REPORT TO THE TWENTY-THIRD HAWAII STATE LEGISLATURE 2005

PURSUANT TO SENATE CONCURRENT RESOLUTION 106 - REQUESTING AN INQUIRY INTO THE DELAYS IN PAYMENT TO DEVELOPMENTAL DISABILITY PROVIDERS.

DEPARTMENT OF HUMAN SERVICES
DEPARTMENT OF HEALTH
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TABLE OF CONTENTS

EXECUTIVE SUMMARY

SCR 106 requests an inquiry into the payment delays to Medicaid providers who offer waiver services to individuals with developmental disabilities/mental retardation (DD/MR). Specifically, SCR 106 directed the Department of Human Services (DHS) and the Department of Health (DOH) to complete the following tasks:

1. A status update on corrections made to resolve the billing and claims processing problem;
2. An investigation of alternative methods of speeding up the processing of claims within thirty days upon receipt of the claim;
3. Immediate advance payment to those developmental disability providers whose claims are still unpaid;
4. Identify the specific problems with short-term and long-term solutions to speeding up the processing of claims on a timely basis;
5. Identify statutes, administrative rules, policies, and directives to revise or adopt to encourage the timely processing of claims;
6. Determine and define "timely" with a specific number of days; and
7. Determine whether to eliminate the prior authorization requirement.

The DHS and the DOH were requested to submit a report on a quarterly basis during the interim beginning July 1, 2004, to the Legislature regarding the progress and status of the tasks described above. The Departments were also requested to submit findings and recommendations to the Legislature not later than June 30, 2004.

The DHS and the DOH received certified copies of SCR 106 on May 20, 2004. This did not provide enough time for the Departments to complete a thorough response to SCR 106 by the requested date of June 30, 2004. The period covered in this report includes claims and payments from October 2002 through December 2003.

The resolution of outstanding claims and implementation of improvements to the claims process continues through this period and are still on-going. While significant progress to remedy system interface issues between the Departments has been made, some payment delays will occur due to the timing of changes, approvals, and claims submissions. The overlapping authority and need to coordinate every proposed and implemented remedial action of the Departments also make progress slower than desired. Fortunately, the DHS and the DOH are committed to making the most feasible improvements to the system, with or without an on-going legislative mandate to do so.

SCR 106 contended that there is an outstanding balance of $7 to 8 million in claims that were owed to 49 providers for claims billed from 2003. Currently the outstanding claims from 2003 are less than $300,000 and these were mostly properly denied claims for unauthorized services. The Departments have worked diligently together with DHS' Medicaid fiscal agent, Affiliated Computer Services (ACS), to review claims and payments from the period of October 2002 through December 2003. The DHS and the DOH have extensively analyzed and greatly improved the billing system while evaluating all remaining claims submitted by providers for this time period.

In February 2003, fifteen months prior to the Legislature's passage of SCR 106, the DHS paid over $4.5 million in estimated delayed payments to providers. Reconciliation of the estimated payments required by Federal Centers for Medicare and Medicaid Services (CMS) has been tedious but was accomplished by the concentrated efforts of the DHS, the DOH, ACS, and the providers.

A subsequent review begun in April 2004, prompted by SCR 106, identified a maximum possible delinquent amount of $1.9 million in additional outstanding claims. The DHS and the DOH have reviewed these claims and approved $1.4 million for payment. As of November 2004, $1.4 million in claims has been paid to providers and $239,629 was denied. In total, the Departments have made over $6 million in payments to waiver providers whose payments for verifiable services were delayed.

Factors that contributed to the delayed payments:

- Due to the new Health Insurance Portability and Accountability Act (HIPAA), the mandated 278 transaction for prior authorizations does not contain enough data fields to accurately and completely transmit prior authorization information. This made it impossible to communicate prior authorizations electronically between systems from Arizona, the DOH, the DHS , and ACS until it took time for the Federal government to help the States resolve the proper claims processes for Medicaid relating to prior authorizations; it was thus impossible to communicate prior authorizations electronically between systems from Arizona, the DOH, the DHS, and ACS.
- Department of Health case managers had responsibility to initiate services but did not have access to information in the payment system for eligibility and troubleshooting of claims.
- Initially, the DHS was not able to easily separate DD/MR provider claims in reports to the DOH nor had designated staff to troubleshoot claims.
- Some DD/MR providers did not quickly adapt to the higher accuracy standards required for claims submitted to the DHS. Most providers added staff and improved accuracy of claims within six months, but reconciliation of the claims for which DHS paid $4.5 million in estimated delayed payments to providers was challenging for both the Departments and the providers.

- An October 2002 change to the billing system required direct submission of claims by providers to ACS without the review of DOH case managers.
- Under the previous system (prior to HIPAA), providers depended upon case managers to clean up the claims prior to submission to DHS for payment.

These factors that earlier contributed to the delayed payments have since been resolved and many more improvements, as detailed in this report, are on-going to enhance accurate and timely payments to all Medicaid providers.

ROLES OF AGENCIES INVOLVED IN PAYMENT PROCESS

- The Department of Human Services (DHS), Med-QUEST Division (MQD), administers the State's Medicaid program consisting of the Fee-For-Service (FFS) program and the QUEST managed care program. These programs provide medical assistance to eligible individuals under Title XIX of the Social Security Act. The FFS program includes acute care services (including hospitalization and nursing homes) as well as "waiver" services, which are provided in non-institutional home and community-based settings.

- The Department of Human Services, Social Services Division (SSD) serves as administrator and fiscal accountant for the State's Medicaid Waiver and the Pre-PACE services. The SSD either provides case management services directly or designates outside agencies to provide case management services for all waiver recipients except those who are in the Department of Health's Developmentally Disabled/Mentally Retarded (DD/MR) waiver program.

- The Department of Health (DOH), Developmental Disabilities Division (DDD), provides direct case management and State match funding for the Developmental Disabilities/Mental Retardation (DD/MR) Medicaid waiver program.

- Affiliated Computer Services (ACS) serves as the DHS' Medicaid fiscal agent. As fiscal agent, ACS services to the MQD include claims processing, claims payment, provider relations call center support, provider training, third-party liability recoveries, issuance of plastic identification cards, provider bulletins, and notification of patient eligibility via an automated voice response system.

- All Medicaid services are paid to providers through the Hawaii Prepaid Medical Management Information System (HPMMIS) system. The Arizona Health Care Cost Containment System (AHCCCS) manages and operates the HPMMIS Medicaid automated information system that supports the DHS Med-QUEST Division's Medicaid programs.

STATUS UPDATE ON CORRECTIONS MADE TO RESOLVE THE BILLING AND CLAIMS PROCESSING PROBLEM

Department of Human Services Authorized $4.5 Million in Payments for System-Related Delays in February 2003

The new Hawaii Prepaid Medical Management Information System (HPMMIS) claims processing system was first activated for dates of service for the Medicaid Fee-For-Service (FFS) program starting October 1, 2002. For the first four months, from October 1, 2002 to January 31, 2003, a number of initial system-related problems and providers having difficulties using the new system caused only 10% of the volume of claims submitted by waiver providers to be paid by HPMMIS. Simultaneously, billing errors by providers were common which also contributed to payment delays.

Recognizing the need to address the delayed payments to providers to prevent a crisis for Medicaid clients who depend on continuing services, in February of 2003, the new Director of the DHS issued estimated payments totaling over $4.5 million to all waiver providers for services not yet properly claimed by providers, who were having difficulty with the new system, to compensate for system-related delays.

These estimated payments were required by the Federal Centers for Medicare and Medicaid Services (CMS) to be offset by actual verifiable claims submitted later by the providers. Further, significant recordkeeping by ACS was required to monitor this process and ensure full recoupment, as required by CMS, of the $4.5 million payments to waiver providers.

Some providers neglected to submit claims correctly to offset payments made to them and also failed to reconcile accounting records to the payments made. Thus, providers believe they have never been paid for services because of inadequate record keeping on the part of the provider.

Full reconciliation of the estimated payments (with one exception[1]) was completed in September 2003.

Departments of Health and Human Services Joint Reconciliation Project 2004

In SCR 106, outstanding payments to DD/MR waiver providers were estimated to be between $7,000,000 and $8,000,000 for the period from October 2002 through December 2003. In preparing this report the DHS, the DOH, and ACS launched a reconciliation project to identify which claims still had not been paid in full and estimate the total outstanding amount for each provider. In April 2004, ACS offered

[1] One provider no longer provides waiver services so recoupment was not completed. MQD is pursuing a collection action for the overpayment to this provider.

assistance to DD/MR waiver providers to identify outstanding claims for dates of service from October 2002 through December 2003. Specific instructions were provided to expedite the review and processing of claims. Providers were requested to provide an estimate of the total amount owed and submit associated claims to ACS.

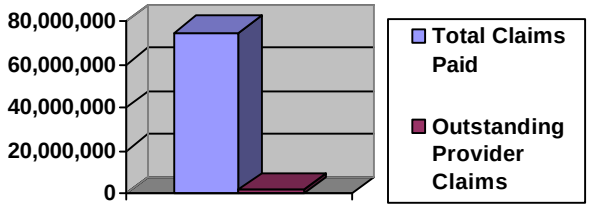
The due date for submitting estimated amounts and claims was May 26, 2004. A total of 2,724 claims were submitted by 31 of 49 DD/MR waiver providers (63%); two providers submitted over half of these claims (55%); 18 providers reported no significant outstanding payments.

Based on ACS' analysis of claims submitted by providers for the reconciliation project, the total amount estimated by providers for payments owed is $1,929,306.00. (See Appendix A for a detailed analysis of the reconciliation project.) Table 1 compares the estimated amounts owed to DD/MR providers reported in SCR 106 with the actual claims amount submitted by providers for payment.

TABLE 1.	**Total Outstanding Payments**	**Outstanding Payments as a % of Total Provider Payments**
SCR 106	$8,000,000	11%
Actual Provider Claims	$1,929,306	2.6%

Table 2 to the right shows total payments for DD/MR waiver services from October 2002 through December 2003 were over $75 million. The estimated outstanding balance of $1,929,306 represents only 2.6% of what the State paid for DD/MR waiver services from October 2002 through December 2003.

TABLE 2. Millions Paid for DD/MR Services October 2002 - December 2003



To Date Payment Highlights

The DOH and ACS worked with the DD/MR waiver providers to resolve the estimated $1.9 million in estimated claims.

- Sum of the estimates submitted by providers: $1,929,306
- Total amount that will be paid: $1,659,916
- Total amount paid to date: $1,427,287
- Total dollars denied: $232,629
- Amount overestimated by providers: $502,019

PROBLEMS AND SOLUTIONS

Because of the similarity and relationship of requests #2 and #4 of SCR 106 (see Executive Summary page 3), the Department of Human Services and the Department of Health combined the answers for these into one section: Problems and Solutions. This section will include the identification of specific problems that have occurred in the billing process, an investigation of alternative methods of speeding up the process, and short-term and long-term solutions that the Departments have implemented.

HPMMIS Operations: How It Works

HPMMIS supports the processing and payment of all Medicaid claims. From October 2002 to December 2003, over $868 million dollars were paid through HPMMIS for QUEST and Medicaid FFS, including waiver services. Payments were made on 2 million claims from the October 2002 to the December 2003 time period for all Medicaid claims.

Over 6,000 providers submit claims to ACS for payment through HPMMIS. Providers have adjusted to the new system and experience isolated, periodic payment problems. The $1.9 million in outstanding claims to DD/MR providers amounts to only 0.22% of the total $868 million dollars paid through HPMMIS to providers.

Waiver services are required by contract to be "Prior Authorized" by a DHS/SSD or DOH/ DD/MR case manager to ensure that services comply with the client's Individual Service Plan (ISP). HPMMIS will only pay the amount of the service level authorized by the matching "Prior Authorization" (PA). A claim submitted with additional services or service units beyond what is authorized by the PA will not be paid in full until the additional services are authorized by the case manager and a revised PA is issued and entered into HPMMIS. **This procedure provides Medicaid fraud and abuse protection and is required by CMS under our Medicaid waiver**.

The system is designed to deny claims submitted with errors including services without a PA, multiple claims for same dates of service, invalid recipient ID, incorrect service code, missing "W" indicator for waiver claim, or claims for which the recipient has an eligibility or suspension problem. The SSD, with support from the MQD, developed business rules for all waiver claims processing for payment and budget integrity to prevent Medicaid fraud as required by CMS. The DHS and the DOH in conjunction with ACS continue to work with AHCCCS to identify system issues to correct errors and minimize the need to manually process or special handle categories of claims.

If a provider submits a "clean" claim and a corresponding PA was entered into the system, the claim will pay during the next weekly billing cycle. For providers submitting electronically, data entry errors and the five (5) day data entry time are eliminated.

Problems and Solutions for Delayed Processing of DD/MR Claims

There were a number of system and process problems identified that caused delayed payments to the DD/MR waiver providers, including:

- Lack of direct access for the DOH DD/MR staff to HPMMIS to allow them to view claims and correct/update PAs in a timely manner and limited access to expenditure reports. The DOH was also unable to transmit data between its internal system and HPMMIS.

- An inefficient PA procedure/process including several roadblocks to timely document approval for PA changes and for timely entry of PAs, e.g., rate discrepancy in system and on PA causing PA to be rejected, recipient eligibility status preventing entry of PA, recipient suspensions for hospital stays or travel out of area, exacerbated by the frequency of PA changes necessary.

- Eligibility denials of DD/MR individuals due to lack of income verification.

- Difficulties experienced by the DOH case managers including insufficient training.

Systems and Process

When the FFS program claims payment system changed to the automated HPMMIS system, the DOH case manager did not have access to HPMMIS and, therefore, could not “see” the complete system to update service units, correct provider’s error or assist with tracking Medicaid eligibility of an individual. DOH case managers were unable to monitor the submission and resubmission of invoices for denied services. DOH staff had limited access to expenditure reports and was unable to transmit data between its internal system and HPMMIS. PA input was labor intensive, requiring staff to manually input PAs into HPMMIS from a paper report. At that time, DOH’s internal system, DDCARES, was being developed and an interface with HPMMIS was explored but was not viable due to HIPAA requirements.

In addition, each month, approximately 50% of DD/MR waiver services are modified to accommodate a variety of changes to client's ISPs. This need for frequent changes is at the "heart" of the delayed payment problems. The DOH DD/MR case manager reviews change requests with the individual client and/or client's guardian; as a result, some are approved and some are denied based on needs and available resources. The claims approval process at the DOH also required several levels of review.

The need for frequent PA changes, the DOH's limited access to HPMMIS and the limitations of its internal information system made management of the PA process

difficult. Changes in PAs were not being entered in a timely manner into HPMMIS and claims were therefore being denied.

Several corrective measures were implemented and are still being evaluated to further improve the claims billing process.

- In the fall of 2003, DOH developed an access database to create a "flat file" to electronically load PAs into HPMMIS. While this was an improvement over the initial manual process, it still required manual creation of the file and significant work for DOH case managers.

- In October 2003, DOH implemented its new client information system, DDCARES. Since June 2004, DOH case managers are able to modify service information at their computers and DOH fiscal staff is able to generate reports of services changes and input directly into HPMMIS. DDCARES is also now able to produce the monthly "flat file" electronically instead of manually for input directly into HPMMIS.

- As of July 1, 2004, with new connectivity to HPMMIS and access to data, DOH has the ability to change PAs in a timelier manner. In August 2004, HPMMIS access enabled DOH to compare claims with prior authorizations in HPMMIS and match this information with internal case management data.

- Each of the system improvements described above have significantly enhanced the efficiency, accuracy, and speed of payments to DD/MR providers. Access to HPMMIS enables DOH staff to input PAs and PA changes directly into HPMMIS, which will speed up the payment process.

- With HPMMIS access, DOH staff now has the capability to respond more quickly to PA requests and questions from case managers and providers. DOH will also have the tools to generate HPMMIS reports and reconcile service utilization data on the claims side with DOH's DDCARES. This will help DOH staff to authorize changes in services more timely and with budget integrity. Twice a week DOH fiscal staff now generate the prior authorization input report with the changes and enter the appropriate changes into HPMMIS. A new PA letter is generated and sent to the provider so that rejected claim submissions are reduced and a claim submitted can be paid timely. DOH has also streamlined its PA approval process by eliminating one level of supervisory review.

- ACS has also improved PA and payment procedures. In September 2003, ACS implemented a direct data entry application via electronic interface for DOH and SSD but for new PAs only. Updating of existing PAs still requires an existing HPMMIS PA number and requires manual keying into the system by DOH staff for changes in existing PAs for DD/MR providers. ACS now data enters all claims within 5 business days. Payment cycles are run every

Saturday. Claims and their corresponding PAs can be entered until 6 PM on Friday to get paid in the next week's payment issuance cycle. Checks are mailed the following Friday.

Lack of income verification caused eligibility denials of DD/MR individuals.

Income verification is required once per year by Federal regulation for Medicaid recipients. All Medicaid recipients are sent postcards annually requiring return for income verification. Some people with intellectual disabilities are not able to read or understand the importance of submitting the card to maintain eligibility within the Medicaid system.

- ✍ Starting December 2004, the DHS/SSD will be providing the DOH DD/MR program with an updated list monthly that shows the client's name, birthday, social security number, total cost share amount for the current month, and the date of eligibility for the Medicaid expiration for all DD/MR clients. This information will allow the DD/MR case manager to track dates that the eligibility renewal is due, prompt and/or assist the client to complete the eligibility review forms, and be notified at the beginning of each month if there is an eligibility status problem for the client. This will give the DD/MR case manager the entire month to address any eligibility status concerns.

DHS and DOH continue to look for automation tools, system capabilities, and procedural changes to improve payment turnaround time for waiver providers.

- ✍ Rather than denying DD/MR claims and bouncing them back to providers, the Departments are attempting to "pend" payments that come back from the system with an error. This proposed solution would create an electronic review process so that the DOH DDD staff are able to review/verify the problematic PAs before sending the claim back to a provider.

  The DHS' Med-QUEST Division will work with AHCCCS to modify HPMMIS to allow the DOH to correct PA mismatches and update PAs on a timely basis.

  - The system will be modified to "pend" claims with a prior authorization mismatch (same recipient and provider, but different services) instead of denying them. The system will also "pend" claims with no prior authorization.

  - A new "pend" location will be created for DOH. All claims "pended" for PA will be sent to this DOH location. DOH will be instructed on how to pull up these claims, complete a review, and take appropriate corrective action.

- Claims with no PA will no longer be automatically denied. If a provider receives a claim denial for no prior authorization, the denial reason is printed on the Remittance Advice. Claims with a matching PA will not require review. These claims will be approved for payment automatically by HPMMIS.

- Claims with a PA mismatch will be reviewed by DOH. DOH case managers determine if billed services were approved. If the PA needs to be updated, DOH can do the update directly in HPMMIS.

Difficulties Experienced by DOH Case Managers and Fiscal Staff

The Home and Community Based DD/MR waiver recipients have increased by 30% in the last two years. Under the new billing system, DOH case manager responsibilities have changed significantly. The learning curve initially contributed to input error by case managers. Additionally, the rapid growth of the Home and Community Based waiver program under the Makin Settlement contributed to increased caseloads and case manager burnout and turnover. New case managers made errors causing valid claims to reject again. Since there was no access to HPMMIS, case manager supervisors could not assist with correction of provider and case manager billing errors prior to submission of provider claims.

- SSD fiscal and information staff are providing technical assistance to DOH staff on HPMMIS navigation and the claims processing subsystem. Training for eleven DOH staff was recently conducted on June 28, 29, and July 1, 2004. This training has prepared staff to efficiently carry out the review of PAs in HPMMIS and make changes to the PAs directly in HPMMIS

- The DOH and the DHS will continue to review their policies and procedures to ensure that their respective case managers and fiscal staff have the tools, guidelines, contractual rules, and training to efficiently process prior authorizations for waiver services. In August 2004, the DOH and the DHS SSD prepared and distributed guidelines to all Medicaid waiver providers and case managers, including those who serve DD/MR waiver clients. The guidelines will clarify standards related to preparing and changing prior authorizations.

In addition, the oversight of this business function has created a cumbersome process and has great impact to the billing system. In order to rectify this issue, both the DHS and the DOH have had to shift resources to triage the situation foregoing other program priorities to accomplish the necessary activities to authorize, track payments, expenditures, and ensure all information is accurate and available to meet Federal standards. While it is possible for the DOH to change its policy, this would mean imposing a limitation on changes of service authorizations which is not desirable because most changes are necessary for the an individual with DD/MR to live within

a community setting of their choice and statutory law mandates the DOH-DDD's programs to "promote self-determination."

Providers also had problems managing the new PA and claims billing process with the implementation of automated claims billing through HPMMIS. Typical provider problems included:

- ✍ Frequent billing errors.
- ✍ Not consistently using the Remittance Advice provided to reconcile their accounting records.
- ✍ Varying abilities of the provider staff and organizational resources to manage the claims billing process.

With the change to the automated HPMMIS claims billing system, provider errors occurred frequently due to a lack of understanding of the new system. Approximately 39% of payment delays are caused by common provider billing errors on the claim form, such as:

- ? Invalid recipient ID number
- ? Invalid procedure code
- ? Not circling the changes on a resubmission
- ? Putting previously paid amount in cost share field
- ? Billing for same procedure on two lines
- ? Billed charges not matching number of units and unit charge
- ? Billing when provider and/or individual is on a suspension period (in cases when provider is in non-contractual compliance or individual not meeting requirements for Medicaid eligibility renewal)
- ? Dates of service not matching prior authorization dates of service

Training for providers was conducted before switching to the new automated claims processing system. In the summer of 2002 just before HPMMIS was implemented, SSD Medicaid Waiver Program staff provided training statewide to orient and prepare providers on the use of new claim tools, the new claim forms, and the use of prior authorizations. ACS held three rounds of targeted training sessions for waiver providers to explain detailed billing instructions and provide sample claim forms. Still, provider errors could be expected because of the learning curve effect. Providers also had difficulty changing from the previous manual "paper" claiming process where the case manager corrected provider billing errors before submission to the DHS for payment, compared to the new automated system with the providers more responsible for submitting a correct claim. This was exacerbated by the system errors and the lack of a "pend" option in HPMMIS for PA inconsistencies that caused claims to be automatically denied.

The continued assumption by the DD/MR providers that someone will correct any errors on their claims is a carry-over from the previous "paper" system and contributes to slowed claim resolution.

Solutions have been and continue to be implemented to help providers competently use the new system and receive timely payments.

- ✍ The DOH, DHS, and ACS has provided and continues to provide and expand outreach and training to waiver providers to help them manage their claims billing and payments process.

  Training has included and will continue to include:
  - ? Review of training materials and billing instructions
  - ? Analysis of common errors
  - ? Hands-on instruction for fixing errors
  - ? Special handling of corrections and resubmitted claim

- ✍ ACS continues to meet individually with providers who still have payment problems to discuss specific claim issues and provide detailed analysis of common errors.

- ✍ Easy-to-use claims submission software and technical support are being offered for free to providers, paid by an additional $2.5 million amendment of its contract with ACS. This contract for the implementation and ongoing support of this new electronic data interchange (EDI) package, WINASAP2003, also allows ACS to hire dedicated ACS staff, three Provider Relations Field Representatives and two Business Analysts, to support EDI and train providers in the use of the EDI.

Providers submitting electronic claims experience the timeliest payment of claims. ACS rolled out an electronic billing system in September 2004. WINASAP2003 is a stand-alone billing system designed for providers submitting fewer than 300 claims per month. This threshold makes it an ideal product for most waiver providers. It is being offered free of charge to providers. It requires only a modem to connect with the ACS electronic data interchange gateway. ACS will install, train, and provide on-site support of WINASAP2003. With this new software, providers will be able to load client and procedure code data to streamline the submission of monthly claims and greatly reduce the potential for errors. Two DD/MR providers are currently submitting claims electronically and getting over 90% of their claims paid within 30 days.

Remittance Advice to manage claims billings are not consistently used.

Approximately 20%-40% of providers do not perform payment reconciliation from the Remittance Advice provided to them by ACS.

The purpose of the Remittance Advice is to document the action and status of each claim processed by HPMMIS during the previous week. Providers are required to use their weekly Remittance Advice to manage their claims billings and reconciliation procedures and should reconcile their accounting records with the Remittance Advice as soon as it is received.

The Remittance Advice serves the provider in the following ways:

- Contains payment and denial information at the claim and line item level. For each claim that pays, either in full or in part, providers should post the information to their internal accounting ledger.

- Claims that do not pay should be researched and, if applicable, corrected and resubmitted by the provider as a new claim (unless the one-year filing deadline has passed). In the case of a partial paid claim, the provider should also research and, if applicable, an adjustment claim should be done referencing the original claim number.

Providers who do not use the Remittance Advice to reconcile their accounts receivables to payments received continue to be mistaken about the status of claim payments. Providers continue to submit claims for additional service units that have been **properly denied**. A recent situation involved a provider submission of over 1,000 claims, 34% of which were properly denied. Appropriate use of the Remittance Advice would substantiate dollar figures for what is "outstanding" and also track payment and claims status information.

- ACS, the DHS, and the DOH continue to offer additional support to providers in this area to help providers accurately do their recordkeeping, claims submissions, and adjustment submissions.

The efficiency of provider accounting procedures varies with providers who experience persistent problems typically depending on staff who do not have adequate business or accounting experience to effectively manage billing and reconciliation activities.

Within the specifications of their contract, Medicaid providers are required to have the necessary internal accounting and recordkeeping procedures in place to run their business. Providers should ensure billing staff is capable of complying with claims submission and payment accounting requirements. Providers who are continuing to experience persistent problems typically depend on staff who do not have adequate business or accounting experience to effectively manage billing and reconciliation activities. The annual claims billing by DD/MR providers for FY 03 was $43.4 million and $63.2 million for FY 04. With annual billings are in the hundreds of thousands of dollars for some providers, the Medicaid waiver providers are business enterprises that require competent accounting and bookkeeping staff to manage.

Based on waiver contracts signed by Medicaid providers, they are responsible for the following:

- Verify Medicaid eligibility before providing services.
- DD/MR providers are instructed to ensure that a DOH case manager has approved the service before providing the service and that an approved prior authorization letter has been received before providing the service.
- Verify that services were actually provided before submitting claims. For example, in one instance, the provider billed according to the PA without verifying that the client had moved and was no longer receiving the services on the PA. This case has been referred to the Medicaid Fraud Investigations Unit in the Office of the Attorney General.
- If a client was suspended from the waiver program during the month, the provider must bill around the suspension period, i.e., providers cannot be paid for services rendered to the client during the suspension period.
- If a suspension is incorrect, providers need to contact SSD to fix the error, e.g., this occurs when short-term suspensions are not closed.
- Providers can call ACS anytime to determine if a prior authorization is in HPMMIS so that a claim for the service can be submitted, cleared, and paid.
- Services listed on the PA letter should be consistent with each client's Individualized Service Plan and provider contract.
- If a PA letter contains incorrect information or if a PA letter has not been received, DD/MR providers are required to contact the DOH case manager to resolve this problem as soon as possible.

✍ As described above, ACS' contract amendment includes funds for ACS to expand its provider services. This contract amendment allows ACS to hire three Provider Relations Field Representatives and two Business Analysts who will meet with providers on a regular basis to assist in all aspects of interaction to identify and resolve issues that prevent timely payment for providers.

✍ SSD is developing detailed contract and billing requirements for all waiver providers and will stipulate provider qualifications for administrative and fiscal operations of programs and services delivered to Medicaid recipients. The guidelines will be distributed by the third quarter of FY 2005 before the new contracting period begins.

The contract and billing guidelines will help to ensure that waiver providers, including DD/MR waiver providers, clearly understand the terms and

conditions of their contract with the SSD. Assistance will be offered to providers who need special help to meet these requirements. Providers provide services under contracts and need to meet the requirements or they could suffer revocation or suspension of their contracts if they continue to be not able to meet the contract requirements or are unable to achieve compliance in their operations.

- The DOH, DHS, and ACS have provided and continue to provide and expand outreach and training to waiver providers to help them manage their claims billing and payments process. Training has included and will continue to include: review of training materials and billing instructions, analysis of common errors, hands-on instruction for fixing errors, and special handling of corrections and resubmitted claims.

- SSD's fiscal and information staff provide technical assistance to individuals and groups to assist providers who are having problems with their claims. DOH staff likewise provide training, assistance, and support to individual providers.

- Providers can call ACS anytime to determine if a prior authorization is in HPMMIS so that a claim for the service can be submitted, cleared, and paid.

- Provider Bulletins contain information specific to waiver providers. Claims status information is available on the MQD's web site.

- The Departments have also initiated outreach services to support our provider community. These services include training workshops, provider site visits, meetings with provider associations, and support for electronic data interchange (EDI) to help providers manage their claims processing activities.

  Continued and expanded outreach will identify providers needing additional help with the billing and reconciliation of claims and provide them with the necessary training to improve their claims billing and payment processes. As an example, in the recent reconciliation project, thirteen providers had a claim error rate over 20 percent. These providers have been scheduled for a site visit and targeted training by ACS.

- DHS scheduled several training sessions in September 2004 for Chief Executive Officers and billing staff from waiver agencies, State case managers, and Legislative committee members. This training is meant to ensure that waiver providers have access to training resources designed to provide information and instruction for accurate billing of waiver services.

Additional Short and Long Term Solutions to Improve Payments for Providers

- **Alternatives to HPMMIS continue to be explored.** A joint Request for Information (RFI) was released at the end of November 2004, for the states of Arizona and Hawaii to procure a new information system to replace HPMMIS in two to three years. The Federal Centers for Medicare and Medicaid Services (CMS) has approved this undertaking.

  The DOH will launch a billing interface early in 2005 to facilitate submission of "clean claims" to HPMMIS. Both the DHS and the DOH are now engaged in discussions with Arizona representatives to improve the service level agreements and prevent future system design flaws.

- **The Department of Health-Developmental Disabilities Division is planning to implement a new improved claims payment interface with HPMMIS early in 2005**. This new interface would have all transactions, from DOH-DDD Case Manager to DD/MR Provider, working in a virtual environment (eliminates paper notices of service authorizations), since all client and service information would be updated daily. DOH would receive and be able to run expenditure and utilization reports from this interface at any of their programs offices with appropriate security access in place (to ensure HIPAA compliance) and will be able to quickly identify problematic claims and resolve in a timely manner.

  The DOH/DDD will develop and maintain a database of all DD/MR providers including which services the provider is certified to perform and the reimbursement rates for each service. DDD will transfer all prior authorization information directly from DDCares to the new interface to support claims payment. No prior authorization for DD/MR waiver services will be entered or maintained in HPMMIS.

  With the new DDD interface, the DOH will pay claims for all DD/MR waiver services with all State funds. DDD will make direct payments to all DD/MR waiver providers through the new interface by submitting an invoice through the Department of Accounting and General Services. No payment to DD/MR providers will be made through HPMMIS. DDD will then submit a group payment claim to HPMMIS. HPMMIS will adjudicate the claims and notify DHS of the correct amount to pay to DDD. The DHS will journal voucher to DDD, the Federal share for all DD/MR claims that were approved in HPMMIS. The DDD will be responsible to resolve any claims that were denied through HPMMIS and to re-submit to receive Federal reimbursement. DHS/SSD will conduct post-audits of paid claims on a regular basis.

  The DOH believes this new claims payment process should streamline and make payments to their DD/MR providers more efficient and timelier, while keeping all parties involved in process informed about status of the services, claims, and payments.

IDENTIFY STATUTES, ADMINISTRATIVE RULES, POLICIES, AND DIRECTIVES TO REVISE OR ADOPT TO ENCOURAGE TIMELY PROCESSING OF CLAIMS

Codifying procedures into statutes or administrative rules would severely limit the ability to implement changes to address problems on a timely basis. All of the changes described above would take over six months to a year to institute if statute or administrative rules needed to be changed.

The policies and procedures described above are being implemented and will be continued to be reviewed and improved to facilitate provider payments.

DETERMINE AND DEFINE "TIMELY"

90 % of accurately submitted claims are paid within 30 days.

✍ "Clean" claims with matching PAs are paid within two to three weeks of submission, meeting the requirement for "timely" payment.

✍ ACS data enters all claims within 5 business days. Payment cycles are run every Saturday. Claims and their corresponding PAs can be entered until 6 PM on Friday to get paid in the next week's payment issuance cycle. Checks are mailed the following Friday.

Thirty day claims processing and payment already occurs for 90% of accurately submitted claims.

✍ For most Medicaid providers, billing errors have been eliminated and payment problems are minimal. For some providers, billing errors and PA issues continue to impact payment. However, DHS, and ACS continue to look for ways to further improve claims processing and payments.

ELIMINATION OF THE PRIOR AUTHORIZATION REQUIREMENT

A prior authorization process is a requirement of our Medicaid waiver approved by CMS. Although, one short-term solution to speeding up the processing of claims is to pay claims without a prior authorization, the Centers of Medicare and Medicaid Services (CMS) requires all waiver services to be prior authorized unless retrospective payment reviews are conducted. Currently, 3,000 DD/MR PAs are electronically submitted prior to the beginning of each month, but approximate 50%

of these PAs require subsequent changes. Accordingly, the workload for retrospective payment reviews is approximately 1500 reviews. DOH does not have the budget or staff to fund this level of effort.

CONCLUSION

For most Medicaid providers, billing errors have been eliminated and payment problems are minimal. For some providers, billing errors and PA issues continue to impact payment.

All components of claims processing must work together to ensure timely payment of claims. HPMMIS is a full-featured Medicaid claims processing system. It requires users and operators to put the correct data in the data fields that identify the provider, recipient, type of service rendered, type of bill, and payment amount. It requires more data than the previous manual approach, but all of these requirements are standard for the current Medicaid industry.

Prior authorizations are a requirement of our Medicaid waiver. Before providing services, providers are contractually required to contact and obtain approval/prior authorization from the individual's case manager. Each claim must have a matching prior authorization already in HPMMIS in order to pay. These policies and procedures ensure that each client receives needed services as well as identifying and preventing possible Medicaid fraud as required by CMS.

Providers are required to implement business and accounting procedures to ensure that services are authorized and that only authorized services are performed.

The prior authorization (PA) process allows DHS and DOH to conduct individual needs analysis and program budget tracking to meet the client's health and well-being needs.

Prior authorization activities are supported by both DHS and DOH systems, policies, and procedures. DOH, DHS, and ACS continue to explore ways to improve the PA, claims billing, and payment processes and procedure and continue to provide outreach, training, and individual assistance to DD/MR Medicaid waiver providers.

APPENDIX A

DEPARTMENT OF HEALTH AND DEPARTMENT OF HUMAN SERVICES JOINT RECONCILIATION PROJECT DETAILS

✍ 31 of 49 providers participated, submitting 2,724 claims.

✍ 16% of the claims were returned to providers for provider billing errors.

✍ 9% of the claims were re-processed after determining that an updated PA had been entered into HPMMIS after the claim was denied. This means that providers submitted claims for payment before they received written confirmation from ACS that the updated PA entered into HPMMIS, which is contrary to our payment process instructions.

✍ 75% of the claims were sent to DOH for review. Of the claims submitted to DOH for review, 60% were approved by DOH for PA update and reprocessing. 27% of the claims submitted to DOH for review were properly denied by DOH for unapproved units/services, meaning that the providers exceeded the services prior authorized without consent by the DOH to do so and they will not be paid for such services in excess of the client's Individual Service Plan (ISP).

✍ For one provider who submitted 1,048 claims, 449 (43%) were properly denied by DOH DD/MR case managers. This means that the DOH DD/MR case managers did not authorize the services rendered prior to the services being rendered and they do not wish to authorize them after the fact because the services exceed the amounts authorized in the client's ISP.

✍ $1.4 million was approved and paid.