

DIVISION OF MEDICAL ASSISTANCE PROGRAMS

CMS Section 1115 Quarterly Report
Oregon Health Plan 2



04/01/11 - 06/30/11
Demonstration Year: 9
Federal Fiscal Quarter: 3



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I. Introduction

A. Letter from the State Medicaid Director

It's official - Effective July, 1, 2011, we are part of the Oregon Health Authority family. The Oregon Health Authority (OHA), created by the 2009 Oregon Legislature, brings most health-related state-administered programs into a single agency.

The creation of OHA consolidated four small formerly free-standing agencies:

- Public Employees' benefit Board (PEBB)
- Oregon Educators' Benefit Board (OEBB)
- Office of Private Health Partnerships (OPHP) and
- Oregon Medical Insurance Pool (OMIP).

Several programs from the Department of Human Services (DHS) moved to OHA, including:

- Public Health Division (PHD)
- Oregon Health Plan (OHP)
- Oregon Prescription Drug Program (OPDP) and
- Office for Oregon Health Policy and Research (OHPR).

DHS will continue to administer Child Welfare, Seniors and People with Disabilities and SNAP, the food stamp program.

This quarter, our attention focused on the legislative outcomes, as health reform was front and center throughout the session. Inside this report, we highlight significant Medicaid legislation.

One was Senate Bill 94, which came from the Oregon Health Policy Board's work to reduce red tape and simplify administrative processes for health care providers. A second bill, Senate Bill 514, ensures year-round access to health care coverage for all of Oregon's children by eliminating the "open enrollment" periods for kids.

Two other key pieces of legislation - the health care system transformation bill (HB 3650) and the Health Insurance Exchange (SB 99) passed.

Since the Oregon Health Program began, the world of health care has changed. Costs outpace inflation and quality is questioned. Providers are not given enough incentives to keep people healthy. No one would design the health care system we have today as a model of health or efficiency. Too many families can't afford coverage and those that can are seeing their out-of-pocket costs increase every year.

We can no longer afford our current health care system. We have created a vision for health care in our state that delivers the right care at the right time in the right place.



*- Judy Mohr Peterson, PhD.
Director, Division of Medical Assistance Programs
Oregon Health Authority*

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, the 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. The current 3-year renewal of the demonstration is scheduled to expire on October 31, 2013. The state's primary objectives under the OHP 2 demonstration:

- 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 use funding lines as a method of controlling costs.

C. State contacts

Demonstration

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II. Events affecting health care delivery

A. OHP Demonstration implementation and/or enrollment progress

OHP Standard enrollment progress

OHP Standard Applications (Nov 2009 - June 10, 2011)		
Applications sent	202,229	100%
Applications returned	90,437	44.47%
Status of returned applications		
Approved	46,844	51.80%
Denied	34,153	37.76%
Pended	2,323	2.57%
Not yet processed	7,117	7.87%

B. Benefits

Nothing to report this quarter.

C. Grievances and complaints

Governor's Advocacy Office				
	April	May	June	Total
Oregon Health Plan	5	1	8	14
Managed Care Plan	2	2	6	10
Eligibility	7	1	3	11
Medical/Dental Provider	3	2	0	5
Other	3	13	11	27
Total	20	19	28	67

DMAP Plans (Jan - Mar 2011, latest available, unaudited)						
Plans	Grievance/Complaint				Appeals	
	Access	Quality of Clinic Care	Interpersonal Care / Quality Service	Other	Service Payment Denial	Prior Authorization Denial
Medical	144	187	240	69	199	843
Dental	14	25	67	24	59	35

Hearing Requests	
<i>Apr - June 2011</i>	
FFS	618
Plans	83
Total	701

D. Quality of care

1. DMAP

Health Quality Report

We contract with Oregon Health Care Quality Corporation (Q-Corp) for managed care and fee-for-service data collection and quality-measure reports as part of our overall effort to monitor quality of care in Oregon.

In addition to Medicaid and Medicare, eight commercial health insurers participate with Q-Corp. The annual report aggregates data from 1.88 million medical claims, 121 million pharmacy claims, and 3.2 million unique patients. The majority of the measures are accredited by HEDIS.

We received a draft report in May that we shared with our managed care plan Medical Directors and the Oregon Health Policy Board. The report reflects information for the measurement year April 2009 through March 2010. It includes, for the first time, OHP fee-for-service data. Medicaid clients represent 5.7 percent of the total patients addressed in the report. Findings include:

- Medicare Advantage plans achieved the highest scores on 9 of the 12 measures for which Medicare data was available.
- Commercial plan scores are higher than Medicaid rates on 15 of the 20 total measures.
- OHP achieved scores higher than commercial plans and Medicare Advantage plans on 3 of the 4 generic prescription drug measures in utilization area.
- OHP scores for diabetes, other chronic disease, and pediatric care are generally lower than rates for commercial and Medicare Advantage plans.
- OHP scores for breast and cervical cancer screening are far lower than commercial plans.

Many of our current quality improvement projects address the issues found in areas needing improvement. Projects in progress include partnering with Healthy Kids and DHS' Senior and People with Disabilities Division; a focus on medical homes; a new in-house medical management process with fee-for-service clients; and a federal grant application for Patient Incentives for Chronic Diseases.

Tobacco Prevention Survey

This is the first year we have systematically assessed how our contracted managed care organizations screen for tobacco use and provide tobacco dependence and cessation services.

The survey is based on Clinical Practice Guidelines. Report highlights include:

- While all 15 plans have some method of identifying tobacco use status, only two report systematically assessing tobacco use status for every member. All plans have some method of documenting tobacco use status at the provider level; four use electronic medical records and one is currently able to identify tobacco use at the plan level.
- All 15 plans provide some form of cessation counseling and cover individual counseling with primary care providers. In addition:
 - Twelve cover individual counseling with other health professionals (e.g., nurse, health educator).

- Twelve cover group counseling in any form (primary care providers, other health professionals, and specific curricula – such as the American Lung Association’s Freedom from Smoking program).
- Eight cover telephonic counseling (via Quit Line vendor or in-house).
- All 15 plans provide coverage for nicotine patches, Wellbutrin and Chantix. Of the other four FDA-approved medications; nicotine gum, lozenges, nasal spray and inhaler:
 - Twelve cover nicotine gum; ten cover nicotine lozenges; six cover nicotine nasal spray; and six cover the nicotine inhaler.
 - Five provide coverage for all seven FDA-approved smoking cessation medications.
 - Prescription drug products for nicotine replacement therapy do not require copayments.
- Patient pharmacotherapy profiles:
 - Thirteen require a prior authorization for at least one of their covered products.
 - Six require enrollment in a counseling program to receive covered products.
 - Three require a documented quit date set before receiving covered products.

Dental Care Organizations also provide tobacco dependency and cessation services to OHP patients. Of the eight plans, seven have some method of identifying tobacco use status:

- Four ask about tobacco use on health history forms or new patient forms.
- Seven record tobacco use status in patient charts or medical history forms.
- Seven provide tobacco cessation counseling through dental providers, dental assistants, and/or registered hygienists.
- Seven refer patients to the Quit Line, and five make referrals to medical providers, primary care tobacco counselors, or other resources.

2. FHIAP - Family Health Insurance Assistance Program

FHIAP mails surveys to members who have been in the program at least six months. The survey features six customer service-related questions to be answered with an Excellent, Good, Fair, Poor or a Don’t Know rating. As of June 30, 2011, 100 percent of those responding so far have rated FHIAP’s overall service as Good or Excellent.

E. Access

FHIAP

FHIAP’s Information, Education and Outreach staff (IEO) is conducting extensive outreach to employers and all families currently on the reservation list to let them know FHIAP is enrolling children. IEO is retooling messaging, applications, the Web site, the producer referral program, outreach materials and all training curriculum to reflect the focus on enrolling children.

IEO has developed a new continuing education training curriculum for the CPA and bookkeeper community. The training educates them on the financial advantages of enrolling uninsured employees and dependants into their group plans by utilizing the state’s subsidy programs.

DMAP

Dental Care Organizations' Head Start project

We contract with eight dental care organizations (DCOs) to provide dental benefits to OHP clients. Even though the majority of children enrolled in Head Start are also eligible and enrolled with OHP and receive dental care benefits, many children have never received a dental exam.

We worked with Head Start Regional Workgroups, DCOs (which enroll over 92 percent of all OHP clients), and the Department of Education to improve and identify strategies to resolve barriers for oral health care. The partnership led to activities such as trainings for Head Start staff on how to help families navigate the OHP system, and open house clinics to provide assessments, prevention services and parent education to help connect families with their child's assigned dental provider.

In addition to helping OHP clients access dental care, staff will provide non-enrolled families with information and application assistance for OHP's Healthy Kids program.

F. Managed care

1. Approval and contracting with new plans

Addictions and Mental Health (AMH) staff have finalized amendments for contracts starting July, 2011. Staff will begin working on amendments for the contract periods beginning on October 1.

2. Rate certification

Nothing to report this quarter.

3. Enrollment and disenrollment

AMH staff have completed enrollment reconciliation efforts.

4. Health plan contract compliance

Nothing to report this quarter

5. Financial performance relevant to Demonstration

Nothing to report this quarter.

G. Legislative activities

Legislative highlights

Now that the 2011 Legislative Session has ended, following are some of the major bills Legislators passed that directly impact the Oregon Health Plan.

HB 2100: The bill defines how DHS and OHA will collaborate and make policy decisions. Following are the major components of the bill:

- The Pharmacy and Therapeutics Committee will maintain the Preferred Drug List (PDL) for the Oregon Health Plan. The committee is essentially performing the functions of the Drug Use Review Board, which is abolished.
- The Health Evidence Review Commission now performs the duties of two abolished groups: the Health Resources Commission, which analyzes and disseminates information

about the effectiveness and cost of medical technologies and their impact on the health of Oregonians, and the Health Services Commission, which determines the Prioritized List of Health Services for the Oregon Health Plan, as well as the clinical and cost-effectiveness of those services.

HB 3650: The bill provides for Oregon's Health System Transformation and establishes Oregon's Integrated and Coordinated Health Care Delivery System in which the state will use Coordinated Care Organizations (CCOs) to improve health, increase the quality, reliability, available and continuity of care and reduce the cost of care.

CCOs will provide medical assistance recipients with health care services supported by alternative payment methodologies that focus on prevention and that use patient-centered primary care homes, evidence-based practices and health information technology to improve health and to reduce health disparities. CCOs will be accountable for managed care and provisions for integrated and coordinated health care for each organization's members, managed within a fixed global¹ budget.

SB 99: The Legislature passed another key health care bill which creates a health insurance exchange where residents shop for government-subsidized health insurance plans. The Oregon Health Insurance Exchange will extend coverage to nearly all Oregonians in 2014. The bill requires OHA to establish the exchanges as a public corporation to be governed by a Board of Directors.

SB 101: The bill authorizes payment for dental wraparound services for children covered under the Family Health Insurance Assistance Program (FHIAP) and KidsConnect.

It directs OHA to implement a new Medicaid fee schedule on September 1, 2011, based on the legislatively-approved budget. The bill also addresses the fees and the process managed care plans must use in contracting with hospitals, both before and after the implementation of the new fee schedule on September 1, 2011. Lastly, the bill requires managed care plans to reimburse hospitals that do not contract with the plans at a rate no less than a percentage of the Medicare reimbursement rate.

SB 201: This bill became effective on June 17, 2011. It requires managed care organizations to maintain a network of providers sufficient in numbers and areas of practice, and geographically distributed in a manner to ensure the services are accessible to members.

It also limits a member's transfer from one organization to another to no more than once during each enrollment period. The bill authorizes OHA to approve the transfer of 500 or more members from one managed care plan to another if the receiving organization accepts the transferring organization's network of providers or allows members to remain enrolled in the transferring organization.

SB 204: This bill has two distinct components that directly impact us: Creating a uniform payment methodology for hospitals and ambulatory surgical centers and sharing health information. The bill allows health care providers and prepaid health care services organizations to disclose the identity of an individual receiving medical assistance to another

¹ *Global budget is defined as a total amount established prospectively by the Oregon Health Authority to be paid to a coordination care organization for the delivery of, management of, access to and quality of health care delivered to members of the coordinated care organization.*

provider or organization to coordinate care and treatment. The bill permits the disclosure without obtaining authorization from the individual, notwithstanding the privacy protections related to mental health information in ORS 179.505.

SB 433: This bill is effective January 1, 2012. It expands the number of women eligible for the Breast and Cervical Cancer Screening program by allowing providers who are certified by the program to provide screening services. This program is a portal to OHP Plus benefits for breast and/or cervical cancer treatment and other health care services. Funding for the screening program is provided by the Centers for Disease Control and Prevention and the Susan G. Komen for the Cure Oregon and SW Washington Affiliate.

HB 3536: This bill is effective on January 1, 2012. It requires the Oregon Health Authority (OHA) to suspend, rather than terminate, medical assistance when a person becomes an inmate of a local correctional facility for less than one year. Upon notification of the individual's release, the OHA and the Department of Human Services will reinstate eligibility. The bill also requires the OHA to report to an interim committee in 2012 on the feasibility of expanding the program to persons incarcerated for longer than 12 months.

H. Litigation status

Nothing to report this quarter.

I. Operational issues

1. DMAP

Electronic Health Record Incentive

In June, we mailed information to all Oregon Medicaid providers introducing the Electronic Health Record Incentive program and an online tool to discover if they are eligible for incentive payments. To view the brochure, go to <https://apps.state.or.us/cf1/OHP/OHPAdmin/files/ehr-incentives0611.pdf>.

Regional meetings occurring throughout the state

OHP semi-yearly regional meetings are a venue to meet with branch staff and field offices from the Division of Children, Adults and Families Division, Seniors and People with Disabilities, Child Welfare and the Area Agencies on Aging with representatives from DMAP, managed care organizations, and local providers to discuss topics relevant to the Oregon medical programs. This is an opportunity for attendees to get program updates and resource materials. Those unable to attend in person may also participate through video conference.

DMAP Provider Training

DMAP now offers additional Provider Web Portal claims training. Providers can now enroll by program-specific claim types: Professional, Institutional, Dental and Pharmacy.

The *OHP Basics* and *Provider Web Portal Claims* (primarily professional and institutional claims) classes continue to be the most popular classes. Satisfaction with all training opportunities continues to be high: 88 percent of returned provider surveys stated participants would definitely recommend the class.

Medicaid Transformation Grant

DHS received a Medicaid Transformation Grant for \$5.5 million from CMS in October 2007 to implement a Health Record Bank. Under direction of our Executive Committee and approval by CMS, we amended the scope of the project, effective April 1, 2010. The balance of funds were re-allocated to initiatives consistent with the original grant intent and used to complement the wider Health Information Technology initiatives funded by the American Reinvestment and Recovery Act of 2009.

We completed the project within time, scope and budget on March 31, 2011. System enhancements also jump-started sharing electronic health data and continues to assist providers participating in the Medicaid Electronic Health Record Incentive Program. In addition, we completed unresolved key policy issues on privacy, security and protected health information from the initial grant phase. The re-purposed grant addressed four initiatives:

- Health Profiles for children in foster care
- Immunization Information System enhancements
- Health Information Exchange Policy and Business Analysis
- School-Based Health Center Health Information Exchange Pilot

The project will continue to:

- Significantly improve access to medical and immunization records for parents, foster parents, caseworkers, and youth making the transition from foster care.
- Help youth transition to adulthood by readily providing more personal health information.
- Help caseworkers use technology to easily access medical and immunization records and provide critical health information to health care providers, substitute caregivers, parents/guardians and youth who transition from foster care.
- Promote future opportunities for continuity and quality of care.

2. FHIAP

Nothing to report this quarter.

3. AMH

Staff is nearing the final stage of work on 1915(i) and personal care rate determination.

4. Future programs and insurance products

Nothing to report this quarter.

5. Program developments, issues or problems

National Correct Coding Initiative (NCCI)

We implemented the National Correct Coding Initiative (NCCI) standard payment methodology on April 1, 2011. The new code set recognizes, identifies and prevents improper payment if providers submit claims with incorrect code combinations. NCCI codes, or edits, fall into two categories: Medically Unlikely Edits recognize inappropriate units of service for specific procedures, and Procedure-to-Procedure Edits identify services that should not be billed together.

MMIS Reconciliation for managed care organizations

At MMIS implementation, some managed care functionality was still in development or not fully functioning. While we could make capitation payments at system implementation, December 2008, system defects affected capitation adjustments, enrollment accuracy and timeliness. During this time, we maintained close communication with our managed care organizations (MCOs) and providers to assure client access and patient safety despite data inaccuracies.

Once we stabilized enrollment files in September 2009, we began addressing deficiencies in the system's auto-assignment function. We performed a system-wide member enrollment correction while we proceeded to correct capitation deficiencies. Once we corrected and stabilized enrollment and recipient information, our financial reconciliation effort began with identifying and correcting eligibility, enrollment and associated capitation payments.

We conducted the MCO reconciliation project in multiple phases from January 2010 through June 2011. Where possible, we corrected global defects through a Systematic Mass Adjustment Process (SMAP). However, reconciliation also required agency and managed care organization staff to make time-intensive manual adjustments in targeted situations.

We are indebted to our managed care organizations for their support and assistance while we performed the fiscal reconciliation. We launched our first Reconciliation Project weekly meeting in January 2010 to address the system errors and explore workable solutions. In addition, we conducted weekly MCO Reconciliation Advisory Committee meetings. The committee monitored the scope of the financial impact and established guiding principles.

The expert advice we received from the MCO representatives helped us develop workable over-arching reconciliation solutions. With the cooperation, advice and patience of our MCO representatives, we finished the process of correcting MMIS defects for enrollment and capitation errors.

III. Status of Corrective Action Plans

Nothing to report this quarter.

IV. Evaluation activities and interim findings

The Oregon Health Study (OHS): *Phase II - Biometric Data Collection Update:*

Medicaid-evaluation matching funds from CMS continue to make a substantial contribution to the on-going success of the Oregon Health Study (OHS). Since our last update, we have finished our initial analysis of the Phase I mail survey data, the hospital discharge data, credit report data and children and family administrative data. We released the analysis online as a working paper for the National Bureau of Economic Research and it has been submitted for peer-review to the Quarterly Journal of Economics. We have begun the process of data cleaning and pre-specifying our analytic plan for the Phase II in-person interview data. We encountered delays in obtaining agreements for the primary data collection of regional emergency department utilization. However, the necessary contracts are in place and the final data set should be in-hand by September, 2011 and will allow

us to triangulate emergency department administrative data with self-report surveys and hospital records. At this point, all of the quantitative data components of the study will be in place, and we anticipate on-going dissemination activities from here on out.

In addition to our progress on the first three phases of study, in the last quarter, the OHS team implemented a fourth phase. This phase of the study consists of qualitative interviews, a research methodology that triangulates well with the quantitative data and allows us to explore the process mechanisms involved in treatment effects and to gather more information about unexpected findings. We have completed the first round of qualitative interviews examining the characteristics of applicants versus non-applicants once selected from the reservation list and the characteristics of successful applicants versus denied applicants. The remainder of the interviews will help us understand the overall impact of insurance status on our outcomes of interest, among important subgroups (e.g. women, individuals with chronic conditions, rural populations) or focused on particular experiences (e.g. ED utilization, personal finances). This phase of the study is still in the field, and we are scheduled to have 600 completed interviews by the end of August.

V. Appendices

A. Quarterly enrollment reports

SEDS reports

Attached as a separate document.

B. State reported enrollment tables

OHP enrollment			
	April 2011	May 2011	June 2011
Title XIX funded State Plan <i>Populations 1, 3, 4, 5, 6, 7, 8, 12, 14</i>	495,275	495,416	495,375
Title XXI funded State Plan	70,622	70,878	71,104
Title XIX funded Expansion <i>Populations 9, 10, 11, 17, 18</i>	78,331	76,798	76,825
Title XXI funded Expansion	1,162	1,152	1,171
DHS Funded Expansion	NA	NA	NA
Other Expansion	NA	NA	NA
<i>Pharmacy Only</i>	NA	NA	NA
<i>Family Planning Only</i>	NA	NA	NA

Ever-enrolled in OHP						
4/1/11 - 6/30/11			Total Clients	Client Months	Previous quarter change	Same quarter Previous year change
Expansion	Title 19; OHP Standard	OHP Parents	24,656	62,363	-1.39%	40.56%
		OHP Childless Adults	54,988	148,349	-2.69%	59.80%
	Title 19; OHP Plus	PLM Children FPL > 170%	1,297	2,861	0.23%	13.72%
		Pregnant Women FPL > 170%	965	2,073	-4.25%	3.42%
	Title 21; OHP Plus	SCHIP FPL > 170%	17,738	44,613	2.09%	30.94%
Optional	Title 19; OHP Plus	PLM Women FPL 133-170%	15,402	34,468	1.85%	1.36%
	Title 21; OHP Plus	SCHIP FPL < 170%	60,681	154,740	1.84%	11.56%
Mandatory	Title 19; OHP Plus	Other OHP Plus	468,907	1,292,397	1.87%	9.26%
Quarter Totals			644,634			
<i>Due to retroactive eligibility, numbers are preliminary for the reporting period.</i>						

Managed Care Plan Enrollment					
<i>Due to retroactive eligibility changes, the numbers should be considered preliminary</i>					
2011	OHP Eligible*	FCHP	PCM	DCO	MHO
April	588,812	493,626	3,199	566,073	543,790
May	587,524	491,359	3,166	564,414	546,140
June	590,406	497,854	3,090	571,046	552,553
1st Q Average	588,914	494,280	3,152	567,178	547,494
		83.93%	0.54%	96.31%	92.97%
<i>*Total OHP Eligibles include TANF, GA, PLM-Adults, PLM-Children, Families, Adults & Couples, OAA, ABAD, FC and SAC.</i>					

Family Health Insurance Assistance Program (FHIAP) Enrollment	
<i>04/01/11 to 06/30/11</i>	
New group enrollments	30
New individual enrollments	19
Total new enrollments	49
Total enrollment on March 31, 2011	7,527
Disenrollment due to non-payment of premium	27
Total number of people ever-enrolled during this quarter	7,882
Other Statistical Data (as outlined in the STCs)	
Transfers from FHIAP to state coverage	7
OHP2 disenrollment requests in first 30 days	2
Number and percentage of FHIAP eligibles enrolling	
New enrollments current quarter	49
Percent change from previous quarter	18% decrease
Percent change from same quarter previous year	8% decrease
Percent approved to enroll	
1st quarter approvals enrolled in 1st quarter	54.4%
2nd quarter approvals enrolled in 2nd quarter	4%

C. Neutrality reports

1. Budget monitoring spreadsheet

Attached as a separate document.

2. CHIP allotment neutrality monitoring spreadsheet

Attached as a separate document.