Oregon Health Plan Medicaid Demonstration Project

Quarterly Report
July-September 2003

Table of Contents

Tables

Attachments

Summary

- Policy staff started planning stages for request for proposal for pharmacy benefits manager. (page 3)
- Policy staff conducted training for school-based health services providers. (page 3)
- The Health Services Commission (HSC) developed a process for using evidence-based research to determine additions/deletions of Prioritized List items. (page 5)
- The Office of Mental Health and Addiction Services (OMHAS) continues to work collaboratively with OMAP and the Oregon State University School of Pharmacy on improving the management of mental health medications. (page 6)
- OMHAS completed final QI reports for two Mental Health Organizations (page 9)
- Medicaid Audit collected $431,946 during the third quarter 2003. (page 10)
- The Family Health Insurance Assistance Program (FHIAP) began a campaign to air public service announcements about the program on radio and television. (page 10)
- Managed care enrollment averaged over 66% for the quarter. MHO enrollment averaged 74% for the quarter. FHIAP enrollment totalled 5,631. (pages 8, 11, 12)
- Delivery Systems Unit (DSU) auto-enrolled clients in specific counties from fee-for-service coverage into managed care. (page 13)
- DSU held regional meetings throughout the state bringing together health plans, providers and DHS staff. (page 14)
- Premium collections for the quarter were 97% of the total billed amount. (page 15)
- Client Advisory Services Unit calls decreased by 15% from the previous quarter. (page 17)
- Communications Unit implemented a change in format for presenting provider information. (page 18)
- System and Encounter Data held provider training sessions related to HIPAA compliance requirements. (page 20)
- The Project: PREVENTION! Task Force merged with the Contractor's Quality Improvement Workgroup to form the Quality and Performance Improvement Workgroup. (page 22)
- Final QI reports were completed for two managed care plans. (page 23)

Administrative Operations

OMAP Program and Policy Activities

During the third quarter 2003, significant activities in program and policy areas included:

- Submission, monitoring and/or approval of several State Plan Amendments.
- Working with three communities in the development of transportation brokerages. Monitoring contracts with established brokerages.
- Continued work on HIPAA transaction and data sets related changes, coordination and training.
- Started planning stages for request for proposal for pharmacy benefits manager per requirements from House Bill 3624.
- Ongoing policy technical assistance for staff, providers and other stakeholders.
- Conducted training for school-based health services providers.
- Developed HIPAA required code changes for school-based health services.
- Development of administrative rules and program coordination to implement legislative and DHS management directives.
- Continued collaboration with other DHS programs and community partners in the areas of:
  - Childhood immunizations
  - Maternity case management
  - School-based health services
  - Pharmaceutical services
  - Breast and cervical cancer Medicaid coverage for uninsured women
  - Tribal issues
  - Federally Qualified Heath Centers and Rural Health Clinics
  - Durable medical equipment
  - Lead poisoning prevention
  - Oral health services

OHP Benefit RN Hotline

The OHP Benefit RN Hotline averaged 1,300 calls per month during the third quarter 2003. Greater than 97% of the calls continued to be from practitioners, with 92% of the calls related to line placement and payment services.

For specific information regarding comorbidity, not covered services, or payment reconsideration, please contact Arlene Nelson via email: arlene.nelson@state.or.us.

OHP Hearings

OHP Hearings
Managed Care and Fee-for-Service
July - September 2003

	Managed Care	Fee-for-Service
Requests Rec'd	140	55
Hearings Held	28	9
Hearings Pending	111	42
Hearings Dismissed	95	47
Claimant Withdrew	39	12
Plan Withdrew/ Agency Withdrew	39	25
No Shows	4	0
No Jurisdiction	1	0
Decisions Affirmed	30	11
Decision Reversed	3	0
Below the Line	20	3
Not Hearable	13	10

Health Services Commission

The **Health Services Commission** (HSC) held two meetings during the quarter. The HSC approved the recommendations of the Health Outcomes Subcommittee for a set of interim modifications to the Prioritized List of Health Services to incorporate the new ICD-9-CM codes.

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. The HSC heard a report from staff on the timeline for this process.

Finally, the Commission 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.

The **Health Outcomes Subcommittee** held two meetings during the quarter. The Subcommittee completed the development of a set of recommendations for the placement of new ICD-9-CM codes. The subcommittee completed work on a guideline for the use of vagal nerve stimulators for selected patients with epilepsy. 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. Finally, the subcommittee continued incorporating pairings of ICD-9-CM and CPT-4 codes identified through OMAP's claims processing, where appropriate.

The **Subcommittee on Mental Health Care and Chemical Dependency** held one meeting during the quarter. In addition, an interim workgroup of the subcommittee held one additional meeting in August. The Subcommittee and its workgroup discussed the applicability of incorporating evidence-based research into the mental health and chemical dependency line items as is being done for the physical health lines.

The **Line Zero Task Force** held one meeting during the quarter. They began looking at specific strategies for potential savings in the Oregon Health Plan. These included lower reimbursement rates for inappropriate use of the emergency department, 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.

Office of Mental Health and Addiction Services (OMHAS)

Administrative Operations

- Frank Moore, Manager of Special Projects at OMHAS, accepted a position as Director for Linn County Health Department.

Policy and Planning Decisions

- OMHAS continues 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 are being taken to put funds into play immediately through amendments to contracts with counties.

- The following "Budget Notes" provide OMHAS with direction from the Legislative Assembly.
  - OMHAS and OMAP are to work with a private organization experienced in performing patient-centered prescription drug management to review state funded Medicaid programs to improve services and to reduce mental health drug expenditures for high volume/high cost patients. No funds have been made available. DHS is to obtain private sector funding to cover costs of the full program.
  - OMHAS is directed to work with stakeholders to integrate child and adolescent Intensive Treatment Services into local management and to ensure that a culturally competent mental health service system will provide the entire continuum of care available to children/ adolescents with severe mental health and emotional disorders.
  - OMHAS, in consultation with stakeholders, the Mental Health Advisory Council, and the Governor's interim mental health task force, shall continue to develop and implement mental health services for individuals in the most integrated, community-based settings suited to their needs.
  - Given the new billing and payment system implemented on July 1, 2003 for child and adolescent day treatment providers, OMHAS will submit a written report to the co-chairs of the Legislative Emergency Board that describes any significant problems encountered in the transition to the new payment methodology and the steps that have been taken to correct them.
- As required by the federal Medicaid managed care regulations (42CFR Chapter 438), OMHAS developed a Quality Assessment and Improvement Strategy to monitor and evaluate the mental health services delivered by Mental Health Organizations (MHOs). The Quality Assessment/Quality Improvement (QA/QI) strategy includes the following objectives:
  - To ensure the quality and appropriateness of care and services provided to MHO enrollees
  - To involve stakeholders in quality assessment and improvement efforts
  - To regularly monitor and evaluate MHO compliance with contractual requirements
  - To promote continuous quality improvement
  - To coordinate implementation of evidence-based practice guidelines

Eligibles and Enrollment *

- MHO enrollment was at 73% in July, 74% in August, and 74% in September. Actual OHP eligibles were as follows:

July	382,573
August	375,887
September	373,859

* MHO enrollment numbers are higher than managed health care enrollment (page 11) because MHOs are available in more counties than managed health care plans.

Benefit Package

- The MHOs developed recommendations to work in partnership with OMHAS, service providers, and consumers to improve the continuity of care and delivery of mental health treatment services to children and families. The following goals were identified:
  - Improve care coordination for youth in state hospital, psychiatric residential treatment, psychiatric day treatment and acute and sub-acute care.
  - Develop an efficient and effective behavioral health approach to dual diagnosis (mental health/chemical dependency) concerns for youth.
  - Eliminate the perverse incentives and existing barriers that limit a community's ability to implement system improvements.
  - Develop local community capacity to implement system of care, evidence-based practices.
- OMHAS Medical Director, Dr. David Pollack, continues to work with community mental health programs, rural health clinics, and Federally Qualified Health Centers to develop integration and collaboration between mental health and primary care.
- OMHAS implemented a new policy for children entering psychiatric residential treatment services. Scheduled effective date is October 1, 2003. The policy will ensure that a child's MHO enrollment will be maintained with the child's "county of origin" to increase incentives for responsive discharge planning and care coordination. Previously, placement of a child in this level of care prompted an address change to the facility, causing the child to be enrolled in the county in which the facility was located, thus breaking the linkage the child had with the local MHO.

Monitoring and Evaluation

- OMHAS recently completed a site visit to Jefferson Behavioral Health. Reports for site visits at Greater Oregon Behavioral Health Incorporated (GOHBI) and LaneCare are included as attachments.
- 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 will be 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 in the process of 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.

Training and Activities

- September 8-9, 2003 - CHARP Conference – Evidence-Based Practice to Children and Families, Double Tree, Portland
- September 19, 2003 - Latina Prenatal Summit, St. Vincent Hospital, Portland
- Pre-Commitment Investigation Examiner Training, Salem

Attachments

- Summary of Complaints – April 1, 2003 through June 30, 2003 (see attachment 1)
- Final site review report for GOBHI (see attachment 2)
- Final site review report for LaneCare (see attachment 3)

Medicaid Audit

For the third quarter 2003, the department collected $396,766.27 in overpayments and recouped $35,179.76 for a total of $431,946.03. One referral was made to the Department of Justice Medicaid Fraud Control Unit.

The department implemented OmniAlert, a new Surveillance Utilization Review System (SURS), during the third quarter. User training has been completed, and staff are now developing and running several different reports using OmniAlert.

Staff have been working on five different pharmacy audits this quarter. Pharmacy audits will continue to remain a priority over the next biennium. Staff are also doing several durable medical equipment audits. Specific areas of focus include incontinence supplies, diapers, ventilators, oxygen, and wheelchairs. Additional audits in process include hearing aids, physician services, laboratory services, Federally Qualified Health Centers, and transportation services.

Family Health Insurance Assistance Program

Administrative Operations/Policy Issues

- Continued collaboration with DHS programs with regards to coordination of program policies where applicable and transfer of OHP Standard clients with employer-sponsored insurance available to FHIAP.
- 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.

Eligibles and Enrollment

OHP Eligibles — July -September 2003

Total actual eligibles were:

July	369,832
August	363,304
September	362,747

OHP Enrollment — July -September 2003

Managed care enrollment*		Actual FCHP enrollment
July	65%	239,117
August	65%	237,216
September	68%	246,204

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

FHIAP Enrollment — July -September 2003

New Group enrollments	449
New Individual enrollments	302
Total new enrollments	751

Total FHIAP enrollment on 9/30/03 5,631

Disenrollment from FHIAP due to non-payment of premium

Total third quarter disenrolled for non-payment 80

Fully Capitated Health Plans

Effective in July 2003

- Kaiser Permanente is no longer a contracted health plan with OMAP.

Dental Plans

Effective in July 2003

- Capitol Dental Care closed to new enrollment in Linn and Benton Counties with a 30 day re-enrollment period.

Effective in August 2003

- Capitol Dental Care re-opened for enrollment in Jackson County.
- Capitol Dental Care re-opened for enrollment in Lincoln and Tillamook Counties.
- Managed Dental Care closed to enrollment in Tri-County area with no re-enrollment period.
- ODS re-opened for enrollment in Josephine, Jackson, Malheur and Tri-County area.

Effective in September 2003

- Capitol Dental Care re-opened for enrollment in Linn, Benton, Marion, Polk, and Tri-County area.

Managed Care Activities

The Delivery Systems Unit (DSU) coordinates the monthly meetings of the managed care plans CEOs and plan contacts. These meetings include Fully Capitated Health Plans (FCHPs), Dental Care Organizations (DCOs), Mental Health Organizations (MHOs) and a Chemical Dependency Organization (CDO). Below are the areas of focus during the third quarter of 2003:

July 2003

- DSU staff worked with the Client Advisory Services Unit to write protocol for violent/threatening behavior.
- The Primary Care Case Management program (PCCM) was renamed to Primary Care Manager (PCM) program.
- Approximately 5,500 OHP clients were auto-enrolled from fee-for-service into managed care in specific counties.
- Effective July 15, 2003, OMAP required pharmacy providers to bill Medicare as a Third Party Resource for OHP recipients with Medicare coverage.
- Healthy Starts Project: CMS requested states to contract for the distribution of 13 pre-printed publications to the families of children born within the state's Medicaid system.
- 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.

August 2003

- Staff implemented HIPAA requirements related to enforcement, contingency planning, as well as security and privacy standards.
- Approximately 4,000 OHP clients were auto-enrolled from fee-for-service into managed care in specific counties.
- 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 will be reported to the Legislative Emergency Board in November 2003.
- Effective August 1, 2003, to comply with the Balanced Budget Act (BBA) requirements, OMAP adopted new OHP rules to change 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.
- Staff continued work on mid-month benefit changes of clients going from the OHP Standard to the OHP Plus benefit package.

September 2003

- OMAP transmitted he final version of the 2003-04 Capitation Report to each of the plans.
- OMAP notified the plans that the fee-for-service rate changes will take place for RVU Weights, DRG Hospitals, Hospice and Durable Medical Equipment and Supplies effective October 1, 2003.
- DSU created an Assignment/Assumption contract for interested FCHP's and DCOs.
- OMAP created a Physician Care Organization (PCO) Implementation team to begin working with various participants to investigate the feasibility of this 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.
- Staff continued work on mid-month benefit changes of clients going from the OHP Standard to the OHP Plus benefit package.

Regional Meetings

Oregon Health Plan Regional Meetings were held in the following areas:

September Grant, Deschutes, Crook, Jefferson, Coos, Curry, Lincoln, Multnomah, Washington, Linn-Benton, Marion, Polk, Yamhill, Columbia, Clatsop, Douglas and Josephine Counties. (see attachment 4)

Premiums and Waivers

OHP Monthly Premium Billing and Payments July - September 2003				
Month	**Households**	**Total Billed**	**Total Receipts**	**% of Total Billed**
July	56,596	$641,541	$667,606	104%
August	49,805	$585,844	$552,346	94%
September	46,675	$594,948	$548,879	92%
Totals	153,076	$1,822,333	$1,768,831	97%

Premium Waivers (Past Premiums - Billed Prior to Feb 2003) July - September 2003			
Waiver Type	**July**	**August**	**September**
Zero Income	488	449	380
Case Discrepancy*	482	601	519
Crime Victim	1	4	4
Domestic Violence	86	78	76
Homeless	184	147	159
Natural Disaster	14	22	10
Death in Family	3	0	5
Total	1258	1301	1153

*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

Telecommunications and Applications

During this quarter, the OMAP Telecommunications Center received a total of 33,685 calls, a decrease from the previous quarter's 36,283. The number of calls abandoned was 3,899, a decrease from the previous quarter's 4,087.

The OHP Applications Center received 49,599 calls, a decrease from the previous quarter's 52,316. The number of calls abandoned, at 2,142, was a decrease from the previous quarter's 2,556. The center received 4,462 hospital hold requests, down from the previous quarter's 6,584.

Telecommunications and Application Center July - September 2003	
OMAP Telecommunications	
Calls received	**33,685**
Calls answered	**29,786**
Calls abandoned	**3,899**
Transferred*	**23.9%**
Avg. calls/agent mo.	**3,310**
OHP Application Center	
Calls received	**49,599**
Calls answered	**47,457**
Calls abandoned	**2,142**
Transferred**	**8.0%**
Avg. calls/agent mo.	**2,921**
Hospital holds	**4,462**
App's requested	**37,552**
Redeterminations mailed	**37,659**

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

Client Advisory Services

During this quarter, the Client Advisory Services Unit (CASU) received a total of 13,256 calls from clients or their representatives. This represents a 15% decrease over the 16,243 calls taken during the previous quarter.

The calls for this quarter and the previous quarter were distributed over the following categories of issues:

	2nd Qtr	3rd Qtr
Problems with Access to or Denial of:		
Medical Services	4,053	3,389
Pharmacy Services	2,339	2,131
Dental Services	706	712
Mental Health or Chemical Dependency Care	210	156
Specific Quality of Care Issues	45	39
Client Receipt of Provider Billings	2,417	2,061
Copayment Issues	422	347
Premium Questions	742	665
Eligibility Questions	1,905	2,166
Other Issues	2,777	1,590
TOTALS:	**16,243**	**13,256**

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.

The 1,590 “Other Issues” include such items as application questions, managed care enrollment or disenrollment requests, requests for client materials, and questions about the Senior Prescription Drug Assistance Program. The unit also processed 268 HIPAA-required certificates of creditable coverage, 487 pharmacy lock-in change requests, and 46 requests for certificates attesting to the lack of prescription drug coverage.

Outreach Activities

During the third quarter 2003, the Outreach Coordinator held a Quarterly Outreach meeting on July 14 with 45 participants attending. Outreach trainings were held in July at the Safety Net Clinic with 15 participants, and in September with 25 participants.

Senior Pharmacy and Communications

Senior Pharmacy and Communications Unit staff worked on revisions to administrative rules to reflect program changes as directed by the Oregon Legislative Assembly. Effective dates for these changes range throughout the third and fourth quarters 2003.

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

Additional projects completed during the quarter include:

- Included an informational brochure regarding the mail order pharmacy program with both July and September Medical Care IDs. (see attachment 5)
- Mailed a notice to clients regarding a change in premium requirements. (see attachment 6)
- Mailed the final in a series of notices to clients regarding Trip Link, a new medical transportation brokerage. Trip Link began serving clients in Marion County during the third quarter 2003. (see attachment 7)
- Mailed a number of notices to fee-for-service OHP clients who were auto-enrolled into managed care in specific mandatory enrollment areas.

- Sent a notice to clients regarding the CareEnhance program for clients with diabetes, asthma or adult heart problems. (see attachment 8)
- Mailed a notice to fee-for-service providers regarding electronic billing changes and HIPAA requirements. (see attachment 9)

Managed Care Client Complaints

The Managed Care Plans Complaints and Grievances Report contains data from the second quarter 2003. Managed care plans are allowed 60 days from the end of the quarter to submit their information, therefore this chart will always show information from the previous quarter. (see attachment 10)

System and Encounter Data

HIPAA

- Established a Trading Partner Agreement (TPA) for Electronic Data Interchange (EDI) submitters and set a compliance date of October 15, 2003, for receipt. Of the 3,000 providers expected to complete an EDI TPA, 1,415 have been received, validated and registered in the data base, 230 await processing, 48 providers have been contacted for assistance and 165 have faxed a response stating they are in the process of completing the TPA. 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. As staff have circulated the various outreach documents, the volume of activity in these two areas has increased by 300%.
- Completed initial release of the Companion Guides for the 820, 834 and 837 transactions. Updating as needed is an ongoing process.
- 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.

- Invited approximately 239 electronic submitters to DHS' third party testing site. Of those fee-for-service submitters, 30 have passed edits for the 837P and 15 continue to test, four passed edits for the 837I and one continues to test, one is currently testing for the 837D. Of the managed care submitters, six have passed edits and three continue to test for the 837P, one passed edits for the 837I and one continues to test, one passed edits for the 837D and one continues to test.
- 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. A workgroup consisting of managed care plans and DHS HIPAA staff meets monthly to review progress, standards, compliance issues, concerns and readiness.
- Conducts 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.
- Completing a gap analysis between the current system configuration and what is needed so that DHS can accept nursing home turn-around document (TAD) claims in the 837 format.

Systems Activity

- Seventy new system requests written.
- Seventy-three system requests completed.
- Implemented a new system request process that more accurately reflects the priority of each request.
- Complete auto enrollment process in multiple plan areas on a county by county basis.

- Continuing work on the ability of users to update Health Services Commission screens.
- Although many of these changes are pending federal approval, work is continuing on establishing the systems requirements resulting from the 2003 Legislative Session, including:
  - Revise OHP Standard benefit package
  - Expand CHIP coverage to 200% Federal Poverty Level
  - Establish MEDS prescription drug program for seniors and disabled
  - Limited hospital benefit for OHP Standard
  - Standard Physician Care Organization
  - American Indian/Alaska Native OHP Standard clients to receive OHP Plus benefits that are subject to 100% federal match
  - Reinstate retroactive eligibility for OHP Standard clients
- Participating in developing a request for participation (RFP) for fee-for-service Pharmacy Benefit Manager/Pharmacy Benefit Administrator function and for any FCHP(s) that might want to piggyback on the contract.
- Activity around access to the online eligibility system included:
  - Created 175 user IDs during the quarter. This includes setting up new users, modifications for current users and re-setting passwords.
  - Created 12 On-Line Access agreements. These are all for new users of the online eligibility system.

Encounter Data Validations

- OMAP provides all managed care plans with one 'rolling' year of data for rate setting on a FTP site, which is updated quarterly for their analysis and review.
- OMAP routinely completes data validation on a variety of areas. The results of these validations are shared with the managed care plans. The most recent validation produced anomalies with surgical maternity claims. Affected managed care plans reviewed and resolved the anomalies.
- Encounter staff has ongoing outreach with the managed care plans to determine status of readiness, problems or concerns related to their transition to HIPAA compliance.
- OMAP staff assist managed care plans to resolve any data integrity issues with rate data.

- Encounter staff work closely with managed care plans to resolve HIPAA transaction and code set concerns.
- OMAP has been working closely with the FCHPs to submit pharmacy data for rate analysis.
- OMAP completed training for all staff on the new Decision Support/ Surveillance and Utilization Review System (DSSURS) data research and analysis system. Encounter staff have begun using this data research tool.

Monitoring and Quality Improvement

Quality and Performance Improvement

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. A copy of the approved charter is included with this report. (see attachment 11)

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 QPI Workgroup will design meetings to be active, participatory, actionable, and to demonstrate the Plan-Do-Study-Act (PDSA) cycle of improvement where possible.

The first QPI meeting was held on September 8, 2003. The agenda included routine updates and announcements for ongoing topics of interest: External Quality Review (EQR) and CAHPS; Performance Measures; the October 14 Statewide Quality Improvement meeting on "Reducing Racial and Ethnic Health Disparities", the Oregon Diabetes Collaborative II, the Oregon Quit Line, and the

"Keeping Oregonians Healthy" publication on chronic disease. The workgroup also discussed and approved process decisions for meeting times, frequency, co-chairs, DCO survey/involvement, and agenda topic selection. Chronic disease self-management support was discussed as an enhancement for patient-provider interactions, medical office environments, and policy and environmental support. Three medical and dental plans gave presentations on their ECCP programs. Additionally, the workgroup initiated a discussion on how to improve performance measures for applicability and meaningfulness to OHP plans. For more specific information, refer to attached minutes. (see attachment 12)

Quality Improvement/Evaluation/Monitoring

Site Reviews

On-site reviews/evaluations of FCHPs and DCOs were conducted, as follows:

August	Hayden Dental
September	MultiCare Dental

Final reports were issued this quarter, as follows:

DOCS (see attachment 13)

Willamette Dental (see attachment 14)

Survey Activities

CAHPS survey is now part of our External Quality Review.

External Quality Review

Update on the three major tasks for the EQR:

- Task 1: Rapid Cycle Improvement. OMPRO, our External Quality Review Organization developed 10 clinical practice summaries from which five will be chosen to conduct in the two years. The first three topics chosen are: 1) Emergency Room use for emergent/non-emergent conditions, 2) access to care, and 3) diabetes. The reviews use administrative/claims data looking for out-of-range variations that will then be followed-up with clinical chart reviews if out-of-range findings are present.

- Task 2: OMPRO began compiling a list of all Quality Improvement and Performance Improvement projects being worked on by the managed care organizations.
- Task 3: The mail-in portion of the CAHPS survey was fielded in late September. Data collection will continue through the fourth quarter.

Collaborative QI and Performance Improvement Projects

Our Quality Improvement staff are working 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.