

Section 1115 Demonstration  
Quarterly Report to CMS  
Oregon Health Plan



10/01/11 – 12/31/11  
Demonstration Year: 10  
Federal Fiscal Quarter: 1



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## Table of Contents

<b>I. Introduction .....</b>	<b>1</b>
A. Letter from the State Medicaid Director.....	1
B. Demonstration description .....	2
C. State contacts.....	3
<b>II. Events affecting health care delivery .....</b>	<b>4</b>
A. OHP Demonstration implementation and/or enrollment progress.....	4
B. Benefits.....	4
C. Grievances and complaints.....	5
D. Quality of care .....	6
E. Access.....	7
F. Managed care .....	7
G. Legislative activities.....	8
H. Litigation status.....	10
I. Operational issues .....	10
<b>III. Status of Corrective Action Plans .....</b>	<b>11</b>
<b>IV. Evaluation activities and interim findings.....</b>	<b>11</b>
<b>V. Appendices.....</b>	<b>11</b>
A. Quarterly enrollment reports .....	11
B. SEDS reports.....	11
C. State reported enrollment tables.....	11
E. Neutrality reports .....	12

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## I. Introduction

### A. Letter from the State Medicaid Director



As you will read in this quarter's report, the end of 2011 saw the Oregon Health Authority (OHA) prepare for the challenges that come with a growing Medicaid population and continued budget shortfall.

In December, OHA held its last OHP Standard applicant drawing until further notice, having surpassed our goal of enrolling an average 60,000 adults into this expansion program; and our Healthy Kids population continues to grow.

Meanwhile, we prepared for the benefit changes effective January 1, 2012.

- DMAP worked with contracted dental plans and other stakeholders to make sure the reductions to OHP Plus dental benefits maintained access to appropriate preventive dental care for all clients.
- Eliminating coverage of another 13 lines on the Prioritized List of Health Services was a difficult step to take, but necessary in light of the Oregon Legislative Assembly's request for all agencies to present a list of budget reduction options that total a 10.5% reduction of their 2011-2013 budgets.
- OHP Standard hospital benefits will be equal to OHP Plus benefits, to include scheduled, medically appropriate hospital inpatient and outpatient services. The hospital tax used to fund OHP Standard services was increased one percent to fund this change.

Responding to the needs of our clients is always important, and requires clear, consistent communication of client concerns across all delivery systems.

- OHA continues to monitor grievances, complaints and requests for administrative hearings. At the same time, we are using this data to inform how we might improve the grievance and complaint reporting process across medical, dental and mental health plans.
- Consistency in all plan reporting and contracting processes will be a major focus as we move to integrate medical, dental and mental health service delivery into a single Coordinated Care Organization-based system with Health System Transformation.

We are also addressing concerns regarding inappropriate billing of OHP clients, on a case-by-case and system-wide basis. One of the systemic solutions we are working toward is consistency in the Notices of Action issued to OHP clients in the event of service denials.

Improved communication in all areas of health service delivery means better coordination of care. Efforts to improve reporting of client concerns and required notifications will go a long way to empowering our most vulnerable populations to get the right care, at the right place, at the right time.

A handwritten signature in black ink that reads "Judy Mohr Peterson". The signature is written in a cursive, flowing style.

*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 state's primary objectives under the OHP 2 demonstration include:

- 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

In 2009, a major amendment to the demonstration added the Healthy Kids program to Oregon's Medical Assistance programs. Amendments currently in review by the Centers for Medicare and Medicaid Services (CMS) will, if approved, extend the demonstration through June of 2017 and allow the state to develop the Coordinated Care Organization as the centerpiece of the public health care delivery system.

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 and Quarterly Reports**

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## II. Events affecting health care delivery

### A. OHP Demonstration implementation and/or enrollment progress

#### OHP Standard

Outreach materials for OHP Standard program were updated with new messaging, branding and simplified languages.

- Instead of referring to the OHP Standard program and reservation list, the new outreach materials refer to “the OHP Medical Program for Adults” and “drawing list.”
- The new messaging helps clarify and distinguish the program and process better for the public and potential clients.

In December, OHA selected 6,400 applicants from the OHP Standard Reservation List; they will have until February 13, 2012, to establish a date of request for the applications.

Due to budget constraints, OHA has since suspended new OHP Standard enrollment, with no applicant drawings planned for January or February 2012. The overall OHP Standard enrollment is above the forecast for the biennium.

#### Healthy Kids

The OHP 7210 application packet – including the OHP 7210 Medical Application and the OHA 9025 Green Booklet - have been updated and improved. The purpose of these revisions was to transform the OHP 9025 Green Booklet into a step-by-step guide, and to update the OHP 7210 Medical Application to reflect recent policy and process changes. The new forms became available October 10.

The following chart shows Healthy Kids enrollment progress for the quarter:

Date	Total Enrollment	Target Enrollment Increase	Net Increase	Actual Net Increase	Progress Toward Goal
2009	300,545	30,000	30,472	30,472	101.57%
2010	342,956	80,000	42,411	72,883	91.10%
11-Oct	374,963	80,000	3,462	104,890	131.11%
11-Nov	376,314	80,000	1,351	106,241	132.80%
11-Dec	378,221	80,000	1,907	108,148	135.19%

#### FHIAP - Family Health Insurance Assistance Program

Staff developed several Web information videos that help consumers better understand the eligibility and enrollment process for OPHP’s subsidy and high-risk programs.

### B. Benefits

#### Benefit changes effective January 1, 2012

Due to reductions of the state’s general fund budget, there have been reductions to some client benefits beginning January 1, 2012.

- **Adult dental benefits reduced for OHP Plus, OHP with Limited Drug and CAWEM Plus - DCOs** provide dental care to more than 90 percent of OHP clients. To keep DCO coverage as affordable as possible in light of the 11 percent reduction, DMAP and the DCOs agreed on limitation changes to OHP Plus dental coverage for adults age 21 and older. Coverage for those under age 21 will not change.

## Oregon Health Authority

- **Benefit reductions for all clients** - Benefits will be reduced for all clients by removing coverage for 13 lines of the Prioritized List of Health Services. Beginning January 1, 2012, OHP will only cover the first 498 lines on the Prioritized List of Health Services. Some treatments for the following conditions will no longer be covered: Keratoconjunctivitis, mutism, hemorrhoids, chronic otitis media, rectal prolapse, otosclerosis, anal fistula, fractures of the vertebral column, conduct disorders for children, disorders of the breast, disorders of the vagina, and cysts of Bartholin's gland<sup>1</sup>.
- **Hospital benefits expanded for OHP Standard clients** - Non-emergency hospital services will be covered for OHP Standard clients. These services are not funded by the state general fund but through a one percent hospital tax increase, approved by the legislature earlier this year. This means that OHP Standard will cover scheduled, medically appropriate, inpatient and outpatient hospital care and surgeries, in addition to the current coverage of emergency hospital services. Like current coverage, new coverage is subject to benefit package limitations and prior authorization requirements. This change will make OHP Standard hospital benefits the same as hospital benefits for OHP Plus clients.

### C. Grievances and complaints

#### Managed care plan grievances

The state's grievance system includes clients' rights to appeals and hearings on denials of services, contract requirements for plans to report grievances, legal and understandable notices of action so clients can respond, strict time lines for plans and the Authority to complete the appeal or hearing process, and other important efforts to protect clients' rights.

- During this quarter, DMAP and AMH conducted and received training on how to report grievances and appeals for consistent reporting across dental, medical and mental health plans.
- The following chart shows the types of grievances received this quarter.

Medical Plan	Access	Quality of Clinic Care	Interpersonal Care/Quality Service	Other	Total Grievances/Complaints	Per 1000 PMPM
CAREOREGON	38	87	58	19	202	1.28
CASCADE COMPREHENSIVE CARE INC	0	0	1	8	9	0.96
DOCS OF THE COAST SOUTH	43	20	46	0	109	9.28
DOUGLAS CO IPA	2	3	1	1	7	0.42
FAMILYCARE INC	0	1	1	2	4	0.09
FAMILYCARE PCO	0	1	0	0	1	0.09
INTERCOMMUNITY HLTH NETWORK	1	0	7	3	11	0.36
KAISER PCO	6	16	34	2	58	4.82
LANE INDIVIDUAL PRACTICE ASSN	5	33	18	14	70	1.46
MARION POLK COMMUNITY	1	1	2	2	6	0.10
MID ROGUE IPA	2	4	11	0	17	0.75
ODS MEDICAL	1	1	1	0	3	0.23
OREGON HEALTH MANAGEMENT SVCS	0	1	0	0	1	0.18
PACIFICCARE (COIHS)	6	6	10	3	25	0.64
PROVIDENCE HEALTH PLAN	0	1	0	0	1	0.04
TUALITY HEALTH ALLIANCE	0	1	1	0	2	0.19

<sup>1</sup> The funding line for the newly organized January 2012 Prioritized List of Health Services was going to be 511. This reduction will eliminate coverage for lines 499 - 511, making the new funding line for January 1, 2012, Line 498.

Dental Plan	Access	Quality of Clinic Care	Interpersonal Care/Quality Service	Other	Total Grievances/Complaints	Per 1000 PMPM
ACCESS DENTAL	0	0	2	0	2	0.24
ADVANTAGE DENTAL SERVICES LLC	4	4	21	2	31	0.17
CAPITOL DENTAL CARE INC	0	1	32	2	35	0.18
FAMILY DENTAL CARE	3	3	1	21	28	3.62
MANAGED DENTAL CARE OF OR	0	1	0	0	1	0.06
MULTICARE DENTAL	0	2	3	0	5	0.14
OREGON DENTAL SERVICE	27	14	10	4	55	0.81
WILLAMETTE DENTAL GROUP PC	0	2	3	12	17	0.22

### State Administrative Hearings

When Medicaid coverage of a health care service is denied, clients have the right to request contested case hearings under the Administrative Procedures Act. The division’s Hearings Unit processes and coordinates requests for these hearings.

- During this quarter, DMAP received 563 hearing requests; of those, 89 percent were from managed care plan members, and 11 percent were from clients receiving their services on a fee-for-service basis.
- The top three categories of hearing requests were to contest denials of surgery (31 percent), referrals<sup>2</sup> (28 percent) or prescription drugs (20 percent).
- DMAP resolved 591 requests; the resolutions are summarized below.

<b>Total requests resolved</b>  <b>591 (100%)</b>	<b>Resolved before hearing (77%)</b>	Decision overturned by plan after second review	27%
		Client withdrew request after pre-hearing conference with state hearings representative	25%
		Dismissed by DMAP as not hearable*	22%
		Dismissed by DMAP for other reasons**	2%
	<b>Resolved at hearing (23%)</b>	Decision affirmed	15%
		Client failed to appear	9%
		Decision reversed	0%

\* Dismissed because service was not denied, or there was a billing/claims issue.

\*\* Dismissed because non-timely, or judge did not have the authority to make a decision on the case.

## D. Quality of care

### External Quality Reviews completed

Acumentra Health is the external quality review organization contracted to perform external quality reviews (EQRs) on OHA’s contracted health plans). The mandatory subjects reviewed and validated include:

- Compliance with federal and state regulations and contract provisions for access to care, operations, and quality improvement;
- Evaluation of performance improvement projects (PIPs) and performance measures (PMs); and
- Assessment of information systems.

Together, we work with the Plans to improve the quality of OHP health services based on the findings in the external quality review.

<sup>2</sup> “Referral” is a multi-faceted category, generally meaning there was not a denial of a service or the issue pertains to billing/claims.

## Oregon Health Authority

### Pharmacy and Therapeutics Advisory Committee formed

On September 5, 2011, OHA formed the Oregon Pharmacy and Therapeutics (P&T) Advisory Committee to replace the Drug Utilization Review Board. During this quarter, OHA began actively engaging stakeholders to join the new committee.

The P&T Advisory Committee is an 11-member volunteer advisory group of five doctors, four pharmacists and two individuals who are neither a doctor nor a pharmacist. The committee is responsible for ensuring safe, effective and affordable medications for Oregonians, performing drug use review and drug policy recommendations for our OHP clients.

The committee maintains OHP's Preferred Drug List and develops policy recommendations in relation to Drug Utilization Review (DUR). Visit the P&T Committee's home page for further information at <http://www.oregon.gov/OHA/pharmacy/therapeutics>.

## E. Access

### Client billing issues

DMAP has formed a taskforce to identify, resolve and eventually prevent client billing issues. Plan representatives, client advocates, and other stakeholders are working together to identify solutions on a case-by-case and system-wide basis.

The goal is to educate clients on when they may or may not be billed for health care services so that clients feel confident in obtaining health care services that Medicaid covers.

### Affordable Care Act implications on provider enrollment and claim payment

Some providers, particularly out-of-state, have been reluctant to provide required information under the Affordable Care Act. When providers refuse to send the required information, the claim is denied. In some cases, providers are billing the clients for payment, even though the service is covered by Medicaid.

DMAP is working to resolve these issues with providers and plans, seeking CMS guidance on examples from other states.

### Dental care outreach

Contracted dental plans are actively partnering with Head Start to educate clients about how to access OHP dental care services. During this quarter, activity included an 8 day screening event. 764 children in dental plans received limited exams and fluoride varnish. The rounded cost for providing those services was about \$15 per child.

## F. Managed care

### 1. Approval and contracting with new managed care organizations

During this quarter, FamilyCare ended their Fully Capitated Health Plan (FCHP) contract in Morrow and Umatilla counties. FamilyCare now serves these counties as a Physician Care Organization.

### 2. Rate certification

Effective October 1, 2011, the OHA established the new FCHP capitation rates with the base DRG hospital rate at 68% of Medicare rates. OAR 410-120-1295 has been amended, effective October 1, 2011, to describe the hospital reimbursement rates required to be used by a FCHP for non-participating hospital providers.

### 3. Enrollment and disenrollment

Nothing to report this quarter.

### 4. Health plan contract compliance

#### ***Notice of Action Workgroup formed***

Client protections are a fundamental concern of CMS and they require NOAs as part of that protection. That in turn, is built into the managed care contracts and rules. Due to recent concerns and questions about NOAs, DMAP has formed a group to follow up with plan-specific and general concerns regarding NOAs. One of the products of this group has been to develop and present a training for plan representatives and DMAP staff about writing for Medicaid clients.

#### ***OHP Performance Assurance and Improvement Committee***

The OHP Performance Assurance and Improvement Committee (OPAI) was formed to provide high level oversight and direction of managed care and fee-for-service performance, focusing on client access, quality assurance, and improvement; ensure compliance with applicable regulations and contractual requirements; and provide direction and oversight of DMAP performance improvement activities and corrective actions.

Review of plan performance over the quarter identified the following issues:

- Provider access for 3 plans
- Provider capacity for 1 plan
- Fraud, waste and abuse requirements for 1 plan
- Service denials for 2 plans
- Encounter data reporting for 1 plan

DMAP worked with plans via phone conferences, work plans and follow-up reviews to ensure a return to contract compliance.

### 5. Financial performance relevant to Demonstration

Nothing to report this quarter.

## G. Legislative activities

### General Fund reduction options

As a result of the ongoing economic concerns facing the state and the potential for additional projected revenue declines in future forecasts, Oregon's Legislative Fiscal Office (LFO) requested the submission of reduction options from all state agencies.

LFO requested a list of a total of 10.5 percent in reduction options below the 2011-13 legislatively adopted budget level (and including the 3.5 percent supplemental ending balance adjustment amount.)

- Reaching a 10.5 percent general fund reduction below the 2011-13 budget would result in more than \$188.4 million in General Fund reductions for OHA.
- The agency draft lists are a starting place for lawmakers if they are faced with the task of further reducing the state budget during the February session. The list will be looked at in the context of the entire state budget rather than in isolation of one agency.

The draft budget can be found at <http://www.oregon.gov/OHA/budget/2011-2013/index.shtml>.

**CCO workgroup presentations**

On November 16, the Legislature received an update from the CCO workgroups. The update included:

Workgroup	Updates
<p><b>CCO Criteria Work Group</b> CCO Criteria focuses on considerations to qualify an entity to become a CCO, including financial reporting, the governance model, health equity and patient rights and responsibilities.</p>	<ul style="list-style-type: none"> <li>■ <b>CCO governance:</b> Under House Bill 3650, there must be a CCO board and a community advisory council. A majority of the board members should represent those who take financial risk. Further, the board must also represent the community at large. There is strong support for the chair of the community advisory council to serve on the board.</li> <li>■ <b>Financial solvency:</b> There is general consensus from the work group that the two most telling factors will be the CCO risk reserves and the level and type of reinsurance. Other factors, such as possible risk-sharing arrangements with the state and minimum enrollment levels, also were discussed.</li> <li>■ <b>Health equity:</b> There is general agreement that as part of the application process, a CCO should address health equity. But it should be broadly framed – that it’s not only about race and ethnicity, but that other factors, such as disability and geography, create inequities as well. As part of the application process, a CCO should be required to perform a data-driven community needs assessment.</li> </ul>
<p><b>Global Budget Methodology Work Group</b> This group focuses on risk sharing and risk adjustment, quality incentives, and principles and priorities for which Medicaid program dollars should be included or excluded from the CCO global budget.</p>	<ul style="list-style-type: none"> <li>■ <b>Risk:</b> There is general agreement that while risk adjustment is imperfect, the method currently used by the state is designed for a Medicaid population and is a good starting point.</li> <li>■ <b>Quality incentives:</b> Incentives should focus on outcomes, with the understanding that gradual implementation will be important.</li> <li>■ <b>Inclusion/exclusion criteria:</b> General consensus has been to focus on programs where the majority of current Medicaid dollars are and on the dollars that will have the greatest potential for achieving better health, better care and lower costs.</li> </ul>
<p><b>Metrics Work Group</b> This group focuses on the principles the Oregon Health Authority should apply when selecting measures that hold CCOs accountable for improved health outcomes.</p>	<ul style="list-style-type: none"> <li>■ <b>Alignment:</b> Measures should be aligned with other reporting efforts to minimize administrative burden.</li> <li>■ <b>Uniformity:</b> There should be a set of core uniform metrics across all CCOs as well as individual CCO-specific metrics. Specific recommendations could be set up in three general “buckets,” including a core set of metrics, a menu set from which a CCO could choose, and a transformational set or measures that reflect transformational work (for example, better integration of care and services).</li> </ul>
<p><b>Medicare-Medicaid Integration Work Group</b></p>	<ul style="list-style-type: none"> <li>■ The focus has been on the structural disconnects or misalignments of incentives in the Medicare and Medicaid health and long-term services that lead to inappropriate, expensive or poor quality services for people.</li> <li>■ Program coverage rules that do not align, separation of funding streams and delivery systems, and issues with payment incentives and cost shifting are among the main concerns.</li> </ul>

**Senate Bill 101 implementation**

SB 101 (2011) required hospitals and FCHPs to work in good faith toward new contracts effective on or after September 1, 2011. OHA is required to report to the legislature on the progress with these contracts.

DMAP asked FCHPs to send us data regarding the number of contracted and non-participating hospitals each FCHP reimburses on and after September 1, 2011, for the legislative report.

SB 101 also amended ORS 414.743, requiring the non-participating hospital to be reimbursed at a specified percentage of the Medicare cost used by the OHA in calculating the base hospital capitation payment to the FCHP, excluding any supplemental payment.

## Senate Bill 201 implementation

The passage of Senate Bill 201 allows Oregon Health Plan clients the option to disenroll from their current managed care plan electively *once* during an enrollment period. This is in addition to other cause-based reasons for disenrollment requests.

During this quarter, DMAP added this new enrollment reason into the MMIS and shared this new enrollment option with DHS/OHA staff.

## H. Litigation status

Nothing to report this quarter.

## I. Operational issues

### Medicaid Integrity Recovery Audit Contractor

DHS/OHA awarded the Recovery Audit Contractor (RAC) contract was awarded to the New York firm, HMS. HMS is the nation's leader in coordination of benefits and program integrity services for health care payers. HMS works with more than 40 states; over 120 Medicaid managed care plans; the Centers for Medicare and Medicaid Services (CMS); and Veterans Administration facilities.

HMS will help maintain the integrity of Oregon's Medicaid program. Their contract extends through September 14, 2014.

### HIPAA 5010 and NCPDP D.0 implementation

On November 17, the Centers for Medicare & Medicaid Services (CMS) announced that it would not enforce compliance with 5010 X12 Transaction and NCPDP Version D.0 until April 1, 2012.

- Based on this guidance, DMAP offered a limited time for 4010/5010 dual processing beyond January 1, 2012 for some transactions.
- Fee-for-service pharmacies' compliance date for NCPDP D.0 remains January 1, 2012. Pharmacies unable to submit D.0-compliant Point of Sale claims may use the Provider Web Portal.

### Statewide hiring freeze

A statewide hiring freeze was declared and will last at least through the February legislative session and perhaps longer depending on Oregon's economy. While there is an exception process for this freeze through the Department of Administrative Services, as an agency, OHA will be requesting exceptions infrequently and only for positions that are critical for our mission.

This hiring freeze is not markedly different than the one we have been operating under but it does call attention to the fact that now, more than ever, we have to be deft and strategic in how we allocate our human resources to meet top priorities.

### Delays in internal enrollment requests due to e-mail system changes

DHS/OHA completed a transition to a new e-mail system this quarter, which resulted in difficulties accessing shared mailbox accounts, or resulted in missing accounts.

DMAP's Client Enrollment Services Unit also experienced difficulties receiving or responding to requests for plan enrollment changes as a result.

## Future programs and insurance products

### Coordinated Care Organizations

In November, OHA issued the draft Coordinated Care Organization (CCO) Implementation Proposal, a working document from the Oregon Health Policy Board, for public review.

- The draft proposal is a working document from the Oregon Health Policy Board
- There were two public comment periods: December 14 – January 3 and January 11 – January 18; OHA also accepted comments via the Health System Transformation Web site at <http://health.oregon.gov>.

After all public comment is reviewed, the policy board will finalize the proposal and submit it to lawmakers for the legislative session that begins on February 1, 2012. If approved by Oregon lawmakers, the CCO plan goes to the federal government for approval. The first CCO could potentially begin serving clients this summer.

### Program developments, issues or problems

Nothing to report this quarter.

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## III. Status of Corrective Action Plans

Nothing to report.

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## IV. Evaluation activities and interim findings

Nothing to report.

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## V. Appendices

### A. Quarterly enrollment reports

Attached as a separate document.

### B. SEDS reports

Attached as a separate document.

### C. State reported enrollment tables

#### OHP enrollment

Enrollment	October 2011	November 2011	December 2011
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	511,529	512,778	515,850
Title XXI funded State Plan	75,927	76,490	76,786
Title XIX funded Expansion Populations 9, 10, 11, 17, 18	70,391	71,419	73,043
Title XXI funded Expansion Populations 16, 20	1,124	1,125	1,167
DSH Funded Expansion	NA	NA	NA

Enrollment	October 2011	November 2011	December 2011
Other Expansion	NA	NA	NA
Pharmacy Only	NA	NA	NA
Family Planning Only	NA	NA	NA

## Ever Enrolled in OHP

POPULATION			Total Number of Clients	Member Months	Percent change from previous quarter	Percent change from previous year
Expansion	Title 19; OHP Standard	OHP Parents	22,883	59,761	-3.43%	-1.76%
		OHP Childless Adults	49,833	137,901	-4.88%	1.73%
	Title 19; OHP Plus	PLM Children FPL > 170%	1,535	3,355	10.10%	19.02%
		Pregnant Women FPL > 170%	967	2,155	0.41%	-2.79%
	Title 21; Plus	SCHIP FPL > 170	18,899	47,743	2.64%	12.93%
Optional	Title 19; Plus	PLM Women FPL 133-170%	15,701	34,702	0.50%	5.53%
	Title 21; Plus	SCHIP FPL < 170%	63,587	165,130	1.66%	8.98%
Mandatory	Title 19; Plus	Other OHP Plus	484,361	1,353,343	1.18%	7.52%
<b>QUARTER TOTAL</b>			<b>657,766</b>			

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

## FHIAP

Family Health Insurance Assistance Program (FHIAP) Enrollment 10/1/11 to 12/31/11	
New group enrollments	26
New individual enrollments	48
<b>Total new enrollments</b>	<b>74</b>
Total enrollment on December 31, 2011	7,365
Disenrollment due to non-payment of premium	27
<b>Total number of people ever-enrolled during this quarter</b>	<b>7,720</b>
Other Statistical Data (as outlined in the STCs)	
Transfers from FHIAP to state coverage	15 lives
OHP2 disenrollment requests in first 30 days	8 (all denied)
Number and percentage of FHIAP eligibles enrolling	
New enrollments current quarter	74
Percent change from previous quarter	1.5% increase
Percent change from same quarter previous year	1.5% increase
Percent approved to enroll	
4 <sup>th</sup> quarter approvals enrolled in 4 <sup>th</sup> quarter	94.5%
3 <sup>rd</sup> quarter approvals enrolled in 2 <sup>nd</sup> quarter	2%

## E. Neutrality reports

### 1. Budget monitoring spreadsheet

Attached as a separate document.

### 2. CHIP allotment neutrality monitoring spreadsheet

Attached as a separate document.