Oregon Health Plan Medicaid Demonstration Project

2002-2003 Annual Report

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Contents

OMAP Administrative Operations

This report of the Oregon Health Plan Medicaid Demonstration Project covers the time period from October 1, 2002, through September 30, 2003.

Program and Policy Activities

OHP Expansion, Education and Training

Office of Medical Assistance Programs (OMAP) developed education plans and documents about the expansion of the Oregon Health Plan (OHP) for different audiences. These were released in late November/early December 2002. Staff also developed numerous sets of frequently asked questions (FAQs) related to the OHP changes for providers, clients, and the general public for posting on the Department of Human Services (DHS) Web site.

DHS clusters, including OMAP, Children, Adults and Families (CAF), and Seniors and People with Disabilities (SPD), as well as the Family Health Insurance Assistance Program (FHIAP) worked collaboratively to organize comprehensive day-long trainings for over 1600 DHS field staff. Staff also provided training to over 200 outreach workers at outreach centers throughout the state.

Standard Benefit Package Reductions

During this fiscal year, policy staff were involved with coordination of Standard Benefit Package reductions due to ongoing budget shortfall issues. OMAP implemented changes to the Oregon Health Plan benefit packages and coverage levels including elimination of coverage of durable medical equipment and supplies, dental services, outpatient chemical dependency services and outpatient mental health services. Pharmacy benefits were eliminated March 1, 2003, and then restored mid-March.

Transportation Brokerage

Policy staff continued work with development of new transportation brokerages. A new brokerage, Trip Link, became operational in spring 2003, providing medical transportation services to Marion, Polk and Yamhill counties. OMAP plans to develop additional brokerages throughout the state during the next year.

School Based Health Services Training

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

HIPAA

Policy staff worked on coordination and implementation of DHS HIPAA privacy policies, transaction and data code set changes, and related staff training.

State Plan Amendments

Policy staff worked on submission and monitoring of several State Plan amendments in the following areas: changes in hospital payment methodologies, increase in drug reimbursement rates for institutional pharmacy, decrease in reimbursement rate for retail pharmacy, and elimination of coverage of clients in the Medically Needy program.

Senate Bill 5548

OMAP coordinated and implemented the restoration of pharmacy benefits for certain clients previously covered under the state funded Medically Needy program. Following the elimination of the Medically Needy program, the state legislature passed Senate Bill 5548, which restored limited pharmacy benefits to clients "to support organ transplants and remediate HIV positive symptoms."

Hearings

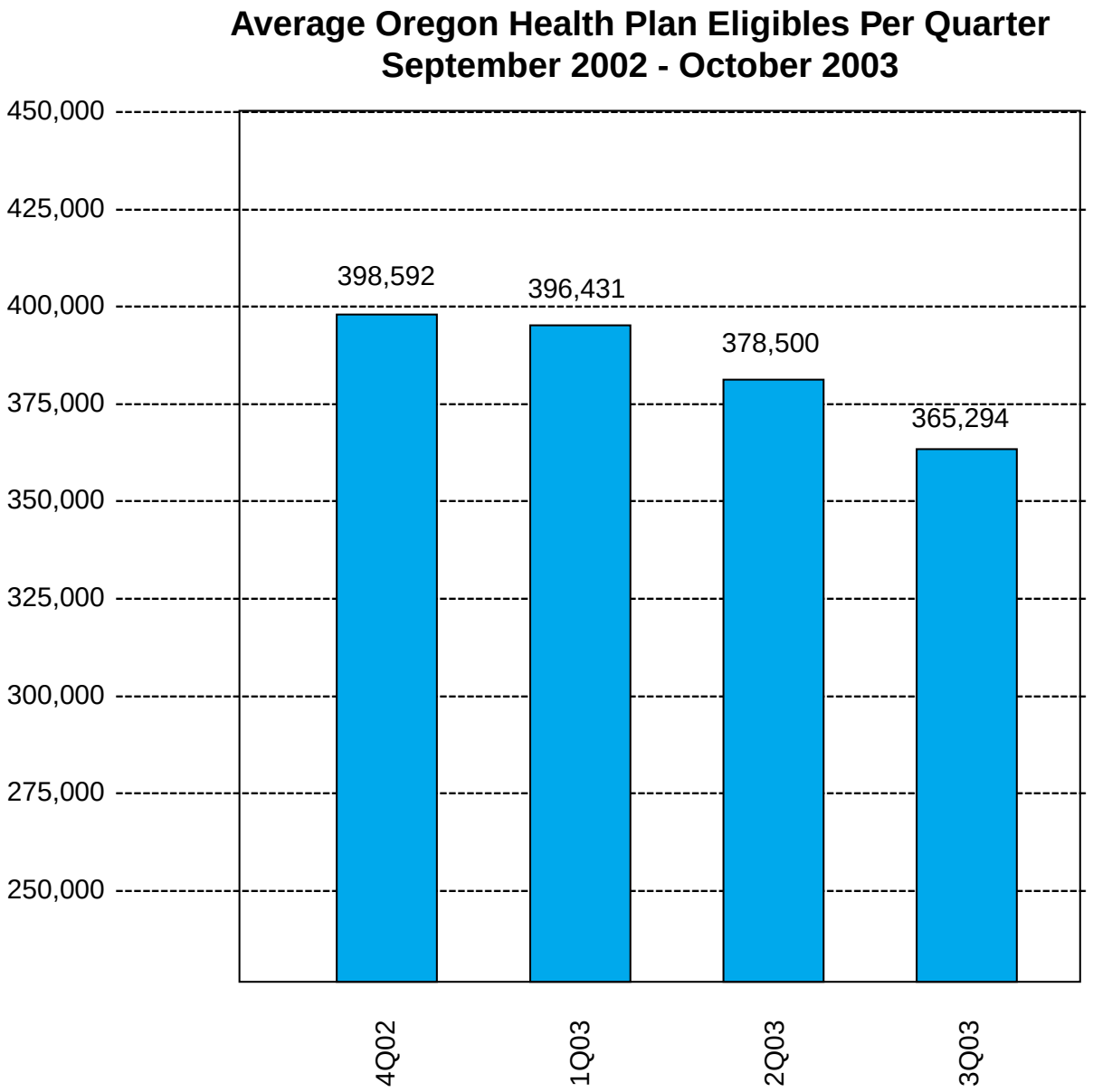
OMAP Hearings Unit totals for this reporting period reflect 826 hearing requests received during the period October 2002 through September 2003, with 180 hearings actually held. This was an average of 207 hearings requested and 45 hearings held per quarter.

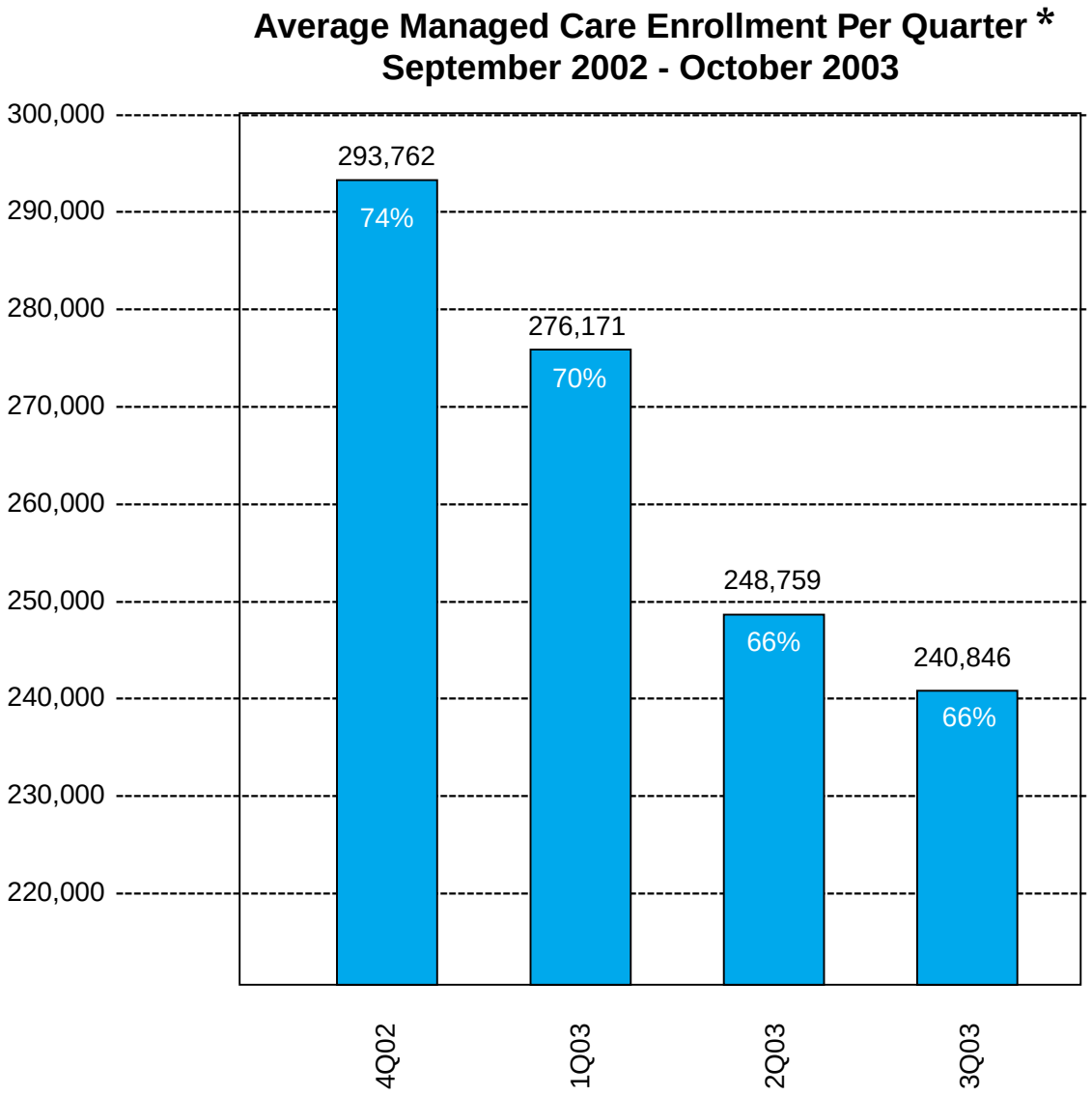
OHP Benefits RN Hotline

The OHP Benefits RN Hotline received an average of 1,539 calls per month during the period October 2002 through September 2003. This was a decrease 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 Health Services Commission (HSC) Prioritized List of Health Services.

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 October 2002 through September 2003 (fourth quarter 2002 through third quarter 2003).





*Enrollees as percent of total eligibles. Some eligibles cannot be enrolled in managed care.

Delivery Systems

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

Fourth Quarter 2002

- OMAP and PricewaterhouseCoopers developed fee-for-service (FFS) and capitation rate increases to reflect the increase in liability insurance costs for obstetricians. Increases were approved by the November Emergency Board and implemented in December 2002.

- OMAP notified plans of the technical changes to the HSC Prioritized List. Changes include new CPT codes, deletion of invalid CPT/HCPCS codes, replacement of some OMAP unique codes with national recognized codes and other changes recommended by the HSC and reflected by national coding standards.
- OMAP amended all Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO) and Chemical Dependency Organization (CDO) contracts to extend them from December 1, 2002, to February 1,2003, due to delay in implementation of the OHP Expansion.
- Based on decisions by the Legislative Emergency Board, OMAP notified plans of the OHP Standard benefit package changes to be implemented on March 1, 2003. Plans were also advised of the delay in the OHP Standard expansion from 100%-110% FPL until July 1, 2003, the decrease in pharmacy reimbursements from AWP –14% to AWP –17% and the increase in reimbursements for institutional pharmacies to AWP –11% and the dispensing fee to $3.91.
- OMAP began Gap Analysis between current contracts and rules and the Balanced Budget Act (BBA) CFRs finalized on June 14, 2002, and taking effect August 2003.
- OMAP decided to give the plans the option to serve only the OHP Plus population beginning March 1, 2003. DSU surveyed the FCHPs on their intent to serve the OHP Standard population.

First Quarter 2003

- OMAP sent notification to plans that, due to programmatic reductions by the Legislative Emergency Board, coverage for mental health services under the OHP Standard benefit package would be eliminated March 1, 2003.
- The Pharmacy Mail Order Program vendor changed to Wellpartner Pharmacy effective February 1, 2003.
- Implementation of voluntary copayments on drugs ($2 generic/$3 brand) and ambulatory services ($3) began for OHP FFS clients.
- Coverage was eliminated for lines 559-566 on the HSC Prioritized List of Health Services.
- OMAP staff worked with Seniors and People with Disabilities (SPD) staff to transition the responsibility for the Statewide OHP Regional Meetings to the DSU. There has been a reduction in staff attendance due to budget constraints.
- FFS workgroup was convened to explore issues related to an increase in FFS clients and the impact on OMAP work units and partners.
- OMAP implemented expansion of coverage for pregnant women and children under age 19 from 170% FPL to 185% FPL. OHP Standard benefit package began for approximately 110,000 clients. Changes for these clients include: elimination of coverage for vision exams and eyeglasses; elimination of non-

emergency medical transportation; elimination of most medical equipment; reduced dental benefits; mandatory copayments for most services (both FFS and managed care). A more stringent premium policy for OHP Standard clients was also implemented, as well as a 6-month uninsurance requirement for new OHP Standard clients. OMAP delayed expansion of OHP Standard from 100% FPL to 110% FPL until July 2003.

- OMAP reduced funding to counties for mental health crisis response services and reduced funding for outpatient alcohol and drug treatment for non-Medicaid clients.
- Ten FCHPs made the decision to provide medical services for the OHP Standard client population.

Second Quarter 2003

- OMAP continued efforts to increase managed care enrollment throughout the state.
- OMAP made the decision to accept claims and pay medical providers directly for application of fluoride varnish to young children.
- Staff continued review of OHP administrative rules for BBA/CFR, HIPAA rules, managed care contracts for BBA/HIPAA compliance, Client Denial Notices and Provider Capacity reports.
- Staff worked with DHS Information Systems to allow OHP clients to be auto-enrolled into multiple plan/mandatory counties to enhance managed care plan enrollment.
- Staff developed a plan to manage the issue of mid-month benefit changes of a OHP Standard client changing to an OHP Plus client.
- DSU drafted a contract amendment for all of the managed care plans to bring the contracts into compliance with the BBA/CFRs.
- Staff completed a revision of the Early Childhood Cavities Prevention (ECCP) Manual with the ECCP Education committee.
- Staff participated in quality improvement reviews and prepared financial reports.

Third Quarter 2003

- DSU staff worked with the Client Advisory Services Unit (CASU) to write protocol for violent/threatening behavior.
- Approximately 9,500 OHP clients were auto-enrolled from FFS into managed care in specific counties.
- Staff prepared a Medical Loss Ratio and Administrative Summary to be used for evaluation processes during a quality improvement review.

- Staff finalized rules, amendments and exhibits for FCHPs, DCOs and CDO agreements for August 2003.
- OMAP put together a work group to examine ways to follow the legislative direction of House Bill 3624 and develop a work plan to simplify or reduce administrative burden. This information was reported to the Legislative Emergency Board in November 2003.
- OMAP adopted new OHP rules, effective August 1, 2003, to comply with BBA requirements, which changed the administrative hearing process.
- OMAP transmitted to the plans changes to the Prioritized List for October 1, 2003. Changes include the addition of new CPT codes and the deletion of invalid CPT/HCPCS codes.
- OMAP created a Physician Care Organization (PCO) Implementation team to begin working on the program.
- OMAP sent a waiver amendment request to the Secretary of Health and Human Services at CMS for approval of changes to the OHP demonstration project.

Premiums and Waivers

OMAP changed the premium requirements for OHP clients beginning in February 2003. Some premiums were increased, and if premiums are not paid on time, all clients on OHP Standard in the household lose OHP coverage before the end of their current enrollment period. Clients who lose coverage for not paying their premiums must wait six months before they may qualify for OHP again.

OMAP also eliminated the waiver element of the premium process. Only past-due premiums owed before February 1 2003, can be waived. Therefore, premium waivers shown on the second chart reflect the reduction in waived premium numbers starting with the first quarter 2003.

OHP Monthly Premium Billing and Payments

October 2002 - September 2003

Quarter	Households	Total Billed	Total Receipts	% of Total Billed
4Q02	257,528	$2,476,615	$1,595,210	64%
1Q03	243,394	$2,466,953	$2,023,448	82%
2Q03	195,112	$2,488,641	$2,044,910	82%
3Q03	153,076	$1,822,333	$1,768,831	97%

Premium Waivers (Past Premiums - Billed Prior to Feb 2003) October 2002 - September 2003				
Waiver Type	**4Q02**	**1Q03**	**2Q03**	**3Q03**
Zero Income	9461	5765	2742	1317
Case Discrepancy*	4776	3164	3029	1602
Crime Victim	40	34	20	9
Domestic Violence	675	512	321	240
Homeless	1527	1055	665	490
Natural Disaster	73	96	56	46
Death in Family	17	10	12	8
Totals	**16,569**	**10,636**	**6,845**	**3,712**

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

Service and Information

Client Advisory Services

The Client Advisory Services Unit (CASU) received a total of 56,141 calls from clients or their representatives during the four quarters from October 1, 2002 through September 30, 2003.

Beginning in 2002, CASU began focusing less on traditional advocacy for OHP clients and more on a coaching model of assistance. Clients receive education on strategies for resolving their issues themselves, rather than simply relying on a public agency to take care of their concerns. This new mission promotes self-sufficiency and more closely mirrors customer service in commercial health care plans. To reflect this new orientation, Client Advocate Services Unit changed its name to Client Advisory Services Unit.

During the fourth quarter 2002, CASU staff answered calls from recipients of a letter sent by the Social Security Administration to Medicare beneficiaries about possible Medicaid benefits. CASU agreed to take calls from recipients of those letters and direct them to the closest individual senior services field office.

Also during the fourth quarter, OMAP started enrolling certain OHP eligibles into specific pharmacies of pharmacy chains during the previous quarter. CASU was the point of

contact for clients needing additional information about the pharmacy management program or requesting a change in their pharmacy enrollment. CASU staff also answered calls from clients inquiring about the January 2003 copayments and impending benefit reductions in the OHP expansion and in other Medicaid programs.

In the first quarter 2003, CASU staff referred many clients losing prescription drug coverage to the charity and low-cost pharmacy programs offered by various pharmaceutical companies. Applications for those companies' benefits usually require some kind of evidence that the applicant had no medication coverage through an insurer. CASU developed a program for accepting requests for proof of non-coverage of drugs and providing certificates to eligible clients on the day of request.

During the second quarter 2003, CASU started serving as the medical assistance hotline for parents of adopted children. Historically, this function had been handled exclusively by the department's Adoptions Assistance Unit, which served also as a privacy safeguard for these children. At the request of that unit, CASU opened its toll-free number to adoptive parents and began providing them information about OHP benefits and health plan delivery.

Throughout this reporting period, problems of access to medical care and pharmacy services appear to dominate in the fee-for-service environment. Of all calls related to access to, or denial of, medical care, 70.5% were from clients outside a managed health care plan. Of all calls about access to, or denial of, pharmacy benefits, 83.2% were from clients without a plan.

OHP Outreach

Outreach staff conducted outreach trainings and quarterly outreach meetings throughout this reporting period. During the fourth quarter 2002, staff also made a presentation on the OHP to a Russian Delegation.

During the first quarter 2003, the Outreach Coordinator also traveled the state doing OHP training for staff and outreach facilities related to the upcoming changes to the OHP. Approximately 1800 staff and outreach workers attended the trainings.

Telecommunications and Applications

The Telecommunications and Application Center, operated by Inside Oregon Enterprises at Oregon State Correctional Institution, answered nearly 350,000 calls from medical providers, OHP members and potential members, and the public during this reporting period. They also mailed over 155,000 new applications for the Oregon Health Plan, as well as over 195,000 redeterminations (current members who are reapplying for benefits). The chart below shows totals per quarter.

OMAP Telecommunications and Application Center

October 2002 - September 2003

	4Q02	1Q03	2Q03	3Q03	Total
OMAP Telecommunications					
Calls received	33,584	38,726	36,283	33,685	142,278
Calls answered	31,644	36,106	32,196	29,786	129,732
Calls abandoned	1,940	2,620	4,087	3,899	12,546
Transferred*	21.29%	24.5%	29.78%	23.9%	24.9%
Avg calls/agent qtr	2,304	3,135	3,577	3,310	12,326
OHP Application Center					
Calls received	61,984	66,521	52,316	49,599	230,420
Calls answered	57,599	63,834	49,760	47,457	218,650
Calls abandoned	4,385	2,687	2,556	2,142	11,770
Transferred*	7.76%	7.7%	10.32%	8.0%	8.4%
Avg calls/agent qtr	3,583	2,699	3,357	2,921	12,560
Applications req'd	43,079	38,735	36,397	37,552	155,763
Redeterminations mailed	50,709	58,103	49,374	37,659	195,845

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

Communications

During the latter part of 2002 and early 2003, Communications staff continued to develop and distribute client and provider informational materials related to the upcoming changes to the OHP. These notices included new copayment and premium requirements, as well as information on changes to the benefit package.

Staff worked on revisions to administrative rules throughout the reporting period and revised related materials to reflect program changes as directed by the Oregon Legislative Assembly. The majority of projects were related to the expansion of the Oregon Health Plan or reduction or elimination of benefits due to budgetary rebalancing.

Communications staff finalized and implemented a change in the format for presenting administrative rules and additional provider information. Previously, staff incorporated administrative rules for each program area into specific "provider guides", which also contained supplemental billing information. This information is now provided in separate documents on the OMAP website. This change will enable providers to access the most current administrative rules for their program in a more timely manner than the previous format. The new format may be viewed at:

http://www.dhs.state.or.us/policy/healthplan/guides/

Staff also coordinated OMAP responses to bills introduced in the 2003 Legislature. This involved assigning bills to program experts, analyzing bills, and writing testimony.

System and Encounter Data

HIPAA

During this reporting period HIPAA privacy policies went into effect. Staff completed privacy training in March 2003. Each DHS cluster designated a Privacy Coordinator to act as liaison between staff and the Privacy Officer. A notice of Privacy Practices was mailed to all Medicaid households.

Staff completed a variety of tasks related to HIPAA compliance. These included :

- Established a Trading Partner Agreement (TPA) for Electronic Data Interchange (EDI) submitters and set a compliance date of October 15, 2003, for receipt. Staff completed additional outreach to the remaining providers requesting submission by October 31, 2003.
- Established a phone number and web site to receive questions specifically related to transaction and code set testing.
- Completed initial release of the Companion Guides for the 820, 834 and 837 transactions.
- Developed business rules for Medicaid Management Information System (MMIS) limitations on more than 28 detail lines on a claim.

- Developed an invitation to bid for implementation of a Transaction and Code Sets Service Continuation Plan.
- Developed crosswalks for encounter error codes to HIPAA adjustment reason codes.
- Held three training sessions for providers: 1) how to complete a TPA, 2) how to begin third party testing, and 3) how to begin business to business testing. Attendance was low considering the number of providers needing to complete these steps.
- Outreach: Provided statewide information on HIPAA Transaction and Code Set implementation through our OHP Regional Meetings. DHS distributed a survey statewide asking for provider readiness. DHS sent out a Good Faith Policy on completing a TPA by October 15, 2003. DHS sent pharmacy providers clarification on which lines of business would need to complete a TPA and submit claims electronically using the 837 transaction. DHS published a policy statement for non-emergency transportation providers.
- Conducted weekly meetings between the Office of Information Systems, the EDI testing team, EDI registration team, the HIPAA project office, and other Medicaid agencies needed to be HIPAA complaint.
- Completed a gap analysis between the current system configuration and what is needed so that DHS can accept nursing home turnaround document (TAD) claims in the 837 format.

Systems Activity

Systems staff implemented a new system request process that more accurately reflects the priority of each request.

During this report period, system staff work was centered around the implementation of HIPAA and the expansion of the OHP. Staff also began preliminary systems work related to establishing the numerous systems requirements resulting from the 2003 legislative session.

Training

OMAP completed training for all staff on the new Decision Support/Surveillance and Utilization Review System (DSSURS) data research and analysis system. Encounter staff, as well as other OMAP staff, have begun using this data research tool.

Monitoring and Research

Project: **PREVENTION!**

The Project: **PREVENTION!** Task Force continued to meet for the first three quarters of this reporting period with primary focus on tobacco cessation for OHP smokers and the Early Childhood Cavities Prevention (ECCP) project. During the third quarter 2003, the Project: **PREVENTION!** Task Force and the Contractor's Quality Improvement Workgroup merged to form the Quality and Performance Improvement (QPI) Workgroup. The purpose of this merger was to meet the federal Balanced Budget Act (BBA) requirements and implement administrative streamlining. The QPI serves as an active working body for the promotion and integration of quality and performance improvement requirements and activities for the Oregon Health Plan. Statewide performance improvement activities will continue to address tobacco cessation, early childhood cavities prevention (ECCP), and chronic disease. A planning group of MCO and OMAP representatives met in June and July, and developed the plan, charter, and process for the new QPI Workgroup.

The QPI Workgroup established a monthly planning teleconference to develop the strategic plan and monthly agenda for the QPI Workgroup meetings. The planning group includes representatives from five FCHPs, five DCOs, medical directors, partners from the Tobacco Free Coalition of Oregon, the DHS/HS offices of Disease Prevention & Epidemiology, Family Heath, the External Quality Review Contractor - OMPRO, and OMAP staff. The first QPI meeting was held on September 8, 2003.

Survey Activities

The final report of the Consumer Assessment of Health Plan Survey (CAHPS) was released during the first quarter 2003. The report is available online at:

http://www.dhs.state.or.us/healthplan/data_pubs/ncbdfinal2003.pdf

External Quality Review

Staff executed a contract with quality improvement organization for external quality review (EQR) activities. The contract was awarded to OMPRO. The three major tasks for the EQR are:

- Task 1: Rapid cycle improvement, using 5 clinical practice summaries/topic areas over two years. The reviews begin using administrative/claims data looking for out-of-range variations that will be followed up with clinical chart reviews if out-of-range findings are present.
- Task 2: Review of performance improvement projects, performance measures and managed care quality improvement program.
- Task 3: CAHPS survey of adults/children.

Quality Improvement/Evaluations

Quality Improvement (QI) staff worked with DHS Office of Family Health staff on pilot projects to improve access to dental care through prevention efforts to pregnant women and children age 0-2. This effort is funded through an RWJ grant.

Staff worked with managed care organizations on technical aspects of their contracted performance measures including provision of preventive dental care for DCOs, HEDIS timeliness of prenatal care and HEDIS immunizations for 2 year olds for the FCHPs.

During this reporting period, OMAP's evaluation team conducted on-site reviews/evaluations of 12 managed health care and dental plans.

Medicaid Audit

During this reporting period, October 2002 through September 2003, the Audit Team collected $1,243,473 in overpayments and recouped $169,866 for a total of $1,413,339.

The department implemented OmniAlert, a new Surveillance Utilization Review System during the third quarter 2003. Staff completed user training and are developing and running several different reports using OmniAlert.

Staff worked on numerous types of audits during this reporting period, including five different pharmacy audits. Pharmacy will remain a priority over the next biennium. Other specific areas of focus include durable medical equipment audits, hearing aids, physician services, laboratory services, transportation services and Federally Qualified Health Centers.

Health Services Commission

The Health Services Commission (HSC) met 5 times between October 2002 and September 2003. Key issues addressed during this period were:

The Commission began discussing services on the Prioritized List with high cost and high utilization that are of questionable benefit. The HSC plans to review existing evidence-based research in examining the effectiveness of these services. They heard a presentation from Dr. Mark Helfand of the OHSU Evidence-based Practice Center on how they conduct evidence-based research for the Health Resources Commission in their development of the Practitioner Managed Prescription Drug Plan for the Oregon Health Plan. The Commission then convened the Evidence-Based List Task Force, which developed a process for using evidence-based research conducted by recognized sources to determine: 1) whether new technologies should be added to the Prioritized List, and 2) whether services currently on the list that are shown to be ineffective or potentially harmful should be removed from the list or prioritized lower.

At their March 2003 meeting the Commission heard testimony from three state representatives on the continued importance of the Prioritized List of Health Services as the legislature began to look at restructuring the Oregon Health Plan in response to the state's current fiscal crisis. The representatives encouraged the HSC to continue in their new focus on the use of evidence-based research to make sure that the state's limited resources are being used to provide the best possible health care.

Early in 2003, the Commission created the Line Zero Task Force to examine potential savings that can be achieved in the areas of diagnostic and ancillary services. Specifically, the task force will look at those services not associated with specific line items on the list but still covered by the Oregon Health Plan.

During their 2003 session, the Oregon State Legislature passed a bill directing the HSC to consider cost-effectiveness as well as clinical effectiveness in their prioritization process. The Commission heard a presentation from Frances Lynch, PhD, of the Kaiser Permanente Center for Health Research on how cost-effectiveness analysis can play a role in health coverage decisions. Additional legislation directs the HSC to retain an actuary in order to determine benchmark reimbursement rates for both the capitated managed care plans and fee-for-service providers. The Department of Human Services will then explain any differences between these rates and those developed by their own actuary for the 2005-07 biennium.

Finally, the HSC approved the recommendations of the Health Outcomes Subcommittee and Mental Health and Chemical Dependency Subcommittee for two sets of interim modifications to the Prioritized List of Health Services to: 1) incorporate new CPT-4 codes, new ICD-9-CM codes, guideline revisions, and previously nonpaired codes, and 2) delete inappropriate pairings.

Health Outcomes Subcommittee

The Subcommittee developed recommendations on the placement of new CPT-4, ICD-9-CM and HCPCS codes. The Subcommittee also made recommendations on the continued incorporation of pairings of ICD-9-CM and CPT-4 codes identified through OMAP's claims processing, where appropriate. The Subcommittee revised the guideline for clinically significant spinal deformity (line 143) to indicate their intent that this only be applied to the condition of scoliosis. Later work will explore the possibility of developing a guideline for spinal stenosis, which also resides on that line. The Subcommittee completed work on a guideline for the use of vagal nerve stimulators for selected patients with epilepsy. They also recommend adding smallpox to line 207, Herpes Simplex and Herpes Zoster with Neurological and Ophthalmological Complications, on a temporary basis until a new line can be created during the next biennial review. Complications of smallpox vaccination (vaccinia) will be place on line 148, Complications of a Procedure Always Requiring Treatment.

The Subcommittee took testimony on ambiguities in the Prioritized List on the coverage of chemotherapy that is expected to prolong life for a period less than five years. They also took over the work begun by the Evidence-Based List Task Force to identify services that are shown to be ineffective or potentially harmful in evidence-based research and may be removed from the Prioritized List.

Mental Health and Chemical Dependency Subcommittee

The Mental Health and Chemical Dependency (MHCD) Subcommittee discussed the use of detection and treatment of early psychosis and confirmed its placement on the list at line 190.

They completed their work on the crosswalk of local procedure codes for MHCD services to CPT-4 and HCPCS codes as required by HIPAA. During this process they also identified other procedure codes that were inappropriately paired with diagnoses that they are recommending be removed from the Prioritized List.

The MHCD Subcommittee heard a report on the process being developed by the Evidence-Based List Task Force and began a discussion whether such a process for the incorporation of evidence-based research can be used in the maintenance of the line items on the Prioritized List involving mental health and chemical dependency services.

The Oncology Task Force

The Oncology Task Force held one meeting during the year. The Task Force was given an overview of the HSC's prioritization process and was told that they will be advising the Commission in three areas: 1) what indications for high-dose chemotherapy with bone marrow/stem cell transplant (BMSCT) are currently not paired with the treatment on the Prioritized List; 2) what conditions are inappropriately paired with high-dose

chemotherapy with BMSCT on the list; and 3) advise the HSC on the issues of recent advancements in BMSCT technology such as tandem transplants, retransplantation, mismatched transplants, and the use of BMSCT in treating graft vs. host disease and nonhematologic diseases.

The Evidence-Based List Task Force

The Evidence-Based List Task Force developed a process for using information on effectiveness of treatments available from sources on evidence-based research for evaluating the placement of services currently on the Prioritized List and the potential placement of new technologies. They tested the process on three selected services and recommended the incorporation of this process into the ongoing maintenance of the list.

The Line Zero Task Force

The Line Zero Task Force began looking at specific strategies for potential savings in the Oregon Health Plan from such areas as the inappropriate use of the emergency department, the abuse of non-emergent transportation, the exclusion of PET scans for purposes other than the diagnosis of certain malignancies, lowering the maximum number of incontinence supplies allowed in a month, and management strategies for reducing overutilization of other imaging services.

Mental Health Services

Policy and Planning

During the fourth quarter 2002, the Legislative Emergency Board authorized elimination of outpatient mental health treatment, an optional Medicaid benefit, for approximately 118,000 people eligible for the OHP Standard benefit package effective March 1, 2003.

OMHAS staff completed work to transition all Oregon unique mental health and chemical dependency treatment codes to the newly developed national standard codes.

During the first quarter 2003, OMHAS completed its work to implement the required set of national mental health procedure codes to replace Oregon's unique BA/ECC codes for mental health treatment services.

A workgroup convened to discuss and develop recommendations for the management of mental health psychiatric medications.

A workgroup also convened, at the request of the mental health plans, to identify and research the feasibility of alternatives to full risk capitated contracts. Discussion included options such as partial risk to full risk management, plans as administrative service organizations with no risk, and plans as primary care case managers.

A review of the Secure Children's Inpatient Program (SCIP), opened in January 2002 as a community-based alternative to an institutional setting, showed that during the first year of operation the average length of stay was reduced from an average of 258 days at Oregon State Hospital (OSH) to an average of 126 days at SCIP. The SCIP program provides a critical level of care for Oregon's children in the mental health system, and has exceeded expectations during its first year of operation.

The Mental Health Planning and Management Advisory Council, the primary advisory group to OMHAS which meets CMHS requirement of 50% consumer participation, was convened during the first quarter 2003. Discussions included recent Community Mental Health Program (CMHP) site reviews, review of Block Grant performance measures for children and adults, and proposed legislative bills.

A workgroup was convened during the second quarter 2003 to develop recommendations for cost containment strategies for mental health medications. The use of generic prescriptions, provider profiling, and bulk purchasing were some of the ideas discussed.

OMHAS introduced a plan to change billing and payment procedures for psychiatric day treatment providers in April 2003 to bring that process into compliance with HIPAA transactions and code set requirements.

OMHAS submitted a grant application for the development of dual diagnosis treatment infrastructure for three pilot sites. The money is to be used for planning and implementation, not for actual treatment services.

OMHAS continued to work on a collaborative project with OMAP and the Oregon State University School of Pharmacy on the development of recommendations for improving the management of mental health medications and achieving some cost containment. Currently, 31% of the OHP's overall drug budget is spent on mental health related medications. A draft issue paper describes a set of strategies that relies on collaboration and coordination of care between all health care providers - mental health, physical health, nursing and pharmacy.

The 2003 session of the Oregon Legislature restored some non-Medicaid cuts that were taken in February 2003 for mental health crisis services and adult mental health outpatient services. The allocations do not bring support to the level of funding at the beginning of the last biennium. Steps were taken to make funds available through amendments to contracts with counties.

Benefit Package

During the fourth quarter, MHOs and FCHPs discussed their respective roles and payment responsibilities for the limited mental health benefits available for OHP Standard eligibles after March 1, 2003. These limited services include psychiatric inpatient hospitalization (including professional fees), psychotropic medication management, and psychiatric consultation.

The MHO Agreement was amended in February 2003 to include OHP benefit package changes (OHP plus and OHP Standard) and revisions needed to comply with new Balanced Budget Act (BBA) Medicaid Managed Care Rules.

The MHO Agreement was amended in March 2003 to eliminate the outpatient mental health benefit package for OHP Standard clients. Limited mental health services remaining for this population include inpatient psychiatric hospitalization, emergency room services, and outpatient medication management by psychiatrists or psychiatric mental health nurse practitioners. The March amendment to the MHO Agreement also reduced the administrative fee paid to MHOs from 8% to 7.25%.

The MHO Agreement was amended in February to include OHP benefit package changes (OHP plus and OHP Standard) and revisions needed to comply with new Balanced Budget Act (BBA) Medicaid Managed Care Rules.

Training and Activities

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

- A workshop on Integrated Approaches for Youth and Families with Co-Occurring Disorders was held on October 2-3, 2002.
- OMHAS sponsored a Child and Adolescent Mental Health Conference on April 22-23, 2003, in Springfield, Oregon. The conference focused on providing technical assistance to child and adolescent mental health professionals on implementing a system of care using evidence-based practices. A number of national experts participated.
- The FCHP Exceptional Needs Care Coordinators roundtable was held November 6, 2002. Topic items for discussion focused on improving communication between FCHPs, DCOs, and MHOs.
- OMHAS convened a meeting of an oversight group that includes community providers, consumers, and other interested parties to coordinate the implementation of the OMHAS Trauma Policy.
- OMHAS reconvened the first meeting, after a long hiatus, of the MHO Medical Directors/Clinical Supervisors Workgroup.

- DHS and OMHAS staff worked closely with MHOs to revise contractual financial reporting requirements. Contract revisions that take effect February 1, 2003, should result in greater comparability across MHOs, and a more accurate analysis of cash flow, net worth and financial solvency.
- OHP Integration Workgroup – LaneCare presented preliminary data from the Targeted Case Management Pilot Project. An enhanced database was developed for this project that collects information on prescription utilization and mental health service utilization for clients involved in the project.
- The MHO Quality Improvement Coordinators discussed new contract requirements for practice guidelines. They researched current evidence-based practices to develop a resource list for MHOs.
- OMHAS staff completed HIPAA privacy training requirements.
- OMHAS received a grant from SAMHSA for Emergency Preparedness Response to develop and implement a comprehensive mental health and substance abuse plan in the event of a large-scale emergency. OMHAS will conduct a needs assessment regarding local and state-level planning and response capacities. These results will be used in the planning of an annual training agenda.
- OMHAS provided a three-day technical assistance workshop, June 2003, "Hands on Discussion on Keeping Hands Off." The training focused on the reduction of seclusion/physical restraint in children's psychiatric residential treatment services system. OMHAS is working collaboratively with the provider system to develop and implement this quality improvement imitative.
- OMHAS, in partnership with MHOs, Oregon Family Support Network, and Child and Adolescent Residential Psychiatric Programs provider organization, conducted a statewide conference, "Get The Picture: Bringing Together Those Who Care About the Mental Health Future of Oregon's Children."
- September 8-9, 2003 - CHARP Conference – Evidence-Based Practice to Children and Families was held at the Double Tree Hotel in Portland.
- September 19, 2003 - Latina Prenatal Summit was held at St. Vincent Hospital in Portland.
- During the third quarter 2003, Pre-Commitment Investigation Examiner Training was held in Salem.

Monitoring and Evaluation

During the reporting year, OMHAS developed and worked on the following Monitoring and Evaluation activities:

- MHOs participated in an encounter data claim validation pilot project. Electronic worksheets developed by OMAP assist MHOs to validate on a weekly basis the encounter data submitted to OMAP.

- DHS and OMHAS staff worked closely with MHOs to revise contractual financial reporting requirements. Many of the MHOs have also provided technical assistance to their risk-based subcontractors in an effort to update cost allocation plans and enhance financial management, reporting, and oversight. The contract revisions took effect February 1, 2003, and should result in greater comparability across MHOs, and more accurate analysis of cash flow, net worth, and financial solvency.
- An evaluation was conducted on the MHO Intensive Treatment Service Pilot Projects and showed the following:
  - Length of stay was 98 days less than traditional programs.
  - Children served have the same or higher psychiatric acuity level.
  - Discharge to family and/or relatives at a higher rate (70%) than traditional programs (50%).
  - Overall clinical improvement upon discharge higher (89%) than traditional programs (86%).
  - More families served (8%) than traditional programs.
  - High Parent/Guardian satisfaction with services provided.
- OMHAS staff completed site visits at Mid-Valley Behavioral Care Network (MVBCN) and Accountable Behavioral Health Alliance (ABHA).
- A representative from the HHS Office of Inspector General visited Oregon to gather fiscal information on Medicaid contractors who are also governmental entities.
- OMHAS completed site visits to Mid-Valley Behavioral Health Care Network (MVBCN), LaneCare, and Greater Oregon Behavioral Health Incorporated (GOBHI). Site reviews identify MHO strengths and assess MHO compliance with state and federal regulations. Final reports identify specific areas that require corrective action and provide comments and recommendations on review elements.
- OMHAS completed a site visit to Jefferson Behavioral Health.
- Client Process Monitoring System (CPMS) is designed to track episodes of care for clients utilizing mental health services who meet a certain criteria. Effective October 1, 2003, submission was required for all clients. OMHAS plans to provide MHOs with reports based on the data collected, such as the number of clients readmitted to a higher level of care within 30 days of termination from a lower level of care, or changes to level of care functioning upon termination of treatment.
- The MHO QI Coordinators workgroup developed a resource guide of mental health practice guidelines and related topics.
- OMHAS is developing a request for proposal for an external quality review (EQR). The previous EQR in June 2000 identified five potential QI issues: diagnosis, case formulation, treatment planning, consumer involvement in treatment, and referral to alcohol and drug treatment.

Family Health Insurance Assistance Program (FHIAP)

During the fourth quarter 2002, information about FHIAP was incorporated into the quarterly OHP report to CMS. Highlights of administrative operations and program activity are summarized below:

Fourth Quarter 2002

- Implemented Section 1115 and HIFA waivers for FHIAP and began claiming FFP on November 1, 2002.
- Promulgated administrative rules to implement legislative, technical and waiver-related changes to FHIAP.
- Developed and presented continuing education training on FHIAP and other OHP programs for health insurance agents.
- Continued work on HIPAA components (privacy, transactions and codes, and security) changes, coordination and training.
- Continued collaboration with DHS programs (particularly OMAP) with regards to coordination of program policies where applicable, and future transfer of OHP Standard clients with employer-sponsored insurance available to FHIAP.
- Revised FHIAP benefit benchmark per legislative instruction in Oregon House Bill 2519 (2001) for IPGB Board approval in November 2002.
- Developed Request for Proposal (RFP) for a survey/study of employer-sponsored health insurance in Oregon.
- Revised all publications to incorporate new subsidy, income guidelines, and eligibility changes.
- Prepared fiscal systems for federal reporting requirements.
- Modified database system to accommodate federal fiscal reporting system.

First Quarter 2003

- Developed and presented training on FHIAP in conjunction with DHS for DHS staff across the state.
- Continued work on HIPAA components (privacy, transactions and codes, security) changes, coordination and training.
- Developed a survey/study of employer-sponsored health insurance in Oregon to be conducted by the Lewin Group of Washington, D.C.
- Revised all publications to incorporate 2003 federal poverty level income guidelines.

- Contracted with an actuarial firm to do an analysis of benchmark.
- Conducted recruitments to fill staff positions needed for expansion and approved by Legislative Emergency Board in 2002.
- Phone call volume increased to approximately 1,500 per week during this quarter from an average of 900 calls per week in 2002.

Second Quarter 2003

- Continued work on a survey/study of employer-sponsored health insurance in Oregon to be conducted by the Lewin Group of Washington, D.C.
- Phone call volume averaged approximately 1,300 per week during this quarter from an average of 1,500 calls the previous quarter and 900 calls per week in 2002.
- Marketing efforts continued across the state with face-to-face meetings with employers, agents and other stakeholders.
- The marketing team had interactive contact with almost 550 agents and employers during the quarter.
- Almost 4,300 employers were contacted by mail about the program in the first phase of an employer mailout.

Third Quarter 2003

- Phone call volume averaged approximately 1,300 per week during this quarter. Previous quarter calls also averaged 1,300 calls per week. Calls in 2002 averaged 900 calls per week.
- New six-month Non-Commercial Sustaining Announcement (NCSA) campaign began in July, in cooperation with the Oregon Association of Broadcasters. Similar to Public Service Announcements, NCSAs are aired by radio and television stations across the state. Announcements aired at the following times during the quarter: July 7-20, August 4-14, September 1-14, and September 29-30 (carried over into next quarter, through October 12).
- Marketing efforts continued across the state with face-to-face meetings with employers, agents and other stakeholders. FHIAP staff made over 125 presentations across the state during the quarter.
- Staff contacted almost 11,148 employers by mail about the program in the second phase of an employer mail-out, with 376 employer mailer response cards returned requesting additional information.
- The program had three pieces of relevant legislation passed during the quarter:
  - House Bill 2159 changed terminology in a section of statutes to make them consistent with remainder of statutes. It also allows the state agency to

administer the day-to-day operations of the program instead of a third party administrator.

- House Bill 2160 allows the program to subsidize dental premiums in the group market if enrollment in a dental plan is required by an employer, and it permits FHIAP to pay for age-appropriate immunizations if not provided by a health benefit plan.
- House Bill 2189 increases income eligibility to 200 percent of the FPL and removes the statutory directive to split funding equally between the group and individual markets. It allows FHIAP to pay for costs of administering health benefit plans for FHIAP members enrolled in the Oregon Medical Insurance Pool (OMIP) that are above and beyond the premium revenue generated from those members and which are recouped through the OMIP assessment process. It also changes the FHIAP definition of family to include dependent children of dependent children, de-links the benchmark from the small employer insurance market thereby allowing FHIAP to use benefit information from all types of Oregon employers when setting the benchmark, and clarifies the definition of insurance for the purposes of the program.

FHIAP Enrollment

FHIAP Enrollment October 2002 - September 2003				
Enrollment	**4Q02**	**1Q03**	**2Q03**	**3Q03**
New group enrollments	133	508	586	449
New individual enrollments	238	606	905	302
Total new enrollments	371	1,114	1,491	751
Total FHIAP enrollment	3,239	3,995	5,054	5,631

FHIAP Disenrollment due to non-payment of premium October 2002 - September 2003				
	4Q02	**1Q03**	**2Q03**	**3Q03**
Disenrollments	not reported	81	61	80