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SCHOOL OF PUBLIC HEALTH
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DEPARTMENT OF HEALTH POLICY

IMPROVING MEDICAID: ASSESSMENT OF DISTRICT OF COLUMBIA AGENCIES' CLAIMS PROCESSES AND RECOMMENDATIONS FOR IMPROVEMENTS IN EFFICIENCY AND CUSTOMER SERVICE

Report prepared for the Department of Health Care Financing,
District of Columbia
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I. Introduction

The District of Columbia Department of Health Care Finance (DHCF), like other state Medicaid agencies, is constantly challenged to improve service delivery and reimbursement for Medicaid services. In the District, several governmental agencies ("Partner Agencies") play an instrumental role in Medicaid – either as a Medicaid provider or in operating a Medicaid program. Today, each Partner Agency may retain its own system and process for claims submission, provider enrollment, and administrative claiming as it relates to Medicaid. For these reasons, the DHCF initiated an assessment of the Medicaid claims processes for Partner Agencies. The purpose of the assessment is to identify areas of duplication and inefficiencies and recommend a solution(s) to the DHCF to improve efficiency and customer service.

The central recommendation arising from this assessment is that the District of Columbia procure the services of a single administrative services organization (ASO) to perform billing, claims submittal, and related administrative functions for the identified DC agencies examined as a means of achieving greater efficiency and improved customer service. Implementation should consist of building the full ASO capacity at the outset while phasing in the conversion of agency business processes and systems over time, beginning with the District of Columbia Public Schools (DCPS), Children and Family Services Agency (CFSA), and Department of Mental Health (DMH). We believe the procurement process can begin in January 2009 and go-live of ASO services for the first agencies no earlier than the Fall of 2009, depending on schedules of the Partner Agencies, the needs of the District and the aggressiveness of the vendor.

The District of Columbia contracted with George Washington University (GWU) Department of Health Policy to analyze the feasibility of procuring a single Administrative Services Organization (ASO) to perform claims submission and other administrative functions on behalf of the various District agencies (also referred to as Partner Agencies) that work with the Medicaid Agency, which was the Medicaid Administration Agency (MAA) prior to October 1, 2008, and the Department of Health Care Finance (DHCF) effective October 1, 2008, to provide various Medicaid services to eligible District residents. During August and September 2008 GWU staff, along with Health Management Associates (HMA) conducted interviews with MAA and Partner Agencies to determine current Medicaid business processes at the agencies The interview tool used during these "As-Is" interviews is included as Appendix A, and the detailed findings from these interviews are described in Appendices C and D of this report.

This self-assessment is focused on the area of billing functions. The District used the CMS Medicaid Information Technology Architecture (MITA) framework to provide a structure for the self-assessment process. This report identifies business process transformation options that the District of Columbia intends to address through various Medicaid Management Information System (MMIS) health information technology tools

and infrastructure. A more detailed discussion of the MITA framework along with related documentation is attached in Appendices B-E.

The GW/HMA team began by meeting with key staff of the agencies involved and reviewing documentation on the relevant agency functions and supporting business processes. The agencies interviewed included: CFSA; DMH; Department of Disability Services (DDS); Office of the State Superintendent of Education (OSSE); DCPS; Charter Schools; Department of Youth Rehabilitation Services (DYRS); and the Medicaid Management Information System (MMIS) staff. To complete our understanding of how the agencies currently are doing this business, we also met with the DC Primary Care Association and with representatives of the Quality Trust for Individuals with Disabilities, the Healthy Families/Thriving Communities Collaborative, the DC Fiscal Policy Institute, and the Children's Law Center.

Following those meetings which focused on the current processes, meetings were held with the same group of agencies to discuss the functions which an ASO should logically provide for the agencies. The details of those meetings are described in Appendix D of this report. In addition, a Medicaid Information Technology Architecture (MITA) maturity analysis is provided in Appendix E to assist the District in complying with federal requirements for obtaining enhanced matching funds to design, develop, implement and operate an ASO if that is the decision of the District.

A full list of meetings held, dates, and attendees is included in Appendix F.

II. Summary of Findings

A. Administrative Services

1. The District is not fully utilizing its claiming of federal funds through the use of Medicaid Administrative Claiming (MAC).

2. District agencies approach MAC inconsistently. Among the issues:
   - Not all agencies submit administrative claims, even where they may have claimable costs.
   - Agencies that do use MAC have different approaches to cost allocation.
   - Not all agencies have cost allocation plans.

B. Direct Services

1. It is duplicative for multiple agencies to perform certain administrative functions related to District and Medicaid payments for direct services. These functions include licensure, provider enrollment and training,

collection of information for and production of provider directories, billing and claims payment. This duplication results in unnecessary costs and a lack of standardization consistent with best financial practices. It also constitutes an unnecessary burden on providers who provide services across multiple agencies.

2. Each agency has its own capacity – staff, systems, and other resources -- and procedures for processing claims for non-Medicaid services.

3. A number of the identified District agencies pay at least some providers through an invoicing process which, by and large, is free of the kinds of edits and audits that help assure payment accuracy. The complexity of administrative interaction with multiple agencies noted above reinforces provider preferences for a consistent invoicing process.

4. More than one agency contracts with an intermediate entity which in turn subcontracts with providers which means the District is paying more than once for the overhead costs associated with the intermediary function.

5. At least one agency has historically operated its own claims system in order to collect clinical data and directly manage prior authorization.

6. Several agencies are using separate proprietary systems which mean the District is paying for amortization of development costs and/or profit on each of those systems.

7. Multiple proprietary systems also may have ancillary systems associated with them for which the District is also paying, e.g. imaging.

8. Where imaging is not available across the board, the District may be paying unnecessary costs associated with original document retention and storage.

9. There is no evidence that rate development is standardized across the agencies. Given the overlap in provider bases, at best this means inconsistency in the assumptions on which rates are based and at worst, that providers are being overpaid for some services and underpaid for others.

10. The level of audit related to billing and claims payment for direct services varies from agency to agency, rendering a common standard of accountability difficult if not impossible to achieve.

C. Relationship between Partner Agencies and Medicaid as well as the MMIS Vendor

1. Communication between the Medicaid Agency and other agencies was identified as a major issue and should be improved. Interviewees said that:

   - In the past, MAA has implemented policy changes without notifying the agency
   - Previous MAA provider bulletins may not always be up to date
   - Previous MAA Coding Books are not readily accessible by all agencies, either in hard copy or online.

2. The information previously supplied to Medicaid by Partner Agencies was not always accurate. (Problems were noted with misspelled items and wrong digits in Medicaid numbers.)

3. Much of what we heard related to the need for further oversight by Medicaid of the Partner Agencies' roles in the District's Medicaid program, which in our experience often leads to federal funds disallowances.

4. The process used by Medicaid and some agencies to monitor claims processes and trends is not formalized. A more formalized process could assist in fully utilizing federal reimbursement.

5. Currently, agency interactions with the MMIS vendor are minimal. In one of the two cases in which agency systems exchange claims data with the MMIS, there has been a problem matching payments and prior authorizations because of differing identification numbers.

III. Recommendations

A. Recommendation A: Single ASO

Based on the information obtained in the meetings described above and our subsequent analysis, we recommend that a single ASO be procured to provide the necessary Medicaid, as well as all non-Medicaid, administrative and billing functions for the District agencies that provide services to Medicaid. We make this recommendation for the following reasons:

1. A single ASO will provide a comprehensive, uniform approach to administrative claiming. The ASO would be able to analyze participation across all Partner Agencies and could be charged with determining the optimum funding source for each type of service being provided. Careful analysis by an ASO will define the documentation and claims submission requirements and make the appropriate tools available to the Partner Agencies to allow them to efficiently report billable services. Both Medicaid and non-Medicaid billing will be handled by the ASO.

2. The ASO would provide better documentation for claims submitted, and would maintain them in a single repository. This will make claims easily defendable and should significantly reduce denials and federal recoupment after the fact.

3. The ASO will provide an opportunity to enhance Medicaid billing so that the District can pay for services using 70% federal match that are now being paid for with entirely District funds. The ASO will be responsible to assure all funding sources are billed in a priority that fully utilizes Federal Financial Participation and that alternate funding sources are used whenever appropriate.

4. The ASO will improve the MITA maturity level of the District's operation, and will improve the overall efficiency of operations for all of the affected agencies.

5. The ASO will be able to provide reports on trending to demonstrate the effectiveness of improved billings, as well as on the health outcomes of the participants as they span multiple programs. The ASO will also ensure that the generation of data and reports, as well as payments made, comply with all court orders affecting the partner agencies.

B. Recommendation B: ASO Functions

The recommendations for the specific functions to be assumed by the ASO are included in the MITA to-be analyses, Appendix D, in significant detail. In summary, the ASO should be responsible to:

1. Record provider participation in Medicaid and with the Partner Agencies in a function that mirrors the Medicaid provider enrollment process and that accounts for unique qualities of non-Medicaid programs in each agency.

2. Record recipient/member/participant information with regard to each Partner Agency and Medicaid, verifying eligibility for Medicaid and other agency programs on a regular and automated basis.

3. Determine for each Partner Agency what services may qualify for payment by Medicaid and by other non-Medicaid sources, and determine the claims submission and documentation requirements for each.

4. Provide efficient systems, methods, hardware and software to record billable services rendered by each Partner Agency, including all required data and documentation.

5. Provide a uniform and coordinated billing system to claim payment for services rendered that will fully utilize FFP and external funding.

6. Provide effective program management and reports to improve the process, defend claims submitted, reduce recoupment, and meet all federal standards and Medicaid guidelines.

7. Provide web portals for provider enrollment, claims data submission, and general information for providers and participants.

8. Provide help desk and call-center services to verify eligibility and assist with claims resolution and reconciliation.

In addition to the specific recommendations contained in the MITA to-be analysis, any ASO should also meet certain global requirements. For example, the ASO's solution should include:

1. Web-based data warehouse access to DHCF and Partner Agencies;

2. Role-based security;

3. Controlled access for data modification to assure that users can access information only related to their providers or service recipients;

4. Maintenance of all security and confidentiality standards, e.g. HIPAA and program-specific such as mental health and substance abuse;

5. Record retention in compliance with the most stringent District and federal requirements;

6. Call centers with standardized hours in locations approved by DHCF, accessible via toll-free numbers, and meeting District customer service standards relating to performance and cultural appropriateness;

7. All hardware, software, facilities, equipment, communications, and staff necessary to deliver the contracted services;

8. Initial and ongoing staff training for the ASO itself, DHCF, and Partner Agencies

9. Analysis of existing DHCF and Partner Agency systems and provision of DHCF- and Partner Agency-friendly interfaces and data conversion; and,

10. Production of correspondence and manuals to and for providers and recipients.

These requirements are described more fully in Appendix G.

C Recommendation C: ASO Management

We further recommend that the ASO be procured and operate under the direction of the new Department for Health Care Finance (DHCF) who will be assisted by a Steering Committee that has a representative of each of the agencies that will utilize the services of the ASO. This structure is recommended for the following reasons:

1. A single contract administrator is needed for management purposes;

2. Medicaid staff are experienced with meeting CMS requirements to procure federal funds for information technology services;

3. The opportunity for enhanced federal funding would be improved if the ASO were a contractor of DHCF; and

4. The Steering Committee is a necessary forum for addressing individual agency issues with ASO operations and deliverables.

D Recommendation D: Procurement Process and Implementation

An RFP should be issued to procure the services of the ASO. The process should begin with Advance Planning Documents (APDs) and consultation with Centers for Medicare and Medicaid Services (CMS) officials to determine the enhanced Federal Financial Participation (FFP) available for the development of the ASO.

The District should review the recommendations contained in our report and determine the requirements to be included in the RFP. The RFP should be crafted in a way to invite participation by several qualified bidders.

The RFP will be subject to District and CMS approval. Concurrent with its issuance, the District will need to develop evaluation materials and a method to assure free and fair competition among the vendors and to be able to defend an award against a possible protest by a non-winning vendor.

Once the RFP is issued, the bidders should be given a reasonable amount of time to prepare bids. The District may want to host a bidder conference, after which the District will need to issue bid clarifications. After bids are received, they will be evaluated according to the criteria and method established. After the award is posted and defended against protest if necessary, the District should proceed to contract with the winning vendor in 2009.

During the implementation period, which will take 6-18 months or more, depending on schedules of the Partner Agencies, the needs of the District and the aggressiveness of the vendor, DHCF will need to allocate project managers and secure the participation of the Partner Agencies. It is important for federal enhanced funding that the system development and the resulting system be owned by the "single state Medicaid agency" of the District.

The District should consider a phased implementation plan where each Partner Agency is phased in on a priority basis balancing ASO readiness. It is recommended that DCPS, CFSA, and DMH be placed near the beginning of implementation and certain functions or system capabilities ahead of others.