

**MMIS/MCO WORK GROUP**  
**Managed Care Contractors**  
**June 14, 2006**

**Attendees:**

MCO Participants: Bill Murray - DOCS  
Chris Norman – Intercommunity Health Network  
Maggie Trouslot – OHMS  
Marisia Ybarra – Hayden Family Dental  
Suzanne Saulman – OHMS  
Vickie Tuttle – NW Dental

Stakeholders: Kathy Ottelle – PHTech

DHS Participants: Alice LaBansky, HFO Manager, MMIS/MCO Workgroup co-chair  
Chris Barber – DSU  
Ralph Summers – DHS /OMHAS  
Kathy Wills – OPAR  
Patricia Patten – OPAR  
Patricia Krewson – TEDS  
Ed Deery – Finance and Policy Analysis

Electronic Data Systems (EDS) Paul Combs – Provider/MCO Implementation  
Terry Fisher-Johnson

MMIS Replacement Project Jim Joyce, Project Manager and MMIS/MCO Workgroup co-chair  
Jennifer McKinley, Business Lead

MMIS/MCO Scribe: Dolores Humphreys

Attachments: Issues Log  
MMIS/MCO Workgroup Charter  
OMAP MMIS Project Schedule  
MMIS Talking Points

**NEXT MEETING**  
**July 19, 2006**  
**8:30-10:00 AM**  
**Human Services Bldg. Rm. 473**  
**Salem, OR**

**Agenda Item: Introductions** –Alice apologized to everyone present for the room mix-up and thanked the group for their patience as we worked things out. Everyone introduced themselves by name and whom they represented.

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**Agenda Item: Purpose: Approval of Charter and May Meeting Minutes – Alice LaBansky** – Alice went over the MMIS Workgroup Charter. The purpose of this workgroup is to provide a collaborative effort to inform and gain understanding of the new Medicaid Management Information System (MMIS) functionality and the impact on managed care business rules, policies, contracts and processes. This workgroup is also a forum for problem solving and coordination among the Department of Human Services (DHS), Managed Care Organizations (MCO's), and partners.

This workgroup will serve as a discussion/brainstorming group to review relevant new MMIS functionality. We will identify and discuss the appropriate methods of transition from the current MMIS to the replacement MMIS and we will provide monthly reports to the Oregon Health Plan (OHP) Contractors core groups and the workgroup and/or the Contractors' Workgroup may determine other groups as well. Alice plans on giving updates at the monthly larger contractor work group on Thursday, at least highlights.

As far as the workgroup co-chairs, Jim Joyce and Alice will co-chair this group. We will meet on a monthly basis the Wednesday before the third Thursday, from 8:30 to 10:00 AM. If there are no relevant agenda items or topics the meeting will be canceled and notification will be provided prior to the meeting date.

As far as the meeting Agenda, we will use the last five minutes of our meetings to identify Agenda Items for future meetings and, of course, participants also have the option to send Agenda Items, if you like, that are not on the Agenda that come up during the month. OMAP will make sure that the Agenda Items are prepared and sent out at least one week in advance of every meeting.

As for Workgroup decision-making, the workgroup will follow the MMIS Replacement Project's Guiding Principles when making decisions. The ultimate responsibility, as far as making decisions, lies with our project sponsors. Our Project Sponsors for the MMIS Replacement Project are Clyde Saiki, DHS Deputy Director, Lynn Read, OMAP Assistant Administrator, and Kathy Cooper. OMAP will make sure we take minutes and we will also take responsibility for publishing those minutes and making sure that they get out to the workgroup for approval.

The May 17, 2006, meeting minutes were sent out electronically several times to make sure everyone got the information. Alice asked if there were any revisions. Ed Deery identified the word 'Program' in "Oregon Medical Assistance Programs" was not plural and it should be. This will be corrected.

Alice mentioned that there was a schedule of upcoming meetings on the back table and requested everyone be sure they had a copy. Alice then turned the meeting over to Jim Joyce.

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### **Agenda Item – MMIS PROJECT Overview Schedule – Jim Joyce**

Jim Joyce introduced himself and distributed one page of the 5 pages of charts that were used at the last meeting. Alice mentioned that there were going to be some new attendees at this meeting so Jim did a short summary of what he discussed last month, which is where the MMIS Project is presently and what interface that project has with this workgroup. The chart passed around was a draft plan of the business we intend to do over the next year. He stated that to "kind of set the stage for that plan, it's important for you to understand that DHS entered into a contract with EDS to transfer a MMIS from Oklahoma to Oregon." He then continued to explain the process. We need to modify that system to meet Oregon's Medicaid Programs

and our requirements, and implement by July 2007. We are currently on schedule to meet that implementation date. We have completed those requirements and are currently in the designing process. We expect to be in design through the summer and completing the design by September and we are on schedule to do that. Then there will be instruction, testing and training of internal users of the system and at the same time working with Providers on how the new system will affect the payment process. This is one of the forums we are using to communicate and work collaboratively with Providers as we implement the MMIS.

The overview schedule depicts how over the summer we are currently in design and we will identify issues as they relate to issues with design of the system. We will identify DHS policy issues that need to be discussed and answered by senior management; and we are also discussing with work units the details of how screens and reports and interfaces will work. As we identify issues that impact the MCO's we will be bringing those back for discussion with the group. With the input design process, we expect to bring to this group a draft specification of specifically how the MCO's will interface with the new system. The reason we call it a draft is that we expect there will be some areas that will need to be discussed. We would work through the specifications and make sure there is understanding of how that specifications work and if there is a need to change them or a need for more specificity then we would provide that. The understanding is that through the Fall we would be answering those questions and finalizing the specifications, allowing the MCO organizations to make the necessary changes to there systems in order to facilitate testing the system next spring.

We expect to use this meeting and Emails as a means to communicate what the specifications are and the implementation plan in process as we shoot for July 2007.

That is my three-minute summary of my twenty-minute presentation of the last meeting.

Now at the last meeting somebody asked the question, "How big of an impact do we expect the new MMIS to have on MCOs?" and I was reluctant to get into details because I wasn't prepared to get into the details. One of the things we would like to do is talk about what the

impact, we expect, is; realizing that we are still in the design process, and that we haven't resolved those issues yet. We would like to begin a conversation about what we expect the impact to be. I asked Paul Combs to talk at a high level about what the major impacts are going to be.

Jim asked if there were any questions.

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### **Agenda Item – EDS Presentation New Functionality – Paul Combs, EDS**

Paul is the point person with EDS, building and executing the plan for helping Providers/MCOs transition to the new MMIS. Paul reviewed this handout: "Talking Points for MMIS/MCO Workgroup Update on 6/14/06".

We're still in the design phase and this is an attempt to give you a general picture of the changes that are coming and there will be more detail to follow. There are probably things that will impact MCOs that aren't on this list, it's also possible there are things that we anticipate as an impact might be less of an impact. We just want to give you an idea of what is going on with a little more detail than just a small, medium or large impact. Paul noted that he categorized things in basic areas of Functionality.

#### WEB Functionality

I understand that today MCOs submit financial spreadsheets, hard copy into DHS and that's a function that will be supported on the WEB. You will be able to make those submissions to the WEB Portal. You will also have the ability to upload Provider files via the WEB, along with other functions including submitting encounters, voiding adjudicated encounter claims, program announcements, information downloads, contract information submission, submission of their provider network information and complaint submissions. Basically there will be a lot of functionality, a lot of opportunities to communicate and share information via the WEB that are done in different ways now.

MCOs will be able to check eligibility through the web, set up and maintain access for clerks. One of the functions the WEB portal will

have for Providers; the ability to set up different levels of functionality on the WEB portal and also the ability to designate for e.g. a clerk in an office will have the ability to view certain kinds of information and another clerk will have the ability to submit or modify claims and Providers, MCOs will have the ability to break up that responsibility within their office.

Paul asked if there were any questions about WEB Functionality?

Vickie Tuttle: On the last bullet, checking for eligibility, right now some Plans are testing with the 270/271 response where they submit for eligibility request, would it be something similar to that or a new interface to check eligibility?

Paul: What won't be supported on the web is an eligibility transaction submitted from the port. Not an interfaced transaction, but a transaction where there is actually panels on the web.

Alice: In other words, someone could sit down at the computer and bring the WEB portal up and take a look at the screen and see eligibility.

Paul: They would not need any application, except a browser, to submit new claims.

Vickie: Some Plans have set up there own interfaces to do something like that, this would be part of our normal contract and part of our normal interaction.

Jim: My understanding is currently MCOs get a copy of eligibility information and then have your own mechanism of distributing that eligibility information. We will continue that if necessary.

Vickie: Will that be available at the Provider level as well, or only the Plan?

Answer: undetectable

### Client Transition

Another feature we are working on and the design for the ability to pass information to the MCOs when a Medicaid client transitions from

FFS to managed care, for e.g. when a client had prior authorizations for a specific service, that's information that might be of value to the MCOs. As a Fee For Service client, what special services was this client receiving and how does it apply to the MCO. There is a little more detail here about how the prior authorizations will be handled. The main point here is that MCOs will get the transition information on the client.

### Eligibility

DHS has made a policy decision to implement a semi-permanent Medical ID Card for Medicaid clients. It is not a smart card; it's an ID card. It just has information required to identify the client, moving more to a model where eligibility is verified each time service is rendered. The card itself is not a guarantee of eligibility; it's an identifier for the client.

Alice: We can add to that, it means, at this point, we would not be sending out a monthly 8 1/2 x 11 card, so the card right now that we send out, gives a whole lot more information than just identifying the client. We have some decisions to make on the design of that card, but we would not be able to put all that information on the smaller card. We would ask the Providers to go the WEB portal to get that type of information.

The Department just made this policy decision in May, so we now have all the work it takes to make this change. But we do feel it's moving us forward toward more of what are the industry standards in healthcare, as to what the private commercial payers are doing with cards. We are also hoping it will benefit the clients so they will not look different than other subscribers with insurance plans.

More discussion followed on what will be the changes in checking eligibility.

Alice went over the comments that were made from the business when making this decision, so you know where we are at in this.

### Encounter Submission/Transactions

The ANSI X 12 837 transaction will be used for the submission of encounter claims to DHS, which is the same format that is used today. If specification changes are required, they will still be in this format.

The current requirement that MCOs submit their adjustment reason codes used to determine if they accepted or rejected the provider's claim when submitting encounters to the MMIS will remain in place

Vicki: Would the only difference be that we would be submitting that normal transaction through a different portal instead of the mailboxes that we currently have?

Paul: That is still under review, so I cannot answer that question. If there are any other changes that come out, as far as what values are going to be reported, those are changes that may be coming out.

Bill: It would be nice if everything went through one portal, instead of "for this you do this, for this you do that". It would just be nice for us to know that everything went through the portal. It would be more efficient.

## Contracts

Some modifications to contract language will be required associated with changes.

Reporting is going to look a little different than what you have today. Exactly how it's going to look different, I can't really tell you until the design has been finalized. Be prepared that it will.

Ralph Summers, OMHAS: Reminded the group to make sure that your Project team is aware of the timeline that it takes for us to implement contract changes. It takes approximately six months between when we are finished negotiating the specifics of the requirement and the language to be used to getting that contract approved by CMS and signed by everybody and effective. So we have to be pretty much done with specs and done with all of the negotiations around the specific language and requirements to be used six months prior to implementation and we have already missed

the opportunity to have these requirements in a contract on January 1. We are talking about and Amendment, which we try to avoid.

Jim: We are scheduling for that. We already have Jeremy Emerson involved in all the contract changes.

Bill M: We need enough time to know if we are going to have to change something on our side. It can't be we made final specs decisions on June 5 and you are going to have to do this July 1<sup>st</sup>.

### General

Because of the enhanced features of the new claims processing system and reporting, we hope and expect that is going to result in better data available including actuarial studies.

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### **Agenda Item – Issues Identified – Patricia Krewson**

I want to ask the group, Alice and Jim, as we meet and we discuss new system processes whether or not we should identify specific issue(s) that the group wishes to track? I am going to add them as they come up from the areas that I attend as part of the project work and bring them forward as that information is available, but if there are others that I didn't think should be added, should we have a discussion to say yes or no; things that you want to be added. I'm just throwing it out there. This is just something to think about. If you think I should put it on our policy issues or just our issues tracking.

Patricia: That's what I have been tasked with and I was just thinking rather than me being the only source of the information that goes on the log, since the original list was generated from the Plan, and now I am going to add things that I identified like the Medical ID card. Maybe in this meeting if we have a discussion and decide collectively, yes, that one needs to go on there then I will add that.

Alice: I think so too, that this should be made available to the Contractors as a handout at least.

Patricia: The reason I didn't bring the other one forward is I am changing the format of it a little bit, so it is clear and understandable. Next month I will have a list to share and then every month forward.

If you remember in March, I attached an e-mail that I sent, when we were in Provider requirements sessions earlier in the year; the reporting feature that the Plans would be notified if a Provider were sanctioned. That report would be generated. I suggested that would go back to the Plans and I requested your input and how you would like to see that. The handout that you have is the responses that I've gotten up until now, as you can see, three from the bottom. These are the folks I have heard from, the rest I have not. One correction, #10 should say Marion-Polk not Mid Valley, and Marion Polk on the second page needs to be changed to Mid Valley. This is where we are. It looks like it's primarily going to be a monthly report, if there is something to report. If there is nothing to report, then there won't be a monthly report.

The data element that I suggested in the email, seem to be OK with everybody. One person, Marion-Polk, asked for it to be an Excel spreadsheet and I don't know that we have developed the format with the project. I don't have any idea what the format will be, but that is a suggested format. The response was 50/50 on if you want a report on all Providers or just Providers specific to your area. We need to get a consensus on that and I would have to confirm that with the project staff. It seems it would be easier, but it is very rare that we get sanction information. That's what I have so far on that issue. We have asked the question and here are the responses. It has been three months and I will carry this forward to the Project just as it is and with the suggestions that are here. We will work on the "majority rules" process.

That is all I have at this point. Questions?

Chris N: Is information transitioned to you?

Patricia: yes

It was suggested by one of the MCO participants that the Medical ID card issue be directed to the Enrollment – Disenrollment Workgroup. **Action Item:** the Medical ID card will be forwarded to the E/D WG.

Chris: And then between both groups will bring these issues up or how if I don't attend the meeting, how will I get this issue to you?

Patricia: I hope, I think the suggestion was to take the one, ID card issue to Provider Enrollment/Disenrollment workgroup. If that type of thing went down, then it would need to come back up here so I could continue to track it and have that type of exchange going on, so the Encounter Data Workgroup came up with something, then it needs to come up to this group so we can track it.

MCO participant: With the HIPAA Group we had a liaison person that the Encounter Workgroup would get a report about what happened in the earlier meetings so that we could do that with the Enrollment/Disenrollment and have someone that went to both meetings report back what happened.

Patricia: We could follow that same format. Alice and I could take it back. I don't see why we couldn't.

Alice: One thing that we do need to put on the agenda for future meetings, is how we are going to present to you all the decisions that have been made. I saw this happening in the issues list that Patricia is handling, realizing that not every policy decision that is made by DHS is going to become an issue. We are committed to bring back all the decisions to this group that we feel do impact managed care. We would even share what we feel you might be interested in knowing about and not sharing the entire list.

We have a process in place for making these decisions. Last month we had a whole set of business decisions that we made in regard to policy, and the ID card is one of those. I would like to go over with you how this was presented. The issue on the ID card and how it was written up is the MMIS transfer systems configure to produce medical ID cards. DHS will adopt a semi-permanent medical ID cards and daily eligibility status changes as this supports industry best practices and meets DHS Guiding Principal #3 which is "To strongly consider the best practices and processing proven in other states to gain significant Medicaid Program performance".

I just wanted you to know that this is where we are, at this time. There is still going to be a lot of discussion on how this is going to work. I appreciate the discussion today and comments that were made.

Any other comments

Again I apologize about the meeting, the scheduling conflict. We will make sure that does not happen again. I appreciate everyone's patience. We will adjourn.

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## **Agenda Item – Questions and Answers**

Issues List

### **Actions:**

What is available?  
What will be available?  
How policy is made?