

Oregon Health Plan 2

Section 1115 Quarterly Report



Demonstration/Quarter Reporting Period:

Demonstration Year: 8 (10/01/09 - 9/30/10)
Federal Fiscal Quarter: 4/2010 (10/09 - 12/09)

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I. Introduction

A. Letter from the State Medicaid Director

In the first quarter of Federal Fiscal Year 2010, the Department of Human Services (DHS) practiced the art of doing more with less, no more so than in the arena of providing health care coverage for Oregonians.

On the side of doing more, Oregon made significant progress in both the roll out of the new Healthy Kids program and the expansion of the existing Oregon Health Plan (OHP) Standard program for low-income adults. By the end of the reporting period, more than 30,000 more children had health care coverage in Oregon thanks to Healthy Kids, and that number will increase greatly in the months to come as outreach efforts come into play through the Application Assistance Program and the Targeted Outreach and Enrollment Grants Program. Both facilitate partnerships between the state and community organizations to better reach those children who need assistance most.

In November, the department drew the first 2000 names to determine who would receive applications for the OHP Standard program. Only those people whose names were on the 2008 reservation list and wanted to be added to the 2009 list were included in the November pull, giving them the first chance to be enrolled. By December, more than 56,000 people had already put their names on the new reservation list.

Doing more with less is the theme of DHS' Transformation Initiative, and, as of December 2009, the Division of Medical Assistance Programs (DMAP) estimates a yearly savings of \$5.4 million through improved efficiency and cost saving measures. For example, during the reporting period, the division moved forward with electronic billing efforts to save money and time spent on processing paper claims.

I would also like to make note of the great strides made towards the successful implementation of new Medicaid Management Information System (MMIS). In addition to the steady correction of system defects, the department continues to partner with the managed care plans, and together we will resolve the remaining issues for the end result of better-served OHP clients.

With the current state of the economy, the need for health care coverage is only expected to increase, and state revenues will not recover for more than a year. However, since the inception of the Oregon Health Plan, we have built an internationally recognized program designed around the principal of using limited resources to serve the most people as possible. DHS will continue to provide essential health care services through the innovation of such projects as the Transformation Initiative, support from our Legislature to fund our programs, and our dedication to the citizens of Oregon.

— *Judy Mohr Peterson, PhD., State Medicaid Director*

B. Demonstration description

The Oregon Health Plan (OHP) is the state's demonstration project, funded through titles XIX and XXI of the Social Security Act. A demonstration project under Section 1115 of the Social Security Act, OHP began in phases in February 1994.

- Phase I started on February 1, 1994, for Medicaid clients in the Poverty Level Medical (PLM) and Aid to Families with Dependent Children (AFDC, now known as Temporary Assistance to Needy Families/TANF).
- One year later, Phase II added persons who are aged, blind, and disabled, and it added children in state custody/foster care.
- Following the creation of Title XXI of the Social Security Act by Congress in 1997, Oregon's State Children's Health Insurance Program (SCHIP) was incorporated into the Oregon Health Plan. From its inception, SCHIP provided eligible people with essentially the same benefit package available to all OHP-Medicaid clients, as well as a seamless delivery system.

On October 15, 2002, CMS approved Oregon's current section 1115 demonstration, Oregon Health Plan 2, and began implementation on November 1, 2002. This demonstration is scheduled to expire on October 31, 2010. Under the OHP 2 demonstration, Oregon expects to achieve the following to promote the objectives of Title XIX and Title XXI:

- Health care coverage for uninsured Oregonians
- A basic benefit package of effective services
- Broad participation by health care providers
- Decreases in cost-shifting and charity care
- A rational process for making decisions about provision of health care for Oregonians
- Control over health care costs

Two unique features of the Oregon demonstration are:

- It makes Medicaid available to people living in poverty regardless of age, disability or family status.
- It structures benefits using a prioritized list of health care conditions and treatments. This approach enables Oregon to sharply focus its resources towards prevention and also use funding lines as a method of controlling costs.

C. State contacts

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Quarterly Report

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II. Events affecting health care delivery

A. OHP Demonstration implementation and/or enrollment progress

Expansion of OHP Standard

During the reporting period, DHS added more than 56,000 individuals to the current reservation list, including 19,000 who “opted in” from the 2008 list.

In November, before the current list was opened to additional names, DHS randomly selected 2,000 names from just those from the 2008 list who chose to put their names on the 2009 list. DHS sent applications to these 2,000 households. As of February 1, DHS has received 1,244 applications from this drawing, of which 724 have been approved, 259 have been denied and 261 applications are still pending. DHS will monitor enrollment against revenue on an ongoing basis and make adjustments, if necessary, to the number of names drawn and/or the frequency of drawings.

Having received federal approval, DHS will keep the reservation list open throughout the biennium and to hold drawings on a monthly basis. People can sign up for the reservation list online at www.ohplist.oregon.gov, by calling the toll-free number at 800-699-9075, by going to their local DHS office or by mail.

The department will send notices to those on the reservation list at a minimum of every 12 months to ask if they want to remain on the list and if they need to update their contact information.

People signing up can name a “third party contact,” someone whom, in addition to themselves, they would like to be notified when their name is drawn and when they are sent an application.

DMAP is working with the Office of Health Policy Research (OHPR), the Addictions and Mental Health (AMH) Division and a range of community organizations to perform outreach and provide application assistance to those who request it.

Family Health Insurance Assistance Program

Starting October 8, 2009, FHIAP started sending a thousand lives worth of applications weekly to the group reservation list.

Healthy Kids

Through December 2009, DHS has 30,755 more kids enrolled in the Healthy Kids program.

New eligibility requirements

During the reporting period, federal approval allowed the state to provide medical assistance to families with incomes above 185 percent FPL:

- OHP Plus coverage for children with family income through 200 percent FPL.
- Premium assistance on a sliding scale for employer-sponsored insurance for children with family incomes from 200 to 300 percent federal poverty level (FPL).
- Premium assistance for Healthy KidsConnect, the new private insurance option, for children with family incomes through 300 percent FPL.

In addition, the state received federal approval to implement federally approved provisions to streamline eligibility for children and families, such as:

- Extending continuous eligibility from six to twelve months for all children;
- Eliminating asset tests; and
- Lowering the uninsurance requirement from six to two months.

Outreach

Throughout the reporting period, the Office of Healthy Kids continued to hold information sessions around the state for those interested in either of the Healthy Kids outreach programs – the Application Assistance Program and the Targeted Outreach and Enrollment Grants Program.

The Office of Healthy Kids began approving applications for Certified Application Assistance Organizations applications. More than 100 organizations signed up, and approximately 250 Application Assisters were trained by the end October 2009.

The due date for responses to the Request for Grant Proposal (RFGP) for Targeted Outreach and Enrollment Grants was extended to November 24 and then reopened from December 9 through December 17 to allow grantees enough time to submit all the necessary documents. So far, Healthy Kids has awarded grants to 14 community-based organizations around the state, and the office plans more award more grants in February 2010.

Healthy Kids printed promotional materials and distributed them to DHS branch offices statewide, and the office created an e-mail address for taking orders from interested partners, hkp.orders@state.or.us.

B. Benefits

2009-2011 budget reductions: Vision and dental benefits

The 2009-2011 Legislatively Approved Budget passed in June limited vision and dental benefits for OHP Plus clients who are non-pregnant adults, 21 years and older. A summary of the benefit reductions is available at www.oregon.gov/DHS/healthplan/plus-changes.shtml.

In preparation for the January 1 effective date, DMAP mailed all OHP households a letter explaining the benefit reductions in November. The letter resulted in increased calls to the managed care plans, providers, OHP Client Services and the DHS Governor's Advocacy Office.

The division developed several communication tools, including the Web page above, to help the plans, providers and DHS staff respond to questions about the benefit reductions.

Health Services Commission

During the reporting period, the Health Services Commission (HSC) finalized the Prioritized List of Health Services that went into effect on January 1, 2010. This new list reflects the changes approved by the HSC in June 2008 as a part of the biennial review of the list mandated by state statute. As the previous biennial review had involved the development of a new prioritization methodology and a complete re-ranking of the list, the HSC felt few changes were necessary. The two changes of significance were:

- Autism spectrum disorders were split out from their inclusion on a line for chronic organic mental disorders and placed on a new line right next to it; and
- Treatment of all urinary tract calculus (stones) was combined on the higher of two lines.

Additional changes approved at the October HSC 2009 meeting involved moving the placement of resin versus cast-metal partial dentures to coincide with a legislatively directed coverage decision and current clinical practice. As of January 1, 2010, the funding line was changed from line 503 to line 502; however, the services covered remain the same. This change reflects the physical removal of a previous line for comfort care services, which have appeared more explicitly through a statement of intent attached to the list since the interim modifications made in October 2007.

H1N1 Vaccinations

During the reporting period, DMAP sent all OHP clients information about when the H1N1 vaccine would become available and where they could get the vaccinations. While the H1N1 vaccinations were available free of charge, DMAP paid for the administration of the vaccination for OHP fee-for-service ("open card") clients, and managed care plans covered the cost for their enrollees.

DMAP also issued communications for all prescribers and pharmacies that explained how to bill for H1N1 administration and contained reminders about billing for seasonal flu vaccinations.

C. Grievances and complaints

No trends were identified this quarter other than a surge in calls protesting the dental and vision benefit reductions effective Jan. 1, 2010 for non-pregnant adults covered by OHP Plus.

D. Quality of care

1. Fee-for-service

Nothing to report for this quarter.

2. Managed care

Nothing to report for this quarter.

E. Access

1. Fee-for-service

Nothing to report specific to fee-for-service clients.

2. Managed care

Physician Access Improvement Plan

DMAP completed its final measurement of the fully capitated health plans (FCHPs) under this CMS-approved project initiated to increase prevention and primary care services provided by the plans. DMAP determined that all FCHPs met their required performance targets under this project.

DMAP held a best practices evaluation session with the FCHPs to debrief on the project's success and gather insight from the plans on best strategies and interventions to increase prevention and primary care services.

F. Managed care

1. Approval and contracting with new plans

Nothing to report for this quarter.

2. Rate certifications

During the reporting period, the department's Actuarial Services Unit (ASU) finished developing and certifying the OHP managed care capitation rates internally for the first time. This marks the completion of the transition to an internal actuarial function, saving approximately \$600,000 per year of total funds compared to using external actuaries.

ASU also created a model for the calculation of managed care organization (MCO) liability for hospital reimbursement adjustment (HRA) payments. This provides new functionality required by statute for MCOs to pay the appropriate hospital reimbursement adjustment included in the capitation payments while facilitating reconciliation with the MCOs.

In addition, ASU developed an electronic capitation rate file for upload to the new Medicaid Management Information System (MMIS). This saves 250 hours of data entry for the Delivery Systems Unit each time capitation rates are updated while providing better accuracy compared to manual entry.

3. Enrollment and disenrollment

Nothing to report for this quarter.

4. Health plan contract compliance

DMAP

- Effective October 1, Advantage Dental acquired all of Hayden Family Dental Group's (HFDG) service areas, increasing its maximum enrollment limits from 69,250 to 199,950 members. This action is the final phase of Advantage Dental's purchase of HFDG on July 31, 2009. Also effective October 1, DMAP terminated the HFDG contract. There was no impact on the clients as Advantage assumed all of the Hayden providers and service areas with the sale. Both DMAP and HFDG had sent notices to the affected clients notifying them of the change in September, and Advantage sent them a welcome letter in October.
- During the reporting period, DMAP assisted Family Dental Care (FDC) with issues surrounding its contractually required enrollment reconciliation reports and the provider capacity reports. DMAP developed an informal work plan and is providing assistance and extra monitoring via the managed care collaborative. Through a series of monthly meetings, DMAP worked with FDC and its third party administrator, PHTech, to fix a problem with the communication between the different party's computer systems. All issues are expected to be resolved by the end of the next quarter.

AMH

- Effective October 14, 2009, Greater Oregon Behavioral Health, Inc. (GOBHI) completed its corrective action plan. As a result of the action plan, GOBHI updated its server, allowing for better security of protected health information and growth in GOBHI membership. AMH requested the corrective action plan following an Information Systems Capability Assessment conducted by Acumentra, the AMH external quality reviewer, during the March 2009 site review. Both Acumentra and AMH approved the action plan.
- On October 8, 2009, OHP mental health contractor LaneCare notified AMH of its intent to terminate provider Valia as a subcontracted provider of services, effective October 15, 2009. CMS reviewed and approved the member notification templates and the contingency plans. LaneCare sent notices, approved by both AMH and CMS, to all affected members. Members involved had provisions made for services by other providers as medically appropriate.

5. Financial performance relevant to the Demonstration

Nothing to report for this quarter.

G. Legislative activities

Nothing to report for this quarter.

H. Litigation status

Nothing to report for this quarter.

I. Operational issues related to:

1. OHP Plus

During the reporting period, the division began working with Hewlett Packard to create a procedure for identifying clients affected by the January 1 OHP Plus benefit reductions within the Medicaid Management Information System (MMIS). The department expects to have a new benefit package for pregnant adults in place by March 2010.

2. OHP Standard

The following operational issues apply to both OHP Plus and OHP Standard.

MMIS

The department continued to address issues surrounding implementation of the new Medicaid Management Information System (MMIS). Progress was as follows:

- During the enrollment period, the department completed the successful auto-assignment for managed care plans. All counties now have auto-assignment of OHP clients into mental health, dental, and medical health plans (fully-capitated health plans and the physician care organization). This will ensure an even distribution of clients among the plans. The auto-assignment process will also include a function to ensure newborns are enrolled in the same managed care plan as their mothers.
- The department formed a leadership team to address financial, eligibility, and enrollment issues experienced by the managed care organizations (MCOs). The leadership team began working with HP and the MCOs to reconcile discrepancies in enrollment and eligibility data.
- DHS hired Point B Consulting to support the department's communication, facilitation and action planning efforts related to system issues that impact managed care organizations (MCOs). Over 120 days, the firm will produce the following:
 - Project work plan
 - Weekly status reports
 - 120-day action plan
 - Communications plan
- DMAP Provider Training and Hewlett Packard trainers continued to teach providers how to use the Provider Web Portal through classroom sessions, over the telephone and in one-on-one trainings. In the trainings, providers learned how to use the Web site to verify client eligibility, request prior authorizations, file claims, find information on covered drugs, perform demographic maintenance (e.g., updates to contact information and office hours) and determine whether a procedure/diagnosis is covered according to the client's OHP benefit package and/or the Prioritized List of Health Services.
- For fee-for-service claims, DMAP began:
 - Processing suspended claims for manual review within seven to ten days from date of receipt; and
 - Processing adjustment within five days of receipt.

Transformation Initiative

DHS launched the Transformation Initiative in December 2007 in order to improve efficiency and effectiveness throughout the department. The initiative is designed to enable DHS to continue providing quality services in a time when the demand is outpacing revenue.

DMAP has identified several transformation initiatives for the division that will result in cost savings and/or increased efficiency. Each initiative is in varying stages of development depending on the scope of the project. Although pending validation, DMAP estimates savings at almost \$5.4 million between December 2009 and December 2008.

Several initiatives are contributing to the estimated savings and those include:

- Electronic Communications for Providers – On June 1st, DMAP stopped mailing OHP Provider Announcements, which saves on postage and printing costs.
- Electronic Billing – Since December 2008, DMAP has increased the number of providers billing electronically, reducing per claims cost.
- Provider Trainings – DMAP has increasingly offered trainings using different types of technology, such as VCON, web-based, and other forms of distance learning that reduce staff and travel time.
- School-based Health Services (SBHS) VCON Pilot – DMAP has worked with Educational Service Districts (ESDs) to ensure clear and consistent communication with the use of monthly VCON meetings, which also saves ESDs staff and travel time.
- Third Party Liability (TPL) / Recovery – As a result of a rapid process improvement (RPI) event in August 2009, staff from the Office of Payment Accuracy and Recovery (OPAR) changed some of their processes, which has increased the speed at which TPL is identified, reducing the amount needing recovery.

Other benefits resulting from these initiatives include:

- Reduced processing time in several areas (e.g., identification and validation of TPL);
- Reduced processing errors (e.g., electronic billing of claims), and
- Improved provider and staff satisfaction.

During the reporting period, DMAP made significant progress in the following initiatives.

■ **Enforceable Preferred Drug List:**

The division sent an announcement to providers in December that educated prescribers about the drugs that will be on both the mandatory physical and voluntary mental health drug PDLs. The communication also explained grandfathering of existing prescriptions; how to submit and review prior authorization (PA) requests using the Provider Web Portal; and how to determine whether specific drugs are covered by OHP.

■ **Electronic Billing and Electronic Funds Transfer:** 85 percent of claims submitted to DHS are Electronic Data Interchange (EDI) claims. Because EDI has been an option for several years, this initiative assumes that the remaining 15 percent do not have the resources or claim volume to justify billing through EDI, but could now bill on the Web.

- To track progress, DMAP reviews weekly claim processing reports that indicate the number of claims submitted via paper, Web, or EDI.
- For Long-Term Care (LTC) providers, both EDI and Web are new options. For all other providers, only Web is a new option. Pharmacy claims are not tracked because they are all electronic, except when paper is required.
- As of October 31, 32 percent of incoming hospital inpatient claims were Web claims; 72 percent of professional claims were Web claims; 62 percent of dental claims were Web claims; and 84 percent of Long-Term Care claims were EDI or Web claims.

■ The **Lean Daily Management System (LDMS)** is one of the division's most important initiatives. It provides a forum for staff to regularly communicate with those in their own work units through routine huddles. Using LDMS, a team can measure the success of its work and visually display improvements, as well as create a culture of continuous improvement through staff suggestions. By the end of the reporting period, approximately 25 percent of division staff have attended formal LDMS training, 94 percent of work units are participating in LDMS huddles, and 12 staff suggestions for improvement have been completed. These numbers are expected to increase, especially with the transition to the Oregon Health Authority.

3. FHIAP

Nothing to report for this quarter.

4. Future programs and Insurance products

Healthy Kids

During the reporting period, the Office of Private Health Partnerships (OPHP) reviewed responses to the Request for Proposals for Healthy KidsConnect, the private insurance option for families with incomes above 200 percent of the FPL.

In addition, OPHP delivered presentations to 20 insurance groups statewide during November and December.

III. Status of Corrective Action Plans

Nothing to report for this quarter.

IV. Evaluation activities and interim findings

Oregon Health Study

The Oregon Health Study is a landmark, statewide study of people's health and access to care. Phase I Survey fielding efforts are mostly complete. The last batch of 12-month follow-up surveys was mailed to participants in October 2009 and responses are still being collected. The contract with the University of Washington Survey Research Division has been extended. Staff are performing intensive tracking for hard-to-find participants, and their effort will continue through the end of April 2010. Phase II is currently in progress, and it is expected to last one year. It involves in-person interviews with 12,000 study participants, ages 20-64 years. As of January 2010, 3,000 interviews have been completed.

Ever Enrolled Number For Oregon Health Plan
QUARTER 10/1/2009 - 12/31/2009*

POPULATION			TOTAL NUMBER Member OF CLIENTS Months	Percent change of clients from previous quarter	Percent change of clients from same quarter previous YR	
Expansion	Title 19; OHP Standard	OHP Parents	11,688	29,152	0.21%	5.86%
		OHP Childless Adults	17,000	45,148	-0.22%	-14.34%
	Title 19; OHP Plus	PLM Children FPL > 170%	857	2,006	3.27%	6.18%
		Pregnant Women FPL > 170%	818	1,829	3.30%	26.53%
Title 21; Plus	SCHIP FPL > 170	7,341	18,198	6.23%	19.26%	
Optional	Title 19; Plus	PLM Women FPL 133-170%	14,609	32,494	-0.73%	30.50%
	Title 21; Plus	SCHIP FPL < 170%	48,912	127,544	1.45%	16.65%
Mandatory	Title 19; Plus	Other OHP Plus	398,581	1,108,927	3.38%	18.45%

QUARTER TOTALS

499,806

* Due to retroactive eligibility changes, the numbers should be considered preliminary

**CMS Quarterly Report
Fourth Calendar Quarter 2009
Family Health Insurance Assistance Program**

FHIAP Enrollment

Enrollment - FHIAP – From 10/1/09 to 12/31/09

New Group enrollments.....	33
New Individual enrollments.....	192
Total new enrollments.....	225
Total enrollment on December 31, 2009.....	6,139
Disenrollment due to non-payment of premium.....	30
Total number of people ever enrolled during this quarter... ..	6,417

Other Statistical Data (as outlined in the STCs)

1. **Transfers from FHIAP to State coverage:** 26 lives transferred from FHIAP to OHP
2. **MOE Requirements MOE Requirements:** Effective November 1, 2007 OPHP no longer has an MOE requirement.
3. **OHP2 Disenrollment Requests in First 30 Days:** 3 requests; 3 request denial
4. **Number and Percentage of FHIAP Eligibles who Enroll:**
 - **New Enrollments current quarter (Q4) – 225**
 - **Percent Change from previous quarter (Q4) 4% increase**
 - **Percent Change from same quarter previous year (Q4 2008) 90% increase**
 - **Percent approved to enrolled – 69.5% of 4th Q approvals enrolled in Q4
1% of 4th Q approvals enrolled in Q3**