Oregon

2006

Oregon Health Plan Annual Report

Medicaid and State Children's Health Insurance Program
Section 1115(a) Medicaid demonstration extension

DHS
Oregon Department
of Human Services

Letter from the Director

Allen Douma, M.D., State Medicaid Director

In the past 12 months, the Department of Human Services (DHS) and Office of Private Health Partnerships (OPHP) accomplished extensive work to maintain the sustainability of the Oregon Health Plan (OHP) for the coming biennium. In addition to the many activities summarized in the OHP's Year in Review (page 1), we are particularly proud of the following accomplishments:

Preserving OHP Standard

Effective June 1, 2006, DHS no longer charges a premium to OHP Standard clients whose household income is 10% or less of the Federal Poverty Level (FPL). This allows those most in need to retain much needed health care coverage. In addition, OHP Standard clients whose income is above 10% FPL must now pay current and past-due premiums at the time of reapplication in order to remain eligible for continued OHP Standard coverage. This change allows all eligible OHP clients to retain their health care coverage for a minimum of six months, and keeps OHP Standard enrollment at a sustainable level, funded by provider taxes assessed upon Medicaid managed care organizations (MCOs) and hospitals.

Children's Health Insurance Program (CHIP) Expansion

According to a January 2006 research brief by the Oregon Health Research & Evaluation Collaborative <www.oregon.gov/DAS/OHPPR/OHREC/index.shtml>, one reason that children went without health coverage was that parents did not reapply for OHP benefits at the end of their six-month eligibility period.

To help change this trend, the April 2006 Special Session of the Oregon Legislative Assembly allocated DHS $1.1 million of OPHP's remaining Special Purpose Appropriation funds to expand CHIP eligibility from six to twelve months. DHS sought and received approval to amend the OHP demonstration so that effective June 1, 2006, children are now certified eligible for CHIP coverage for twelve months, which minimizes gaps in their health insurance coverage.

Leading OHP Clients to Appropriate Care

In December 2005, DHS' Division of Medical Assistance Programs (DMAP) added two disease states, chronic obstructive pulmonary disease and coronary heart disease, to the OHP's disease management program for fee-for-service (FFS) clients. This program helps clients receive the care and education they need to better manage their own specific health conditions.

At the same time, DMAP implemented a 24-hour Nurse Advice Line for OHP FFS clients to call, where they can receive health care information on both treatment options and local health care resources. The Nurse Advice Line responds to client questions, and helps patients decide the most appropriate avenue of care. This service helps clients towards self-care and redirection to lower, less costly, and more appropriate levels of care.

These achievements help DHS extend OHP benefits to as many Oregonians as possible, and ensure that these benefits are used to access the most appropriate care available.

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Year in Review

October 1, 2005 to September 30, 2006

Specific activities for each quarter of the reporting period can be found in the OHP Quarterly Reports <www.oregon.gov/DHS/healthplan/data_pubs/quarterly/main.shtml>.

OHP Policy Issues

New State Plan Amendments: Changing payment methods on imaging services to hospitals; Medicare Part D medical transportation coverage; annual Community Spousal Resource standards; changing 2006 PACE rates; eliminating payments for Indirect Medical Education and Direct Medical Education.

Emergency Department (ED) Triage and Screening: Although DHS has decided to not require ED screening by policy, it still anticipates that continued education and use of the McKesson Nurse Advice Line will decrease ED visits and hospital admissions for non-emergent conditions.

Re-Prioritized List: The Health Services Commission (HSC) developed a new Prioritized List of Health Services for the 2007-09 biennium that emphasizes preventive care and chronic disease management. The HSC believes the new list could potentially be used by the Legislature as a tool to offer OHP Standard to a greater number of low-income Oregonians by drawing a second funding line in defining the OHP Standard basic benefit package. Implementation of this list beginning in 2008 requires approval from both the Oregon Legislative Assembly and the Centers for Medicare and Medicaid Services (CMS).

OHP Operational Issues

HIPAA Compliance: DHS focused on meeting the December 31, 2005, deadline. All primary paying providers using the 837P and 837I transactions met this deadline. By 3rd Quarter 2005, all managed care organizations (MCOs) were exchanging HIPAA-compliant transactions with DHS. National Provider Identifier (NPI) implementation is DHS' current focus.

Managed Care: The Division of Medical Assistance Programs (DMAP) proposed changes to solicit additional MCOs to participate in OHP's delivery system and ensure appropriate enrollment of OHP clients across DHS divisions. Work with plans focused on streamlining the rate development, capitation payment, and encounter data submission processes. Addictions and Mental Health Division (AMH) and DMAP worked together to help the MCOs develop collaborative Performance Improvement Projects (PIP) linking physical and mental health services.

Medicaid Management Information System (MMIS): DMAP continued to participate in requirements, design, and other planning sessions in support of the replacement MMIS.

Mental Health Program Changes: AMH remained focused on implementing the Children's Mental Health System Change Initiative. AMH also established strategies to help measure provider/partner fidelity to the adoption of Evidence-Based Practices (EBP) in the areas of Technical Assistance, Targeted Fidelity Monitoring, and QA/QI Capacity.

Family Health Insurance Assistance Program (FHIAP)

Focused on the group market and partnered with various organizations to provide Oregon workers and their families access to affordable health care insurance.

OHP Enrollment

DHS administers the following programs to support Medicaid coverage under the Oregon Health Plan demonstration:

- **OHP Plus** is a full benefit package provided to children and adults who are eligible for traditional Medicaid programs or for the Children's Health Insurance Program (CHIP). The OHP Plus benefit package does not have premiums. Some adults have small copayments for some outpatient services and prescription drugs.
- **OHP Standard** is a limited benefit package provided under a specific medical program. The program covers only a limited number of uninsured adults who are not eligible for traditional Medicaid programs. Most people who get OHP Standard pay monthly premiums. OHP Standard does not have copayments.
- The Oregon **Children's Health Insurance Program (CHIP)** provides OHP Plus coverage to children from birth to age 6 with family incomes between 133 percent and 185 percent of the Federal Poverty Level (FPL) and to children from age 6 to age 19 with incomes between 100 percent and 185 percent of the FPL.

As indicated in Figure 1 (right), enrollment in the Oregon Health Plan declined for the OHP Plus and OHP Standard populations during this reporting period.

Meanwhile, Oregon's CHIP population increased during this reporting period. This is partly in thanks to increased outreach efforts and communications linked to the Governor's Healthy Kids Plan initiative, which expanded awareness of existing state health care resources for children under age 19.

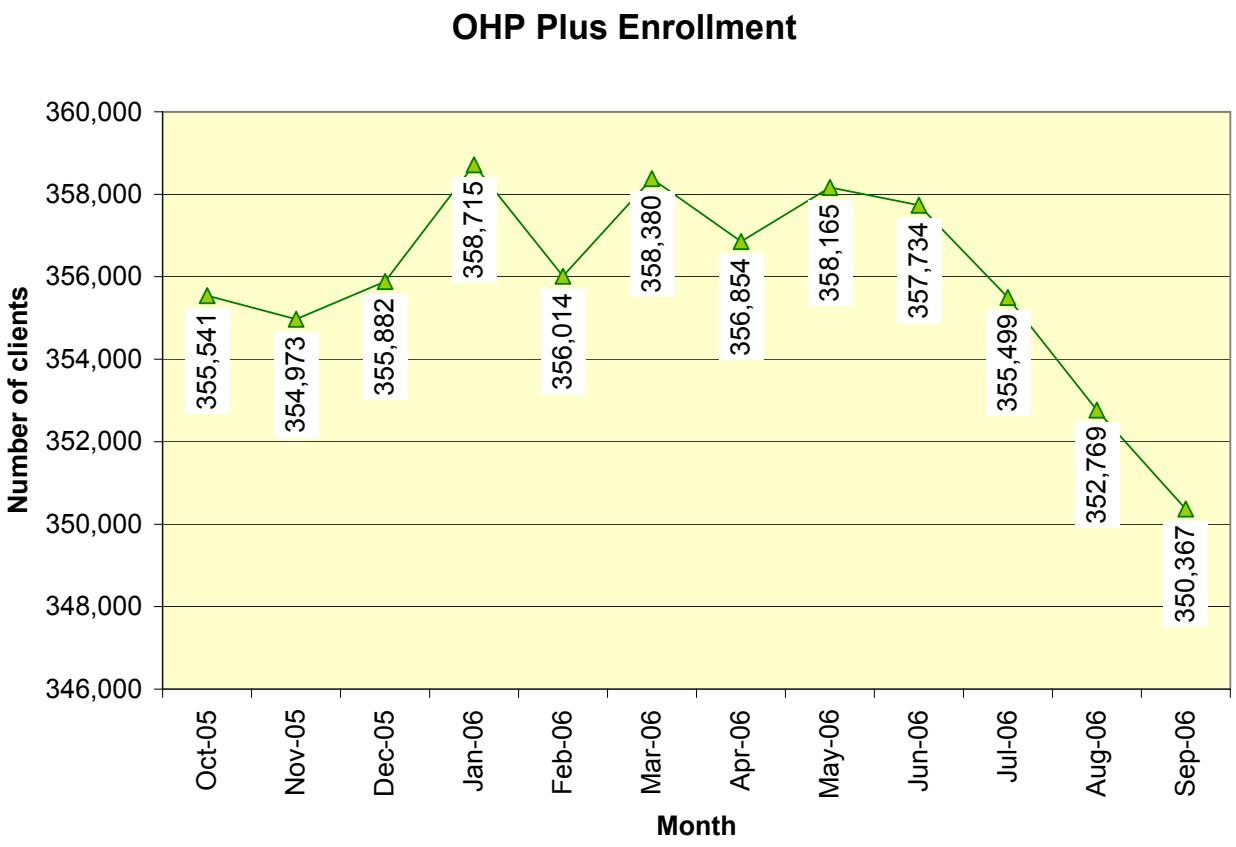
Figure 1: Monthly OHP Enrollment Counts

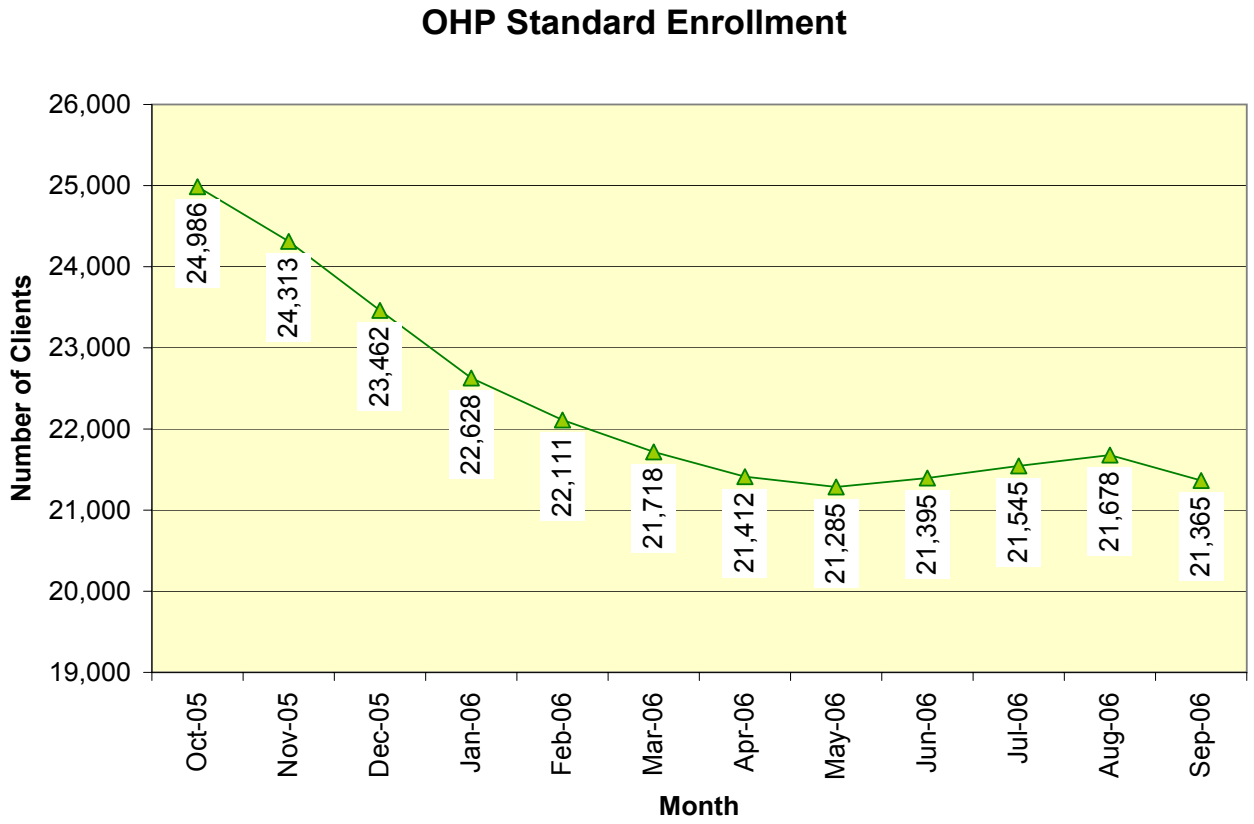
Counts reported here were made approximately 20-25 days after the census date and should be considered preliminary.

Month	Plus	Standard	CHIP	Total
Oct-05	355,541	24,986	27,157	380,527
Nov-05	354,973	24,313	28,334	379,286
Dec-05	355,882	23,462	29,192	379,344
Jan-06	358,715	22,628	30,139	381,343
Feb-06	356,014	22,111	29,984	378,125
Mar-06	358,380	21,718	30,215	380,098
Apr-06	356,854	21,412	29,721	378,266
May-06	358,165	21,285	29,532	379,450
Jun-06	357,734	21,395	29,430	379,129
Jul-06	355,499	21,545	29,511	377,044
Aug-06	352,769	21,678	29,813	374,447
Sep-06	350,367	21,365	30,104	371,732

355,908

Average number of clients on the OHP Plus benefit package



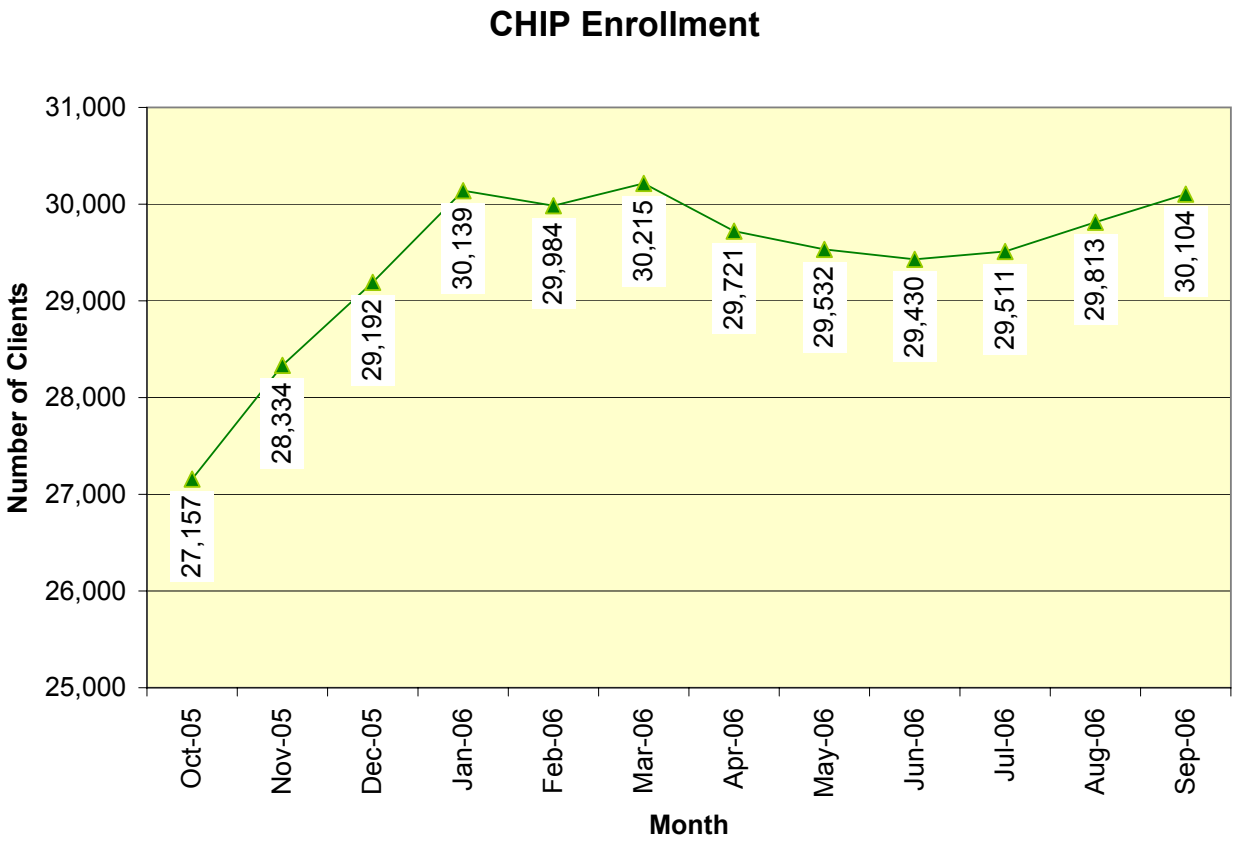


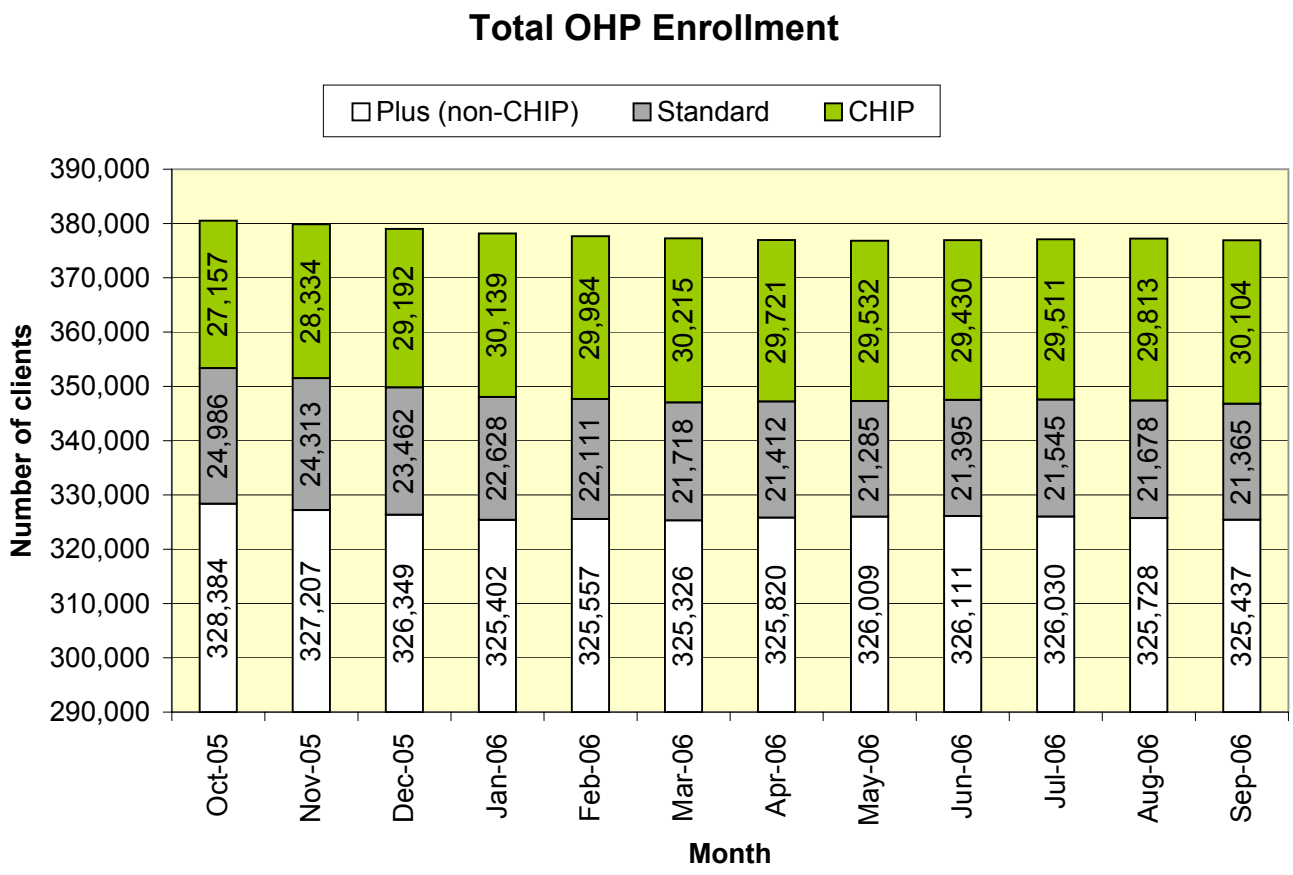
22,325

Average number of clients on the OHP Standard benefit package

29,248

Average number of clients in the
Children's Health Insurance Program





378,233

Average number of clients enrolled in the Oregon Health Plan

OHP Managed Care

Managed Care Enrollment

Seventy-seven percent (77%) of all OHP clients receive their primary medical care services through an OHP managed care organization (MCO) or primary care manager (PCM). Wherever possible, OHP enrolls clients in fully-capitated health plans (FCHPs) as the best means of controlling costs of health care. DMAP's current goal is to enroll 80 percent of OHP clients in managed care, for the following outcomes:

- **Access to routine care:** People who have access to and use routine care have improved health outcomes; and health care is delivered in a more cost-effective manner.
  - Accessing routine care allows diseases to be diagnosed and treated before they become serious and debilitating.
  - In addition, preventive health screens and anticipatory guidance given as part of routine primary care helps to promote early diagnosis and treatment, healthy lifestyles and wellness.
- **Access to preventive care:** Routine health care visits lead to increased access to preventive and primary health care, which may reduce unnecessary and more expensive health care in the hospital or emergency room setting.
  - Routine primary and specialist care are most effectively and appropriately delivered in a clinic or office rather than an emergency room.
  - Clients in managed care utilize preventive and primary care services at higher rates than other clients. Therefore, one way DMAP promotes routine health care services is through enrollment in managed care.
- **Managed quality of care:** Managed care plans participate in quality improvement and prevention activities including Performance Improvement Projects and performance measures. Past and present focuses include tobacco cessation, asthma, diabetes and prenatal care, early childhood cavity prevention, and childhood immunizations.

Managed care *ensures increased access to routine health care, preventive and primary care services, and quality of care for Oregon Health Plan clients.*

Medical Enrollment

Thirty-five of Oregon's 36 counties (97%) have managed medical care. For 32 counties, this care is through FCHPs or a Physician Care Organization (PCO). Primary Care Managers (PCMs) manage care in Gilliam, Lake, and Tillamook Counties.

- Figure 2 (right) shows, per Oregon county, the number of OHP clients who enrolled with a FCHP/PCO or PCM for the reporting period, as well as the number of clients who received their primary medical care on a fee-for-service (FFS) basis.
- FFS clients may include those who are not required to participate in managed care enrollment for one of the following reasons:
  - Eligible for services through an Indian Health Services program
  - Scheduled for surgery
  - In the last three months of a pregnancy
  - Has End Stage Renal Disease (ESRD), receives routine dialysis treatment, or has received a kidney transplant within the last 36 months
  - No participating managed care plan in client county or ZIP code
- Figure 3 (next page) shows the participating medical plans for the reporting period.

77%

of all OHP clients enrolled with a primary medical care manager (FCHP, PCO, or PCM)

Figure 2: Medical Managed Care Enrollment by County

Detailed monthly enrollment data for each delivery system, by county, is available on the OHP Web site <www.oregon.gov/DHS/healthplan/data_pubs/enrollment/main.shtml>.

County	*FCHP*	*PCM*	*FFS*
Baker	7	464	1,524
Benton	4,237	31	632
Clackamas	18,077	85	3,987
Clatsop	1,879	20	1,650
Columbia	2,686	12	1,782
Coos	7,379	56	954
Crook	1,725	5	254
Curry	5	22	2,199
Deschutes	9,752	22	1,631
Douglas	11,949	20	1,562
Gilliam	1	81	55
Grant	538	22	92
Harney	671	1	138
Hood River	2,121	51	258
Jackson	2,208	1,943	16,411
Jefferson	1,667	8	1,145
Josephine	10,276	73	1,276
Klamath	7,791	17	1,347
Lake	68	438	415
Lane	28,039	262	7,889
Lincoln	12	750	5,213
Linn	12,830	60	1,473
Malheur	144	26	4,459
Marion	36,443	67	3,923
Morrow	1,338	1	128
Multnomah	69,408	1,729	10,690
Polk	6,095	55	1,060
Sherman	153	8	33
Tillamook	3	1,712	785
Umatilla	7,658	25	1,727
Union	2	294	2,745
Wallowa	2	13	610
Wasco	2,562	151	503
Washington	29,397	222	4,037
Wheeler	44	8	59
Yamhill	1,778	1,568	5,999
Unknown	7	9	332
Total	278,953	10,329	88,974
%	**74%**	**3%**	**23%**

OHP Managed Care

Figure 3: Participating medical managed care plans by county

Current plan information for each county is on the OHP Web site <www.oregon.gov/DHS/healthplan/data_pubs/planlist/main.shtml>.

	CareOregon	Cascade Comprehensive Care	Central Oregon Individual Health Solutions (COIHS)	Douglas County Independent Physicians Association (DCIPA)	Doctors of the Oregon Coast South (DOCS)	FamilyCare, Inc.	InterCommunity Health Network	Kaiser Permanente Oregon Plus (PCO)	Lane Independent Physicians Association (LIPA)	Marion-Polk Community Health Plan (MPCHP)	Mid-Rogue Independent Physicians Association (MRIPA)	ODS Community Health	Oregon Health Management Solutions (OHMS)	Providence Health Assurance	Tuality Health Alliance
Baker												x			
Benton							x								
Clackamas	x					x		x						x	
Clatsop	x														
Columbia	x														
Coos	x				x										
Crook			x												
Curry															
Deschutes			x												
Douglas	x			x							x		x		
Gilliam															
Grant			x												
Harney			x												
Hood River			x												
Jackson	x					x					x	x	x		
Jefferson			x												
Josephine						x					x		x		
Klamath	x	x	x												
Lake			x												
Lane									x						
Lincoln						x	x								
Linn															
Malheur												x			
Marion	x							x		x					
Morrow	x					x									
Multnomah	x					x		x						x	
Polk	x							x		x					
Sherman			x												
Tillamook															
Umatilla	x					x									
Union												x			
Wallowa												x			
Wasco			x												
Washington	x					x								x	x
Wheeler			x												
Yamhill	x													x	

Dental Enrollment

All Oregon counties have managed dental care through an OHP dental care organization (DCO). Figure 4 (right) shows, per Oregon county, the number of OHP clients who enrolled with a DCO for the reporting period, as well as the number of clients who received their primary dental care on a fee-for-service (FFS) basis.

- FFS clients may include those who are not required to participate in managed care enrollment for one of the following reasons:
  - Eligible for services through an Indian Health Services program
  - Scheduled for surgery
  - In the last three months of a pregnancy
  - Has End Stage Renal Disease (ESRD), receives routine dialysis treatment, or has received a kidney transplant within the last 36 months
  - No participating managed care plan in ZIP code
- Figure 5 (next page) shows the participating dental plans for the reporting period.

93%

of all OHP clients enrolled with a dental plan to receive managed dental care services

Figure 4: Dental Managed Care Enrollment by County

Detailed monthly enrollment data for each delivery system, by county, is available on the OHP Web site <www.oregon.gov/DHS/healthplan/data_pubs/enrollment/main.shtml>.

County	DCO	FFS
Baker	1,869	125
Benton	4,482	418
Clackamas	20,942	1,208
Clatsop	3,226	322
Columbia	4,091	390
Coos	7,996	392
Crook	1,929	55
Curry	2,082	145
Deschutes	10,952	452
Douglas	13,109	422
Gilliam	85	52
Grant	427	225
Harney	771	39
Hood River	2,321	109
Jackson	19,118	1,445
Jefferson	1,931	889
Josephine	11,068	558
Klamath	8,483	671
Lake	879	42
Lane	34,117	2,072
Lincoln	4,301	1,674
Linn	13,397	965
Malheur	2,492	2,137
Marion	37,519	2,914
Morrow	1,390	76
Multnomah	77,655	4,172
Polk	6,614	596
Sherman	167	27
Tillamook	2,281	220
Umatilla	8,704	707
Union	2,956	86
Wallowa	594	31
Wasco	3,039	176
Washington	32,011	1,644
Wheeler	105	6
Yamhill	8,558	787
Unknown	7	341
Total	351,663	26,592
%	**93%**	**7%**

OHP Managed Care

Figure 5: Participating dental managed care plans by county

Current plan information for each county is on the OHP Web site <www.oregon.gov/DHS/healthplan/data_pubs/planlist/main.shtml>.

	Capitol Dental Care	Hayden Family Dentistry, Inc.	Managed Dental Care Services of Oregon	Multicare Dental	Northwest Dental Services	ODS Dental	Willamette Dental Services
Baker					x	x	
Benton	x	x				x	
Clackamas	x	x	x	x		x	x
Clatsop	x					x	x
Columbia	x	x				x	x
Coos		x			x		x
Crook		x			x	x	
Curry					x		
Deschutes		x			x	x	
Douglas		x			x		x
Gilliam	x	x					
Grant	x	x			x		
Harney					x	x	
Hood River	x				x	x	
Jackson	x				x	x	x
Jefferson					x	x	
Josephine	x				x	x	x
Klamath	x	x			x		
Lake	x	x			x		
Lane	x	x			x	x	x
Lincoln	x	x				x	x
Linn	x	x				x	x
Malheur					x	x	
Marion	x	x				x	x
Morrow	x	x					
Multnomah	x	x	x	x		x	x
Polk	x	x				x	x
Sherman	x	x			x		
Tillamook	x	x				x	x
Umatilla	x	x			x		
Union					x		
Wallowa					x		
Wasco	x	x			x	x	
Washington	x	x	x	x		x	x
Wheeler	x	x			x		
Yamhill	x	x				x	x

Mental Health Enrollment

All Oregon counties have managed mental health care through an OHP mental health organization (MHO). Figure 6 (right) shows, per Oregon county, the number of OHP clients who enrolled with an MHO for the reporting period, as well as the number of clients who received their mental health care services on a fee-for-service (FFS) basis.

- FFS clients may include those who are not required to participate in managed care enrollment for one of the following reasons:
  - Eligible for services through an Indian Health Services program
  - Scheduled for surgery
  - In the last three months of a pregnancy
  - Has End Stage Renal Disease (ESRD), receives routine dialysis treatment, or has received a kidney transplant within the last 36 months
  - No participating managed care plan in client ZIP code
- Figure 7 (next page) shows the participating mental health plans for the reporting period.

Figure 6: Mental Health Managed Care Enrollment by County

Detailed monthly enrollment data for each delivery system, by county, is available on the OHP Web site <www.oregon.gov/DHS/healthplan/data_pubs/enrollment/main.shtml>.

County	MHO	FFS
Baker	1,823	172
Benton	4,302	598
Clackamas	19,301	2,849
Clatsop	3,229	320
Columbia	3,940	541
Coos	7,460	928
Crook	1,784	200
Curry	2,043	183
Deschutes	10,150	1,254
Douglas	11,926	1,605
Gilliam	121	16
Grant	588	64
Harney	711	99
Hood River	2,174	256
Jackson	18,402	2,161
Jefferson	2,062	757
Josephine	10,491	1,135
Klamath	8,101	1,053
Lake	858	63
Lane	32,187	4,003
Lincoln	5,371	604
Linn	12,896	1,467
Malheur	4,179	450
Marion	36,024	4,408
Morrow	1,317	149
Multnomah	73,618	8,209
Polk	6,350	860
Sherman	175	19
Tillamook	2,294	207
Umatilla	8,294	1,116
Union	2,674	368
Wallowa	573	52
Wasco	2,845	371
Washington	29,962	3,693
Wheeler	100	11
Yamhill	8,473	872
Unknown	13	335
Total	336,810	41,445
%	**89%**	**11%**

89% of all OHP clients enrolled with a mental health plan to receive managed mental health care services

OHP Managed Care

Figure 7: Participating mental health managed care plans by county

Current plan information for each county is on the OHP Web site <www.oregon.gov/DHS/healthplan/data_pubs/planlist/main.shtml>.

	Accountable Behavioral Health Alliance (ABHA)	Clackamas County MHO (CCMHO)	FamilyCare, Inc.	Greater Oregon Behavioral Health Services (GOBHS)	Jefferson Behavioral Health (JBH)	LaneCare, Inc.	Mid-Valley Behavioral Care Network (MVBCN)	Verity Integrated Behavioral Health Services (VIBHS)	Washington County HHS (WCHHS)
Baker				x					
Benton	x								
Clackamas		x	x						
Clatsop				x					
Columbia				x					
Coos					x				
Crook	x								
Curry					x				
Deschutes	x								
Douglas					x				
Gilliam		x							
Grant				x					
Harney				x					
Hood River		x							
Jackson					x				
Jefferson	x								
Josephine					x				
Klamath					x				
Lake				x					
Lane						x			
Lincoln	x								
Linn							x		
Malheur				x					
Marion							x		
Morrow				x					
Multnomah			x					x	
Polk							x		
Sherman		x							
Tillamook							x		
Umatilla				x					
Union				x					
Wallowa				x					
Wasco		x							
Washington			x						x
Wheeler				x					
Yamhill							x		

Managed Care Expenditures

Managed care plans contract with DHS to provide physical, dental, mental health, and/or chemical dependency services for OHP clients. DMAP pays these plans a monthly fee for each enrolled person (*i.e.*, a capitation fee) for the services they provide.

As shown in Figure 8, the majority of OHP capitation expenditures is for primary medical care services rendered by FCHPs.

Figure 8: Capitation Payments by MCO Type

The following chart shows, for the reporting period, payments to contracted managed care organizations (MCOs) for health care services by rate group and MCO type.

Rate Group	Description	CDO	DCO	FCHP	MHO	PCO
ABAD	Aid to the Blind or Disabled	$76,852.69	$10,950,863.76	$203,921,610.16	$51,305,251.03	$3,935,841.21
ABAD-MED	Aid to the Blind or Disabled - Medical only	$17,783.31	$7,603,888.42	$34,797,706.61	$20,252,958.45	$567,030.49
CHILD 00-01	CHIP eligible, age < 1, <185% FPL	$67.91	$26,093.99	$110,696,826.59	$52,224.53	$956,727.13
	PLM child, age < 1, < 133% FPL					
CHILD 01-05	CHIP eligible, age 1-5, < 185% FPL	$162.65	$12,067,565.64	$47,937,041.17	$2,826,610.42	$575,287.81
	PLM child, age 1-5, < 133% FPL					
CHILD 06-18	CHIP eligible, age 6-18, < 185% FPL	$49,608.40	$26,926,148.58	$66,243,996.28	$23,018,429.71	$999,069.49
	PLM child, age 6-18, <133% FPL					
OAA	Old Age Assistance	$3.72	$260,422.50	$4,089,650.35	$74,979.13	$108,872.24
OAA-MED	Old Age Assistance - Medical only	$961.45	$5,924,175.37	$33,976,359.52	$2,461,892.75	$405,588.92
OHPAC	OHP Adults and Couples, age 19+, < 100% FPL	$89,087.27	$1,159,610.65	$55,113,609.43	$4,310,061.82	0
OHPFAM	OHP Families, age 19+, < 100% FPL	$12,792.33	$422,284.94	$12,014,458.08	$589,678.05	0
PLMA	OHP pregnant female, < 185% FPL	$21,169.36	$1,838,983.70	$68,374,112.07	$527,528.37	$307,847.82
SCF	Foster children - SCF	$9,723.04	$3,672,801.08	$15,129,092.25	$40,102,177.62	$386,753.44
TANF	Temporary Assistance to Needy Families	$203,576.92	$15,591,251.26	$103,605,697.56	$10,036,188.24	$1,465,569.50
Grand Total		**$481,789.05**	**$86,444,089.89**	**$755,900,160.07**	**$155,557,980.12**	**$9,708,588.05**
% of Total Capitation Payments		**.05%**	**9%**	**75%**	**15%**	**1%**

OHP Managed Care

Quality Activities and Measures

Division of Medical Assistance Programs (DMAP)

For the current reporting period, DMAP initiated and monitored quality improvement of the dental and medical managed care plans in the following areas:

- **Annual Quality Reviews.** As indicated in Figure 9 (next page), DMAP completed 11 reviews for various FCHPs, DCOs, and one CDO during this reporting period. Half the plans reviewed required no corrective action plan.
- **Quality and Performance Improvement (QPI) Workgroup.** This workgroup includes MCO and DHS quality improvement coordinators and medical directors, other DHS staff and partners who serve as resources and experts on given quality improvement and chronic disease topics. The workgroup met 11 out of 12 months this year. Presentations and discussions during this reporting period focused on:
  - EQR structure and operations (compliance protocol), performance measures and Performance Improvement Projects (PIP)
  - Chronic disease management
  - Prevention and awareness strategies
  - Reprioritization of the Health Services Commission's Prioritized List of Health Services for 2007-2009 biennium
- **Performance Improvement Projects (PIP)**
  - *PIP Collaborative.* DMAP and AMH are working together to develop guidelines for an integrated PIP that addresses both physical and mental health. DMAP surveyed the MCOs for topic suggestions, and formed a PIP Collaborative workgroup to discuss development concerns.
  - DMAP solicited an *Asthma PIP* as part of this year's Asthma Performance Measure submission and is currently reviewing the submissions received from the MCOs.
- **Performance Measures.** DMAP issued dental and asthma care performance measures and technical specifications to the MCOs for calendar year 2005.
  - *Asthma:* Indicators to track ED or follow-up primary care visits, and medications dispensed to treat persistent asthma criteria.
  - *Dental:* Indictors to track number of enrollees who received preventive dental care services.
  - DMAP is also in the process of developing a *Well Child Measure*.

Figure 9: DMAP Annual Quality Reviews

The following table lists the Annual Quality Improvement Reports finalized by DMAP for the current reporting period.

Year 2004 Quality Reviews			
Date Completed	*Plan Name*	*Enrollment*	*Corrective Action Plan*
10/25/2005	FamilyCare, Inc.	16,043	Completed July 2006
10/25/2005	IHN	16,204	Completed July 2006
11/03/2005	Capitol Dental Care	116,266	None
12/14/2005	Cascade Comprehensive Care	6,392	None
12/14/2005	COIHS	19,170	Completed March 2006
12/15/2005	Managed Dental Care Services of Oregon	13,249	None
01/12/2006	Northwest Dental Services	69,782	Yes
01/18/2006	OHMS	4,227	None
01/19/2006	MRIPA	5,338	Completed July 2006
01/25/2006	Deschutes County Chemical Dependency Organization	9,750	Completed November 2006
Year 2005 Quality Reviews			
Date Completed	*Plan Name*	*Enrollment*	*Corrective Action Plan*
08/03/2006	OHMS	4,004	None

Ensuring quality of care

To keep Oregon Health Plan clients independent, healthy and safe

OHP Managed Care

Addictions and Mental Health Division (AMH)

For the current reporting period, AMH initiated and monitored quality assurance (QA) and quality improvement (QI) of the OHP-contracted mental health care plans in the following areas:

- **MHO QI Coordinator Workgroup.** The group had a joint meeting with the DMAP QPI Workgroup. The QI Coordinators explored ways to engage in collaborative Performance Improvement Projects (PIPs). The MHO QI Coordinator workgroup met following the joint meeting to discuss ongoing MHO QI Issues. PIPs and the external quality review have been discussed in relation to this contract year and the next.
- **QA/QI Training Activities.** AMH is planning training for the MHOs in November 2006 addressing PIP questions that have been raised as the PIPs have been validated during the 2006 contract year. Included in the training will be the incorporation of PIPs into the Annual Quality Improvement Work Plans and Reports.
- **Performance Improvement Projects.** AMH's Quality Improvement and Certification unit continued annual external quality review activities this year with the MHO PIP Validations.
  - As indicated in Figure 10 (below), AMH completed 9 PIP validations of the mental health plans for the current reporting period. Figure 11 (next page) provides more detail about the PIPs reviewed.
  - Plans with scores on any PIP of "Partially Met" or below were asked to submit a timeline for completing the PIP because the score was due to validation occurring prior to completion of the project. These are not considered corrective action plans.

71%

Average Non-Clinical PIP Validation Score

74%

Average Clinical PIP Validation Score

Figure 10: AMH PIP Validation Score Summary

The following table lists the clinical and non-clinical PIP validation scores for each participating MHO. Scores are pro-rated on a 100% scale.

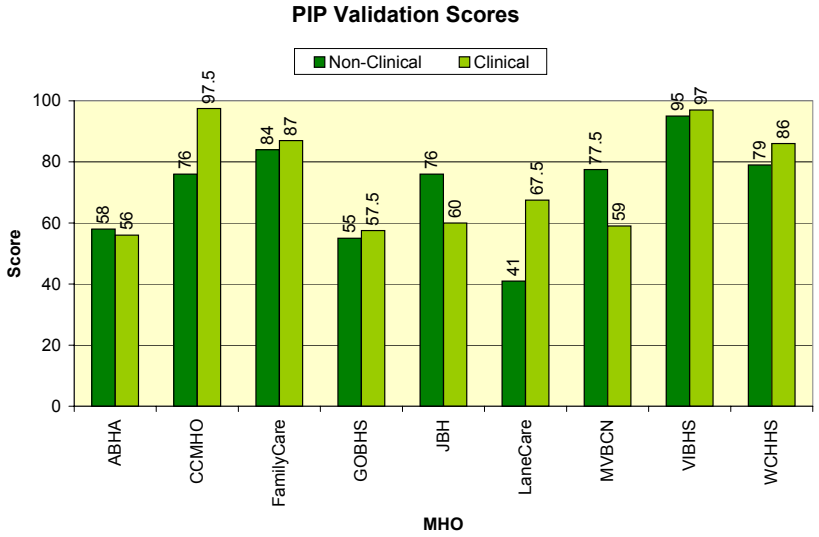


Figure 11: AMH 2006 PIP Validation Reviews

The following table summarizes AMH's Annual Performance Improvement Project (PIP) validation reviews finalized for the current reporting period.

Date Reviewed	MHO	PIP Type	PIP Topic	Report Completed	Rating	Score
02/21/06	MVBCN	Non-Clinical	Increasing Access to Community-Based Treatment Services	04/06/06	SM	77.5
		Clinical	Implementing the Multi-Family Psychoeducation (MFPE) Model		PM	59
03/07/06	ABHA	Non-Clinical	Increasing Use of the Oregon Change Index	04/21/06	PM	58
		Clinical	Ensuring Timely Level of Need Determinations		PM	56
04/07/06	LaneCare, Inc.	Non-Clinical	Timely Resolution of Pended Authorizations	06/01/06	MM	41
		Clinical	Reducing Hospital Utilization Through Preventive Interventions		PM	67.5
04/21/06	FamilyCare, Inc.	Non-Clinical	Improving Identification of Behavioral Health Special Needs & Access to Needed Services	06/07/06	FM	84
		Clinical	Improving the Rate of 7-Day Ambulatory Follow-Up After Inpatient Psychiatric Discharge		FM	87
05/09/06	GOBHS	Non-Clinical	Improving Inter-Rater Reliability of Chart Audits	06/19/06	PM	55
		Clinical	Increasing Services for Children in Child Welfare Custody		PM	57.5
05/09/06	WCHHS	Non-Clinical	Implementing a Fee-for-Service Payment System	07/13/06	SM	79
		Clinical	Reducing Psychiatric Hospitalization Through Intensive Community Treatment		SM	86
07/06/06	VIBHS	Non-Clinical	Initiation and Engagement	09/05/06	FM	95
		Clinical	Reducing Inpatient Utilization		FM	97
07/31/06	CCMHO	Non-Clinical	Increasing Treatment Follow-Through	10/03/06	SM	76
		Clinical	Ambulatory Care Appointments Following Hospital Discharge		FM	97.5
08/25/06	JBH	Non-Clinical	Improving Access for Hispanic Enrollees	10/07/06	SM	76
		Clinical	Dual Diagnosis Treatment Assessment		PM	60

PIP Scoring Legend

FM: Fully Met
SM: Substantially Met
PM: Partially Met
MM: Minimally Met
NM: Not Met

OHP Services

Utilization

For clients who are exempt from managed care plan enrollment, OHP paid for over 3.9 million fee-for-service claims during the reporting period.

- As indicated in Figure 12 (below), the majority of claims paid were for physician services (19.22%), indicating a continued focus on accessing primary physical care services.
- Figure 13 (next page) summarizes DMAP's total fee-for-service claim expenditures. This data has no relationship to the capitation expenditures paid to the plans (see page 13) except as a consideration in setting future capitation rates.

Figure 12: Fee-for-Service Claims by Type of Service

The following chart lists the number of claims paid by service type for the current reporting period. Because it takes up to 6 months for all claims to adjudicate, this data should be considered preliminary.

Description	Total Claims	%
Alcohol and Drug	54,006	1.36%
Ambulatory Surgical Center; Birthing Centers	4,073	0.10%
Audiology/Speech/ Hearing	3,073	0.08%
Behavioral Rehabilitation Services	1,620	0.04%
Contracted RN's	40,159	1.01%
DME Installation; Admin Exams	22,273	0.56%
DME Purchase	113,164	2.86%
DME Rental	53,310	1.35%
DME Repair	1,028	0.03%
Emergency Dental	1	0
Family Planning Clinics	23,231	0.59%
Lab/Radiology: Full Fee	140,743	3.56%
Lab/Radiology: Professional	164,381	4.15%
Lab/Radiology: Technical	183,169	4.63%
Non-Covered Programs	2,499	0.06%
Nurse Practitioner	19,542	0.49%
Optometry; Glass Lenses	13,725	0.35%
Pharmaceutical Services	220,712	5.58%
Physician Services: Anesthesia	17,553	0.44%
Physician Services: Assistant at surgery	3,020	0.08%
Physician Services: ♦ Medicine/Naturopathic Special Services: ♦ Rural Health ♦ Indian Health ♦ Federally Qualified Health Center	760,591	19.22%
Physician Services: Primary Surgery	104,155	2.63%
Podiatry	6,447	0.16%
Pre-Natal Clinics	4	0
Qualified Medicare Beneficiary: ♦ Deductibles, co-insurance and premiums for Medicare-covered services	4,056	0.10%
Qualified Medicare/Medicaid: ♦ Deductibles, co-insurance and premiums for Medicare-covered services ♦ Medicaid services not covered by Medicare	4,631	0.12%
Registered Physician Assistant	386	0.01%
School Based Services	52,740	1.33%
Special Medical Services; Targeted Case Management	210,868	5.33%
Special Services, not limited to: ♦ Ophthalmic Materials (Frames, plastic lenses and miscellaneous items) ♦ Dental ♦ Home Health ♦ Psychologist ♦ Social Worker ♦ Dietary Counselor ♦ Mental Health Clinics ♦ Home EPIV Services In-Home Services Medicare-Medicaid Crossovers	576,548	14.57%
Specialized Mental Health Programs	38,534	0.97%
Transportation: Emergency	17,168	0.43%
Transportation: Non-emergency	1,099,147	27.78%
Total FFS Claims	**3,956,557**	**100%**

Figure 13: Fee-for-Service Payments by Eligibility Group

The following chart shows, for the reporting period, total payments made to fee-for-service health care providers by OHP eligibility group. Because it takes up to 6 months for all claims to adjudicate, this data should be considered preliminary.

Program	Group Description	Total FFS Payments
AB	Aid to the Blind	$3,462,607
	Aid to the Blind - Medical only	$8,960,826
AD	Aid to the Disabled	$125,311,855
	Aid to the Disabled - Medical only/Presumptive Eligibles	$220,455,651
ADC	TANF - Extended medical	$12,962,732
ADC-SAC	TANF - Medical only under age 21 (substitute adoptive care)	$19,673,520
ADC-UN	TANF - Unemployed	$2,810,233
BCP	Breast and Cervical Cancer Program (not Title XIX eligible)	$4,918,214
CAWEM	Eligible except for citizenship; emergency services only	$12,186,348
CHIP	CHIP eligible, < age 1, 170% to 185% FPL	$41,272
	CHIP eligible, age < 1, 133% to 170% FPL	$138,475
	CHIP eligible, age 13-18, 100% to 170% FPL	$1,762,319
	CHIP eligible, age 13-18, 170% to 185% FPL	$197,037
	CHIP eligible, age 1-5, 133% to 170% FPL	$1,124,583
	CHIP eligible, age 1-5, 170% to 185% FPL	$304,783
	CHIP eligible, age 6-12, 100% to 170% FPL	$2,036,872
	CHIP eligible, age 6-12, 170% to 185% FPL	$213,326
FC	Foster children - SCF	$183,938
	Refugee children in foster care	$1,742,122
	General Assistance - SCF	$1,213,024
OAA	Old Age Assistance - Medical only	$377,665,564
	Old Age Assistance	$27,903,014
OHP	Native American/Alaska Native, < 100% FPL	$247,686
	Native American/Alaska Native, < 100% FPL	$56,738,466
	OHP child, age < 1, < FPL	$7,698,799
	OHP child, age < 1, 100% to 170% FPL	$3,755,807
	OHP child, age 13-18, DOB >=10/1/83, < FPL	$6,185,613
	OHP child, age 1-5, < FPL	$4,957,077
	OHP child, age 1-5, 100% to 170% FPL	$1,973,869
	OHP child, age 6-12, < FPL	$4,333,799
	OHP non-pregnant age 19 no child or unborn, 0<10% FPL	$6,029,259
	OHP non-pregnant age 19 no child or unborn, 10<50% FPL	$2,122,425
	OHP non-pregnant age 19 no child or unborn, 50<65% FPL	$789,605
	OHP non-pregnant age 19 no child or unborn, 65<85% FPL	$1,024,143
	OHP non-pregnant age 19 no child or unborn, 85<100% FPL	$859,279
	OHP non-pregnant age 19 w/child &/or unborn, 0<10% FPL	$220,502
	OHP non-pregnant age 19 w/child &/or unborn, 10<50% FPL	$678,785
	OHP non-pregnant age 19 w/child &/or unborn, 50<65% FPL	$513,388
	OHP non-pregnant age 19 w/child &/or unborn, 65<85% FPL	$800,025
	OHP non-pregnant age 19 w/child &/or unborn, 85<100% FPL	$624,285
OHP 2	OHP child, age <1, 170% to 185% FPL (AEN)	$400,727
	OHP pregnant female, 170% to 185% FPL	$833,496
OHP-PLM	OHP pregnant female < FPL	$11,732,249
	OHP pregnant female, 100% to 170% FPL	$5,119,662
QMB	Medicare beneficiary before spend-down	$3,326,102
REFG	Refugee (families)	$181,616
TANF	Emerg assist w/30 days medical, ADC or ADC-UN	$5,169
	Temporary Assistance to Needy Families	$50,017,004

OHP Services

Participating primary care providers

Providers who accept Oregon Health Plan clients help meet Oregon's goal of improving access to routine, preventive, and quality care for those most in need of health services.

2004 Physician Workforce Survey

Question 15 of this survey <www.oregon.gov/DHS/healthplan/data_pubs/reports/04opsurvey.pdf> asked physicians if their office accepted, limited acceptance, or did not accept Medicaid managed care (MCO) or Medicaid fee-for-service (FFS) clients. Responses are summarized in Figure 14 (below).

Figure 14: Responses to Question 15 of 2004 Physician Workforce Survey

	MCO Clients		FFS Clients	
Survey Responses	**Number**	**Percentage**	**Number**	**Percentage**
Accept all	1,260	49.96%	1,292	51.23%
Limit acceptance	559	22.16%	584	23.16%
Accept none	362	14.35%	315	12.49%
Total	2,181	86.48%	2,191	86.88%

Estimated Provider Participation

Based on these responses, and the number of currently licensed physicians in Oregon according to the Oregon Board of Medical Examiners <www.oregon.gov/BME/TotalByStatusAndType.shtml>, DMAP estimates the number of Oregon physicians who accept MCO clients and FFS clients as follows:

Licensed Active Physicians	Accepting Some MCO Clients		Accepting Some FFS Clients	
	Number	**Percentage**	**Number**	**Percentage**
12,454	8,982	72%	9,264	74%

OHP providers

help make the Oregon Health Plan a working health care benefit for those in need

OHP Services

Children's Mental Health System Change Initiative

Overview

To enable children and their families to receive mental health services in the most natural environment and minimize the use of institutional care, the 2003 Legislative Assembly attached a Budget Note directing DHS to take significant action steps to increase community-based mental health services.

Previously, funding for these services was separate from the acute care and outpatient services administered through the MHOs and Community Mental Health Programs (CMHPs). Psychiatric Day Treatment Services (PDTS) and Psychiatric Residential Treatment Services (PRTS) were administered through direct contracts outside of the local system.

To follow the Legislature's direction, AMH established Oregon Administrative Rules (OARs) that set the standards for Children's Intensive Community-Based Treatment and Support Services during the summer of 2005. On October 1, 2005, the MHO Agreement was amended to help implement the Children's System Change Initiative (CSCI). This action brought a shift of intensive mental health services under the authority of the MHOs, the ultimate goal being to bring the majority of these services into the managed care delivery system.

The managed care contracts were amended, as were the fee-for-service contracts. The number of beds in PRTS and number of slots in PDTS fee-for-service contracts were revised down to the estimated amount of those services that would be provided to children who were not enrolled with an MHO.

Approximately 20 percent of the previous service capacity remains in AMH direct contracts with PRTS programs. In addition, AMH has direct fee-for-service contracts for the Oregon State Hospital replacement services for children and adolescents, now delivered by a private non-profit agency.

Intended System Benefits

- **Local or regional children's mental health system** – Single points of authority and accountability
- **Decreased system fragmentation** – To eliminate inefficiencies; increase accountability; increase flexible community-based care; allow meaningful family involvement and community involvement; and coordinate mental health services with other child serving agencies
- The MHO contract requires all funds related to children's mental health services be used for children's services.
- AMH established a **Statewide Children's Mental Health System Advisory Committee** and each MHO established a similar structure at the local or regional level.

Intended Family Benefits

- **Services are community-based** with management, decision-making and service delivery occurring at the local level.
- **Active family involvement** at the case and system level positively impacting the quality and flexibility of services.
- **Earlier community recognition of children who need mental health services.** Services are to be provided for the right amount of time in the right location in the intensity needed to meet the child and family needs and strengths.

Corrective Actions

Completed:

- System put in place to prevent FFS payment to be made on behalf of member enrolled in managed care
- **Administrative Rule Change:** Effective May 2006, temporary rule OAR 410-141-0060 (made permanent in October 2006 as OAR 410-141-0050) provides the following:
  - Children in custody of DHS' Children, Adults, and Families (CAF) Division are not exempt from mandatory enrollment, regardless of Third Party Resource status, except as permitted under this rule.
  - All FFS client cases will be reviewed at the time of a change in circumstance for Medicaid eligibility re-determination.
  - Mental health enrollment will be maintained through temporary placements to provide continuity of care.
  - Authority to authorize disenrollments from managed care is centralized in AMH.
- **DHS Staff Changes:** The number of state staff allowed to make enrollment changes was narrowed to one person in CAF, the Children's Medical Team Project, and no more than two staff in DMAP's Health Maintenance Unit. Decisions on disenrollment or enrollment, other than auto-enrollment are limited to two AMH staff.
- **Automated Weekly MHO Enrollment:** Implemented in July 2006, this updated the MHO auto-enrollment from a monthly process to a weekly process. This change allows newly eligible individuals to be enrolled into managed care more quickly.
- **Admission Authorization:** Beginning October 1, 2006, all FFS children referred to PRTS services must have an identified care coordinator, an ICTS provider, a Child and Family Team, and a service coordination plan. Authorization for admission will not be processed without this documentation.

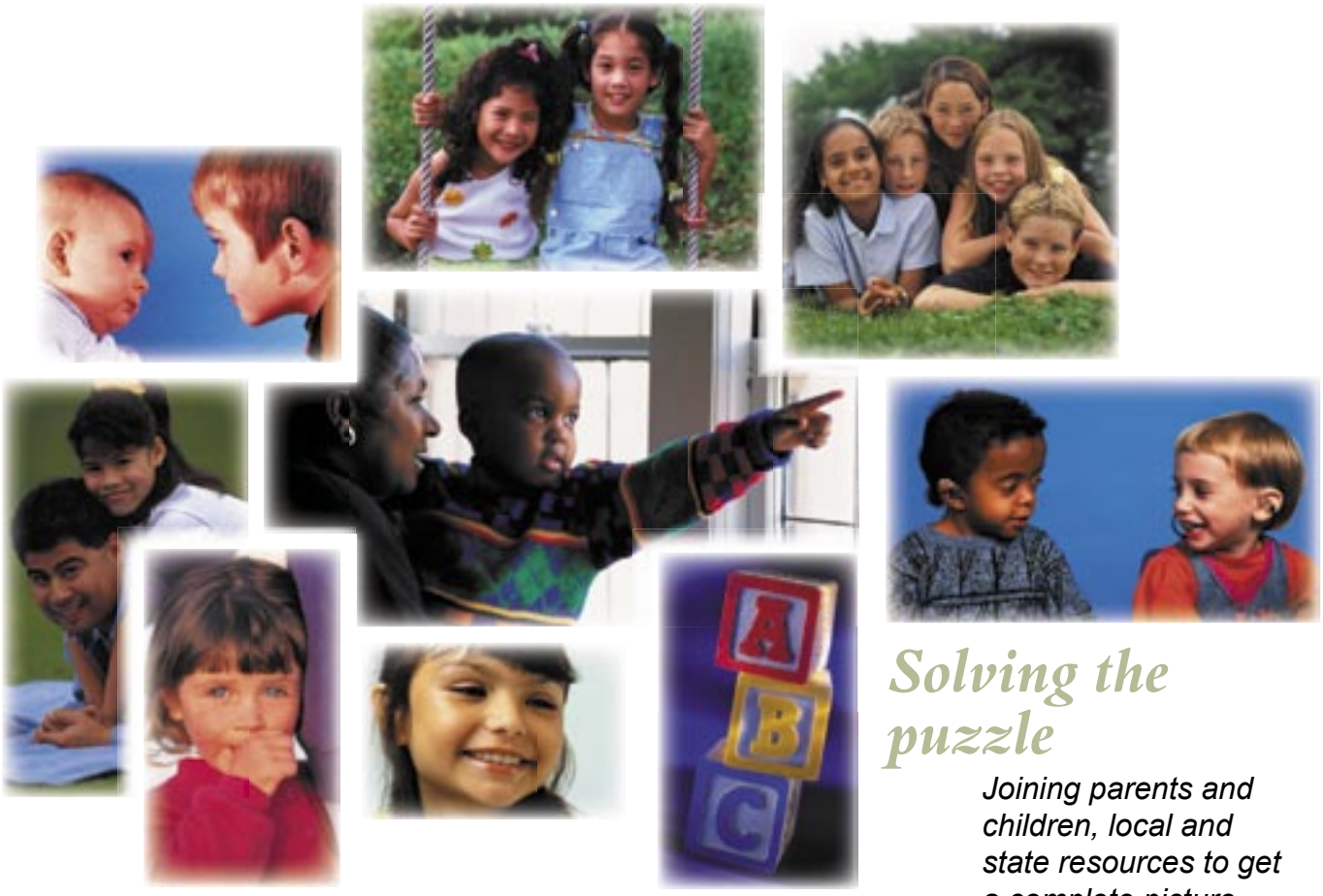
In Process:

- **Utilization Management:** AMH and CAF staff review clinical records of children billed FFS for PRTS services and provide technical assistance to ensure appropriate placement and transition to the community when appropriate.
- The MHOs have reviewed and are continuing to review youth who were inappropriately disenrolled from managed care. MHOs are accepting retroactive re-enrollment in some instances, even though it means accepting liability for PRTS payments of three youths whose admission the MHO did not prior authorize.

Current Status

MHO rate setting includes PRTS payments in three eligibility categories: SCF Children; PLM, TANF, and CHIP Children 6-18; and Aid to the Blind/Aid to the Disabled without Medicare. Increasing the rate of enrollment in managed care is one indicator of the success of the corrective actions.

On a program level, we are seeing benefits for the children who are enrolled in managed care. They are less often served in institutional settings; when they must be served in a residential setting, they now experience shorter lengths of stay and are returned to the community with the supports necessary for success.



Solving the puzzle

Joining parents and children, local and state resources to get a complete picture of children's mental health needs

OHP Progress

DHS Performance Measures

Since 2002, DMAP has monitored two Key Performance Measures (KPMs) to assess the OHP's effectiveness in meeting the DHS goal of keeping people healthy. The data for the following measures is updated on a calendar year reporting cycle. Data for all DHS performance measures is available at <www.oregon.gov/DHS/publications/pm_reports/index.shtml>.

To take into account the typical OHP six-month certification cycle, both measures include clients who have been enrolled for six months or more within a 17-month period. This population includes many clients who began their OHP enrollment at the end of the year before the next measurement year and continued their enrollment into the measurement year.

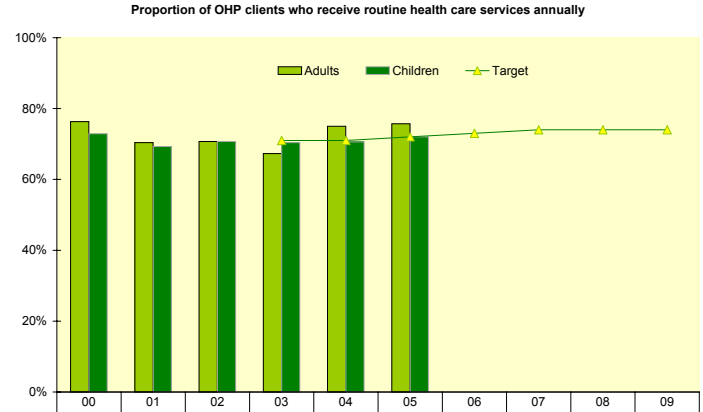
Routine Health Care Provided to OHP Clients

This measure looks at the proportion of Oregon Health Plan (OHP) clients who receive routine health care services annually: a) adults, b) children.

Since 2001, for both adults and children, the general trend shows a favorable increase in the proportion of OHP clients who receive routine health care services. From 2001 to 2005, the rate for adults increased 5.3 percentage points from 70.4 to 75.7 percent, while the rate for children increased 2.7 percentage points from 69.3 to 72.0 percent.

- As shown in Figure 15 (below), the rates for adults and children increased in 2005 and are above the 2005 targets. Increasing the proportion of clients enrolled in managed care and having a medical home facilitates this measure.
- Barriers include health care providers that do not accept Medicaid clients and a lack of knowledge among some clients that routine health visits are necessary and important.
- DMAP is adding more explicit standards to the MCO contracts to make certain there is adequate network capacity to provide routine and preventive services.

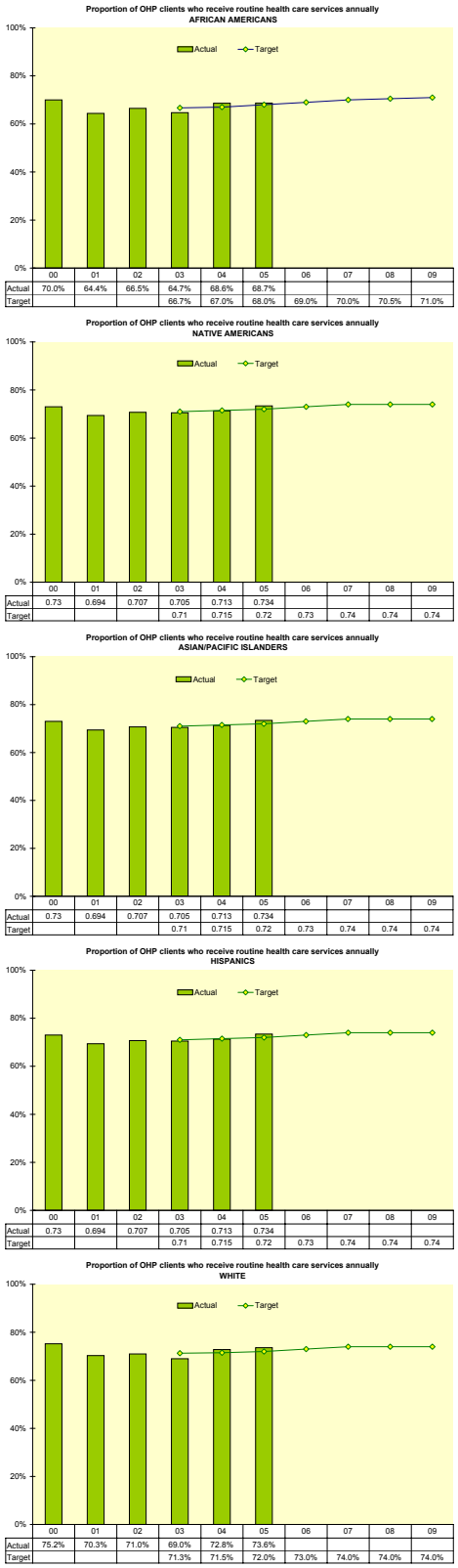
Figure 15: DHS KPM 25 – Routine Health Care Provided to OHP Clients



	00	01	02	03	04	05	06	07	08	09
Adults	76.3%	70.4%	70.7%	67.3%	75.0%	75.7%				
Children	72.9%	69.3%	70.7%	70.4%	70.6%	72.0%				
Target				71%	71%	72%	73%	74%	74%	74%

Figure 16: DHS KPM 26 – Racial/ Ethnic Variation of Routine Health Care Provided

Race/ethnicity is self-reported by the client or reported by their caseworker. A client may be in only one of the five race/ethnic categories to be counted in this measure.



Racial/Ethnic Variation of Routine Health Care Provided

Reducing health disparities is a DHS priority. This measure (KPM 26) looks at the proportion of OHP clients who receive routine health care services annually: a) African Americans, b) Native Americans, c) Asian/Pacific Islanders, d) Hispanic, e) White.

Since 2001, for all race/ethnic categories, the general trend shows a favorable increase in the proportion of OHP clients who receive routine health care services.

- As shown in Figure 16 (left), the rates for all race/ethnic categories increased in 2005 and all are above their 2005 targets. Increasing the proportion of clients enrolled in managed care and having a medical home facilitates this measure. Another facilitator is the number of clients whose medical home is a Federally Qualified Health Clinic or a Rural Health Clinic, as these clinics have a high level of cultural competence.
- Barriers are health care providers that do not accept Medicaid clients and a lack of knowledge among some clients that routine health visits are necessary and important.
- DMAP will continue to collaborate with community, public health, and federal partners on initiatives and projects that focus on reducing health care disparities, in such areas as:
  - Collaboration with the federal Center for Health Care Strategies (CHCS) to develop performance measures for reducing health care disparities, including contracted targets and incentives for OHP MCOs.
  - As part of a state team, working with the federal Agency for Healthcare Research and Quality (AHRQ) to develop a state plan to reduce pediatric asthma health care disparities.
  - Providing an increasing number of educational materials in languages in addition to English.

OHP Progress

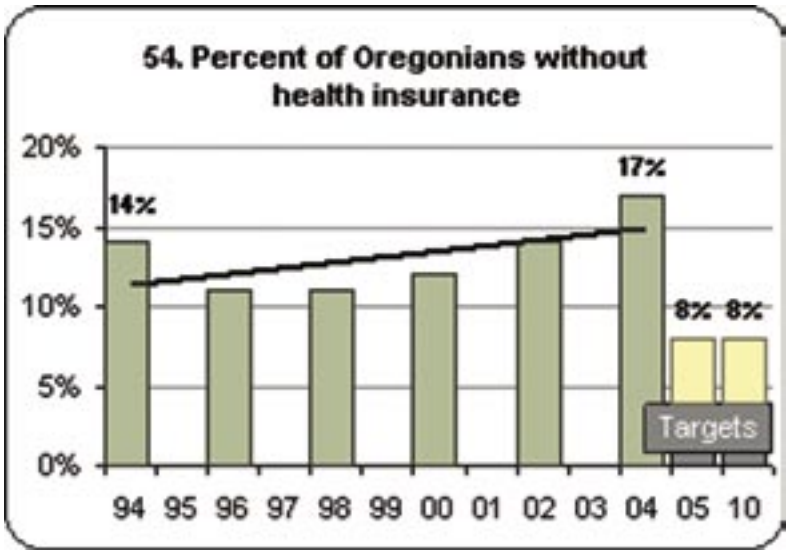
Oregon Benchmarks

The Oregon Progress Board monitors the percentage of Oregonians without health insurance (Oregon Benchmark 54). This benchmark aims for an 8 percent rate of uninsurance by 2010.

- 2005 Current Population Survey data from the US Census and Bureau of Labor Statistics <http://pubdb3.census.gov/macro/032006/health/h06_000.htm>indicates that Oregon's uninsurance rate was 16 percent in 2005.
- This is a 1 percent decrease from the uninsurance rate reported in the Progress Board's 2005 Benchmark Survey, shown in Figure 17 (below, based on 2003 data).

Figure 17: Measure of Oregon Benchmark 54

Oregon Benchmark data is available on the Oregon Progress Board Web site <www.oregon.gov/DAS/OPB/>.



Highlights and Successes

Introduction

In the past year, the Family Health Insurance Assistance Program (FHIAP) served more than 22,000 Oregonians, or an average enrollment of 15,085 people at any one time. All but 152 FHIAP members enrolled this year were eligible for benefits under the OHP Medicaid expansion demonstration. As summarized in Figure 18 (below), the agency distributed nearly $39 million to low-income Oregonians to subsidize private health insurance, both through their employers and in the private-sector individual market.

Figure 18: Premium Subsidy Totals

The following chart summarizes annual premium subsidies paid to FHIAP medical plans and group (or employer-sponsored) plans for the reporting period.

Plan	*Subsidies Paid*
HealthNet	$428,426.24
Kaiser	$2,883,945.42
LifeWise	$2,627,068.00
ODS	$351,249.22
Pacific Care	$1,250,976.50
Pacific Source	$752,340.55
Regence Blue Cross	$5,422,186.58
OMIP	$18,410,267.02
FHIAP Plan Subtotal	**$32,126,459.53**
Employer-Sponsored Subtotal	**$6,708,691**
Total Premium Subsidies Paid	**$38,855,150**

15,085

Average monthly enrollment in FHIAP

22,000

Oregonians benefited from FHIAP services

$39 million

distributed to low-income Oregonians to subsidize private health insurance

FHIAP members are extremely grateful to have quality health insurance at rates they can afford. Thanks to the subsidies, some experience commercial insurance for the first time; others discover FHIAP during a difficult period in their lives. In the words of one member:

"Your program was a godsend for me, as I am sure it is for countless others.

"When someone is struggling to regain a productive role in society, the last thing she needs is to be beaten down by an illness or injury that goes untreated, or to be consumed by debts from medical bills.

"For me, it truly made the difference of allowing me to always buy my groceries and to keep my work status as part time, while enrolled as a full time student. I was therefore able to complete a two-year degree and re-enter the job market as soon as possible.

"Many heartfelt thanks — Keep up the good work! There is a great need for the service that you offer."

Customer Service

FHIAP Member Surveys

FHIAP mailed 1,722 surveys to members who have been in the program at least six months. A total of 585 surveys, or 34% of the total, were returned. More than 96% of the respondents rated FHIAP's overall service as "Good" or "Excellent."

Some commented specifically on the streamlined application. Many customers praised FHIAP staff and the program itself:

"If not for FHIAP, our family wouldn't have insurance.

"This program is a gift. Thank you."

"You are wonderful.

"Thank you so much for all your help and enabling me to have health insurance for the first time in many years!"

Streamlined Application Materials and Process

In early 2006, FHIAP responded to advocates and member comments by designing a streamlined application packet. FHIAP also developed an electronic version to make access easier. This change decreased the number of incomplete applications received by FHIAP from 65 percent to 30 percent. In addition, customers reported:

"I appreciate how FHIAP treats clients with respect,

whether by their friendliness and helpfulness to even the efficient, clear-cut application process."

"Keep up the good work!

"I appreciated how you streamlined the paperwork involved in the application process."

Customer Service

Phone Calls

Phone call volume averaged approximately 1,782 per week during the past year. Customers rated their phone experience as positive.

"Very courteous.

Quick to respond."

"Everyone

I have talked to or been in contact with has been very professional and pleasant."

Deficit Reduction Act (DRA)

FHIAP phased implementation of the DRA requirements that became effective July 1, 2006. These requirements mandated proof of identity and U.S. citizenship when citizens apply for certain programs. FHIAP's implementation plan included:

- Database enhancements and new work processes to support proof of citizenship and identity requirements.
- Updating the streamlined application packet to include information needed to identify Oregon-born applicants and obtain other citizenship information.
- A letter to all active FHIAP members notifying them of the new federal requirements and suggesting they begin work on gathering documents to either submit with their redetermination application or ahead of time. The letter provided space to identify Oregon-born members who can be verified via online records.

This campaign has almost been too successful. FHIAP has received hundreds of letters from Oregon-born residents. While this allows us to reduce the amount of processing necessary at the time of reapplication, it is creating a considerable workload for operations staff currently. However, we anticipate that this proactive approach will enable us to verify most of members by the time they reapply.

Unfortunately, the DRA has had a negative effect on efforts to streamline the eligibility determination process. Prior to implementation of the DRA, about 30% of our total applications needed to be "pended" for additional information. This statistic has risen to approximately 70% during the post-implementation period.

Partnerships

Homecare Union Benefits Board (HUBB)

FHIAP partnered with the Service Employees International Union (SEIU) Homecare Union Benefits Board (HUBB) to provide affordable health insurance to Oregon homecare workers and their families. The result of this collaboration is that every HUBB member and potential HUBB member learns of the opportunity to apply to FHIAP for help paying for health insurance offered through HUBB.

- FHIAP and HUBB staff worked together to develop systems, procedures, and data reporting for an April 1, 2006, implementation.
- FHIAP's Information, Education and Outreach staff also attended a dozen HUBB open enrollment meetings to assist homecare workers with the FHIAP application and eligibility process.

American Federation of State, County and Municipal Employees (AFSME)

FHIAP is working with AFSME and Northwest Employee Benefits (NEB) to explore a similar effort with Oregon childcare workers and their families. FHIAP developed a survey designed to identify potential FHIAP eligibles. The information will be used to secure insurance carrier interest in offering benefit plans to the childcare workers and their families. Carriers believe that FHIAP subsidies will assure increased and stable enrollment.

Governor's Healthy Kids Plan

The Governor's Healthy Kids Plan, if enacted and funded by the Legislature, would give all uninsured Oregon children under age 19 an opportunity to enroll in comprehensive private or public health insurance coverage. OPHP and FHIAP may play an important role in this plan in two ways – by administering a private-market health insurance component and by coordinating the statewide marketing and education efforts for Healthy Kids.

- **Collaborative Efforts.** OPHP and FHIAP policy and management staff have been working in collaboration with the Governor's Office and the Department of Human Services (DHS) in designing the benefits and cost-sharing components of the plan, as well as specifics of the sliding scale subsidies associated with the private-market option.
- **Request For Information (RFI).** This year, OPHP will release an RFI to gather suggestions on how to configure the benefits, define service areas, and other issues. The RFI precedes the formal Request For Proposal (RFP) to select carriers for the plan.

FHIAP Enrollment

In February 2006, FHIAP achieved a record-high enrollment of over 16,700. In October 2005, FHIAP reached budget capacity in the individual market for people who can't get insurance at work. Figure 19 (below) lists the number of FHIAP clients enrolled in each participating plan for the reporting period.

- As of October 17, 2005, FHIAP stopped releasing applications as members were added to the list and sent applications to those in this market only when existing members left the program.
- By the end of 2005, the list had grown to nearly 8,000 individuals waiting to apply for assistance in paying their individual insurance premiums. By the end of the first quarter of 2006, the list had risen to about 17,000, and finally peaked at over 27,200 early in September 2006.
- As a result of available budget capacity, FHIAP released additional individual applications, beginning September 2006, thus decreasing the number waiting for an application.

Figure 19: Monthly FHIAP Enrollment by Participating Plan

The following chart summarizes monthly individual FHIAP enrollment by plan. Group enrollment statistics cannot be broken down by carrier and are not included in this chart. Monthly enrollment statistics are also available on the FHIAP Web site <www.oregon.gov/OPHP/FHIAP/statistics.shtml>.

Month	Health Net	Kaiser	LifeWise	ODS	Pacific Care	Pacific Source	Regence Blue Cross	OMIP	Total
Oct-05	130	956	876	164	300	362	2,874	4,048	9,710
Nov-05	121	943	888	176	277	364	2,925	4,236	9,930
Dec-05	155	988	965	170	284	375	3,029	4,555	10,521
Jan-06	189	1,040	1,045	179	292	402	3,077	4,678	10,902
Feb-06	219	1,082	1,078	174	303	434	3,099	4,729	11,118
Mar-06	343	1,087	1,036	162	278	433	3,077	4,796	11,212
Apr-06	400	1,044	999	164	269	428	2,935	4,605	10,844
May-06	241	1,018	958	145	271	417	2,823	4,460	10,333
Jun-06	236	1,006	926	142	264	401	2,715	4,320	10,010
Jul-06	230	975	868	132	258	379	2,662	4,117	9,621
Aug-06	225	955	854	129	245	361	2,585	3,978	9,332
Sep-06	221	929	829	125	230	352	2,543	3,848	9,077
Average Monthly Enrollment	226	1,002	944	155	273	392	2,862	4,364	**10,218**

Outreach and Training

Focus Shift to Group Market

Upon reaching budget capacity in the individual market, FHIAP's Information, Education and Outreach (IEO) staff shifted their focus to the employer market. Outreach efforts included:

- Personal meetings with Oregon's domestic carrier top executives for help in promoting the use of FHIAP subsidies in the group market through joint marketing efforts.
- Ongoing meetings with individual health insurance producers (agents) to remind them how FHIAP works in the group market.
- News releases, newsletter inserts and e-mails to FHIAP stakeholders announcing immediate openings for group market subsidies.
- Coordination with employers to get the word out and, in some cases, to add FHIAP applications to employer enrollment packets.

Producer Training

IEO staff held 21 classes throughout the state to explain all state health insurance programs, including OHP and CHIP, to newly licensed producers. Producers received continuing education credit for the class.

Training Our Partners

IEO staff provided monthly training on FHIAP to business partners in the Department of Human Services (DHS) Central and Field Offices.

Creating opportunity

FHIAP works with Oregon's private insurance companies, individual health insurance agents, employers, and business partners on joint marketing efforts, information sharing about FHIAP resources, and more.

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