A publication of the Oklahoma Health Care Authority Summer 2002

HIPAA Compliance Still On Track

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is federal legislation mandating that several of the major health care electronic data exchanges (i.e., electronic claims and remittance advices) be standardized into the same national format for all payors, providers and clearinghouses. These Administrative Simplification provisions of HIPAA were passed with the support of the health care industry to lower the cost and administrative burdens of health care.

For more information on this legislation and its effects, providers may want to contact their provider associations, accreditation organizations or access the website for the federal Department of Health and Human Services (DHHS) at **http://aspe.os.dhhs.gov/admnsimp/index.htm.** The Centers for Medicare & Medicaid Services maintains a website that provides specific HIPAA information as it pertains to Medicaid at **http://www.hcfa.gov/medicaid/hipaa/adminsim/default.htm**.

OHCA Status

The Oklahoma Health Care Authority (OHCA) continues to transition to a new fiscal agent. On Jan. 1, 2003, OHCA will implement a new Medicaid Management Information System (MMIS). The change will have an impact on providers and particularly those who already submit electronic claims to the current OHCA fiscal agent, Unisys. Providers who currently submit on paper will be able to continue to do so.

OHCA intends to implement the HIPAA Transaction Set Standards and the associated electronic claims formats in the new system***. The current electronic claims formats will not be implemented in the new system.*** All providers who submit claims electronically to Medicaid will begin using the HIPAA format in mid-December 2002.

If a provider currently sends one of the electronic formats listed on page 4, they will need to transition to the new HIPAA format by mid-December. The specifications for the HIPAA electronic formats can be accessed at **http://hipaa.wpc-edi.com/HIPAA_40.asp**

OHCA will create training to prepare providers for implementation of the new MMIS and hence the HIPAA Transaction Set Standards based on the results of a survey sent to all active Medicaid providers.

Providers who submit claims electronically also need to be in close communication with their billing services, software vendors and clearinghouses to ensure they are prepared and ready to address the HIPAA changes. Ultimately, the provider is still responsible for

(continued on page 4)

More Moms Taking Advantage of Prenatal Care in Medicaid

The number of women receiving prenatal care in the first trimester jumped almost 20 percent over a four-year period for participants in Oklahoma's Medicaid urban managed care plans, according to a report in *The Journal* of the Oklahoma State Medical Association.

The Oklahoma Health Care Authority (OHCA) and the Oklahoma Foundation for Medical Quality analyzed documented patterns of care from the health maintenance organizations in Oklahoma's Medicaid managed care programs on an annual basis from 1995 through 1998.

The study found that in 1995, 31.3 percent of the patients had sought prenatal care in the first trimester with that number jumping to 50.6 percent in 1998. The number of patients receiving no prenatal care also decreased from 3.2 percent in 1995 to 2.9 percent in 1998.

"The Medicaid managed care program, both directly and indirectly, has shown improvement in early prenatal care, lower C-section rates, and lower instances of low and very low birth weight rates. Even with the improvement in rates over the four years of the

(continued on page 4)

Satisfaction with *SoonerCare* Shows Overall Increase

Consumer Assessment of Health Plans Survey (CAHPS®) results indicate an overall increase in the levels of satisfaction for the *SoonerCare* managed care programs from 1998 to 2001. The Oklahoma Health Care Authority (OHCA) adopted CAHPS® in 1997 to measure customer satisfaction for *SoonerCare* Plus (urban) and *SoonerCare* Choice (rural). The Oklahoma Foundation for Medical Quality (OFMQ) administers the surveys. Results highlight areas of possible improvement and provide health plans with useful information to enhance their programs.

Different populations are surveyed once per year including the adults and children enrolled in Plus and Choice, adult categorized as aged, blind and disabled, children with special health care needs, and behavioral health and dental care recipients. Approximately 750 people for each special population received a survey while 822 of the general Plus and Choice population received the basic survey. OFMQ selects the survey recipients by establishing the eligible population and then generating a random list.

Those asked to complete the survey normally receive a prenotification card, asking them to fill out the survey when it arrives. They receive the survey up to three times until they complete and return it. Response rates have ranged from 30 percent to 68 percent.

Choice

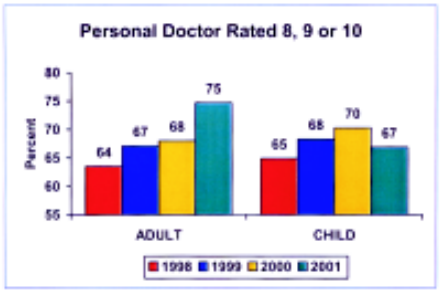
Health Care Rated 8, 9 or 10

The number of adults rating their health care an 8, 9, or 10, on a scale of 0 to 10 with 10 being the best, jumped from 55 percent in 1998 to 70 percent by 2001. For the same years, the number of parents rating their child's overall health care at 8, 9 or 10 remained steady between 65 percent and 68 percent.

Health plan rated 8, 9 or 10

Respondents for both the child and adult surveys for the overall health plan rating indicate a marked improvement in satisfaction, particularly with the adult surveys. In 1998, only 36 percent of adult respondents rated the plan as an 8, 9 or 10 on a 0 to 10 point scale with 10 being the highest. That number climbed to 57 percent in 1999 and ended at 52 percent in 2001. The number of adults who rated their child's health plan at 8, 9 or 10 has risen 12 percent from 53 percent in 1998 to 65 percent in 2001.

Personal Doctor Rated 8, 9 or 10

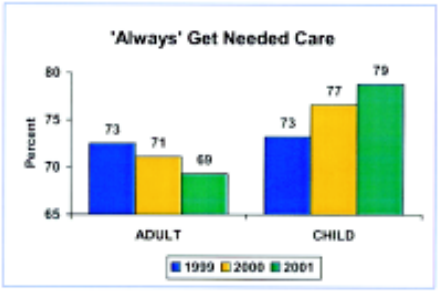


The number of adults who rated their personal doctor an 8, 9 or 10 increased consistently over four years, ending 2001 at 75 percent, 11 percent higher than the 1998 baseline. The number of respondents who rated their child's personal doctor 8, 9 or 10 also increased.

'Always' Get Needed Care*

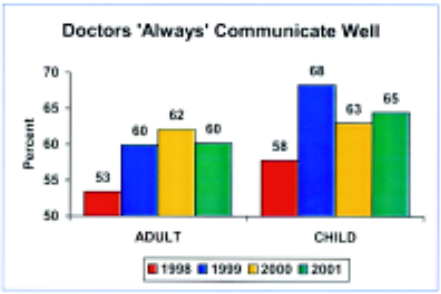
Respondents to the child survey were more likely to report that their children received the care they needed than the respondents to the adult survey. Adult percentages decreased by 4 percent from 1999 to 2001. The child survey response increased 6 percent from 1999 to 2001. This graph is a composite of scores made from sets or groups of like questions. The response format is 'Never,' 'Sometimes,' 'Usually,' or 'Always.'

**This composite was not included in the 1998 survey.*



Doctors 'Always' Communicate Well

Responses for both the child and adult surveys rose and fell from 1998 to 2001. Both scores ended 2001 7 percent higher than the 1998 baseline. This graph is a composite of scores made from sets or groups of like questions. The response format is 'Never,' 'Sometimes,' 'Usually,' or 'Always.'



Plus

Health care rated 8, 9 or 10

For *Plus* recipients, adult satisfaction with their overall health care, rating it at 8, 9 or 10, on a 0-10 scale with 10 being the best, went from 60 percent of the respondents to 69 percent between 1998 to 1999. 67 percent of adult respondents rated their Plus plan at an 8, 9 or 10 in 2001. Percentages for parents rating their child's health care at 8, 9 or 10 varied slightly with no more than a 2 percent difference either way from 1998's score of 71 percent.

Health plan rated 8, 9 or 10

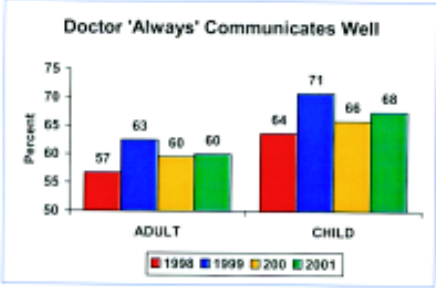
Adult satisfaction overall with their health plan increased six percentage points from the 1998 to the 2001 survey. Adults' ratings of their satisfaction with their child's health plan remained

(continued on page 3)

Satisfaction with *SoonerCare* (continued from page 2)

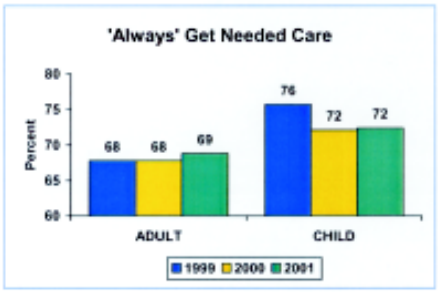
constant through the 2000 survey at 66 percent then dropped 4 percent to 2001.

Doctors 'Always' Communicate Well



Respondents are more likely to report that health care providers communicate well with them for their children than for themselves. Satisfaction with patient communication increased for adults three points between 1998 and 2001. After a jump from 64 percent to 71 percent, satisfaction on the child survey ended 4 percent higher at 68 percent in 2001. This graph is a composite of scores made from sets or groups of like questions. The response format is 'Never,' 'Sometimes,' 'Usually,' or 'Always.'

'Always' Get Needed Care*



Adults reporting they always get needed care remained constant from 1999 to 2001. Adults believing their child "always" got needed care dropped 4 percent to 72. This graph is a composite of scores made from sets or groups of like questions. The response format is 'Never,' 'Sometimes,' 'Usually,' or 'Always.'

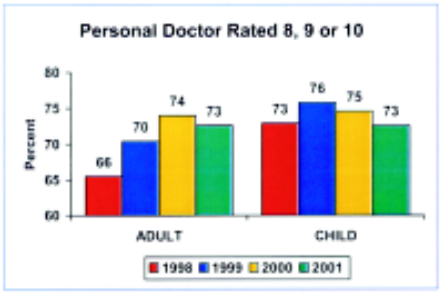
**This composite was not included in the 1998 survey.*

Personal Doctor Rated 8, 9 or 10

Adults who rated their doctor as 8, 9 or 10 changed by 7 percent from 66 percent in 1998 to 73 percent in 2001. Percentages for the child's survey have varied slightly, but were 73 percent for both 1998 and 2001.

Medicaid recipients began transitioning to managed care in 1995. Recent results of the satisfaction survey generally show increased levels of satisfaction with Plus and Choice as members gain more experience with their health plans.

The consumer input provided by CAHPS® is vital to improve services to better meet the needs of the Medicaid



population. It also provides consumers with needed information about quality in health care as well as comparative information about health plans.

The next round of CAHPS® will begin August 2002. Results should be available between the following December and June.

Health Plans Evaluate Performance with CAHPS

The Consumer Assessment of Health Plans Survey (CAHPS®) is the most well known health plan survey currently in use. CAHPS® focuses on information consumers want to know when selecting a health plan, but the results are also useful to health plans in evaluating performance and identifying areas of improvement.

The Oklahoma Health Care Authority began using CAHPS® in 1997 to measure client satisfaction among *SoonerCare* members. CAHPS® has also been adopted by the Health Plan Data Information Set (HEDIS®) for use in certifying health plans. Health plans must conduct the adapted survey to fulfill the requirement of having customer satisfaction surveys for their National Committee for Quality Assurance certification.

A consortium including Harvard University Medical School, RAND and Research Triangle Institute (RTI) developed CAHPS®. The project was funded through the Agency for Healthcare Research and Quality (AHRQ) and, in part, by the Centers for Medicare & Medicaid Services.

CAHPS® questions were subjected to extensive testing which included focus groups, in-depth cognitive testing, pilot studies, methodological experiments and large demonstration studies. While many existing consumer questionnaires about health care were tested only with a psychometric approach, the CAHPS® team used a combination of cognitive and psychometric approaches to try to produce the best possible survey instrument. The CAHPS® core questions were also subject to extensive cognitive testing across all populations to reach the appropriate reading level. The questions focus on what happened to patients and not why. This allows the questions to be utilized by all

(continued on page 7)

HIPAA Compliance Still On Track (continued from page 1)

Unisys/Current Electronic Format	HIPAA Transaction Set
Electronic HCFA 1500	837 Professional Claims
Electronic Dental claim format	837 Dental Claims
Electronic UB92	837 Institutional Claims
(Retail Pharmacy) NCPDP v3.2C or v5.0	NCPDP v5.1 (v1.1 Batch)
Paper R/A's will ***also*** now be available electronically (will still be available via paper)	835 Payment/Remittance Advice

ensuring their electronic submissions are in the HIPAA format.

Legislation to Delay HIPAA Implementation of Transactions and Code Sets

If an organization is not going to be HIPAA compliant with Transactions and Code Sets by Oct. 16, 2002, they must file a compliance plan with the Department of Health and Human Services before the October deadline. Filing the plan allows for an extension of the deadline for a "covered entity" like a provider. The extension is *only* applicable for one year. OHCA intends to file an extension that will be in effect until Jan. 1, 2003. OHCA's compliance plan will only cover OHCA's issues. Providers will have to submit their own compliance plan.

"Compliance" is defined as the ability to conduct the HIPAA transactions. Even if another entity that a provider exchanges data with is not ready yet, the provider is considered in compliance if he is able to complete his electronic business under the HIPAA formats.

Providers can access more information about the extension at **http://www.cms.gov/hipaa/hipaa2/ascaform.asp.**

Although providers can file for an extension, OHCA intends to implement only the HIPAA formats in the new system, *NOT the current electronic claims formats.* All providers who submit claims electronically to Medicaid – even those providers who file an extension – must use the HIPAA formats to submit electronic claims to OHCA by mid-December 2002.

Implementation of HIPAA Privacy Rules

The federal privacy regulations guarantee patients full access to their medical records, give them more control over how their personal information is used and disclosed and provide a clear avenue of recourse if their medical privacy is compromised.

Most entities must be in compliance with the privacy rule by April 13, 2003. It is important for providers to look at these rules and determine how they apply to their current practices. Providers may also want to contact their provider associations and accreditation organizations to find out more about the impact of the privacy rules on their practices.

Secure Website Information

Beginning in July, the Oklahoma Health Care Authority will present the first phase of its secure Internet site, which will give providers access to their Medicaid data electronically.

Initially, the secure site will offer Medicaid providers, billing agents and clerks convenient, yet protected access to specific claim information and status as well as prior authorization inquiries. The site also will include a global messaging system for better communication from OHCA to providers.

Once the second phase of the site is completed in January 2003, authorized users will be able to submit claims, edit claims, verify client eligibility, request prior authorizations (Fee for Service providers), download HIPAA 835 Payment/Remittance Advice statements and search pricing and limitations on procedures and drugs. The site will allow drug manufacturers to download a current quarter's drug rebate invoice files and will let providers make adjustments to their claims online.

A letter with more information on accessing the secure site will be mailed to providers soon.

More Moms (continued from page 1)

study, the OHCA continues to look for ways to increase the number of women within the Medicaid managed care population in Oklahoma who receive prenatal care," according to Dr. Lynn Mitchell, state Medicaid director.

The study also found the number of births by C-section declined over the period from 23.9 percent in 1995 to 20.8 percent in 1998. The number of very low birth weight (defined as below 1500 grams or 3 pounds, 4 ounces) rates was 3.7 percent for 1995 and fell to 1.3 percent for 1998. Low birth weight (between 1500 and 2499 grams or 3 pounds, 4 ounces and 5 pounds, 8 ounces) infants were recorded for 7.8 percent of the live births in 1995, and for 1998, 7.5 percent.

Prenatal care is a critical element in promoting positive outcomes for moms and their babies. Early prenatal care is associated with a reduction in the rate of premature deliveries and other complications of pregnancy. Studies have also linked adequacy of prenatal care with the subsequent quality of medical care the child receives.

In Oklahoma, there were nearly 50,000 births in 2000. The OHCA paid for about 21,500 or 43 percent of these births through the Medicaid program.

The Health Care Authority encourages women who think they may be pregnant and are unsure of their eligibility for Medicaid to contact their local Department of Human Services county office. They may also call the ***SoonerCare*** Helpline at 1-800-987-7767 to receive more information and an application.

Pharmacy Reimbursement Modified

The Oklahoma Health Care Authority Board of Directors approved emergency actions that changed the Estimated Acquisition Cost (EAC) and revised the formula for calculating State Maximum Allowable Cost (SMAC) for prescription drugs. The changes were approved to address the state budget shortfall and should save the state more than $1.5 million annually. These emergency actions are valid only through the end of the state fiscal year. The emergency EAC and SMAC measures have been sent to the legislature as proposed rules for permanent approval in order to extend these actions beyond the current state fiscal year.

Estimated Acquisition Cost

Nancy Nesser, DPH, JD, director of pharmacy programs for OHCA, explained that reimbursement for prescription drugs is divided into two parts: the dispensing fee, which covers pharmacy overhead, and ingredient cost, which is known as the Estimated Acquisition Cost.

"It is called an estimated cost because it is very difficult to ascertain the true cost of a prescription product on any given day," Nesser said. "This difficulty has resulted in a formula for reimbursement that is based on a widely available value, the Average Wholesale Price (AWP)."

AWP is set for each product by the pharmaceutical manufacturer who distributes it. It does not represent the price paid by the pharmacy for the product, Nesser said.

"Although the current OHCA administrative rules reflect an EAC of AWP minus 10.5 percent, the OHCA Board of Directors approved an emergency action that allowed the EAC to be changed to AWP minus 12 percent," Nesser said. "The change took effect Feb. 1, 2002 and is scheduled to remain in place subject to legislative approval."

A recent study by the Office of the Inspector General found that pharmacies usually pay significantly less than this and possibly pay as little as AWP minus 21 percent for branded products. A 2001 survey of acquisition costs completed for the Arkansas Medicaid program revealed that Arkansas pharmacies paid an average of AWP minus 17 percent for all products. As a result of that survey, Arkansas plans to reduce their EAC to AWP minus 14 percent. Thirteen states use an EAC of AWP minus 12 percent or lower. Thirty states use an AWP discount of 10 to 12 percent.

"In order to properly assess future changes in the EAC, OHCA plans to conduct a state-specific study of actual acquisition cost and cost of dispensing," Nesser said.

State Maximum Allowable Cost

The SMAC formula change will affect the prices paid for generic drugs and which generic drugs can be included in the SMAC program. The change will bring the list of generic drugs affected more in line with the needs of Medicaid recipients.

During fiscal year 2000, the original SMAC formula was introduced. The formula included the Maximum Allowable Cost (MAC) values used by the Oklahoma State & Education Employees Group Insurance Board (OSEEGIB) for their prescription drug benefit. The new formula for determining SMAC price is the median of generic equivalent prices from at least three manufacturers. The OHCA Board of Directors approved the new formula as an emergency action in January.

Since its inception, the SMAC program has grown from 150 products to more than 500. Nesser said inclusion of the OSEEGIB MAC price in the original formula was restricting OCHA's pharmacy program.

"First, if a product is not listed on the OSEEGIB MAC list, OHCA is unable to include those products in the SMAC program," Nesser said. "The OHCA client population differs significantly from the OSEEGIB client population. Many other products that would otherwise meet the qualifications for inclusion in the SMAC program were not eligible because they are not included in the OSEEGIB list."

Nesser went on to say that OSEEGIB MAC prices are based on national pricing data and are not reflective of prices available to Oklahoma pharmacies.

"In most cases, the OSEEGIB MAC price is 5 percent to 10 percent higher than the median price from wholesalers doing business with pharmacies in Oklahoma," Nesser said.

Customer Service: Keeping You Informed

Q What is the change that OHCA recently made to Part B Crossovers?

A The OHCA Board has approved a change in the method of payment for Part B Crossovers. This change will reduce the combined payment from Medicare/Medicaid to the Medicaid fee schedule amount. The current Medicaid RVU Based Fee Schedule reimburses at approximately 75 percent of the Medicare fee schedule. This change to Part B Crossovers eliminates payment for Part B coinsurance and reduces the payment for Part B deductible to 75 percent.

Q Why is OHCA making this change in the way it reimburses for Medicare Part B Coinsurance and Deductible?

A The Oklahoma Constitution, Article X, Section 23, prohibits a state agency from spending more money than is allocated. OHCA financial staff and the OHCA Board continually monitor expenditures to ensure that expenditures do not exceed monies allocated. Because of anticipated revenue shortfall, OHCA staff compiled a list of cost saving options for consideration by the OHCA Board and the Legislature. The Oklahoma Legislature reviewed this list, and made a supplemental allocation of additional funds to prevent the majority of the proposed reductions. The change in payment for Part B Crossovers was not one of the issues funded by the supplemental allocation.

Q Is this change permanent?

A This change is a temporary measure enacted on an emergency basis for the remainder of FY 2002. However, OHCA staff will be closely monitoring the appropriation proceedings during the current Legislative session. If the FY 2003 Part B crossover appropriation is not sufficient to return to the previous payment methodology, staff must take immediate steps to initiate emergency rule revisions to make this reduction permanent. It should be noted that the State of Oklahoma is currently experiencing a significant fiscal crisis. It is entirely possible that funds will not be available to prevent this reduction during FY 2003.

Q Medicare does not allow medical providers to routinely write off Part B coinsurance. In fact, Medicare considers this fraud. Are we going to get in trouble with Medicare if we do not bill the patient for the coinsurance OHCA does not pay?

A You are correct Medicare does not allow providers to routinely write off coinsurance. Medicare takes this position in order to discourage providers from inflating the routine charge for a procedure in order to secure 100 percent of the usual and customary charge from Medicare. However, when a provider files a claim with Medicare and the claim is subsequently transferred to Medicaid, the situation changes. The provider has agreed to accept the combined reimbursement from Medicare/Medicaid as full reimbursement. Since Medicaid does not pay on the claim because the Medicare payment exceeds the Medicaid allowable, both Medicare and Medicaid consider the subsequent write-off acceptable.

Q What if I choose not to file crossover claims with OHCA?

A This is not an option for providers with a current Medicaid contract. If the provider has a current Medicaid fee-for-service contract, all claims transferred electronically from Medicare Part B carriers will be processed automatically. In addition, the provider does not have the option of electing to accept assignment selectively.

Failure to file a claim does not release the provider from the Medicaid payment-in-full provision. The provider should not bill a Medicaid patient for coinsurance and/or deductible due on assigned Medicare claims.

Q If for any reason the claim for Part B Crossovers does not crossover electronically to Medicaid, am I required to file a paper claim for the coinsurance I know you will not pay?

A No, you are not required to file a claim if you believe payment will not be made. However, you may wish to do so for accounting purposes.

However, the Medicaid payment-in-full provisions described above remain applicable. The provider should not bill a Medicaid patient for coinsurance and/or deductible due on assigned Medicare claims.

(continued on next page)

Customer Service
(continued)

Q What if I collect the coinsurance from the patient at the time the service is provided?

A Since the Medicaid payment-in-full provisions apply, it would be inappropriate to bill or collect the coinsurance from the patient at any time.

Q Why should I continue to take Medicaid?

A The Oklahoma Medicaid Program has had a long, close relationship with the medical community. The Oklahoma Health Care Authority Board includes several representatives from the provider community. The Board and OHCA staff believe that the majority of medical providers will continue to provide much needed care to the vulnerable population included in the Medicaid program during this difficult financial crisis. The Board and staff of OHCA extend our sincere appreciation to the medical community for the care you provide to Medicaid clients.

Health Plans Evaluate Performance with CAHPS
(continued from page 3)

kinds of providers and health plans.

The surveys include screens, which help ensure that respondents only answer questions that pertain to them.

Three types of questions are included in a CAHPS® analysis:

- Questions that ask respondents to rate dimensions of their care from '0 to 10' where 0 is the 'worst possible' and 10 is the 'best possible.'
- Questions that ask respondents how often something happened for which respondents could choose 'Never,' 'Sometimes,' 'Usually,' or 'Always.'
- Questions that ask respondents whether they experienced a problem with some aspect of their care for which respondents could choose 'A big problem,' 'A small problem,' or 'Not a problem.'

CAHPS® questions are grouped into sets. This allows the results to be reported across a group as a mean or average, creating an easy way to communicate the questionnaire results to consumers. Survey categories include access to care, utilization of services, ability to get care without long waits, communication between health providers and patients, courteousness and helpfulness of office staff and health plan customer service. The survey also asks respondents to give overall ratings of their health plans, health care and personal doctor or nurse.

The surveys were designed to be standardized and practical, but flexible as well. For the CAHPS® Adult Survey 2001 that was sent to *SoonerCare* Plus members, for example, statisticians were able to extract teen smoking rates from the data. Of the 1,346 respondents from the four *SoonerCare* Plus health plans, 109 were 18, 19 or 20 years of age. Approximately 33 percent reported they smoke or did smoke. Of those, 60 percent reported smoking every day, 20 percent smoked some days and 20 percent no longer smoke. The incidence of smoking reflected in the survey data shows a considerable increase between respondents 18 and 19 years of age with more than a 16 percent jump from 21.7 percent of 18-year-olds reporting they smoke to 37.1 percent of 19-year-olds. For the teens who quit smoking, only one had quit smoking less than six months ago, while five had not smoked for six months or more.

Of the teens who smoke and had seen a health care provider, 63 percent had not been advised to quit smoking by their provider within the past six months. Across the entire survey including both adults and teens, 27.8 percent had visits with health care providers within the past six months and were not advised to quit smoking at these visits.

CAHPS® information is helpful across a wide spectrum of applications. While it was designed to help potential members choose a health plan, it also can provide a reminder to providers to consult with patients about their smoking status and encourage them to quit.

The OHCA *Provider Update* is published by the Oklahoma Health Care Authority for Oklahoma's Medicaid providers.

This publication is issued by the Oklahoma Health Care Authority in conjunction with the Oklahoma Foundation for Medical Quality as authorized by 63 O.S. Supp. 1997, Section 5013. Eleven thousand, five hundred printed pieces have been printed at a cost of .308 cents per copy. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.

The Oklahoma Health Care Authority does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services.

Please submit any questions or comments to Jo Kilgore in the Oklahoma Health Care Authority's Public Information Office at 405-522-7474.

Oklahoma Health Care Authority
4545 N. Lincoln Boulevard, Suite 124
Oklahoma City, OK 73105-9901

Oklahoma Health Care Authority
4545 N. Lincoln Boulevard, Suite 124
Oklahoma City, OK 73105-9901