Oregon Health Plan Medicaid Demonstration Project

2001-2002 Annual Report

Oregon

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OMAP Administrative Operations

In order to conform to the federal fiscal year, this report of the Oregon Health Plan Medicaid Demonstration Project will cover the time period from July 1, 2001, through September 30, 2002. Future annual reports will cover twelve months from October through September.

Program and Policy Activities

Prescription Drug Plan

During the 2001 Oregon legislative session, SB 819 created the Practitioner-Managed Prescription Drug Plan (PMPDP). It mandated that the Oregon Health Plan fee-for-service program (open-card) identify the most cost-effective drugs to contain drug cost increases which are expected to be more than 60 percent in the next biennium. OMAP implemented this program Summer 2002.

How was the PMPDP developed?
The Health Resources Commission (HRC) was charged with recommending the most effective drugs from selected classes. The list of effective drugs was created by local experts and by practitioners using standardized evidence-based research methods.

The HRC worked with the Oregon Health & Science University Evidence-based Practice Center to gather and evaluate clinical data. In addition, dossiers were requested from the pharmaceutical manufacturers. All information was evaluated according to established evidence methods and in a public forum. These recommendations were given to the Office of Medical Assistance Programs (OMAP) for pricing. OMAP made cost-effective selections for the list.

The Plan Drug List (PDL) was developed as a tool to identify the most clinically and cost-effective drugs for open-card OHP patients. All drugs on the list will be covered by OMAP.

FDA-approved drugs not on the PDL will be covered only if a notation "medically necessary" or similar language in the prescriber's handwriting accompanies the prescription. The notation may be faxed and filed with the prescription within 30 days. This documentation allows the pharmacist to process and be paid for a drug not on the list. Without this notation, a claim for a drug not on the list will be denied.

Breast and Cervical Cancer Prevention

The Breast and Cervical Cancer Prevention and Treatment Program was implemented in Oregon with an effective date of January 1, 2002. Since that date, 99 women have received OHP coverage for treatment through the program.

Legislation

Also during this reporting period, the Policy Unit has been involved with numerous legislative issues, primarily the review and analysis of proposed legislation affecting the Oregon Health Plan. Due to ongoing budget issues, changes to the Oregon Health Plan benefit packages and coverage levels have been implemented.

Pharmacy Reimbursement Reduced to 86% of Average Wholesale Price

Based on studies that indicate wholesale prices pharmacies pay for prescription drugs ranges is significantly less than the "average wholesale price" for brand name and generic drugs, OMAP implemented a rate reduction to pharmacies September 2002.

Oregon Maximum Allowable Cost

This was implemented per legislative directive by the Department March 2002. It is estimated that this initiative has saved over $16 million in state and federal funds in the last 12-month period.

The Oregon maximum allowable cost, or the maximum amount that the Office of Medical Assistance Programs (OMAP) will reimburse for prescribed drugs, is determined by OMAP's claims processing company, First Health Services. First Health Services determines the maximum allowable cost on selected multiple-source drug designation when a bioequivalent drug product is available from at least two wholesalers serving the State of Oregon.

15 Day Limit on Initial Supply of Chronic Medications

At the direction of the 2001 legislature, the Department implemented this action March 2002. The purpose of this action was to reduce expenditures on chronic medications for initial doses. Unfortunately, no savings resulted from this action due to the fact that the increased quantity of dispensing fees offset the savings. The Department will be re-evaluating this option to determine if savings would result from implementing this on targeted medications only.

Transportation Brokerage

During this fiscal year the Policy Unit continued work with development of new transportation brokerages. A new brokerage, Rogue Valley Brokerage, became operational in September 2001. Development of three additional brokerages throughout the state are planned during the next year.

School Based Health Services Training

May 2002 OMAP conducted five statewide trainings at several locations around the state to train school providers on the school based health services program.

HIPAA

In all OMAP program areas, the Policy Unit continued work on Health Insurance Portability and Accountability Act (HIPAA) changes necessary in both administrative rules and the computer system.

Pharmacy Management Program

On July 1, 2002, the Office of Medical Assistance Programs (OMAP) began the Pharmacy Management program. This programs assigns medical assistance clients to a specific pharmacy for their prescription needs. OMAP anticipates having 60,000 clients enrolled into the program by January 1, 2003.

Hearings

Totals for this reporting period reflect 905 hearing requests received during the period July 2001 through September 2002, with 277 hearings actually held. This was an average of 181 hearings requested and 55 hearings held per quarter, which was a substantial increase from the previous reporting period where the average was 148 requests per quarter and 45 hearings held.

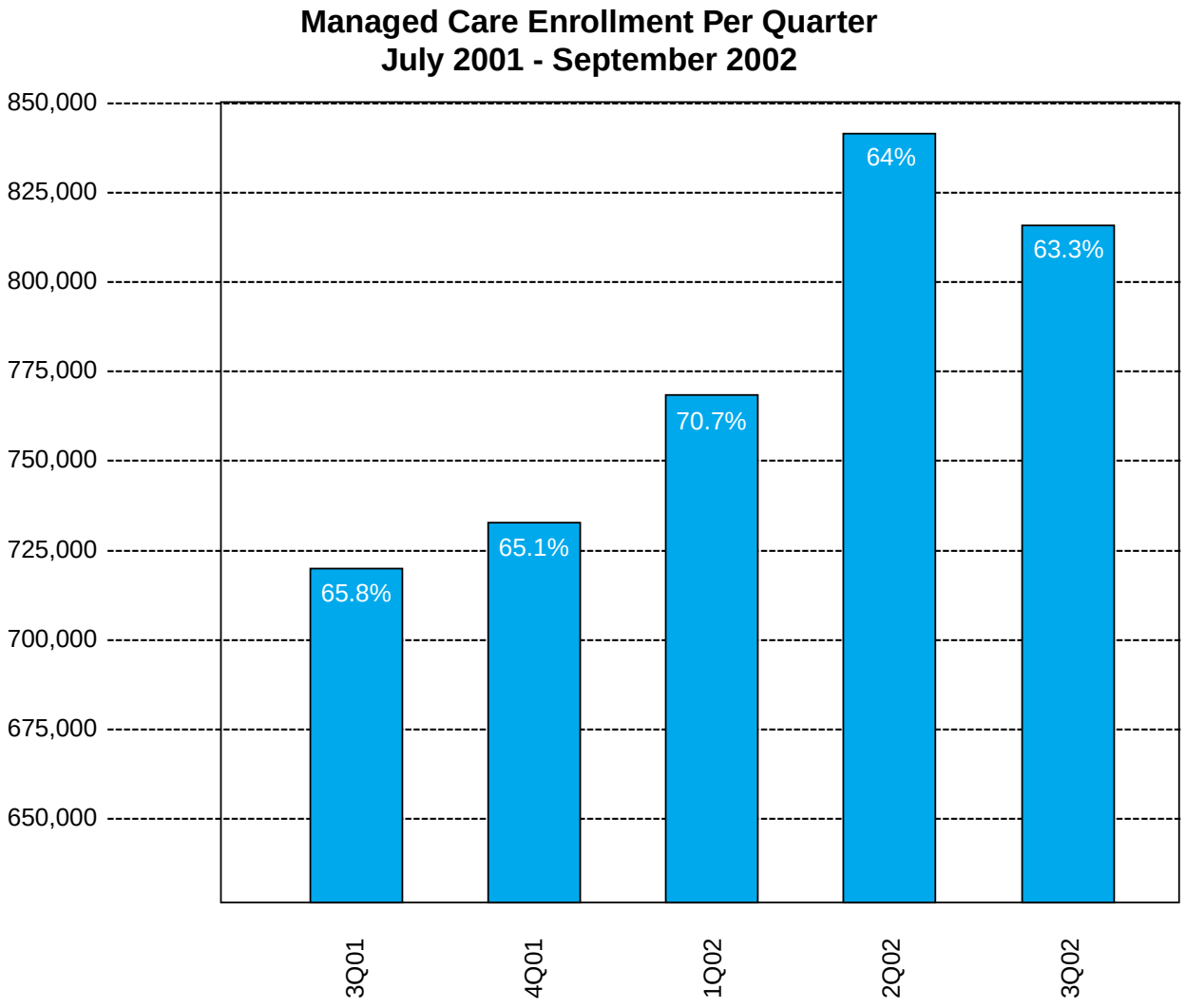
OHP Benefits RN Hotline

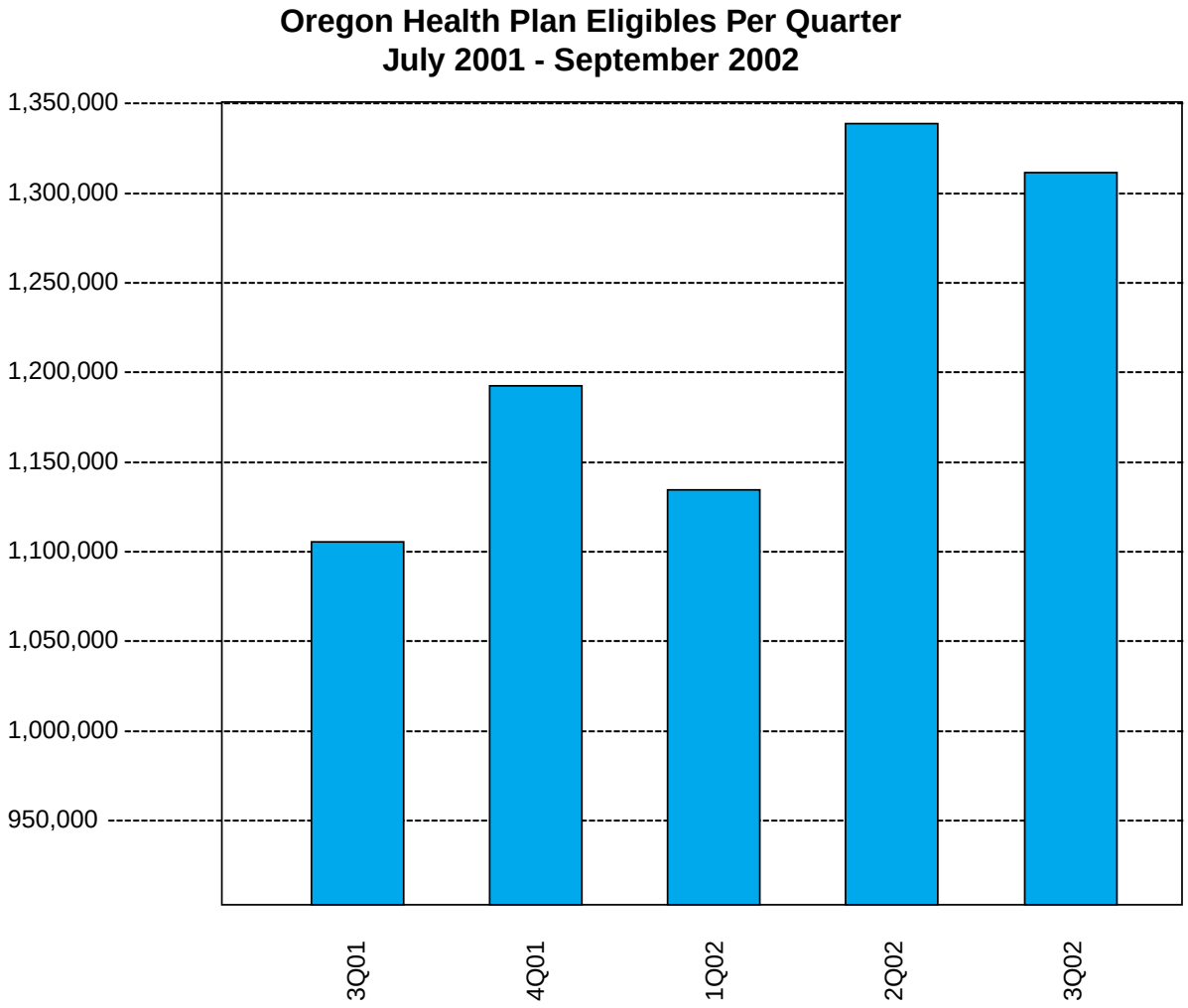
The Oregon Health Plan Benefits RN Hotline received an average of 1,909 calls per month during the period July 2001 through September 2002. This was a 60% increase from the previous fiscal reporting period. Virtually all calls received were from practitioners and the majority were related to placement of conditions and treatments on the Prioritized List of Health Services.

The hotline also received a total of 46 comorbidity requests; 12 were approved, 24 were denied, and 10 were either withdrawn or referred to the patient's managed care plan. There were also 69 requests for payment of not-covered services; 22 were approved, 38 were denied, and 9 were either resolved or referred to the patient's managed care plan.

Eligibles and Enrollment

The following graphs show eligible persons on the Oregon Health Plan each quarter, as well as managed care enrollment percentages, during the period July 2001 through September 2002 (third quarter 2001 through third quarter 2002).





Delivery Systems

Delivery Systems staff continue to work towards assuring access to health care for clients as managed care plans change or depart from coverage areas. Highlights of plan activity during this reporting period are shown below.

Third Quarter 2001

July 3, 2001 - ODS Health Plan closed to new enrollment with no reenrollment period in Malheur County.

July 5, 2001 - Willamette Dental closed to new enrollment with a thirty (30) day reenrollment period in Douglas County.

August 1, 2001 - Family Care reopened to new enrollment in Clackamas and Multnomah Counties.

August 1, 2001 - Managed Dental Care closed to new enrollment with a thirty (30) day reenrollment period in Jackson and Josephine Counties.

September 1, 2001 - ODS Health left Malheur County (8/31/01).

September 10, 2001 - Managed Dental reopened to new enrollment in Josephine and Jackson Counties.

September 15, 2001 - Willamette Dental closed to new enrollment with a thirty (30) day reenrollment period in Linn and Benton Counties.

September 15, 2001 - Willamette Dental closed to new enrollment with a thirty (30) day reenrollment period in Marion and Polk Counties.

September 30, 2001 - Providence Health Plan ceased providing services to OHP clients.

Fourth Quarter 2001

October 15, 2001 - Capitol Dental opened to new enrollment in Lincoln and Tillamook Counties.

November 1, 2001 - Kaiser Permanente closed to new enrollment in Marion/Polk Counties with a thirty (30) day reenrollment period.

November 1, 2001 - Kaiser Permanente opened to new enrollment in Multnomah and Clackamas Counties.

November 5, 2001 - CareOregon closed to new enrollment in Washington County with no reenrollment period.

December 1, 2001 - Oregon Dental Services closed to new enrollment in Lincoln County with a thirty (30) day reenrollment period.

December 13, 2001 - NorthWest Dental Services, LLC closed to new enrollment in Lane County with a ninety (90) day reenrollment period.

December 17, 2001 - CareOregon closed to new enrollment in Clatsop County with a sixty (60) day reenrollment period.

December 31, 2001 - Kaiser Permanente left Washington County. All clients rolled into Fee-for-Service.

First Quarter 2002

January 2, 2002 - Kaiser Permanente terminated its contract for coverage of Washington County.

January 2, 2002 - Providence Health Plan closed to new enrollment in Washington County.

January 2, 2002 - ODS Dental closed to new enrollment in Baker County.

January 11, 2002 - Providence Health Plan closed to new enrollment in Clackamas County.

January 23, 2002 - CareOregon closed to new enrollment in Marion and Polk Counties.

February 19, 2002 - ODS Dental closed to new enrollment in Hood River and Wasco Counties.

March 1, 2002 - ODS Health Plan terminated its contract for coverage of Marion and Polk Counties. ODS Health Plan no longer provides coverage for any OHP clients.

March 1, 2002 - ODS Dental reopened to new enrollment in Crook, Deschutes and Jefferson Counties.

March 21, 2002 - CareOregon reopened to new enrollment in Washington County.

March 21, 2002 - Providence Health Plan reopened to new enrollment in Clackamas County.

March 26, 2002 - ODS Dental closed to new enrollment in Crook, Deschutes and Jefferson Counties.

Second Quarter 2002

April 1, 2002 - Family Care closed to new enrollment in Washington County with no reenrollment period.

April 1, 2002 - Capitol Dental closed to new enrollment in Lane County with a 60-day reenrollment period.

April 1, 2002 - Oregon Dental Service reopened to new enrollment in Umatilla, Tillamook and Yamhill Counties.

April 10, 2002 - Oregon Dental Service closed to new enrollment in Linn/Benton Counties with a 30-day reenrollment period.

April 17, 2002 - Capitol Dental closed to new enrollment in Lincoln and Tillamook Counties with a 60-day reenrollment period.

April 26, 2002 - Tuality Health closed to new enrollment in Washington County with a 30-day reenrollment period.

May 1, 2002 - Providence Health Plan closed to enrollment in Multnomah and Clackamas Counties with a 30-day reenrollment period.

May 2, 2002 - Managed Dental closed to new enrollment in Linn/Benton Counties with a 60-day reenrollment period.

May 5, 2002 - Oregon Dental Service closed to new enrollment in Grant County, with a 60-day reenrollment period.

May 15, 2002 - Oregon Dental Service closed to new enrollment in Umatilla, Tillamook and Yamhill Counties with a 30-day reenrollment period.

May 16, 2002 - Willamette Dental Group opened to new enrollment in Douglas, Marion and Polk Counties.

May 18, 2002 - Kaiser Permanente closed to new enrollment in Multnomah and Clackamas Counties with a 30-day reenrollment period.

June 1, 2002 - CareOregon opened to enrollment in Jackson County.

Third Quarter 2002

July 1, 2002 - ODS Dental reopened to new enrollment in Grant County .

July 3, 2002 - ODS Dental closed to enrollment in Clackamas, Multnomah, and Washington Counties with a (60) day reenrollment period.

July 3, 2002 - ODS Dental closed to enrollment in Jackson/Josephine County with a (60) day reenrollment period

July 3, 2002 - ODS Dental closed to new enrollment in Malheur County with a (60) day reenrollment period.

July 15, 2002 - Providence Health Plan reopened to new enrollment in Washington County.

July 15, 2002 - Tuality Health reopened to new enrollment in Washington County.

August 1, 2002 - Managed Dental Care reopened to new enrollment in Linn and Benton Counties.

September 1, 2002 - Northwest Dental Services reopened to new enrollment in Grant County .

September 1, 2002 - CareOregon reopened to enrollment in Marion and Polk Counties.

September 1, 2002 - Northwest Dental Services closed to new enrollment in Malheur County with a (30) day reenrollment period.

September 15, 2002 - Willamette Dental Group reopened to new enrollment in Linn and Benton Counties.

September 16, 2002 - Providence Health Plan reopened to new enrollment in Multnomah County.

Premiums and Waivers

Beginning with the first quarter 2002, OMAP changed the way in which the premium billing and payment information was reported, reflecting more accurate collections detail.

Premium Waivers July 2001 - September 2002					
Waiver Type	**3Q01**	**4Q01**	**1Q02**	**2Q02**	**3Q02**
Zero Income	8564	9244	10,864	9922	9808
Case Discrepancy*	4282	4302	4611	4263	4759
Crime Victim	35	40	35	44	61
Domestic Violence	546	593	695	666	754
Homeless	1326	1471	1665	1415	1455
Natural Disaster	113	91	134	91	118
Death in Family	23	17	19	21	17
Totals	**14,889**	**15,758**	**17,690**	**16,422**	**16,972**

*Case Discrepancy is primarily used when client has made late payment and the billing office can confirm receipt prior to automated updates by systems.

OHP Monthly Premium Billing and Payments July 2001 - September 2002					
Quarter	**Households**	**Total Billed**	**Monthly Receipts**	**Total Receipts**	**% of Total Billed**
3Q01	205,861	$2,083,431	$867,055	*	*
4Q01	200,069	$2,389,423	$817,029	*	*
1Q02	209,450	$2,543,555	$866,982	*	*
2Q02	253,079	$2,584,779	*	$1,779,248	69%
3Q02	260,809	$2,134,754	*	$1,703,275	67%

* Information not recorded for that quarter.

Service and Information

Telecommunications and Applications

During this reporting period the Telecommunications and Application Center, operated by Inside Oregon Enterprises at Oregon State Correctional Institution, answered over 450,000 calls from medical providers, OHP members and potential members, and the public. Over 200,000 new applications for the Oregon Health Plan were mailed, as well as over 275,000 redeterminations (current members who are reapplying for benefits). Totals per quarter are shown in the chart below.

OMAP Telecommunications and Application Center

July 2001 - September 2002

	3Q01	4Q01	1Q02	2Q02	3Q02	Total
OMAP Telecommunications						
Calls received	31,976	31,712	32,838	33,712	32,725	162,963
Calls answered	28,650	30,689	32,139	30,842	30,816	153,136
Calls abandoned	3,326	1,023	699	2,870	1,909	9,827
Transferred*	19.52%	21.96%	22.44%	17.43%	23.23%	20.9% avg
Avg calls/agent qtr	2,923	2,557	2,325	2,857	3,127	2,758 avg
OHP Application Center						
Calls received	60,036	64,079	71,895	64,632	66,358	327,000
Calls answered	57,304	61,578	66,459	61,417	63,910	310,668
Calls abandoned	2,732	2,501	5,436	3,215	2,448	16,332
Transferred*	5.45%	7.26%	7.64%	7.36%	8.83%	7.3% avg
Avg calls/agent qtr	4,150	3,870	4,197	4,146	3,780	4,029 avg
Applications req'd	39,408	39,512	44,310	42,692	43,072	208,994
Redeterminations mailed	54,869	52,533	56,606	56,605	59,086	279,699

* Some calls are transferred to OMAP Central Provider Services or OHP Central.

Client Advocate Services

During the five quarters from July 1, 2001 through September 30, 2002, the Client Advisory Services Unit (CASU) received a total of 41,783 calls from clients or their representatives.

These calls were distributed over the following categories of issues:

Access to/Denial of Medical Services	6,855
Access to/Denial of Pharmacy Services	2,391
Access to/Denial of Dental Services	1,831
Access to/Denial of Mental Health or Chemical Dependency Care	825
Specific Quality of Care Concerns	589
Client Receipt of Provider Billings	8,392
Other Issues	20,900

Calls in the "Other Issues" category included such items as eligibility or application questions, managed care enrollment or disenrollment requests, address change requests, premium questions, and requests for HIPAA certificates of creditable coverage. CASU also received many calls from recipients of a letter sent by the Social Security Administration to Medicare beneficiaries about possible eligibility for Medicaid benefits. CASU's name and telephone number were included in the letter for recipients to call for information or referral to a local senior services office.

The client's medical delivery system was important in 23,064 calls. Of those calls, 54% were from fee-for-service clients, 44% were from members of managed care plans, and 2% were from PCCM enrollees.

OHP Outreach

Outreach activities during the reporting period included a total of 14 training sessions for contracted OHP Outreach Facilities, as well as quarterly outreach meetings.

Communications

During the third quarter 2002 the Communications Unit was combined with the Senior Pharmacy Programs. One of the programs under this new unit is the Senior Prescription Drug Assistance Program. This non-OHP program will be phased in over a four-month period and will be implemented and administered by OMAP. It is a program for Oregonians age 65 and older authorized by the 2001 Legislature. It will begin February 1, 2003, and could benefit 100,000 seniors. Members of this program will be able to purchase prescription drugs from participating pharmacies at the State Medicaid rate.

The Communications Unit, in conjunction with the Policy Unit, is responsible for much of the administrative process for the notification, filing, and publishing of administrative rule changes for OMAP. During this five quarter period there were many different program changes related to legislative directives, budget rebalance requirements, HIPAA requirements, and the roll-out of the OHP2 expansion. Communications staff ensured that these rule changes were available for each program area, and that these updates were published and distributed appropriately.

Among other activities during the report period, the Communications Unit:

Staff worked with the OMAP Webmaster to develop a new website section on Administrative Rules. This new page contains Notification of Rulemaking or Rulemaking Hearing documents. Visitors to the site can click on the program links to see a summary of proposed rule changes:

www.dhs.state.or.us/policy/healthplan/rules/

Staff made a training presentation covering client alternate format materials to members of the OMAP Program and Policy Section. This training included how to identify the need for an alternate format as well as specific procedures needing to be followed for each format type.

An informational newsletter regarding the Health Insurance Portability Accountability Act (HIPAA) was developed by Communications and distributed to OMAP Staff during the fourth quarter 2001.

Staff developed and distributed numerous client informational notices advising OHP Members of upcoming changes to the OHP including copayment and premium requirements, and changes to the benefit packages. OMAP Medical Providers were also notified of these revisions to policy and procedure.

Notices were sent to prescribing providers advising of recent policy changes in the area of pharmacy services. These included a notice regarding the legislative directive requiring notations on prescriptions for excluded or below-the-line services and a notice clarifying the intent of the Practitioner Managed Prescription Drug Plan.

System and Encounter Data

Rate Setting FTP Site

During the latter part of 2001 and the first quarter 2002 OMAP collected and compiled two years of encounter data for OMAP's actuary for the development of capitation rates for contract year 2003-2005. OMAP's managed care plans, comprised of health, mental, dental and chemical dependency contractors, were granted access to this secure FTP site. OMAP provided plans with a variety of reports that identify by rate category which encounters will be used for rates. One example included the number of emergency room visits. These reports are helpful to plans in determining the accuracy and completeness of the data submitted. The reports included comparisons to other plans. The site, updated monthly, contained cleansed, usable data to be used for rate setting. With password access, managed care plans were able to access their specific encounter data for analysis at their convenience. OMAP staff assisted plans in resolving submissions problems and missing data prior to sending the data to the actuary. Eleven managed care plans voluntarily submitted pharmacy data for rate development. OMAP will require mandatory submission of pharmacy encounter data by contract in October 2002.

By the third quarter 2002 the FTP site contained one rolling year of date for contractors' use and analysis.

HIPAA

During this reporting period OMAP began conducting regular workgroup sessions with managed care plans, third party submitters and vendors to review HIPAA standards and share information. Staff participated in statewide HIPAA forums to gather and share information. OMAP staff and plan representatives also participate in HIPAA sponsored teleconferences to address outstanding issues and general problem solving.

New Systems

At the end of 2001 OMAP staff participated in the planning and joint application development for a new MMIS and a decision support system. The decision support system will contain a SURS component and will enhance OMAP's ability to monitor encounter data. The new MMIS will have features that will make it easier for plans to submit and correct encounter claims, and will give OMAP staff better encounter data reporting.

Training

Staff provided group training sessions and discussed relevant submission issues with the managed care plans at the monthly Encounter Data Workgroup meetings.

Monitoring and Research

Project: **PREVENTION!**

The Project: **PREVENTION!** Task Force has continued to meet during this reporting period with primary focus on tobacco cessation for OHP smokers and the Early Childhood Cavities Prevention (ECCP) project. They have also addressed other prevention topics including immunizations and models of chronic disease management.

Early in 2002 the task force began focus on the initiation of a second statewide tobacco cessation campaign and the development of an OHP Tobacco Cessation 2002 Workplan. The plan included three goals: outreach to clients and providers to raise awareness of the OHP tobacco cessation benefit and the availability of services through the Oregon Quit Line; sharing best practices to decrease variability among plans in access and provision of cessation services; and targeting tobacco cessation services specifically to OHP women, pregnant women, and clients with chronic disease (asthma, diabetes, COPD, and cardiovascular disease).

The ECCP Steering Committee, a subcommittee of Project: **PREVENTION!**, continued to meet quarterly during this reporting period. Statewide ECCP medical and dental provider trainings were held throughout the state and were well received. Five thousand copies of the ECCP Guidelines were printed and distributed. The Steering Committee continues work on developing other opportunities to educate the public and providers about ECCP.

Survey

The Consumer Assessment of Health Plan Survey (CAHPS) was originally initiated in May with vendor selection and contract negotiations following. The survey was fielded August 2001, with preliminary results completed in fall 2001. One additional health plan's CAHPS began in the first quarter 2002, and data was completed in the second quarter 2002.

Quality Improvement Evaluations

During this reporting period, Quality Improvement Evaluations focused on education, community partnerships, prevention, and compliance with OHP administrative rules and contracts, with an emphasis on services for OHP members who are disabled, over the age of 65 or in the care of Children, Adults, and Families (formerly State Office for Services to Children and Families) or the Oregon Youth Authority. OMAP's Evaluation Team conducted on-site reviews for a total of 13 managed health care and dental plans.

Performance Measures

During the latter part of 2001 OMAP staff continued to work on performance measures drawn from OMAP encounter/administrative data utilizing the Health Plan Employer Data and Information Set (HEDIS®) performance measurements developed by the National Committee on Quality Assurance (NCQA). Technical assistance was provided to plans by External Quality Review, Permedion and OMAP staff. The final HEDIS® 2000 Performance Measure Report for OMAP was completed in the fourth quarter. In this report measures are compared by :

- Individual Plans
- Primary Care Case Management
- Fee-for-Service Providers
- National Averages
- State and Federal Goals

Medicaid Audit

During this reporting period, July 2001 through September 2002, the Audit Team conducted 271 audit screenings and collected a total of $2,962,725. Totals for each quarter are shown in the chart below.

Medicaid Audit July 2001 - September 2002					
Quarter	3Q01	4Q01	1Q02	2Q02	3Q02
# of Audits	54	129	59	16	13
$ Collected	$114,488	$100,575	$1,003,296	$809,262	$935,104

Health Services Commission

The Health Services Commission (HSC) met 12 times between July 2001 and September 2002. Key issues addressed during this period are summarized below.

During the third quarter 2001, the Commission incorporated the new ICD-9-CM codes into the Prioritized List of Health Services and adopted the changes incorporating additional appropriate indications for transplantation recommended by the Health Outcomes Subcommittee. The Commission also continued in their work to prioritize benefits for the new OHP Standard benefit package called for with the passage of House Bill 2519. As part of this process, they held a series of nine community forums around the state, as well as over 40 stakeholder meetings.

The Commission completed their charge under House Bill 2519 to create a prioritized list of benefit packages for the new OHP Standard benefit plan. The report was finished by November 1, 2001, as required and delivered to the Waiver Application Steering Committee, the co-chairs of the Emergency Board, and the Leadership Commission on Health Care Costs and Trends. In December 2001, the HSC met to discuss the rejection of the cost-sharing levels included in the OHP Standard Prioritized List of Benefit Packages and to hear strategies on developing a revised list to be used as a tool for establishing benefits for the 2001-03 biennium. Additionally, the Commission discussed a more medically-oriented approach which would allow mitigation of the cost-sharing levels or provide mechanisms for further benefit reductions for future biennia. In addition to using the broad categories of services (e.g. dental, mental health and chemical dependency) reflected in the work done to date, this approach would examine specific services within these broad categories to be identified for potential elimination or tighter management where appropriate.

At their January 2001 meeting the HSC approved changes to the Prioritized List of Health Services to incorporate the new CPT and HCPCS codes for 2002 and to add appropriate pairings of condition and treatment codes that had not been accounted for previously. The Commission heard a report on the benefit package approved by the Waiver Application Steering Committee and reaffirmed their ranking of benefit categories appearing in the October 2001 report on priorities for the OHP Standard benefit package. The Commission also continued their work to identify services for potential elimination or tighter management that could be used to mitigate cost-sharing in OHP Standard or result in further cost savings to the plan.

In April 2002 the Commission continued their work to identify services for potential elimination or tighter management that could be used to achieve savings under OHP2. At this meeting the Commission accepted the recommendations of the Subcommittee on Mental Health Care and Chemical Dependency to expand managed care for chemical dependency services, include coverage for subacute detoxification, exclude certain mental health services from fee-for-service coverage, and restrict coverage for benzodiazepines and other drugs.

At its meeting in May 2002, the Emergency Board directed the Commission to review and modify the Prioritized List of Health Services in working towards a goal of achieving a 10% savings to both the OHP Plus and OHP Standard benefit packages. Because this charge requires benefit changes that would affect the entire OHP population, the Commission shifted their focus from incorporating changes only to the Prioritized List of Benefit Packages for OHP Standard, to making these same or similar changes to the Prioritized List of Health Services.

At their June 2002 meeting the HSC voted on the new Prioritized List of Health Services for the 2003-05 biennium. The Commission found that the majority of those changes initially being considered for OHP Standard were also appropriate for OHP Plus and will therefore appear in this new list. All, or a significant portion, of seven lines were moved from the currently funded region to the currently non-funded region, including the treatment of severe rhinitis and uncomplicated hernias in adults. In addition, many other lines were moved down to the region just above the current funding level, which should facilitate the federal approval of future funding line changes should they be necessary.

In June 2002 the Commission submitted their report on the Prioritized List of Benefit Packages for OHP Standard for the 2003-05 biennium as required by HB 2519. Final actuarial pricing for this list will be reported when it is available. Pricing was not done at this time as the terms and conditions negotiated with CMS could necessitate additional modifications.

In July 2002 the Commission held a one-hour conference call to finalize the Prioritized List of Health Services for the 2003-05 biennium. As the actuaries would not be needing the finished list until later that month, the Commission took the opportunity to incorporate more previously non-paired ICD-9-CM and CPT-4 codes, the new ICD-9-CM codes to go into effect in October 2002, and made some additional minor changes. All changes made during the biennial review process, along with the priced Prioritized List, will appear in the Commission's biennial report to the Governor and Legislature in early 2003.

At their September 2002 meeting the Commission approved recommendations from the Health Outcomes Subcommittee on interim changes to the list. They also displayed an interest in using an evidence-based review process similar to that being used by the Health Resources Commission in developing the preferred drug list for the Practitioner Managed Prescription Drug Plan. If implemented, such a process would look at condition-treatment pairs that are near the funding line that exhibit high utilization, high cost, and high practice variation and where it is felt that evidence exists as to the effectiveness of treatment in question.

Health Outcomes Subcommittee

The Health Outcomes Subcommittee convened 7 times during the reporting period.

During the third quarter 2001 the Subcommittee began planning for the upcoming biennial review of the Prioritized List of Health Services. This year they decided to ask provider reviewers broader questions on their views of the prioritized list. The list has now undergone four biennial reviews which asked for specific comments on the placement of medical codes representing conditions and treatments. In recent years this process has resulted in fewer suggestions that have been incorporated into the list, thus the decision to move forward in a different manner. The Subcommittee also completed their review of the codes that do not appear on the prioritized list, giving OMAP an indication of the Commission's intention for those codes, which was then communicated to the contracted health plans.

During the fourth quarter 2001 the Subcommittee began identifying recommended lines for the placement of the new CPT codes for 2002. Testimony was heard on the cost-effectiveness of baclofen therapy for the treatment of spasticity. The Subcommittee also continued planning for the upcoming biennial review of the Prioritized List of Health Services.

During the first quarter 2002 the Subcommittee finalized their recommendations on changes to the Prioritized List necessitated by new CPT and HCPCS codes. They also developed recommendations on the addition of many CPT codes to lines in order to pair them with appropriate ICD-9-CM codes. The need for these changes came to light through reports from OMAP on claims that were pending due to the non-pairing of these codes. The Subcommittee also continued to be kept apprised of the responses that staff were receiving from provider reviewers regarding the biennial review of the list.

During the second quarter 2002 the Subcommittee continued their work on developing a set of recommended changes to the Prioritized List as part of the biennial review process. These recommendations were finalized and accepted by the full Commission. Of note was a new line item for the use of intestine and intestine/liver transplants for the treatment of short gut syndrome in young children. The Subcommittee also began working on changes to the Prioritized List to incorporate the new ICD-9-CM codes for 2002 and continued to look at appropriate pairings of condition and treatment codes that had not previously been accounted for.

During the third quarter 2002 the Subcommittee continued incorporating pairings of ICD-9-CM and CPT-4 codes identified through OMAP's claims processing, where appropriate. The Subcommittee also recommended a coding change to the breast cancer line to allow for the billing of post-mastectomy breast reconstruction after a significant period of time has elapsed since the original surgery. They also reviewed the placement of irritable bowel syndrome (IBS) and atopic dermatitis based on the availability of new drugs for treatment. Neither drug, Zelnorm for IBS or Tacrolimus for atopic dermatitis,

showed an increase in the cost-effectiveness of treatment to warrant movement of these conditions to higher line items. The Subcommittee also approved a guideline to be associated with line 335 for the recently added treatment of intrathecal baclofen therapy for severe spasticity.

Mental Health and Chemical Dependency Subcommittee

Early in 2002 the Mental Health Care and Chemical Dependency Subcommittee looked at potential mental health and chemical dependency services to eliminate or further manage as part of the Commission's work on OHP Standard. To accomplish this work, the Subcommittee created four workgroups on chemical dependency management, subacute detoxification, mental health lines, and benzodiazapines. Final reports from the first two of these workgroups were accepted for recommendation to the Commission. The first of these recommendations called for the expansion of managed care for chemical dependency to those areas of the state for which none currently exists. The second recommendation suggested that savings can be achieved by moving detoxification from an inpatient setting to a less expensive and often more effective, subacute setting. The Subcommittee also began an in-depth review of the effectiveness of acupuncture in the treatment of chemical dependency.

Later in the year the Subcommittee completed their work on identifying potential mental health and chemical dependency services to eliminate or further manage as part of the Commission's work on OHP Standard. Final reports from the workgroups on mental health lines and benzodiazepines were accepted for recommendation to the Commission. The first of these recommendations called for the elimination of coverage for psychotherapy sessions over an hour in length, acupuncture for the treatment of mental health conditions, and certain other mental health services under fee-for-service care. The second recommendation included shifting coverage of benzodiazepines to generic form only and limiting coverage for sleeping medications and muscle relaxants. The Subcommittee also concluded an in-depth review of the effectiveness of acupuncture in the treatment of chemical dependency, including taking over an hour of public testimony. The unanimous recommendation to the full Commission was that acupuncture continue to be covered for the treatment of chemical dependency as part of a broad spectrum of services.

Workgroup on Public Outreach

The Workgroup held one meeting during this period in which they finalized the presentation materials and the small group exercises that were used in community forums and stakeholder meetings.

Mental Health Services

Policy and Planning

Policy issues of note for the Office of Mental Health and Addiction Services (OMHAS) during the period July 2001 through September 2002 included:

Post Acute Intermediate Treatment Pilot Project - The intent of this non-OHP Medicaid project is to provide post acute treatment services to an adult who has been approved for long term psychiatric treatment, as an alternative to state hospital admission, or as a transition from the state hospital to other community settings. These services will be provided in an intensively staffed 24-hour non-hospital facility approved as a Secure Residential Treatment facility. Persons approved for this project must be clinically appropriate for this level of care and are approved for a specified length of stay of up to 90 days.

Community Based Secure Children's Inpatient Program - OMHAS developed a community based program to provide intensive psychiatric treatment services for children 13 years old and under who meet the criteria for long term care at the Oregon State Hospital. The contract was awarded to Trillium Family Services. Trillium Family Services has a long history of providing high quality psychiatric residential treatment services in Oregon. This program was previously a Behavioral Rehabilitation Services program, providing residential services for children in the care and custody of child welfare. This conversion utilizes funding previously used to finance 22 residential BRS slots. On January 1, 2002 the young child unit at the Oregon State Hospital closed. The new configuration of this program will be the capacity to treat 12 children in psychiatric residential treatment and 20 children in treatment foster care. This change will better address the psychiatric and community placement needs of young children in the care and custody of child welfare.

Dual Diagnosis Implementation Plan - Staff continue to work on the implementation of recommendations from the Dual Diagnosis Task Force. The following issues were identified as the next steps:

- resolution of billing problems for persons served in both mental health and chemical dependency treatment services
- development of standards for dual diagnosis capable and enhanced programs
- development of a strategy for culturally competent services
- facilitate the development of a statewide conference focused on dual diagnosis services for youth

Targeted Case Management Request for Proposals - OMHAS and OMAP released a Request for Proposal (RFP) to implement a one-year pilot program for the case management of OHP Members who are prescribed anti-depressants and anti-psychotics. Three proposals were awarded contracts:

- ABHA/COIHS/GOBHI
- CareOregon/Multnomah Verity/Clackamas MHO
- LaneCare/LIPA

All three proposals demonstrated coordinated and collaborative efforts between a FCHP and one or more MHOs.

Integrated Mental Health and Chemical Dependency Services Behavioral Health Pilot Project Request for Information - OMHAS and OMAP released a Request for Information for a MHO to develop an integrated approach for the delivery of mental health and chemical dependency treatment services for OHP Members. One proposal was received and while fairly comprehensive, several areas of concern were identified. Due to these concerns and other operational considerations, OMHAS and OMAP decided not to proceed with a behavioral health pilot project at this time.

Local Mental Health Planning Process - HB 3024, passed by the 2001 Legislative Assembly in response to recommendations from the Governor's Mental Health Alignment Work Group, represents a major step forward in improved planning for mental health services in Oregon for all age groups. After input from a Guidelines Planning Workgroup, which had representation from the Association of Oregon Counties, community mental health directors, and other local key stakeholders, a document outlining key features for the first round of plans was released on November 2, 2001. Focus areas to be addressed in the local plans include: Consumer-centered community based services, consumer-centered intensive services, suicide prevention, and juvenile and adult corrections.

Oregon Children's Plan (OCP) - Legislatively mandated through HB 3659, the Oregon Children's Plan provides for a systematic and voluntary medical and psychosocial screening for children and their families for the earliest possible identification and treatment of possible problems. Mental health services for children eight years and under and their families are an essential component of the OCP. Early childhood mental health interventions will help reduce risk factors, enhance protective factors, and support young children and their families in achieving optimal levels of development and functioning. Beginning in January 2002, mental health and addiction services in the OCP began in selected counties: Clackamas, Lane, Jackson and Mid Columbia (Wasco, Hood River, Sherman and Gilliam). The selected counties were identified as having early childhood mental health capacity, women specific alcohol and drug services, and an active Healthy Start component. Phase II counties: Umatilla, Linn, Douglas, Marion, Polk and Deschutes, will begin after March 1, with the remaining counties added by June 30, 2002.

An ad-hoc workgroup from the Health Services Commission Mental Health and Chemical Dependency Subcommittee met to discuss the development of guidelines for the delivery of mental health services under the OHP that would reduce cost without compromising quality of care. The workgroup initially focused on five diagnostic categories from the OHP Prioritized List of Conditions and Treatment where it felt that significant cost savings could be achieved through management strategies, such as establishing limits for certain procedures or the case management of clients with anxiety disorders and co-occurring chemical dependency diagnoses who are prescribed anxiolytics.

During a site visit to Warm Springs Community Mental Health Center a need was identified by OMHAS staff to collaborate on assisting the tribe to find culturally competent intensive psychiatric residential and other treatment services. The tribe is currently providing cross training to a residential treatment provider to ensure culturally competent and sensitive services for their tribal members.

OMHAS staff developed a Request for Proposals for mental health evaluation services to the approximately 40 nursing facilities in Multnomah County. This RFP will re-establish a contractor for Preadmission Screening and Resident Review (PASRR) services in Multnomah County.

OMHAS announced the availability of a limited amount of mental health housing renovation funds. These funds are available to help finance improvements to meet code, licensing or sanitation requirements in housing for persons with severe and persistent mental illness. Projects must be completed by June 30, 2003.

OMHAS continues to work with county mental health programs to allocate funds designated by the 2001 Legislative Assembly for the development of community-based alternatives to institutional treatment for children. Funding will be on a child-by-child basis, with children identified and approved using criteria authorized by OMHAS. A workgroup comprised of state and local partners has been formed to advise and assist in the development of criteria and processes to be used in allocating funds.

OMHAS is in the process of development of a "Logic Model" to be used as a method and structure for setting goals and objectives with achievable outcomes for mental health treatment. The proposed model is expected to provide a closer linkage between investment and outcomes, will tie in with the Oregon Progress Board performance indicators and provide useful information for budget documents. Indicators to be measured include: percent of consumers admitted to community based services in a timely manner following discharge from more intense care; percent of consumers readmitted to care at a more intense level within 30 days; and average length of time between acute care episodes. Some efficiency measures will include average cost per client; and timeliness, accuracy and completeness of data.

OMHAS is working with a legislative workgroup to develop a bill to create a youth Psychiatric Security Review Board. The intent of this legislative concept is to give youth with

mental illness who commit a crime the ability to plead an insanity defense and, therefore, the ability to receive appropriate mental health treatment services.

Dartmouth College in New Hampshire is conducting a study of evidence-based practices in six states; Oregon has been selected as one of the states. Three dual diagnosis projects and three supported employment projects will be part of the study. Four counties (Douglas, Polk, Josephine, and Union) will be pilot sites for this study.

Benefit Package

During this reporting period the MHO Clinical Outcomes Workgroup was initiated to identify clinical measures and methodologies that can be useful to MHOs in improving services provided to members. In addition to current outcome measurements, the workgroup is proposing a statewide focus in one key outcome area that would be specific and relevant to a large population. The workgroup will also try to identify a population based outcome measure that is a reliable and valid indicator of MHO service delivery.

Contract changes to the 2001-2002 MHO Agreement effective October 1, 2001 include the following:

- OMHAS shall be responsible for the cost of services for managed care clients who have been accepted for long-term care but remain in local inpatient acute care settings waiting for transfer to a state facility.
- MHOs shall have written policies and procedures for processing service authorization requests.
- MHOs shall provide information in alternative formats and in the languages prevalent in their service delivery area.
- MHOs shall develop and implement policies and procedures to meet the provisions of the HIPAA Administrative Simplification Act and Privacy standards.
- Revision of the MHO Practitioner Report and MHO Complaint Log to improve data collection.

The OHP Integration Workgroup is a collaboration of OHP contractors which seeks to define the responsibilities and improve the coordination of care between historically separate systems of care: medical, mental health, and chemical dependency. The group serves in an advisory role and has worked towards the development of mutually agreeable solutions to help clarify the roles and expectations of these systems. The group produced a document that outlines a process to further improve the coordination of care between mental health and physical health care systems for inpatient hospital admissions for clients presenting with mental health and/or chemical dependency diagnoses.

Future discussion items will include chronic disease, chronic pain and chemical dependency, eating disorders, clients who are high utilizers of services, improved coordination with dental care providers and coordination strategies for shared responsibilities between mental health and chemical dependency.

The MHO Rates and Finance Workgroup had focused discussions about the 2003-05 per capita cost development process for OHP capitation rates. Encounter data submitted for dates of services from July 1999 through June 2001 were used for this rate setting process. A report of the analysis of the data used for this process was received from the actuaries for review by the MHOs. Members of the group agreed that a significant amount of time should be spent in future meetings to evaluate the information that is reported on financial reports required in the MHO agreement.

The MHO Quality Assurance/Quality Improvement Workgroup tried to identify areas of collaboration between medical, dental, and behavioral health systems. Improved communication between these systems will help in the provision of more "seamless" services to OHP clients. Future meetings of this group will focus on identifying the interests and training needs for staff in order to develop a workplan for the group for the next fiscal year.

MHOs participated in discussions on how they could work together with providers to eliminate any barriers to treatment that may be inadvertently caused by copayments. Copayments for pharmacy and ambulatory services are being proposed for OHP fee-for-service clients beginning in January. OHP2 will also include copayments for the Standard Benefit Package and will apply to all the non-categorical eligibles (expansion population).

MHOs have requested written clarification from OMHAS regarding the circumstances under which telephonic services are allowed. An analysis of the question will be initiated with the purpose of developing a formal policy and procedure that is consistent with federal guidelines.

Activities and Training

During this fiscal year, Mental Health Services was involved in a variety of training and related activities. These included:

OHP Statewide Quality Improvement Committee Meeting - MHOs Quality Assurance coordinators and FCHP Exceptional Needs Care Coordinators participated in the OHP Statewide Quality Improvement Committee meeting held in Salem on October 23, 2001. The focus was on youth depression and suicide prevention. Speakers included Robert McKelvey, MD/OHSU Professor and Director of Child/Adolescent Psychiatry, Ron Bloodworth, MA/Oregon Health Division, and Gary McConahay, PhD/Josephine County Mental Health.

Enhancing Core Competency: Tools for Success - OMHAS sponsored a workshop to address the findings of the most recent clinical chart audit completed by OMPRO. Topics of discussion included: Engaging consumers in strengths based assessment and treatment, Skill building, application of the revised ASAM criteria, and Case management.

Pre-commitment Investigator/Examiner Training was held in Newport on February 14 and 15, 2002. These trainings are held for the purpose of certifying persons to perform civil commitment hearings and investigations as mandated under ORS 426. Approximately 7,000 pre-commitment investigations are conducted annually, resulting in approximately 1,100 civil commitment hearings and approximately 1,000 commitment orders per year.

Approximately 70 participants attended the Oregon Children's Plan conference on January 9, 2002. Participants included legislators, state and county officials, state partners, and staff from community mental health programs. The mental health and chemical dependency component of the OCP was discussed in two of the breakout sessions.

OMHAS staff provided training for the 20-hour monthly Personal Care Services Program. This program is designed to assist families to maintain family members with psychiatric disabilities at home and receive support through an array of community wraparound services.

OMHAS staff and OMPRO conducted a three hour training and discussion forum for psychiatric residential treatment programs and Oregon State Hospital focused on the process of admission, continued stay, and discharge clinical chart audits. The role performed by OMPRO and the MHOs in utilization authorization and review of children involved in the Intensive Treatment Services (ITS) Pilot Project was also discussed.

OMHAS staff provided an overview of Oregon's children's mental health system to internal staff. The overview included national and local policy and practices.

Oregon Family Support Network (OFSN) received funding from OHMAS to provide family advocacy training to family members and providers. OFSN completed a project to promote family, or other child representative, participation on MHO advisory committees.

OMHAS and Services for People with Disabilities Central Office staff worked collaboratively to develop and present a training for SPD screeners from around the state and local mental health staff on how to determine service eligibility for individuals with both medical and psychiatric needs.

A workshop on early childhood mental health was held in Portland in September. A workshop on Integrated Approaches for Youth and Families with Co-Occurring Disorders was held in Portland on October 2-3, 2002.

The Oregon Association of Child and Adolescents Psychiatrists and the Oregon Psychiatric Association hosted the 2nd Annual Child Mental Health Forum on October 11, 2002. The focus was on prevention and response to violence on kids throughout their life cycle.

Monitoring and Evaluation

During the third quarter 2001 the OMHAS Quality Improvement Coordinator conducted an informal visit to each MHO with the purpose of gathering information on the structure of each MHO and to provide technical assistance around QI activities.

DHS Auditing & Consulting Services completed an audit of MHO encounter data submissions with a report to the MHOs dated March 4, 2002. The purpose of the audit was to analyze the data for completeness and accuracy. Auditors visited all contracted MHOs, including 104 providers that provided mental health services to OHP clients during the October 1999 through September 2000 contract year. MHOs continue to work with the information provided by the Encounter Data Audit performed by the DHS Auditing & Consulting Services Unit. MHOs will work with their provider system to make improvements to the encounter data submissions.

The MHO Quality Improvement Workgroup continued review of the most recent Performance Indicators Project report and discussed methods to encourage MHOs to use the information provided in this report. In addition, the workgroup discussed the current contract requirements for outcome measures.

An ad-hoc workgroup was formed to identify clinical outcome measures that can be effectively and reliably used across the widest range of populations served by the MHOs. The Outcomes Workgroup recommended the following:

- Have multiple MHO approaches feed in to a statewide reporting system under the umbrella of a single state-wide standard for conducting outcome measures;
- In addition to current outcome measurement studies, for a period of two years all MHOs study one common question;
- Explore the possibility of population based measures that are a reliable and valid measure indicator of MHO service delivery; and
- Discontinue the use of MCAS and CPMS as an outcome measurement tool and CPMS as an outcome measurement system.

In an effort to explore the positive outcomes of case management services, OMHAS Applied Research and Evaluation workgroup examined the relationship between case management services and the rates of civil commitment. The development of case management is in its early stages for many programs in Oregon with regulatory requirements implemented in 2001. As training and experience increase across the state, OMHAS will watch for improved outcomes related to case management services. A series of papers will be produced over the next year about different aspects of the mental health system in Oregon. The first paper explores the current and potential relationship between case management services and civil commitment.

DHS Office of Rate Setting and OMHAS engaged in a study of the rates for child and adolescent psychiatric day treatment programs. The study included an evaluation of financial information from each program as well as a site visit to five programs.

DHS Office of Rates and Financing is in the process of analyzing MHO financial data at the request of the Legislative Fiscal Office. Quarterly financial summaries will be provided to the LFO that will help the LFO understand the variations across MHOs. These quarterly summaries will also be shared with the MHOs.

During the Legislative Assembly's special session, concerns were expressed related to several MHOs reserve levels. Some reserve level is appropriate to cover an organization's risk during times when costs exceed capitated payment revenue. Given the concerns about reserve levels, the following budget note was adopted:

> DHS is directed to review financial reports for MHOs receiving OHP payments and report its findings to the September meeting of the Emergency Board. The report is to include an examination of variations in the rates of expenditures by MHOs and subcontractor county programs as well as variations in accumulated MHO financial reserves. DHS shall recommend administrative actions needed to reduce reserves to reasonable levels necessary to manage financial risk, assure that future capitation rates reflect appropriate service costs and utilization, and perform ongoing financial and service quality monitoring of mental health providers under the OHP.

The MHO Rates and Finance Workgroup will focus on reviewing the financial reporting requirements of the MHO Agreement. It became apparent after some initial discussions that MHOs are not interpreting the requirements in the same way resulting in inconsistency in the data submitted. The workgroup will also discuss the issue of "reasonable reserves" and how this will be determined.

OMHAS received information that MHOs were using facilities for crisis respite or subacute services that were not certified or licensed for that level of care. MHOs providing alternatives to inpatient care must verify that providers are appropriately credentialed for the level of care provided. OMHAS has compiled a list of facilities that have been licensed or certified to provide respite care.

OMHAS staff worked with a contracted professional review organization, OMPRO, on the development of a utilization management process to assure appropriate utilization and quality of intensive treatment services provided in child and adolescent psychiatric residential programs.

OMHAS entered into a data sharing agreement with the Oregon Youth Authority to evaluate adolescents who are served in both the mental health and youth corrections systems. The initial project will look at recidivists in the youth correction system and youth accessing mental health services to compare whether there is a different recidivism rate for those who receive mental health services.