Oregon Health Authority

February 2012 DMAP Update

Oregon is national leader in Electronic Health Record adoption

Background

The Centers for Medicare and Medicaid Services (CMS) provide federal incentive payments to eligible providers and hospitals to adopt, implement, upgrade or demonstrate *meaningful use* of electronic health record (EHR) technology. The incentive program is part of health care reform within the Affordable Care Act.

The term *meaningful use* is defined as *EHR used in a meaningful manner such as e-prescribing, the submission of clinical quality measures, and the exchange of health information to improve the quality of health care.*

A sizable, growing amount of federal incentive payments are making their way into Oregon to help providers and hospitals defray costs of installing and using electronic health records.

Nationally, the percentage of non-hospital based physicians who have adopted a basic EHR has doubled from 17 percent in 2008 to 34 percent in 2011. Nearly 40 percent of primary care providers have adopted an EHR.

Update

Oregon currently leads the nation in electronic health record (EHR) adoption, thanks largely to individual and small-practice providers. A recent survey by the **Oregon Community Health Information Network** shows more than 2,700 Oregon providers and hospitals are participating in the federal incentive program.

To assist with the adoption of EHRs, we are working with multiple key partners including:

— OCHIN

— Oregon Medical Association

— Oregon Office of Rural Health

— ORHQN (Oregon Rural Health Quality Network

— Oregon Health and Sciences University

— Oregon Association of Family Physicians

— Independent Physicians Associations (IPAs)

Oregon Long-Term Care Survey

The **Office of Health Information Technology** conducted a survey on technology adoption within the long-term care community. Results show that Oregon's long-term care community is interested in adopting technology to improve care delivery. Most of the facilities currently use some type of technology, but only 30 percent use electronic health records (EHR). The survey found the main barriers to adoption are cost of implementation and staff training. Despite the low level of current users, there is a clear interest within the long-term care community to expand technology to improve care coordination.

State demonstration grant: Medi-Medi project

Background

Oregon was one of fifteen states selected by Centers for Medicare and Medicaid Services to receive federal grant funds to integrate care for dual-eligible (enrolled in both Medicare and Medicaid) clients. The funds allow states to design innovative ways to meet the medical needs of the nation's lowest -income and chronically-ill citizens. Nationally, dual-eligible clients make up 15 percent of the Medicaid program, but account for 39 percent of claims.

Update

The Center for Medicare and Medicaid Services (CMS) has offered states a new opportunity to pursue three-way contracts among the Oregon Health Plan, managed care plans and CMS. The three-way contracts would blend CMS Medicare funds with Medicaid funds for state administration.

The program's financial responsibility would be retained by the Oregon Health Authority and provide for long-term care services, mental health drugs, and some residential treatment services for clients with severe mental health conditions.

Our design focus is for a person-centered system of care delivered through the *proposed* Coordinated Care Organizations (CCO). The design calls for the *proposed* CCOs and our *current* long term care delivery system to deliver health care services covered by Medicaid and Medicare Parts A, B and D. Financial accountability would be shared between the two programs to ensure cost-shifting does not occur.

In-house Prior Authorization; one year later

On January 1, 2011, we moved *fee-for-service* Prior Authorization (PA) approval from a contracted vendor to in-house. The move saves the state money, assures program consistency and increases process speed. At the same time, we expanded PA criteria for the Oregon Health Plan to include additional surgical procedures and imaging tests.

Processing the PA requests in-house gives us the ability to review areas of overlap, quality-of-care, over-utilization and to communicate directly with the provider. Providers submit PAs through our Provider Web Portal.

Another benefit we realize from processing PAs in-house is the ability to follow-up and sample resulting claims. Our technical staff sample and review 30 PAs each month in non-surgical/non-imaging categories to verify claim payments were received and look for payment discrepancies.

Note: Managed care organizations process PAs for their enrolled providers.

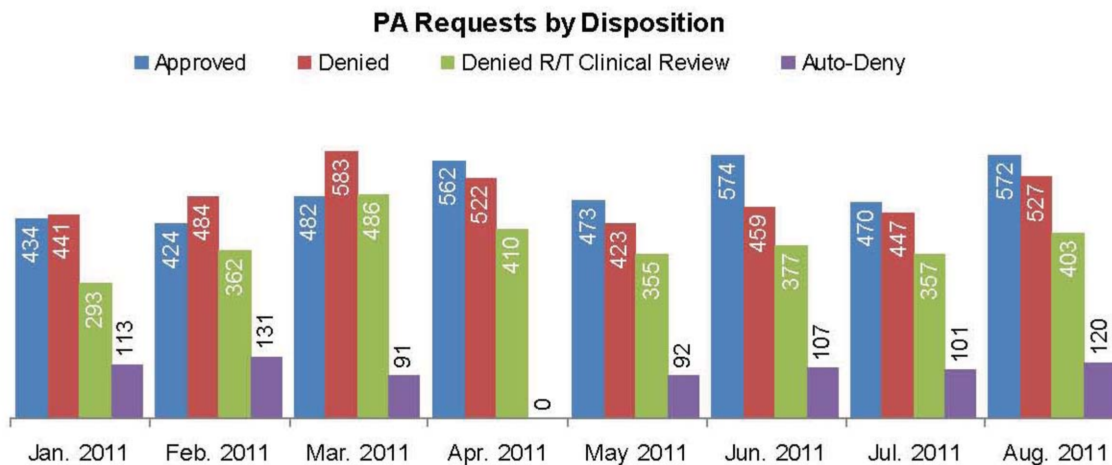
Our Medical Section receives an average of 1,612 Prior Authorization requests each month.

Prior Authorization average monthly requests by category

Category	Total
All	1612
Top category requests	
Lab & X-ray	314
DME	253
Physical Therapy - hospital	58
Hospital - Outpatient	47
Physical Therapy - not hospital	43
Hearing - not hospital	39
Home Health	33
Physician	26
Occupational Therapy - hospital	23

* If a PA request does not meet criteria for approval, staff requests additional information from the provider. At this point, the provider may withdraw the request, choose a different treatment or service, or ask for a review from our Medical Management Committee. Committee members are medical practitioners, policy and delivery system staff. If the PA is denied, providers (and clients) may also request an Administrative review (if the client is a plan member) and Appeal from DMAP.

Prior Authorization by benefit package and denial type



Daily hospital census review

As part of our **Continuous Improvement** program and to increase quality health care, our Medical Section staff has been reviewing and tracking daily hospital census reports from Oregon hospitals with Oregon Health Plan (OHP) client activity. The census report is evaluated for a client's length of stay and adherence to Prior Authorization non-emergency criteria. All procedures that require Prior Authorization or show an OHP client readmission within 15 days, are reviewed. In addition, staff conduct quality control reviews for appropriate *Prioritized List* pairing, adjudication and emergency room criteria as it relates to the different OHP benefit packages.

Winter storms reinforce direct deposit payment method

We have been promoting *direct deposit* as our preference for fast and secure provider payments. The recent winter storms we experienced underscores the value of *electronic fund transfers*.

A trend was discovered during a routine morning briefing (LEAN huddle) when Provider Service representatives noted an increase in provider telephone questions about delayed payments. We began investigating our vendors who process our provider payment checks. We discovered that, due to storm damage, one vendor had not mailed provider checks for nearly two weeks. Unfortunately, the vendor did not alert us to the critical situation and provider checks were delayed.

Setting up direct deposit is easy with our one page form (*Electronic Funds Transfer: Form 189*). Download the form at https://apps.state.or.us/Forms/Served/de0189.doc.

For more information and to speak with Provider Service representative: dmap.providerservices@state.or.us or 1-800-336-6016, Monday through Thursday, 8:30 a.m. to 4:30 p.m. and Friday 10 a.m. to 4:30 p.m. (phone lines closed 11:25 a.m. to 12:30 p.m.)

5010 deadline approaches

Health care providers and associated industries, agencies and individuals throughout the nation are approaching 5010 coding implementation. We are continuing our testing where we confirm billing systems comply with HIPAA 5010 standards, and for Oregon Medicaid providers, DMAP's specific billing requirements.

We are committed to a smooth transition and assisting our providers prepare for the change from 4010 to 5010 coding methodology. Our communication efforts are through a variety of media including mail, eSubscribe, presentations to medical associations across the state, Remittance Advice messaging, training classes, Provider Web Portal and our home Web page. Outreach has been directed to our fee-for-service providers, trading partners and managed care organizations. For questions about 5010 registration or testing, contact Electronic Data Interchange (EDI) staff at dhs.edisupport@state.or.us or call 1-888-690-9888.

5010 compliance for the Oregon Health Plan

Learn more about these steps at www.oregon.gov/OHA/edi/5010.shtml

Feb. 2012	Mar. 2012	Apr. 2012
■ Complete 5010 registration	■ Business-to-business testing	■ 5010 only accepted

For updated information on other areas of interest

- **Oregon Health System Transformation** — To track the transformation process, visit http://www.health.oregon.gov/.
- **Medicaid Management Information System** (MMIS) — Stay up-to-date with news on claim processing and other transaction updates and changes through eSubscribe and Provider Matters.
- **Federal health care reform** — With our own health care reform already underway, Oregon is well positioned to implement the federal legislative changes. For more information, visit the Oregon Health Authority Web site at www.oregon.gov/OHA.
- **Continuous Improvement program** — Enabling DHS and OHA to continue providing quality services at a time when demand is outpacing revenue and create a culture of continuous improvement where change is driven by staff. For more information, please visit www.oregon.gov/DHS/transformation.

Consider eSubscribe to receive information and updates as soon as they are posted. Personalize what information you receive and delivery time and method.

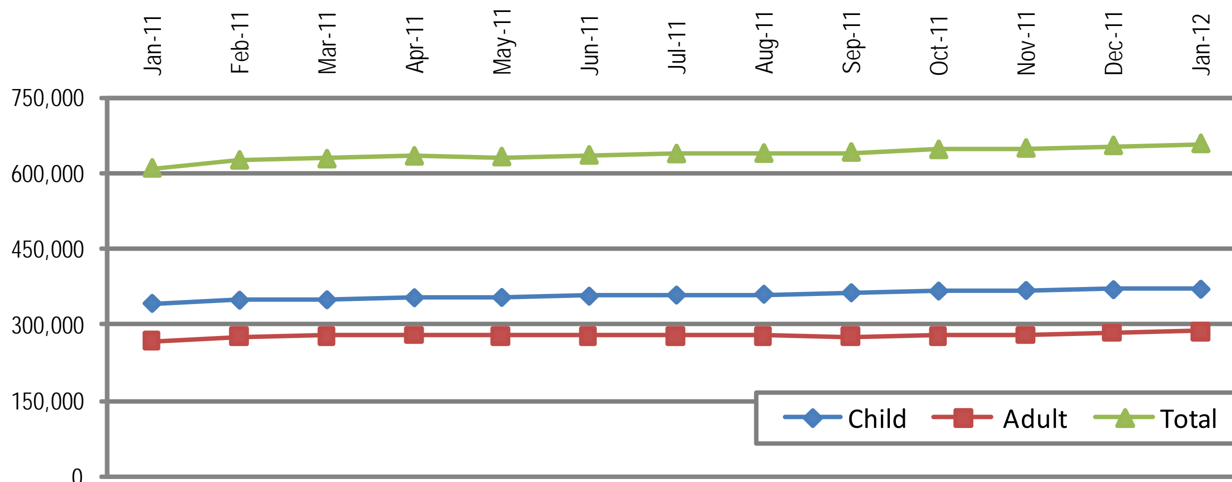
Demonstration and State Plan Amendment status

The following table outlines the status of Demonstration and State Plan Amendments (SPAs) under review by the Centers for Medicare and Medicaid Services (CMS).

Description *(new information is highlighted)*	**Status**	**Rule Change***
Demonstration Amendments		
No demonstration amendments are currently under review.	n/a	n/a
Medicaid SPA		
Targeted Case Management — Self sufficiency program	Submitted 3/17/10	No
Targeted Case Management — Children who are the responsibility of child welfare	Submitted 6/27/08	No
Provider rate change — 2011-13 budget item, rate changes for DME, Dental, Home Health, Clinical lab, Anesthetists and Ambulance. Other services using RVU method are revised for Physicians (non primary care), PT, OT, and speech.	Submitted 7/14/11	Yes
Pharmacy dispensing — 2011-13 budget item change with dispensing fee tier claim volume.	Approved 1/12/12	Yes
1915(i) state plan option for Home Based Habilitation, HCBS Behavioral Habilitation, HCBS Psychosocial Rehabilitation for persons with Chronic Mental Illness — Allows additional flexibility in designing a complete care system for persons with chronic mental illness.	Submitted 7/29/10	Yes
Health homes — A health home model of service delivery that encompasses all the medical, behavioral health, and social supports and services needed by a beneficiary with chronic conditions per the Affordable Care Act.	Submitted 9/7/11	Yes
Dental — Reduce some dental services to pregnant women as a further reduction based upon the 11% biennial budget reductions.	Approved 12/21/11	Yes
Hospital Disproportionate Share (DSH) process — Revise Upper Payment Limit and DSH Distribution method for DSH hospitals in order to maximize the use of the DSH allocation. This SPA will also address the companion letter to SPA 10-17, which requires a narrative description of the process used to determine the UPL.	Submitted 9/29/11	Yes
Nursing facility — This proposed amendment implements a change in the nursing facility rate setting methodology as adopted by Oregon's 2011 Legislative Assembly. Due to decreased state revenues, the Legislative Assembly elected to maintain the nursing facility rates in effect as of June 30, 2011 instead of allowing the normal "rate rebasing" process to proceed.	Submitted 9/29/11	Yes
Pharmacy and Therapeutics Committee — Pursuant to the passage of HB 2100, the DUR Board which is the current recommending body of Prior Authorization Criteria and federally required retrospective and prospective drug utilization review programs will be abolished. It will be replaced by a Pharmacy and Therapeutics committee that will bear the same responsibilities and assume Preferred Drug List (PDL) development responsibilities that will be based on safety, efficacy, and cost.	Approved 1/13/12	Yes
Provider preventable conditions — Implement changes to federal law which mandates a prohibition of payments for Provider Preventable Conditions associated with health care acquired conditions.	Submitted 12/27/11	Yes
"Patient-Centered Primary Care Home" for non chronic conditions — A health home modeled after the Health Home SPA for chronic conditions.	Submitted 12/28/11	Yes
Outpatient Hospital Rate Method — Implements SB 204: requires OHA to develop a uniform payment methodology for hospitals and ambulatory surgical centers. The SPA describes the Ambulatory Payment Classification (APC) methodology used by Medicare.	Submitted 1/12/12	Yes

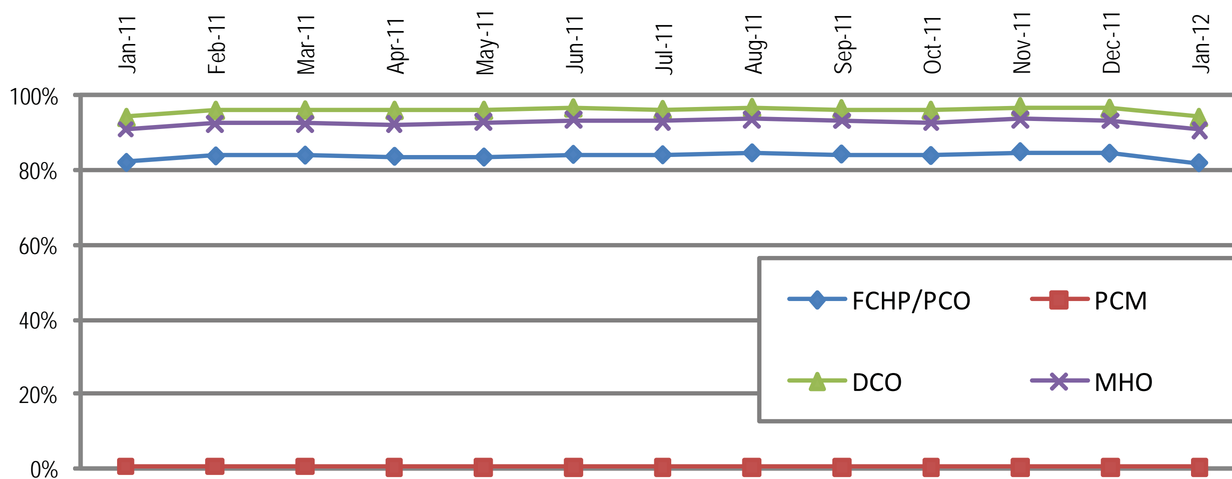
Enrollment Snapshot - January 2012

Number of Oregonians on Medicaid: Total, Adults and Children



Medicaid Enrollment	January 2011	January 2012	Percent Increase
Children (18 and under)	342,272	370,561	8.27%
Adults	267,717	286,496	7.01%
Total	**609,989**	**657,057**	**7.72%**

Percent Enrolled in Managed Care: FCHP/PCO, PCM, DCO, and MHO



Managed Care Enrollment	January 2011	January 2012	Percent Increase
Fully Capitated Health Plans/ Physician Care Organizations	466,247	512,664	9.96%
Primary Care Managers	3,515	2,783	-20.83%
Dental Care Organizations	535,207	586,909	9.66%
Mental Health Organizations	516,045	567,449	9.96%