eXPRS General System Overview – High Level

(updated 9/10/2019)

eXPRS is an electronic, web-based system built to manage service enrollment, reporting, billing and payments for all services provided to individuals with I/DD in Oregon. Since its implementation in August 2005, eXPRS has been expanded to also facilitate additional payment types and system features. As of January 2018, all non-medical services for individuals with I/DD funded from DHS/ODDS are managed via eXPRS.

Hierarchical structure

eXPRS is a system that has a hierarchical design. Meaning, there are foundational data elements that must be in place before other functions & additional services can be successfully implemented or authorized.

User Groups

There are 3 basic user groups in eXPRS to complete the work necessary in authorizing, managing/maintaining & billing for ODDS funded services:

- The **STATE** ODDS staff -- responsible for all the system foundational work *(see below)* such as provider record maintenance, establishing & maintaining contracts & funding allocation limits and other foundational data features.
- The **CASE MANAGEMENT ENTITY** (CME) such as a CDDP or Brokerage -- responsible for establishing & maintaining authorizations (CPAs or POC/SPAs) for direct client services for individuals enrolled with their agency.
- The **PROVIDER --** provides the services once authorized, and then bills for payment *(via billings or claims)*.

>> See Appendix A on page 9 for visual diagram <<<

Foundational Data

There are many foundational data elements that must be established in eXPRS before direct client services can be authorized, billed & paid.
These include:

- The **PROVIDER**'s information, contained in provider records that identify the specific type of provider, service credential information, the provider's ***approved to work*** status & dates, and other information necessary for adjudicating authorizations, billings & payments to the provider for services rendered.
- The system **CONTRACT** entities and biennial contract numbers under which biennial funding limitations will be established. A contracted entity is usually a Case Management Entity *(a CDDP or Brokerage)* or a Direct Contract Services Provider.
- The **FUNDING** allocation limits are established for each contract/contractor. The funding allocation structure is also hierarchical in design, with the lower limits constrained & reconciled to the limits above.
    - The upper most limit is the ***Program Area Limitation*** (PAL) which establishes the entire sum-total contracted biennial amount for the contractor.
    - The next level down is the ***Service Element Prior Authorization*** (SEPA) limit which sets funding limits for specific service benefit groupings, called Service Elements.
    - And finally, the **Provider Prior Authorization** (PPA) limits which establish system CME associations for a contractor or payment limits for a specific service.

  All these levels must be submitted to ***accepted*** status before direct client services can be successfully authorized.
- The **RATE TABLE** that lists the fixed or not-to-exceed (NTE) rate for a specific service, identified by the ***Service Element*** + specific service ***Procedure*** & ***Modifier codes***.
- The **SERVICE DETERMINATION** rules that establish the desired outcome & status for each Service Element/Procedure-Modifier code/client eligibility combination when authorizations, billings & claims are adjudicated through the submission process.
- The **FUNDING RULES** that establish how an approved claim will be financed when paid. Meaning determining the percentage of Federal Medicaid funding that can/will be reimbursed to us *(if any)* for the services billed as provided to the individual. Separate funding rules are set up for each Service Element/Procedure-Modifier code/client eligibility combination.
- **DHS MAINFRAME** database tables to support eXPRS functionality, such as mapping specific provider type/specialty codes to specific Service Element/Procedure-Modifier code combinations the provider is eligible & credentialed to provide.

Direct Client Services

eXPRS' direct client service authorization structure is handled in two (2) separate system modules: the ***Client Prior Authorization*** (CPA) process & the ***Plan of Care*** (POC) process, both of which are a Fee-for-Service (FFS) design.

Both modules of direct client service authorization utilize a hierarchical design structure. The first level being enrollment to Case Management services via successful submission of a Case Management CPA to ***accepted*** status. Once that is completed, other direct client services can be authorized for the individual, using CPAs, POCs or a combination of both, depending on the individual's specific service needs & plan.

- The foundational level for all direct client service authorization is **CASE MANAGEMENT** (CM) services, which is documented via a Client Prior Authorization (CPA).

  Almost all individuals with I/DD *(there are specific exceptions)* must be determined eligible for DD services in Oregon, enrolled with a Community Developmental Disabilities Program (CDDP) & have a CPA for that specific service benefit group, noted by code **SE48***. Once this SE48 CM CPA is successfully submitted to ***accepted*** status, other services for the individual can be authorized, including referral to a different Case Management Entity, such as a Brokerage (**SE148**) or the State Children's Services (**SE248**) program.

  Case Management CPA services are:
  - Case Management from a CDDP – **SE48***
  - Case Management from a Brokerage – **SE148**
  - State Case Management for Children – **SE248**

  >> See Appendix B on page 10 for visual diagram <<<

- The **CLIENT PRIOR AUTHORIZATION** (CPA) module is used to authorize services for individuals who are primarily in an out-of-home *(eg: a residential placement setting)* service setting, such as a Group Home or Supported Living. CPA services are a 1:1:1 design – 1 client, 1 service, 1 provider.

  Services currently managed via the CPA module are:
  - Residential Group Homes for Adults – **SE50**
  - Supported Living for Adults – **SE51**
  - Residential Group Homes for Children – **SE142**
  - Stabilization & Crisis Group Homes – **SE141**
  - Specialized Services to DD client in Nursing Facility – **SE45**
  - Non-Medical Transportation – **SE53/TRFFS**

- PSW Travel Time – **SE153/ORTV1**
- FMAS Service Fee – **SE147/OR560**

- The **PLAN OF CARE** (POC) module is used to authorize services for individuals who are receiving services primarily in an in-home *(eg: a non-residential)* service setting, such as the individual's own or family home. POC services are a 1-to-many design – 1 client, many services, many providers.

  The Plan of Care module is also hierarchical, with 3 levels within itself.
  - The **Overall Plan Information** *(may also be called the "**POC shell**")* - this is the **first level of the POC** & contains the information or parameters that everything authorized within that POC cannot exceed, such as the client, the overall service date range, total monthly attendant care hours, weekly employment service hours, etc.
    - The **POC Service Line** *(also called a "**Plan Line**")* – this is the **second level of the POC** & identifies the specific service information being authorized for the client. A Service Line includes information such as the service name & procedure/modifier code, the total number of service units, the frequency & the date range of the service.
      - Under each Service Line there are provider **Service Prior Authorizations** (SPA) – this is the **third level of the POC**. The SPAs are the authorizations for specific providers to deliver the service identified in the service line the SPA lives under. The SPA identifies the provider of the service line service, the rate, the number of units for that provider & the date range of the authorization. A service line can have multiple provider SPAs underneath. While there may be multiple SPAs under a single service line, each provider SPA operates independent of the others.

>> See Appendix C on page 11 for visual diagram <<<

The Plan of Care module has multiple services, identified by specific **service procedure & modifier codes**, that live within individual ***Service Element*** (SE) benefit groups.

The Service Element benefit groups currently managed via the POC module are:

- DD Foster Care Services – **SE158***(adults)* & **SE258***(children)*
- In-Home Services for Adults – **SE49***(CDDP)* & **SE149***(Brokerage)*
- In-Home Services for Children – **SE151**
- State Children's Intensive In-Home Services (CIIS) – **SE145**

- Family Supports for Children – **SE150**
- Employment Services – **SE54**
- Ancillary Services for Residential Placements – **SE257**

Service Billing, Claims & Payment

Billings & claims for payment can only be submitted & processed successfully against authorizations (CPA or SPA) that are active in the system (ie: in ***accepted*** status). The authorization is what the provider is billing against to receive payment for services rendered.

Direct client services are billed in a **Fee-for-Service** design, meaning services are billed for a fee, after being provided to/received by the individual. Federal regulations stipulate that providers have one (1) year from the date of service to submit their initial billing for payment.

Service Billing & Claims

- Billing for **CASE MANAGEMENT** services -- Case Management service billings are structured as rationed fee-for-service (RFFS) claim, meaning that post service billing claims are paid up to a contractual rationed monthly limit *(or cap)*. CM billing claims are also processed for payment on a defined schedule to manage the release of each CME's monthly capped funding limit. Initially when submitted, CM billings will be ***suspended*** until the scheduled payment process is run by the system.
    - CM services are a Daily service, allowing billing for a client once per day, for a fixed daily rate.
    - The CM billing process is scheduled to run twice per month, on/about the 15th & the last day of each month. It can also be run ad hoc by ODDS, when needed.
    - Unpaid claims remain available for payment in future processing cycles. Unused/unpaid funds also remain available to be used in the future for the payment of CM claims.

- Billing for all other **CLIENT PRIOR AUTHORIZATION** (CPA) & **FOSTER CARE** Service Prior Authorization (SPA) services are made by the rendering provider by submitting direct claims for payment.
    - Other CPA & Foster Care SPA services are a Monthly service, with a client needs driven NTE monthly rate.
    - Claims can be submitted in varying date range segments. The system will pro-rate payment based on the number of dates billed in the claim against the authorized monthly service rate.

- Billing for **PLAN OF CARE** (POC) services *(excluding Foster Care)* is made by the rendering provider or CME by creating/submitting Service Delivered (SD) billings. SD billing entry in to eXPRS can be made in several ways, depending on the type of service being billed and/or the type of rendering provider.
    - POC manages a variety of services with different service unit types, including ***hour, day, mile, event*** or purchase (***each***).
    - SD billings are created/saved in eXPRS by:
        - direct data entry into the **eXPRS Desktop** website format, available for all POC services & all providers
        - entry using **eXPRS-Mobile EVV** format **for in-home attendant care** services. This is to comply with the new Electronic Visit Verification (EVV) requirements from the federal government Medicaid programs.
        - SD billing .**csv file import/upload** process for Agency providers.
    - Claims for POC services are actually created by eXPRS automatically through a system aggregation process and not by the provider. The aggregation process collects SD billing entries in ***approved*** status for a provider/client/service & places those into claim(s) for payment. The system has different aggregation cycle schedules based on the type of rendering provider.
        - For Agency & Independent Vendor providers, the aggregation cycle runs each business day @ ~3am.
        - For Personal Support Worker (PSW) providers, the aggregation cycle runs per the established CBA schedule, ~2 times/month, and ad hoc by ODDS, when needed.

Payments for Direct Client Services

All service billings & claims are processed through a series of system validations upon submission to determine readiness for payment. Claims processed & cleared to ***approved*** status are sent via SFMA to DAS/Treasury for payment each business day @ ~ 5:30pm. Actual payment/release of funds to the rendering provider is managed based on the provider's type.

- Claims for Agency & Independent Vendor providers are paid directly to the provider from DAS/treasury.
- Claims for PSW providers are "paid" to the designated Financial Management & Accounting Services (**FMAS**) provider contracted by ODDS via ETL file. The FMAS provider (currently Public Partnerships, LLC-PPL) received the claims information & funding, then processes payroll & pays PSW providers.

Payments for Allotment (Grant) Services

There are some services paid by eXPRS that are not authorized on a specific individual client basis. These services are usually for CME Administrative costs, or reimbursement for other specialized costs to a provider. They function as a type of grant payment, can be made prospectively or retroactively, and may be a one-time or ongoing payment depending on the parameters of the service for which payment is being issued. While specific client authorization is not utilized for Allotment payments, additional documentation, such as proof of service delivery or payment invoices may be required prior to issuance of payment to the provider or contractor.

- Claims for Allotment paid services are usually scheduled to run 1 time per month, once the Provider Prior Authorization (PPA) for the service is completed & in ***accepted*** status, or ad hoc by ODDS, when needed.
- Allotment service claims processed to ***approved*** status are sent via SFMA to DAS/Treasury for payment each business day @ ~ 5:30pm and are then paid directly to provider.

The eXPRS services currently paid via the Allotment process are:

- CDDP Administration - **SE02**
- DD Abuse Investigation Services – **SE55**
- DD Special Projects – **SE57**
- DD Rent Subsidy – **SE56**
- DD Room & Board – **SE156**
- Transportation Local Match – **SE53/LM**

Payment Adjustments & Reductions

While ***approved*** claims are most often paid for the full amount billed, there may be situations where the amount billed in a claim is reduced or adjusted to result in a net payment that is less than the billed amount.

- Payments on claims for direct client & allotment services can be reduced to recover any net balance owing in the rendering provider's **PROVIDER LIABILITY ACCOUNT** (PLA). A PLA is created to track the amount of funds that are owed back to DHS/ODDS from the provider due to a previously paid claim that was voided or corrected.
  - For Agency & Independent Vendors, future payments will be reduced by 100% until the provider's net PLA balance is $0.
  - For Personal Support Workers (PSWs), future payments will be reduced by the CBA stipulated percentage *(currently, **5%** of the claim being paid)* until the provider's net PLA balance is $0. PSWs also have their claim

payment amounts reduced by the FMAS vendor to account for applicable payroll withholdings.

- Payments on Agency Provider claims for out-of-home residential services *(group homes, supported living & foster care)* may also be reduced to account for any calculated monthly amount some individuals must pay/contribute towards the cost of their residential services. This monthly service contribution amount *(also referred to as the client's "**offset**")* is called the **CLIENT LIABILITY AMOUNT** *(or account)* (CLA). The CLA is calculated based upon the individual's monthly earned & unearned income. The rendering provider must collect this monthly CLA amount that has been deducted from their eXPRS payments directly from the individual *(or their payee)*. This is in addition to collecting the individual's monthly Room & Board payment.

Other Features in eXPRS

eXPRS has been expanded over time to include additional features & information management tools to assist users and the State.

These additional features include:

- **Overall DD Eligibility** -- a process for CDDPs to enter & manage an individual's overall DD eligibility information for services in Oregon, per OAR.
- **DD Eligibility and Enrollment** (DDEE) **--** an internal eXPRS communication process for CMEs to send to ODDS information & documents on client service enrollment information.
- **Oregon Needs Assessment** (ONA) -- (still in development) a process to automate a universal client needs assessment, Level of Care evaluation & service level determination.
- **Supports Intensity Scale** (SIS) **Assessment** results -- allows the client SIS assessment information to be uploaded, displayed for CMEs for service authorization.
- **Reports** – there are numerous reports available for users to access a variety of eXPRS data.

Other Resources & Information

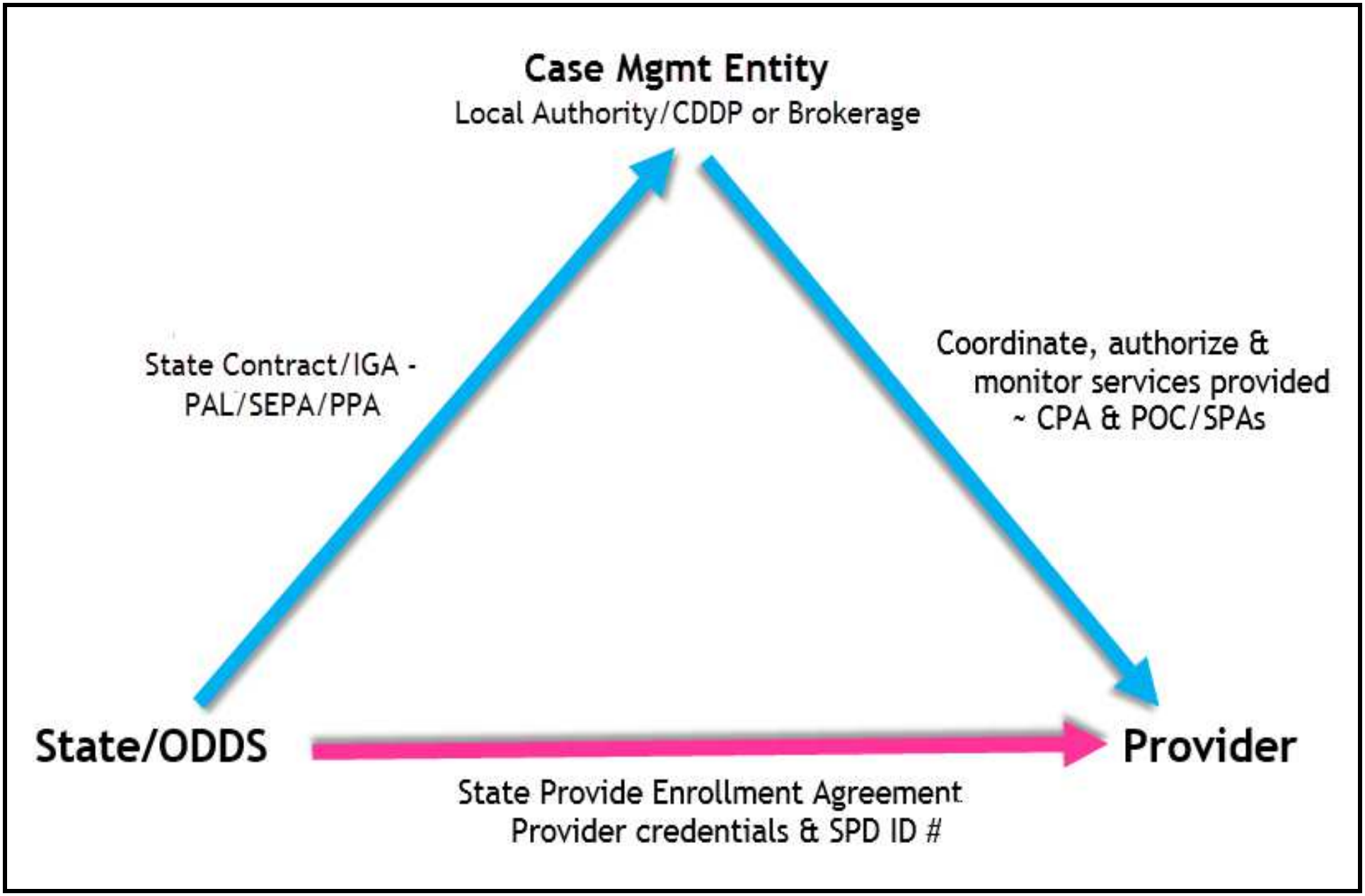
Additional information & resources to assist in understanding the basic structure & processes for eXPRS are available on the eXPRS Help Menu.

Documents that may be particularly useful in reviewing include:

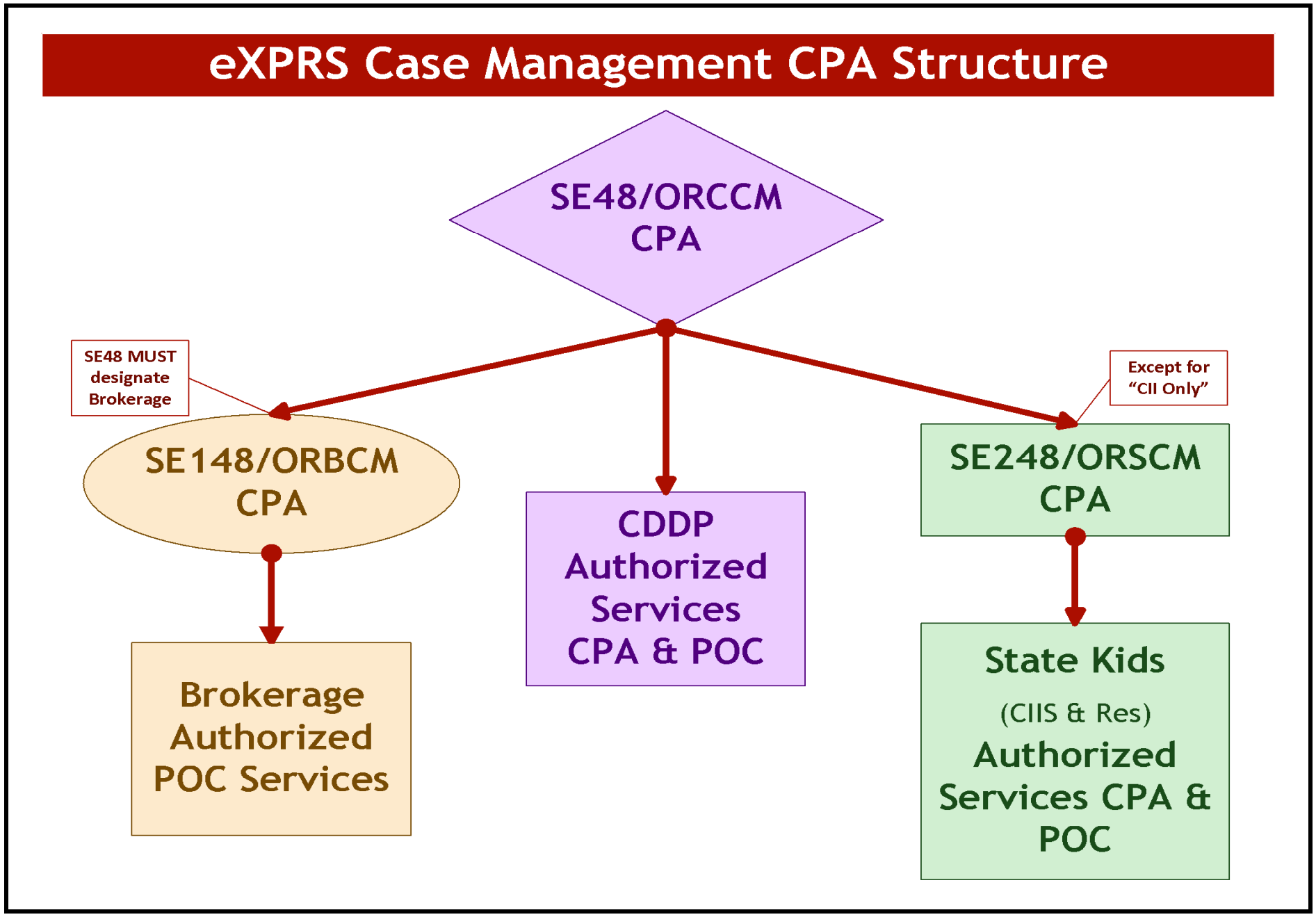
- eXPRS Full System Terms Glossary
- eXPRS Status Definitions

- Service Element Names & Codes
- DD Client Enrollment & CPA Changes Cycle

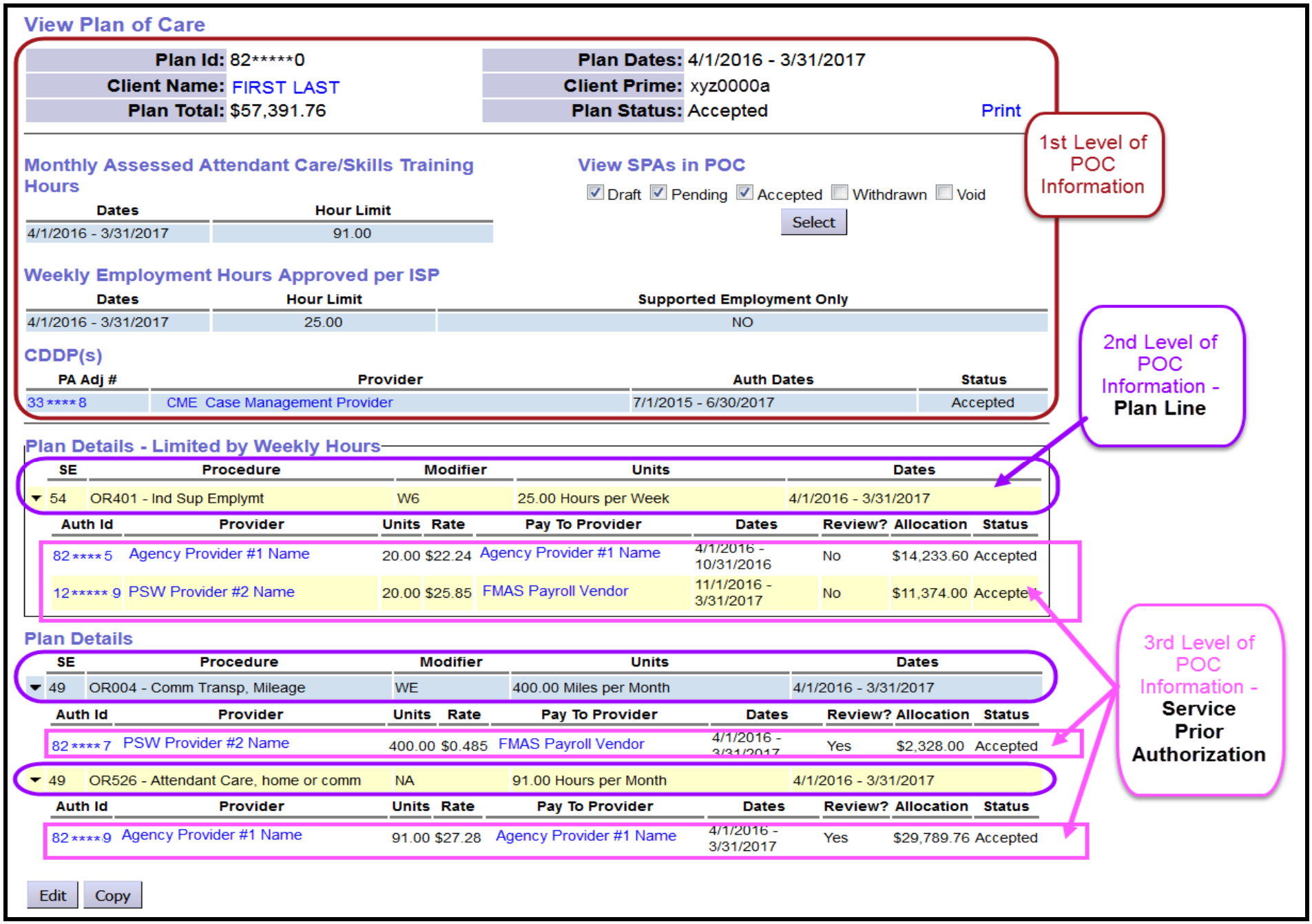
APPENDIX A


Case Mgmt Entity
Local Authority/CDDP or Brokerage
State Contract/IGA -
PAL/SEPA/PPA
Coordinate, authorize &
monitor services provided
~ CPA & POC/SPAs
State/ODDS
Provider
State Provide Enrollment Agreement
Provider credentials & SPD ID #

APPENDIX B


eXPRS Case Management CPA Structure
SE48/ORCCM CPA
SE48 MUST designate Brokerage
Except for "CII Only"
SE148/ORBCM CPA
CDDP Authorized Services CPA & POC
SE248/ORSCM CPA
Brokerage Authorized POC Services
State Kids
(CIIS & Res)
Authorized Services CPA & POC

APPENDIX C


View Plan of Care
Plan Id: 82*****0
Client Name: FIRST LAST
Plan Total: $57,391.76
Plan Dates: 4/1/2016 - 3/31/2017
Client Prime: xyz0000a
Plan Status: Accepted
Print
1st Level of POC Information
Monthly Assessed Attendant Care/Skills Training Hours
Dates
Hour Limit
4/1/2016 - 3/31/2017
91.00
View SPAs in POC
Draft
Pending
Accepted
Withdrawn
Void
Select
Weekly Employment Hours Approved per ISP
Dates
Hour Limit
Supported Employment Only
4/1/2016 - 3/31/2017
25.00
NO
CDDP(s)
PA Adj #
Provider
Auth Dates
Status
33****8
CME Case Management Provider
7/1/2015 - 6/30/2017
Accepted
2nd Level of POC Information - Plan Line
Plan Details - Limited by Weekly Hours
SE
Procedure
Modifier
Units
Dates
54
OR401 - Ind Sup Emplymt
W6
25.00 Hours per Week
4/1/2016 - 3/31/2017
Auth Id
Provider
Units
Rate
Pay To Provider
Dates
Review?
Allocation
Status
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Accepted
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Accepted
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Procedure
Modifier
Units
Dates
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OR004 - Comm Transp, Mileage
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4/1/2016 - 3/31/2017
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Rate
Pay To Provider
Dates
Review?
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Rate
Pay To Provider
Dates
Review?
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4/1/2016 - 3/31/2017
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3rd Level of POC Information - Service Prior Authorization
Edit
Copy