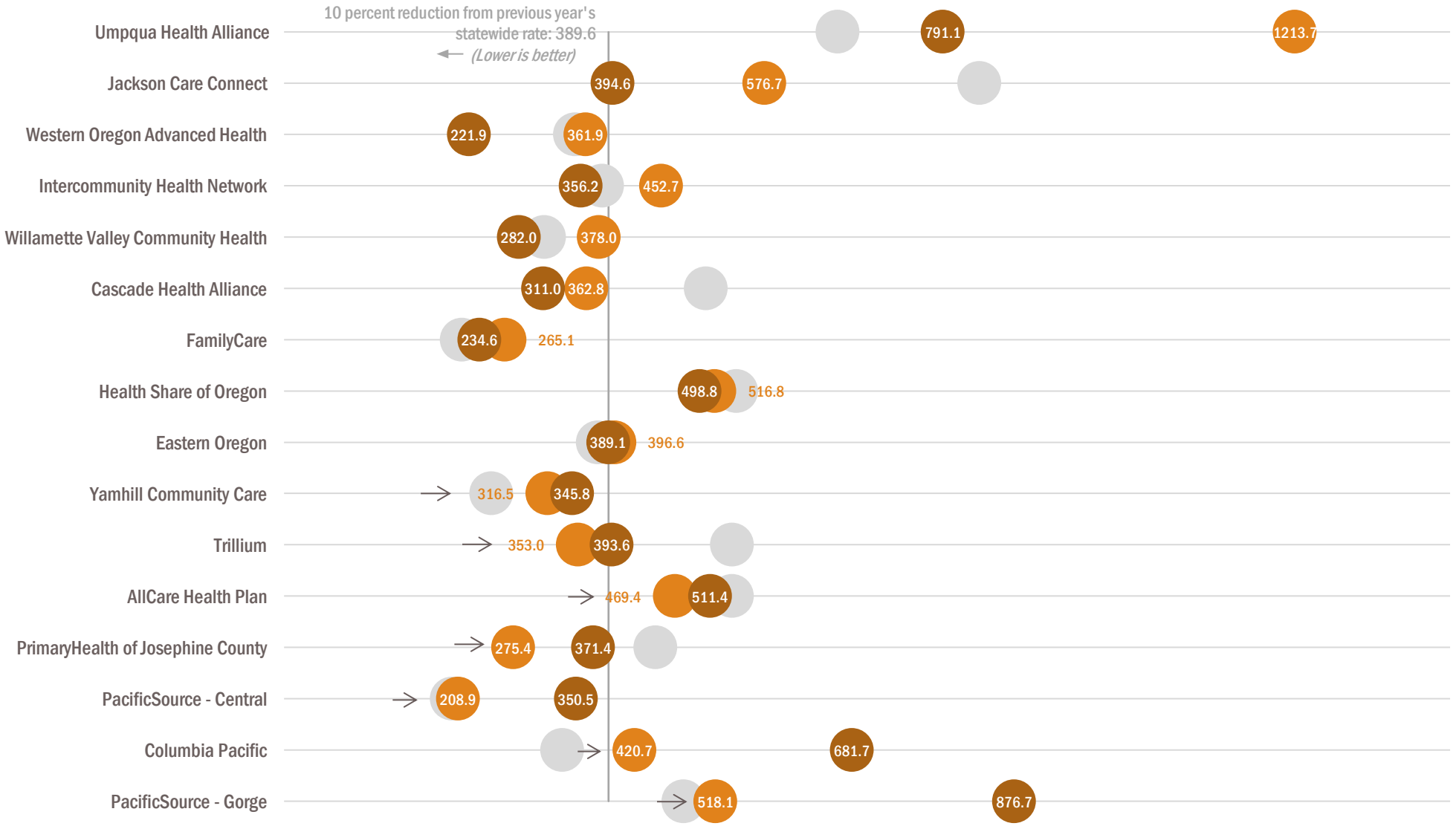
Rates are reported per 100,000 member years / Grey dots represent 2014 / Race and ethnicity data missing for 20.1% of respondents / Each race category excludes Hispanic/Latino



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

Admissions for COPD or asthma in older adults in 2015 & mid-2016, by CCO.

Rates are reported per 100,000 member years / Grey dots represent 2014



PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Congestive heart failure admission rate

Rate of adult members (ages 18 and older) who had a hospital stay because of congestive heart failure. Rates are reported per 100,000 member years. A lower score is better.

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

mid-2016 data (n=6,674,167 member months

Statewide change since 2015: **+3.2%** (lower is better)

Number of CCOs that improved: **11**

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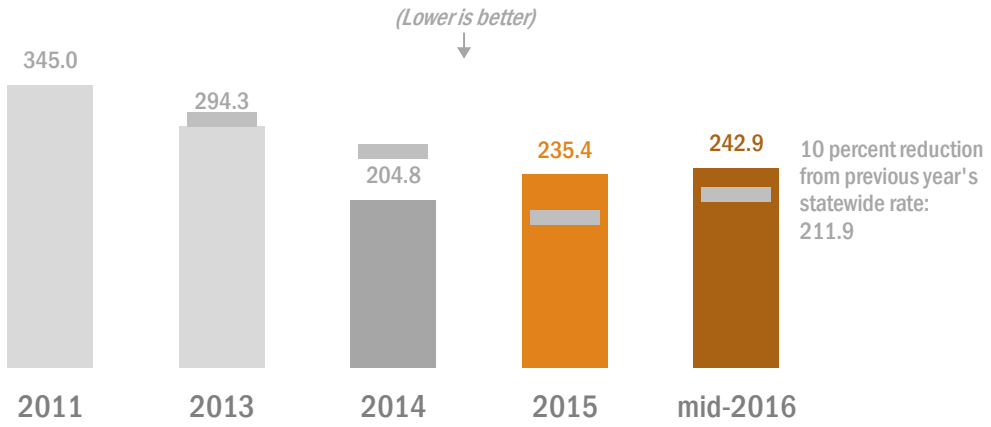
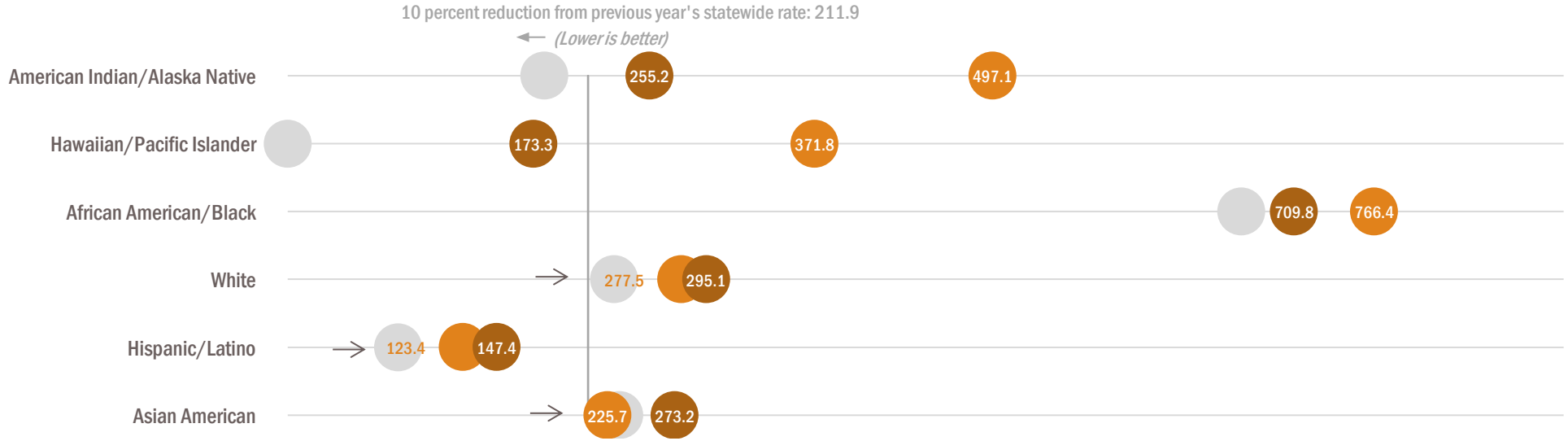
Admissions for congestive heart failure, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Admissions for congestive heart failure in 2015 & mid-2016, by race and ethnicity.

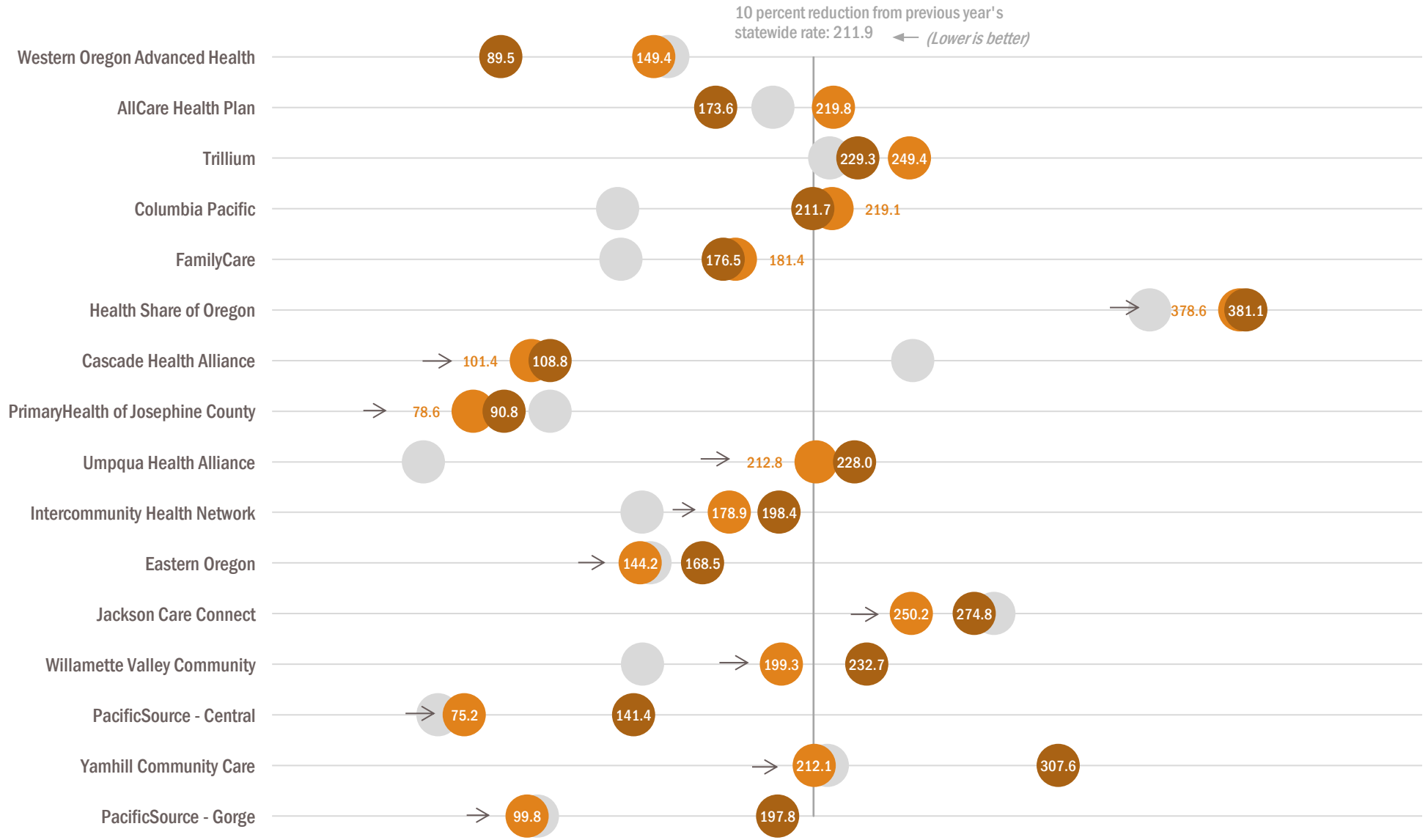
Rates are reported per 100,000 member years / Grey dots represent 2014 / Race and ethnicity data missing for 22.8% of respondents / Each race category excludes Hispanic/Latino



PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Admissions for congestive heart failure in 2015 & mid-2016, by CCO.

Rates are reported per 100,000 member years / Grey dots represent 2014



PQI 15: ASTHMA IN YOUNGER ADULTS ADMISSION RATE

Asthma in younger adults admission rate

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

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

mid-2016 data (n=3,580,267 member months)

Statewide change since 2015: **-13.6%** (lower is better)

Number of CCOs that improved: **12**

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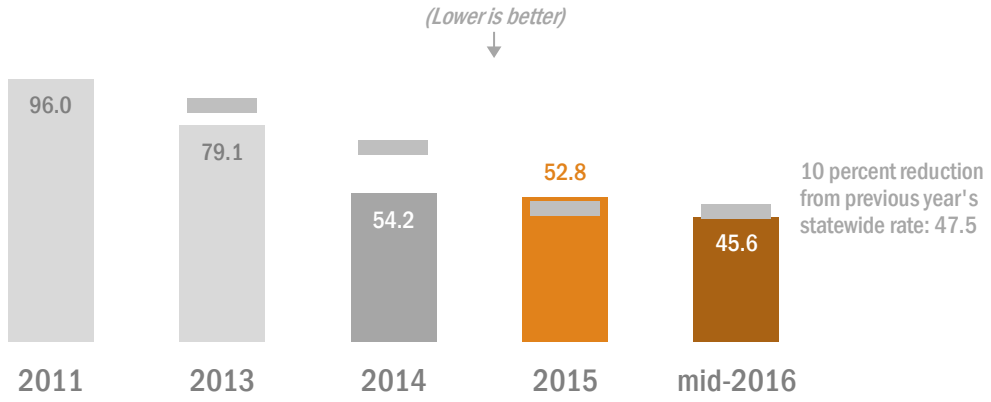
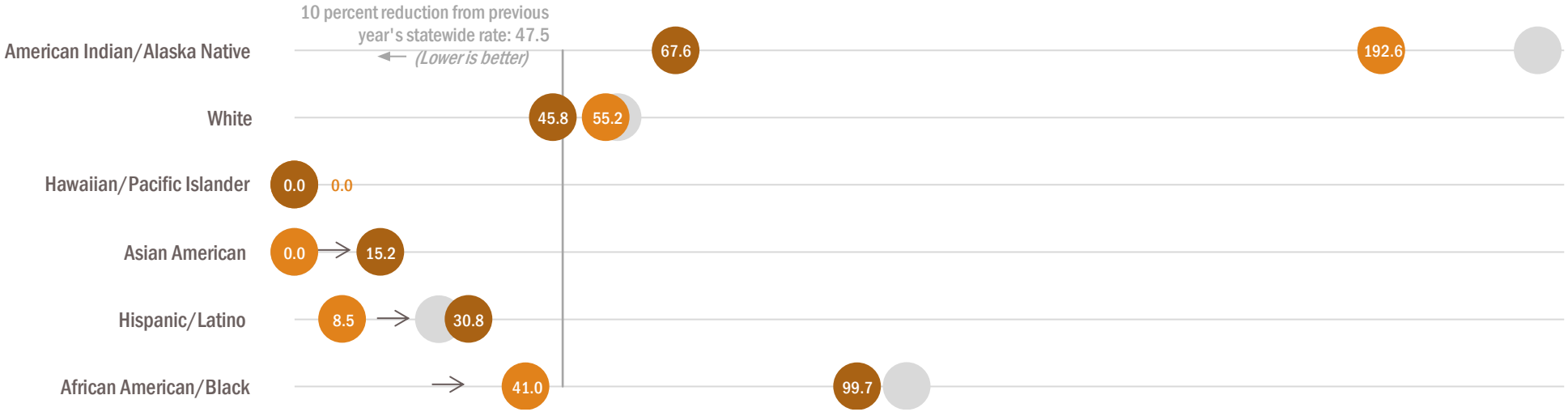
Admissions for asthma in younger adults, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years



Admissions for asthma in younger adults in 2015 & mid-2016, by race and ethnicity.

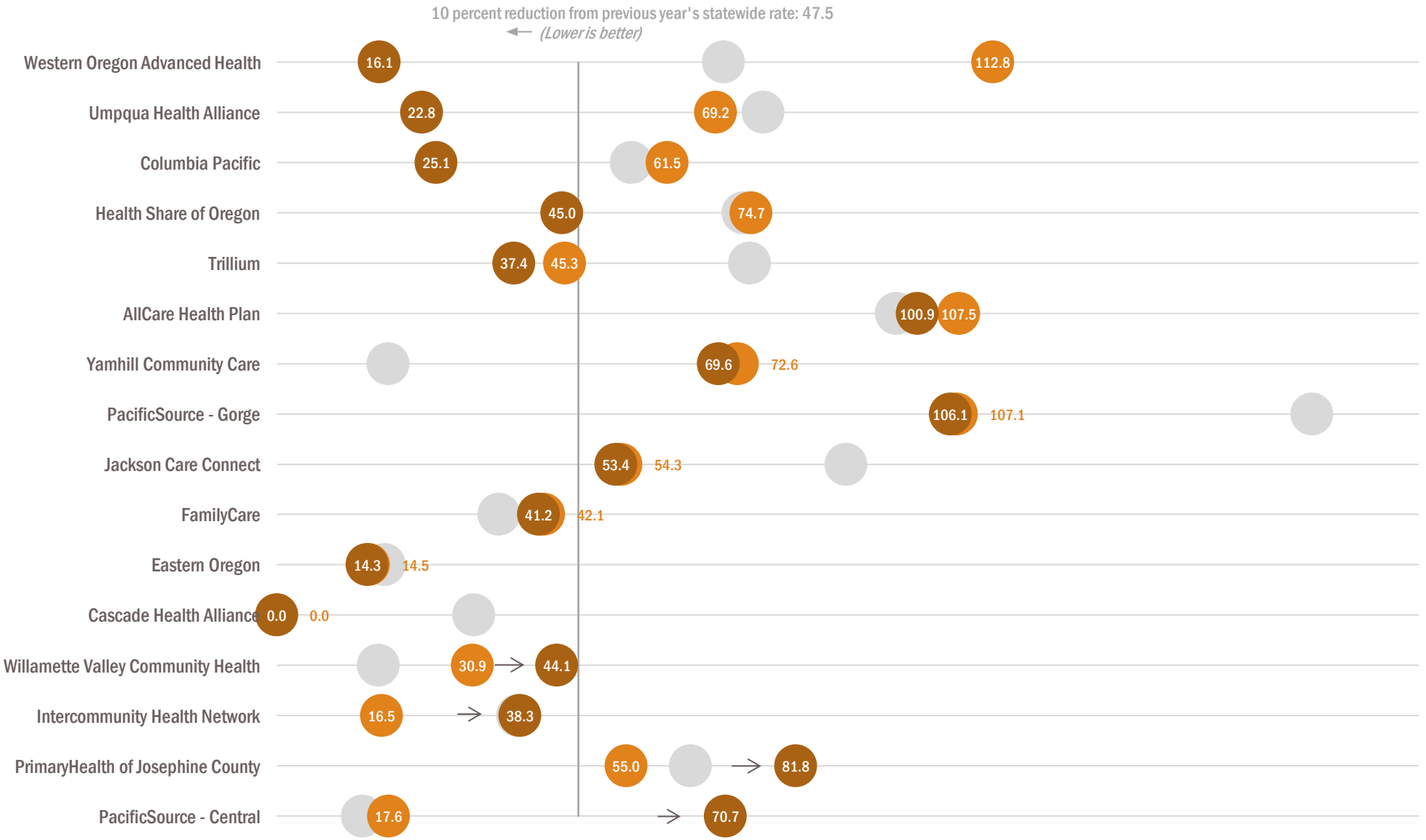
Rates are reported per 100,000 member years / Grey dots represent 2014 / Race and ethnicity data missing for % of respondents / Each race category excludes Hispanic/Latino



PQI 15: ASTHMA IN YOUNGER ADULTS ADMISSION RATE

Admissions for asthma in younger adults in 2015 & mid-2016, by CCO.

Rates are reported per 100,000 member years / Grey dots represent 2014



PQI 90: PREVENTION QUALITY OVERALL COMPOSITE

PQI 90: Prevention quality overall composite

Composite rate of adult members who were admitted to a hospital for any of the following preventable conditions:

- Diabetes with short-term complications (PQI 1, see page 81)
- Diabetes with long-term complications
- Uncontrolled diabetes without complications
- Diabetes with lower-extremity amputation
- COPD (PQI 5, see page 83)
- Asthma (PQI 15, see page 87)
- Hypertension
- Heart failure (PQI 8, see page 85)
- Angina
- Dehydration
- Bacterial pneumonia
- Urinary tract infection

Rates are reported per 100,000 member years and a lower score is better. PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to track avoidable hospital admissions.

mid-2016 data (n=6,689,912 member months)

Statewide change since 2015: **-13.2%** (lower is better)

Number of CCOs that improved: **13**

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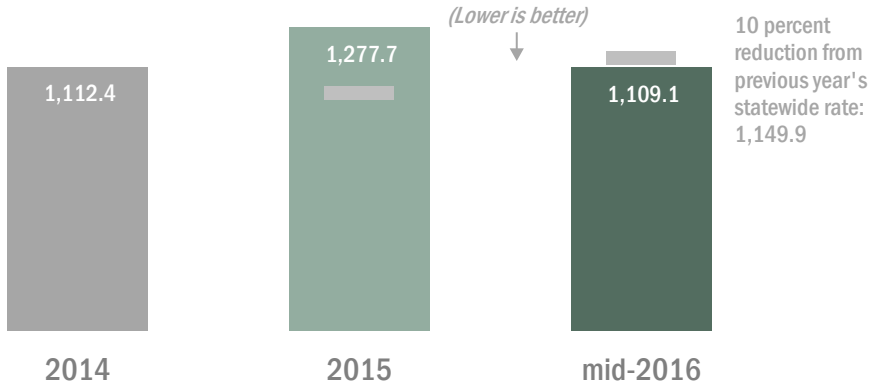
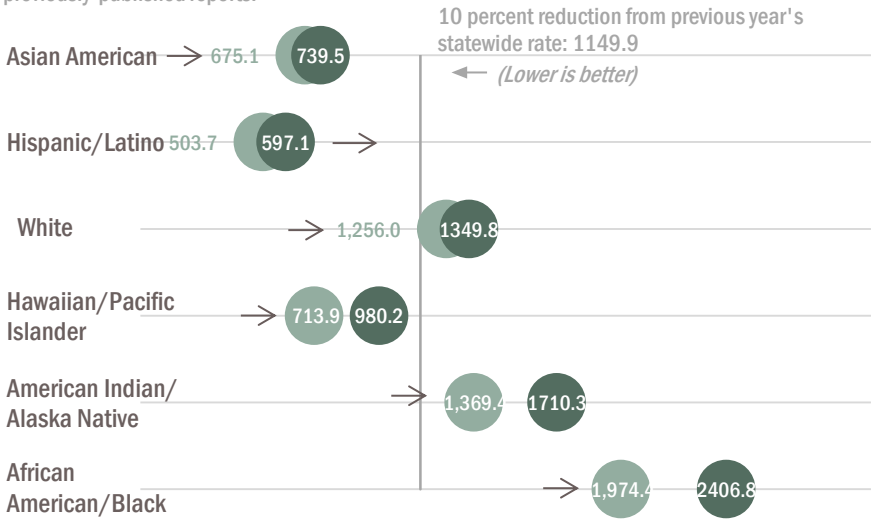
Overall rate of hospitalizations for preventable conditions, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years
2015 results have been updated to include full twelve months of data and should not be compared to previously-published reports.



Overall rate of hospitalizations for preventable conditions in 2015 & mid-2016, by race and ethnicity.

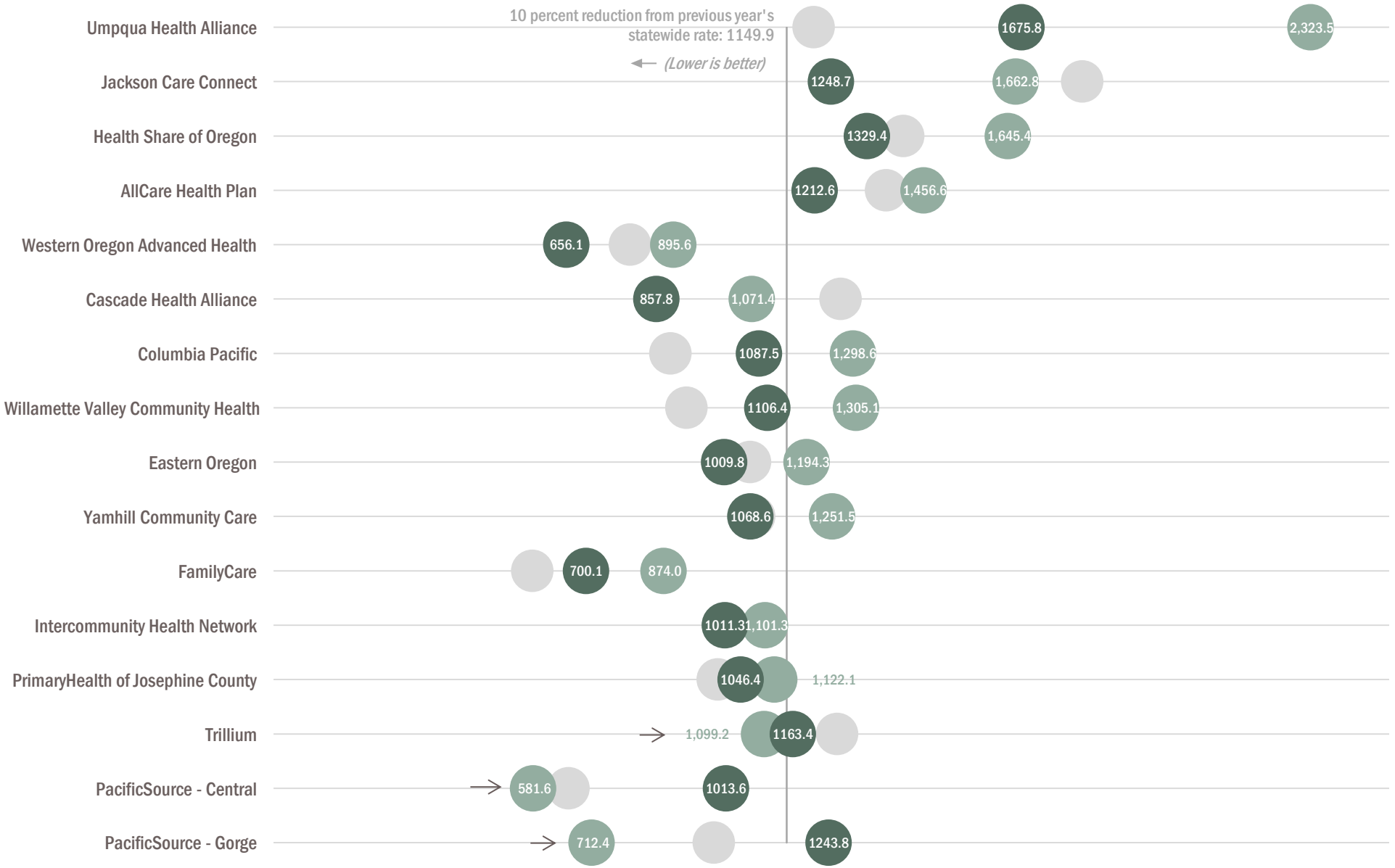
Race and ethnicity data missing for 23.0% of respondents / Each race category excludes Hispanic/Latino / 2015 results have been updated to include full twelve months of data and should not be compared to previously-published reports.



PQI 90: PREVENTION QUALITY OVERALL COMPOSITE

Overall rate of hospitalizations for preventable conditions in 2015 & mid-2016, by CCO.

2015 results have been updated to include full twelve months of data and should not be compared to previously-published reports / Grey dots represent 2014



PQI 91: PREVENTION QUALITY ACUTE COMPOSITE

PQI 91: Prevention quality acute composite

Composite rate of adult members who were admitted to a hospital for any of the following acute conditions:

- Dehydration
- Bacterial pneumonia
- Urinary tract infection

Rates are reported per 100,000 member years and a lower score is better. PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to track avoidable hospital admissions.

mid-2016 data (n=6,689,912 member months)

Statewide change since 2015: **-8.2%** (lower is better)

Number of CCOs that improved: **12**

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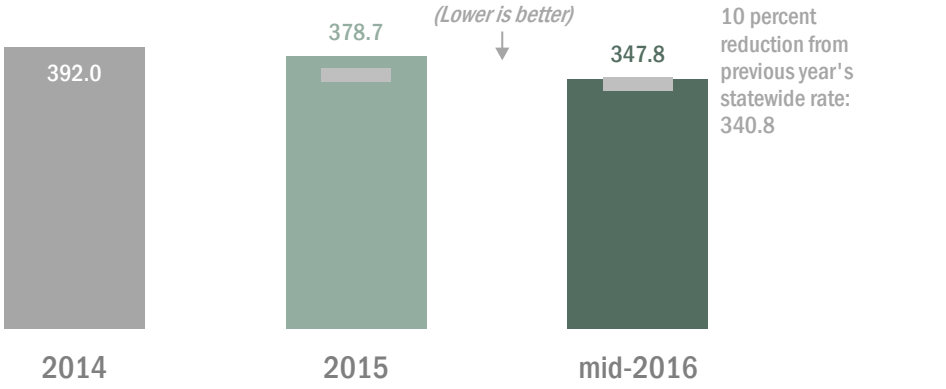
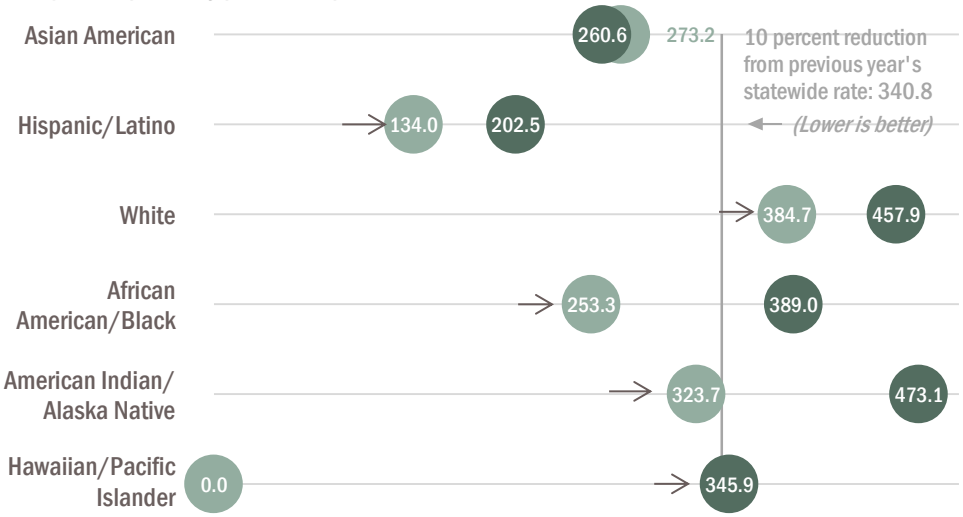
Admissions for acute conditions, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years
2015 results have been updated to include full twelve months of data and should not be compared to previously-published reports.



Admissions for acute conditions in 2015 & mid-2016, by race and ethnicity, by CCO.

Race and ethnicity data missing for 23.0% of respondents / Each race category excludes Hispanic/ Latino / 2015 results have been updated to include full twelve months of data and should not be compared to previously-published reports.



PQI 91: PREVENTION QUALITY ACUTE COMPOSITE

Admissions for acute conditions in 2015 & mid-2016, by CCO.

2015 results have been updated to include full twelve months of data and should not be compared to previously-published reports / Grey dots represent 2014

PQI 92: PREVENTION QUALITY CHRONIC COMPOSITE

PQI 92: Prevention quality acute composite

Composite rate of adult members who were admitted to a hospital for any of the following acute conditions:

- Diabetes with short-term complications (PQI 1, see page 81)
- Diabetes with long-term complications
- Uncontrolled diabetes without complications
- Diabetes with lower-extremity amputation
- COPD (PQI 5, see page 83)
- Asthma (PQI 15, see page 87)
- Hypertension
- Heart failure (PQI 8, see page 85)
- Angina

Rates are reported per 100,000 member years and a lower score is better. PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to track avoidable hospital admissions.

mid-2016 data (n=6,689,912 member months)

Statewide change since 2015: **-15.3%** (lower is better)

Number of CCOs that improved: **12**

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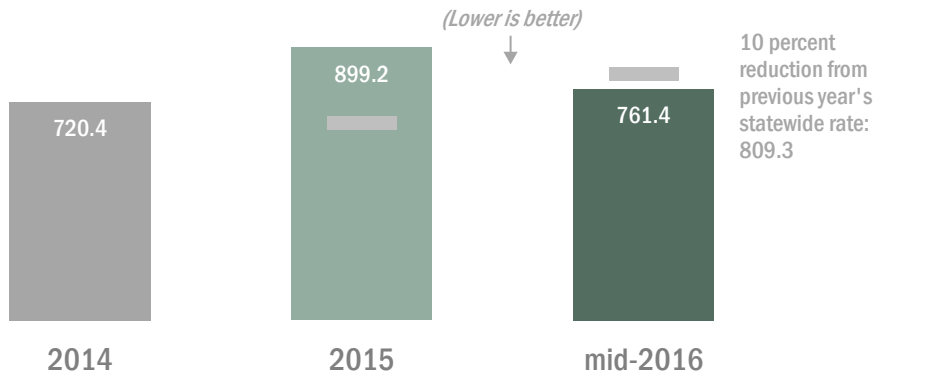
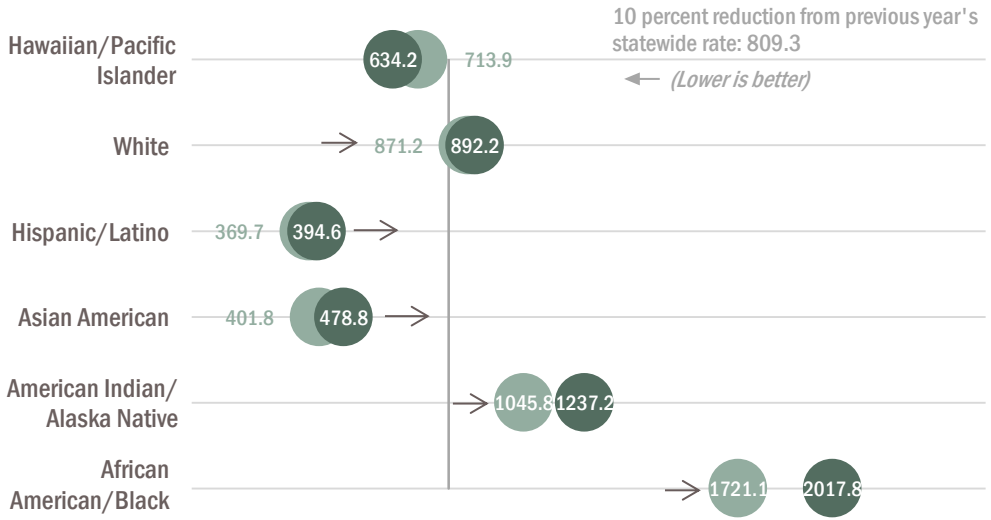
Admissions for chronic conditions, statewide.

Data source: Administrative (billing) claims
Rates are reported per 100,000 member years
2015 results have been updated to include full twelve months of data and should not be compared to previously-published reports.



Admissions for chronic conditions in 2015 & mid-2016, by race and ethnicity.

Race and ethnicity data missing for 23.0% of respondents / Each race category excludes Hispanic/Latino / 2015 results have been updated to include full twelve months of data and should not be compared to previously-published reports.



PQI 92: PREVENTION QUALITY CHRONIC COMPOSITE

Admissions for chronic conditions 2015 & mid-2016, by CCO.

2015 results have been updated to include full twelve months of data and should not be compared to previously-published reports / Grey dots represent 2014

ADDITIONAL MEASURE STRATIFICATION:

MEASURES BY DISABILITY, MENTAL HEALTH DIAGNOSES, AND SEVERE AND PERSISTENT MENTAL ILLNESS

The Oregon Health Authority is committed to providing data on vulnerable or historically underserved members of our community. This section of the report provides a subset of CCO measures stratified by members with disability, with mental health diagnoses, and with severe and persistent mental illness (SPMI).

This is the third time these data have been included in a CCO metrics report, and the first time showing trend over time, comparing calendar year 2015 with measurement period July 2015—June 2016. Also included for the first time are three new measures: Outpatient utilization, childhood immunization status, and immunization for adolescents (mid-year data only; stratified calendar year 2015 results are not available for these measures).

Definitions used in this section:

- With disability means people who qualify for Medicaid based on an impairment that has prevented or is expected to prevent them from performing substantial gainful activity for at least one year. This may include physical, mental, emotional, learning, developmental or other disabilities. These individuals may or may not also be qualified for Medicare. Eligibility codes include: 2, 3, B3, and D4.
- **With mental health diagnoses** refers to people who have had two or more services in the past 36 months with any of the qualifying diagnoses for schizophrenia, bipolar, delusional, developmental, anxiety, personality, or depressive disorders, as well as other mental health disorders (see diagnosis code table on page 106).
- **With severe and persistent mental illness** refers to people 18 years and older who have had two or more services with qualifying diagnosis codes in the past 36 months (see diagnosis code table on page 106). This definition is also used for U.S. Department of Justice reporting (for more information visit www.oregon.gov/oha/bhp/Pages/USDOJ-Agreement.aspx).

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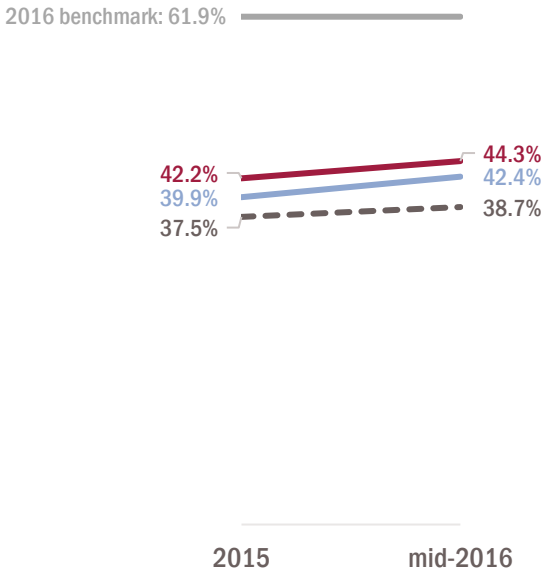
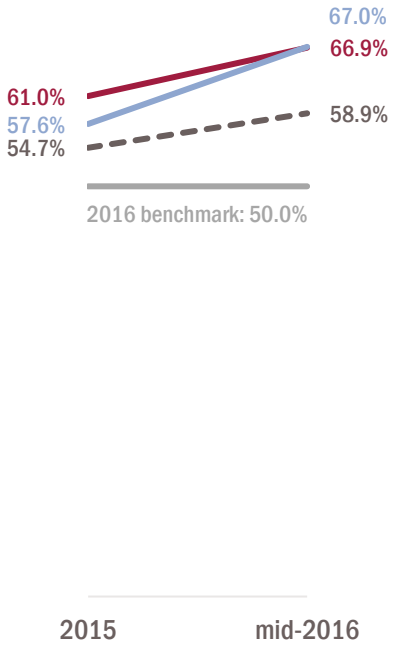
MEASURES BY DISABILITY AND MENTAL HEALTH DIAGNOSES

Adolescent well-care visits



Disability mid-2016 n = 4,654
MHDX mid-2016 n = 31,467
More information on this measure: Page 17

Developmental screening in the first 36 months of life



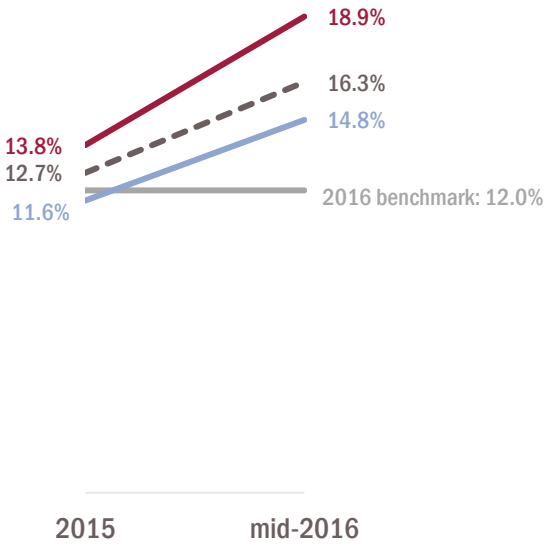
Disability mid-2016 n = 179
MHDX mid-2016 n = 2,095
More information on this measure: Page 59

Statewide | With disability | With mental health diagnoses (MHDx)

MEASURES BY DISABILITY AND MENTAL HEALTH DIAGNOSES

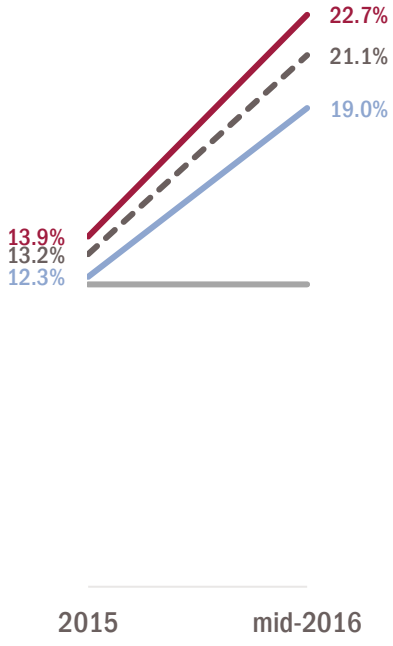
Screening, brief intervention, and referral to treatment (SBIRT)

All ages (12+)



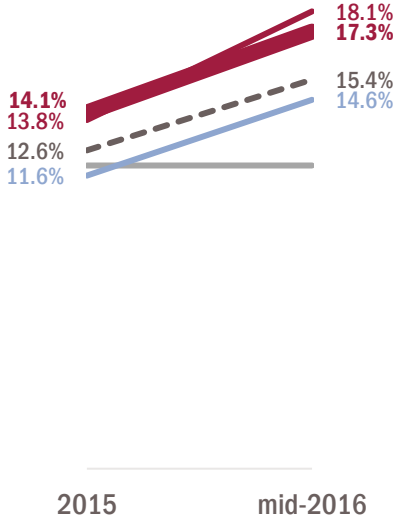
Disability mid-2016 n = 50,631
MHDX mid-2016 n = 172,095
More information on this measure: Page 19

Adolescents (ages 12-17)



Disability mid-2016 n = 2,743
MHDX mid-2016 n = 27,260
More information on this measure: Page 21

Adults (ages 18+)



Disability mid-2016 n = 47,888
MHDX mid-2016 n = 144,835
SPMI mid-2016 n = 58,618
More information on this measure: Page 23

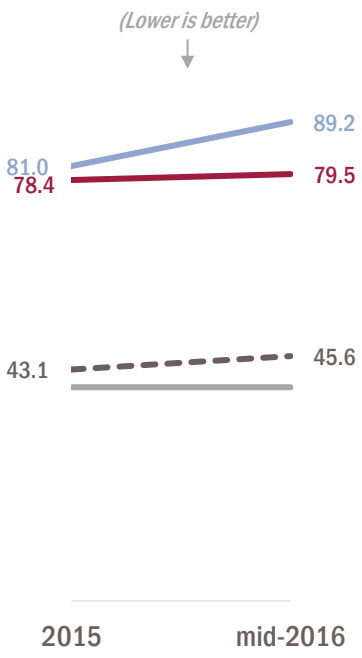
Statewide | With disability | With mental health diagnoses (MHDx) | With severe and persistent mental illness (SPMI)

MEASURES BY DISABILITY AND MENTAL HEALTH DIAGNOSES

Ambulatory care: Emergency department utilization

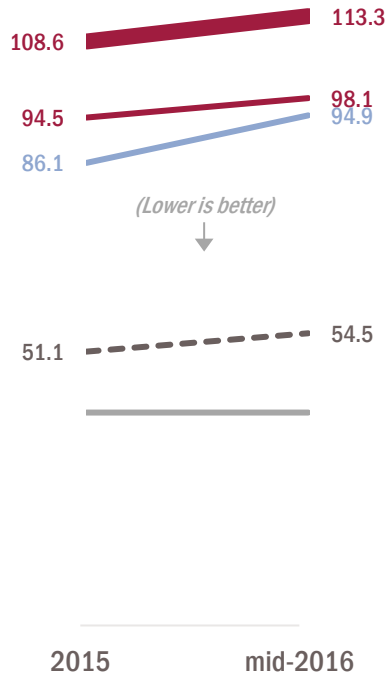
All ages

Rates are reported per 1,000 member months



Adults ages 18+

Rates are reported per 1,000 member months



2016 benchmark: 39.8

Emergency department utilization is stratified by adults here in order to report members with severe and persistent mental illness (SPMI), which applies to adults only.

Statewide | With disability | With mental health diagnoses (MHDx) | With severe and persistent mental illness (SPMI)

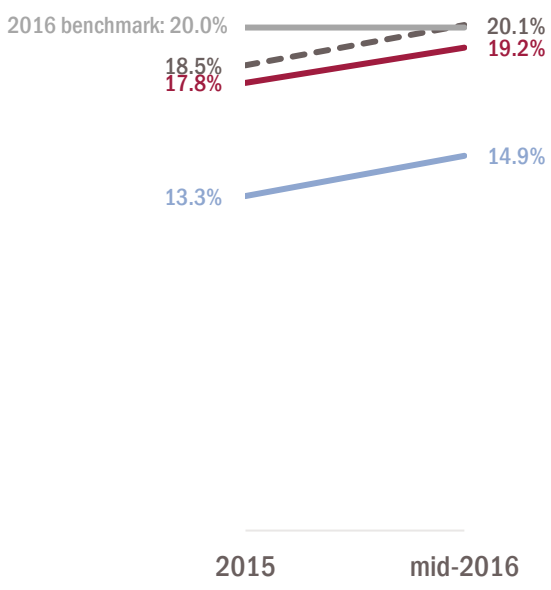
Disability mid-2016 n = 706,684
MHDX mid-2016 n = 2,514,139
More information on this measure: Page 25

Disability mid-2016 n = 630,384 mm
MHDX mid-2016 n = 1,918,605 mm
SPMI mid-2016 n = 711,648 mm

MEASURES BY DISABILITY AND MENTAL HEALTH DIAGNOSES

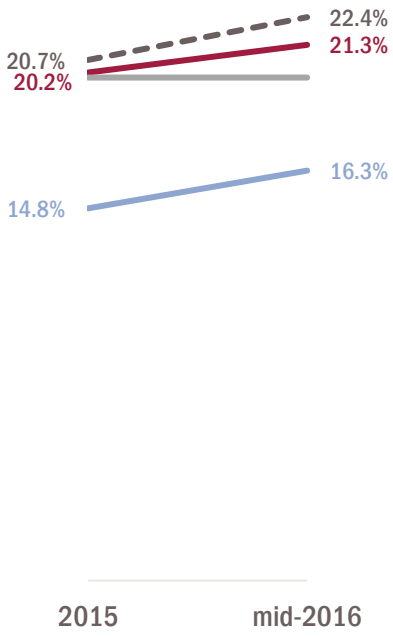
Dental sealants on permanent molars for children

All ages (6-14)



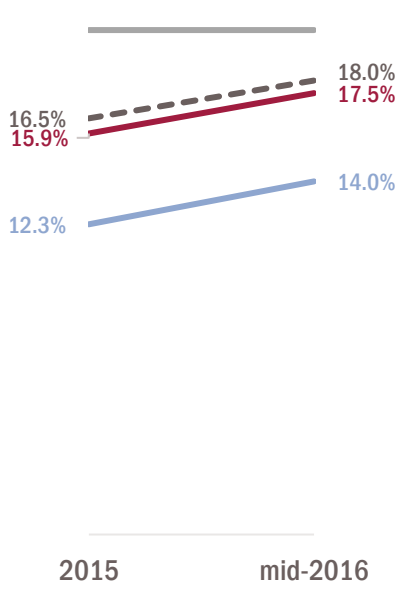
Disability mid-2016 n = 3,649
MHDX mid-2016 n = 30,351
More information on this measure: Page 53

Ages 6-9



Disability mid-2016 n = 1,379
MHDX mid-2016 n = 13,079
More information on this measure: Page 55

Ages 10-14



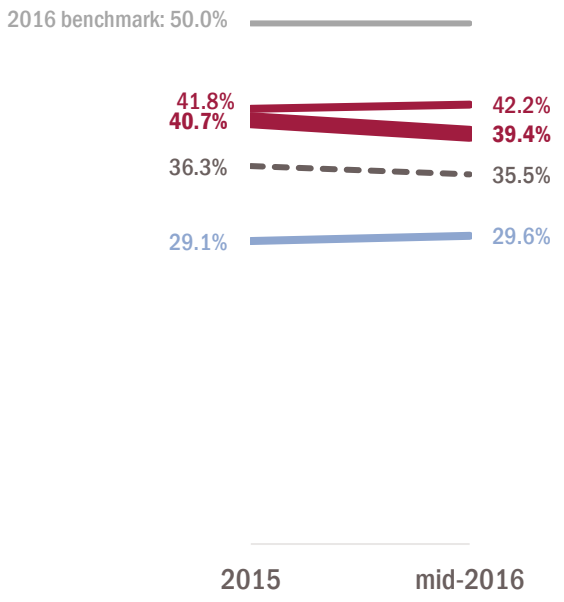
Disability mid-2016 n = 2,270
MHDX mid-2016 n = 17,272
More information on this measure: Page 57

Statewide | With disability | With mental health diagnoses (MHDx)

MEASURES BY DISABILITY AND MENTAL HEALTH DIAGNOSES

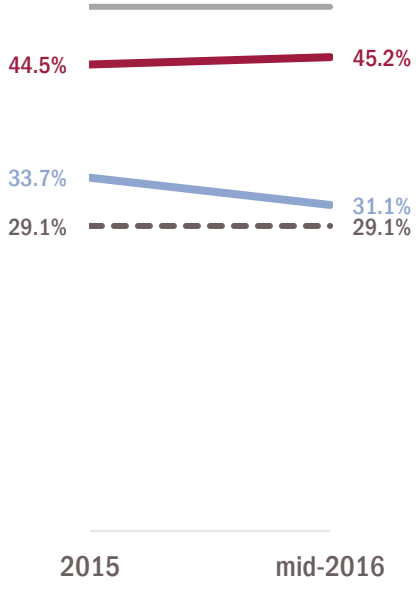
Effective contraceptive use among women at risk of unintentend pregnancy

Adults (ages 18-50)



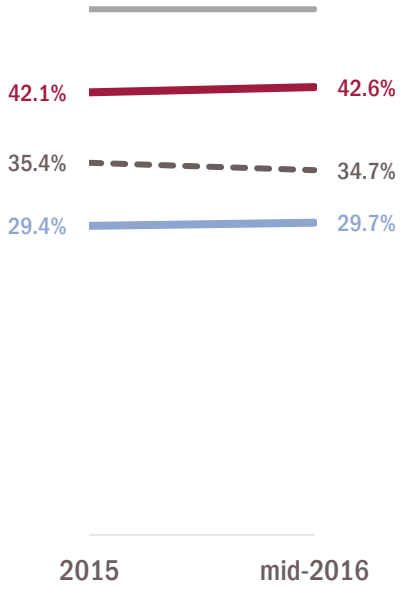
Disability mid-2016 n = 8,439
MHDX mid-2016 n = 42,146
SPMI mid- 2016 n = 16,541
More information on this measure: Page 61

Adolescents (ages 15-17)



Disability mid-2016 n = 450
MHDX mid-2016 n = 6,025
More information on this measure: Page 63

All ages (15-50)

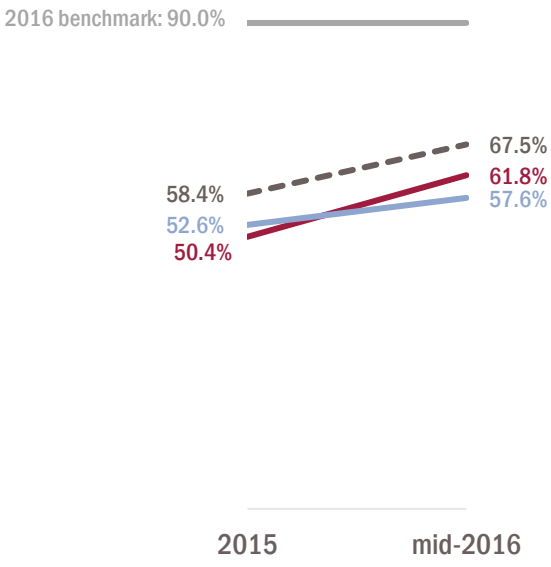


Disability mid-2016 n = 8,889
MHDX mid-2016 n = 48,171
More information on this measure: Page 65

Statewide | With disability | With mental health diagnoses (MHDx) | With severe and persistent mental illness (SPMI)

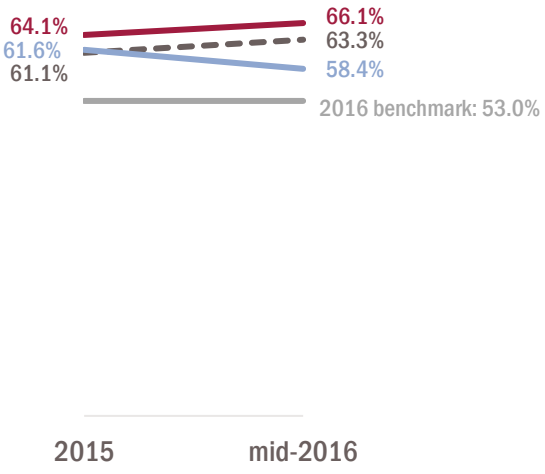
MEASURES BY DISABILITY AND MENTAL HEALTH DIAGNOSES

Mental, physical, and dental health assessments for children in DHS custody (foster care)



Disability mid-2016 n = 33
MHDX mid-2016 n = 897
More information on this measure: Page 33

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

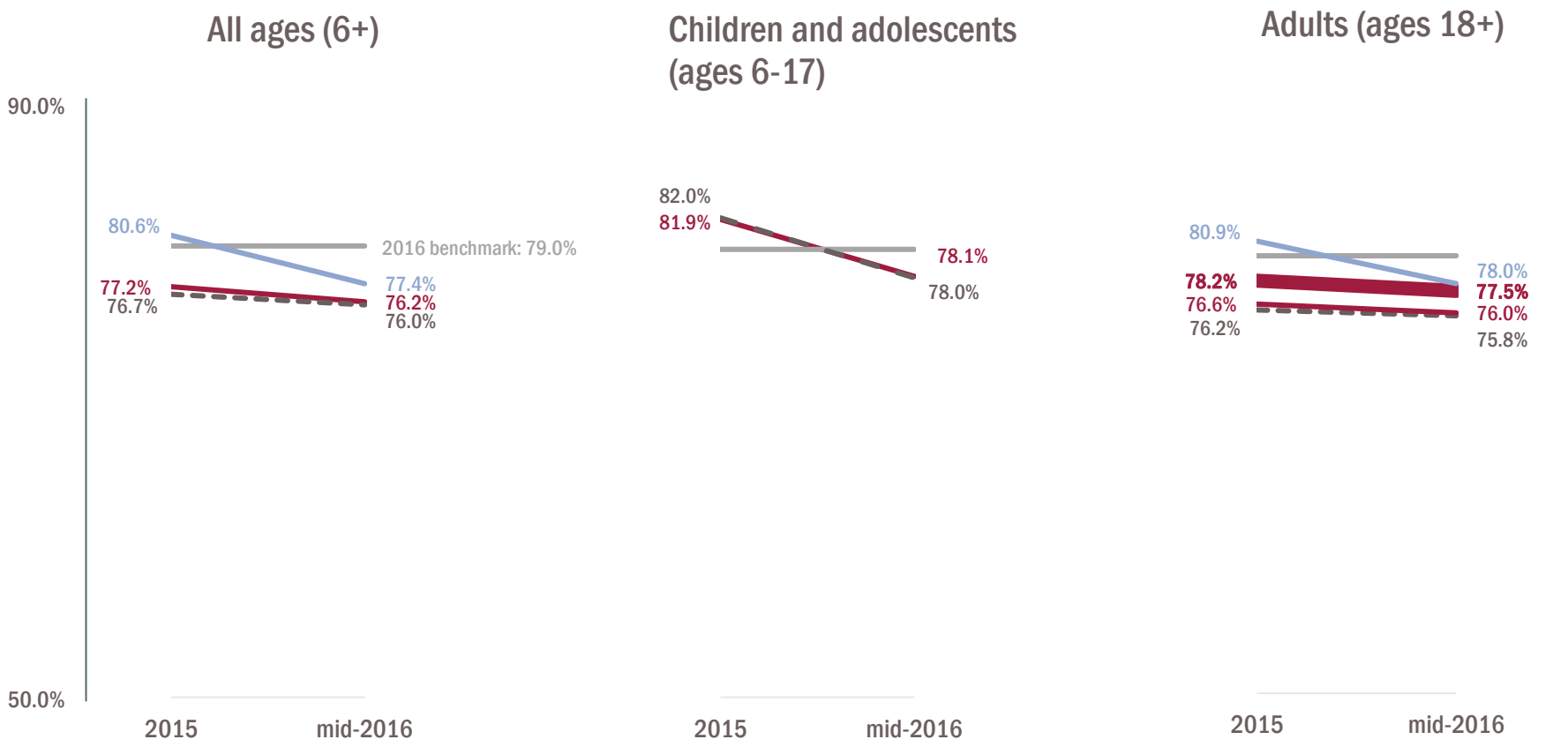


Disability mid-2016 n = 159
MHDX mid-2016 n = 2,212
More information on this measure: Page 69

Statewide | With disability | With mental health diagnoses (MHDx)

MEASURES BY DISABILITY AND MENTAL HEALTH DIAGNOSES

Follow-up after hospitalization for mental illness



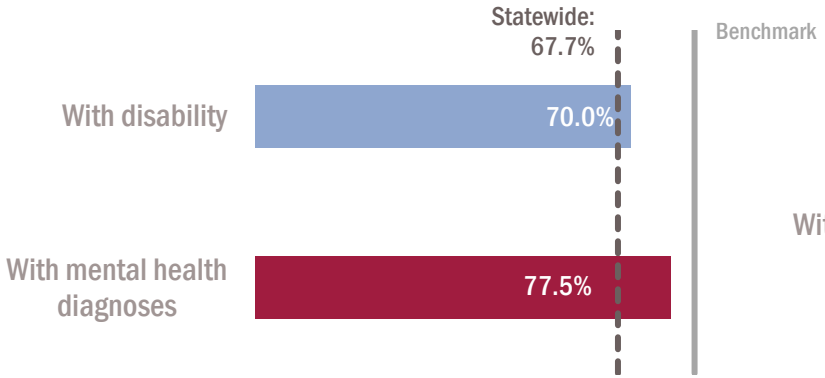
Disability mid-2016 n = 997
MHDX mid-2016 n = 3,266
More information on this measure: Page 67

Disability mid-2016 n<30 (data suppressed)
MHDX mid-2016 n = 311

Disability 2016 = 971
MHDX 2016 n = 2,955
SMPI mid-2016 n = 2,258

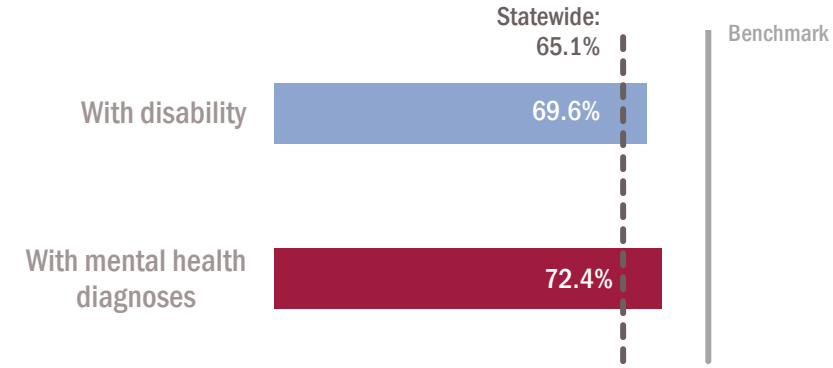
MEASURES BY DISABILITY AND MENTAL HEALTH DIAGNOSES

Childhood immunization status
July 2015 - June 2016



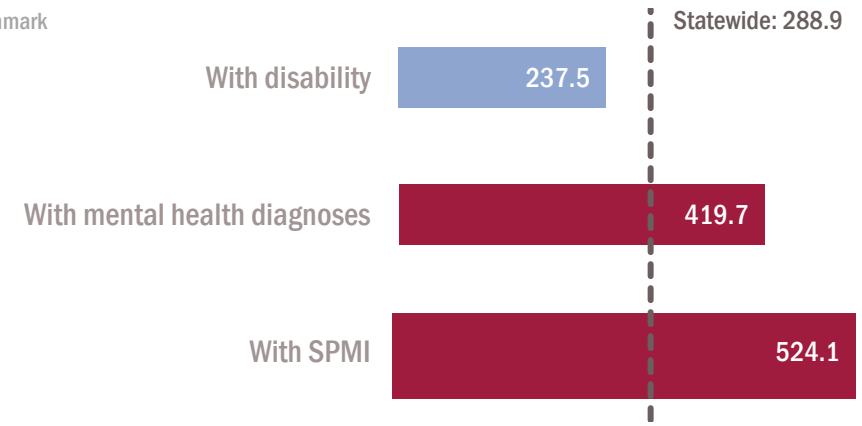
Childhood immunization status:
Disability mid-2016 n = 60
MHDX mid-2016 n = 657
More information on this measure: Page 45

Immunization for adolescents
July 2015 - June 2016



Immunization for adolescents:
Disability mid-2016 n = 484
MHDX mid-2016 n = 3,595
More information on this measure: Page 73

Outpatient utilization
July 2015 - June 2016



Outpatient utilization:
Disability mid-2016 n = 706,684
MHDX mid-2016 n = 2,514,139
SPMI mid-2016 n = 711,648
More information on this measure: Page 29

DIAGNOSIS CODE TABLE

Mental Health Diagnosis Codes:

Mental Disorders due to known physiological conditions: ICD10: F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F04, F05, F06.0, F06.1, F06.2, F06.30, F06.31, F06.32, F06.33, F06.34, F06.4, F06.8, F07.0, F07.81, F07.89, F07.9, F09.

Behavioral syndromes associated with physiological disturbance and physical factors: ICD10: F50.00, F50.01, F50.2, F50.8, F50.9, F51.01, F51.02, F51.03, F51.04, F51.05, F51.09, F51.11, F51.12, F51.13, F51.19, F51.3, F51.4, F51.5, F51.8, F51.9, F52.0, F52.1, F52.21, F52.22, F52.31, F52.32, F52.4, F52.5, F52.6, F52.8, F52.9, F53, F54, F55.0, F55.1, F55.2, F55.3, F55.4, F55.8, F59.

Mood manic and Bipolar:
ICD10: F30, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9.

Mood Major Depression:
ICD10: F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.0, F34.1, F34.8, F34.9, F39.

Schizophrenia and non-mood psychotic disorders:
ICD10: F20.0, F20.1, F20.2, F20.5, F20.81, F20.89, F20.9, F203, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29

Anxiety, Dissociative, stress-related nonpsychotic disorders::
ICD10: F40.00, F40.01, F40.02, F40.10, F40.11, F40.210, F40.218, F40.220, F40.228, F40.230, F40.231, F40.232, F40.233, F40.240, F40.241, F40.242, F40.243, F40.248, F40.290, F40.291, F40.298, F40.8, F40.9, F41.0, F41.1, F41.3, F41.8, F41.9, F42, F43.0, F43.10, F43.11, F43.12, F43.20, F43.21, F43.22, F43.23, F43.24, F43.25, F43.29, F43.8, F43.9, F44.0, F44.1, F44.2, F44.4, F44.5, F44.6, F44.7, F44.81, F44.89, F44.9, F45.0, F45.1, F45.20, F45.21, F45.22, F45.29, F45.41, F45.42, F45.8, F45.9, F48.1, F48.2, F48.8, F48.9.

Personality disorder:
ICD10: F60.0, F60.1, F60.2, F60.3, F60.4, F60.5, F60.6, F60.7, F60.81, F60.89, F60.9, F63.0, F63.1, F63.2, F63.3, F63.81, F63.89, F63.9, F64.1, F64.2, F64.8, F64.9, F65.0, F65.1, F65.2, F65.3, F65.4, F65.50, F65.51, F65.52, F65.81, F65.89, F65.9, F66, F68.10, F68.11, F68.12, F68.13, F68.8, F69.

Intellectual and Developmental disorders:
ICD10: F70, F71, F72, F73, F78, F79, F80.0, F80.1, F80.2, F80.4, F80.81, F80.89, F80.9, F81.0, F81.2, F81.81, F81.89, F81.9, F82, F84.0, F84.2, F84.3, F84.4, F84.5, F84.8, F84.9, F88, F89.

Emotional and Behavioral Disorders with onset during childhood and adolescence:
ICD10: F90.0, F90.1, F90.2, F90.8, F90.9, F91.0, F91.1, F91.2, F91.3, F91.8, F91.9, F93.0, F93.8, F93.9, F94.0, F94.1, F94.2, F94.8, F94.9, F95.0, F95.1, F95.2, F95.8, F95.9, F98.0, F98.1, F98.21, F98.29, F98.3, F98.4, F98.5, F98.8, F98.9.
ICD9: 307.0, 307.20, 307.21, 307.22, 307.23, 307.3, 307.52, 307.53, 307.6, 307.7, 309.21, 309.22, 309.23, 312.00, 312.01, 312.02, 312.03, 312.10, 312.11, 312.12, 312.13, 312.20, 312.21, 312.22, 312.23, 312.4, 312.81, 312.82, 312.89, 312.9, 313.0, 313.1, 313.21, 313.22, 313.23, 313.3, 313.81, 313.82, 313.83, 313.89, 313.9, 314.00, 314.01, 314.1, 314.2, 314.8, 314.9.

Severe and Persistent Mental Illness:

Any SPMI disorder. To be flagged as "Any SPMI" members must have 2+ instances of any of the qualifying diagnosis codes in the past 36 months and be 18+ years of age:
ICD-10 Diagnosis codes include: F200, F201, F202, F203, F205, F2081, F2089, F209, F21, F23, F24, F250, F251, F258, F259, F28, F29, F3010, F3011, F3012, F3013, F302, F303, F304, F308, F309, F310, F3110, F3111, F3112, F3113, F312, F3130, F3131, F3132, F314, F315, F3160, F3161, F3162, F3163, F3164, F3170, F3171, F3172, F3173, F3174, F3175, F3176, F3177, F3178, F3181, F3189, F319, F320, F321, F322, F323, F324, F325, F328, F329, F330, F331, F332, F333, F3340, F3341, F3342, F338, F339, F348, F349, F39, F42, F4310, F4311, F4312, F603.

It is possible that a member may be flagged as "Any SPMI" but not flagged as one of the four SPMI categories. This is because a member may have 2 or more diagnoses that is a combination of the categories, but not 2 or more within any one of the SPMI categories.

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