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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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Department of Health Policy
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and
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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 defensible 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.

Appendix A: District of Columbia ASO Study “As Is” Interview Guide

Name of Agency: _____

Date of Interview: _____

Agency staff (names, titles, email): _____

HMA Interviewers: _____

Does the agency currently submit claims for Medicaid program services?

Yes No

If so, for what services are claims submitted to Medicaid program services?

Yes No

Does the agency currently process claims from providers for non-Medicaid?

Yes No

Does the agency currently submit claims for Medicaid administrative activities?

Yes No

If so, for what administrative services are claims submitted to Medicaid program services?

Yes No

I. Agency Overview

1. How are services purchased (fee for service, managed care, other)? Which are Medicaid services?

6. What Medicaid-related business functions do you consider to be essential (e.g. prior authorization)? Which ones do you do? Which ones does the Medicaid Agency do? Which ones do the providers do themselves? Which ones does an independent/contractor do?

o *Examples of functions:*

Member Outreach, application assistance, eligibility

Provider relations

Explaining Medicaid coverage – how to access services

Case Management

Rate setting

Utilization management

Appeals and grievances

7. Describe the automation supports for these essential functions.

Documents needed:

- o Legal framework documents (e.g. statutory provisions governing agency)
- o Agency Administrative Regulations (from the DC Code)
- o Policies and procedures (e.g., personnel and operational)
- o Provider manual(s)
- o Written description of agency's Medicaid services
- o Organization chart
- o Position descriptions for staff involved in key Medicaid business processes
- o Billing manuals
- o Billing codes (i.e., 834s, 837s) and coding

II. Business Processes for Direct Services Billing

Provider enrollment

8. Is the agency actually a provider or are your Medicaid clients served by community agencies? Are they restricted to ones you contract with? How do you address free choice of provider?

9. Describe how providers are enrolled; is the process electronic? Is the process the same for Medicaid providers as for others?

10. Describe how provider credentials are verified.

11. How many staff are involved in this process? What do they do?

12. What is the connectivity of the provider enrollment process to other functions/agencies?

13. Who maintains the provider directory? What is in the provider directory?

Audit of claims and encounters

14. Describe how claims are submitted by providers.

- To whom?
- Electronic?

15. How are claims verified? How are Medicaid services, providers, clients identified? What is your relationship to MAA Fraud unit?

16. What processes are in place to avoid duplicate payments? What other claims edits and audits are done?

17. How many staff are involved in this function? What do they do? What training/credentials do staff have?

Service Authorization

18. Describe how services are authorized (Medicaid and non-Medicaid). Electronic? Case by case? What is the protocol for service authorization?

19. How many staff are involved in this process? What do they do?

20. How are rates set; which are cost based? How payment rates and Medicaid rates vary?

Manage provider grievance and appeal

21. How do providers submit grievances about payment decisions?

22. How are these grievances processed?

- Who is responsible?
- What is the timeframe for resolution?

23. Describe the provider appeals process.

Inquire member eligibility

24. How is the claims payment system connected to the member eligibility system?

25. Does your agency maintain a separate eligibility system for your services? If so, how is this tied to the Medicaid member eligibility system? How often is it updated?

26. How is member eligibility verified?

- Who is responsible for this?

Develop/maintain benefits package

27. How do you determine which services to purchase/provide?

- Who is responsible?

28. How often are benefits packages reviewed and updated? Are these reviews coordinated with MMA, other agencies?

29. Is the process the same for Medicaid and non-Medicaid funded services?

30. How is rate-setting managed?

Claims payment

31. Describe the claims payment process

- Is it automated?
- Who is responsible?
- How many staff perform this function?
- What are the timeframes for claims payment?

32. What claims forms are used when submitting to the fiscal agent? Do you use 837s?

33. Does the Agency have a specific direct services budget that is appropriated to you for Medicaid that you have to live with?

34. Does the Agency supplement the Medicaid payment that is paid to providers?

35. Does the Agency provide non-Medicaid benefits?

III. Business Processes for Administrative Services

36. Describe the agency's process for Administrative claims.

- What is the legal basis for this?
- What information technology structure supports these activities?

37. Does the agency draw down FFP for administrative functions?

38. Describe the business process for documentation and billing.
Who is responsible for this?

39. Describe the agency's cost allocation plan, documentation and compliance
○ Who is responsible for this?

40. How are requests for reimbursement submitted to MMA?
- Who is responsible for this?
 - How are reimbursements integrated into agency financial system upon receipt of payment?
41. Describe the agency's audit process.
- What process is in place to assure no double billing with services?
 - Who is responsible for this?
42. How is financial oversight performed?
- Who is responsible for this?
 - What procedures are in place to assure accountability?
43. Does the Agency have any current process for routinely evaluating how you might maximize Medicaid funding to the Agency to help fund administrative services?
44. Does the Agency have a process for periodically discussing its administrative budget with the MMA?
45. Does the agency have any CPE or IGT-type arrangements?

IV. Relationship, interaction and compatibility with MMA, other agencies, the MMIS and the MMIS contractor

46. Describe the agency's interaction with the MMIS contractor
- Who is the primary contact?
 - What protocols are in place for this relationship?
 - What legal requirements are in place?
47. How does the agency address denial or request for additional information from MMIS contractor?
48. How are payments from the MMIS system accounted for within the agency system?
49. What documentation is retained for purposes of a look behind? What is the retention process and requirements?
50. What are the agency's responsibilities regarding a look behind?

V. Relationship, interaction and compliance with Medicaid

51. How is the agency notified of changes in federal and District Medicaid policy, laws and regulations?
- How are these changes incorporated into agency policy and practice?
 - Who is primarily responsible for this function?
52. How does the agency monitor trends and issues in the claims processes?
- Who is responsible for this?
53. How does the agency notify Medicaid of trends and operational issues?
- Who is responsible for this?
54. How does the agency ensure the maximization of federal Medicaid reimbursement?
Who is responsible for this?

Appendix B: Medicaid Information Technology Architecture (MITA) Framework

I. Identify the District of Columbia's Goals and Objectives

The process began with the identification and prioritization of the District's goals and objectives for this initiative.

1. To assess the current processes used by District of Columbia Agencies to perform billing functions; and
2. To implement a single effective and efficient way of performing billing functions for Medicaid-funded and other services.

Using the MITA framework to provide structure for the necessary cross-agency discussion and commitment, the objectives of the effort were:

1. To determine the feasibility of system changes,
2. To identify the impact of changes on programs,
3. To prioritize possible system changes with consideration for budgetary and human resource constraints, and
4. To recommend business processes and how they would be incorporated into Medicaid business processes and the MMIS.

The District of Columbia set these goals and objectives to assure the most effective and efficient use of limited resources as it undertakes system changes to enhance accountability and quality in the purchasing, delivery and oversight of publicly funded services.

II. Define the District of Columbia's Current Business Model and Map to the MITA Business Process Model

The next step in the process included the development of detailed documentation of each agency's business processes related to billing functions, with input from key leaders from across the multiple agencies that have a role in the purchase of services and using the Business Process Model in the MITA Framework. This mapping resulted in a description of the "as is" state of the state's business process.

Consistent with the MITA framework and approach, the District of Columbia's self-assessment addressed the following business functions:

1. Provider enrollment

2. Audit of claims encounters
3. Service Authorization
4. Manage Provider Grievance and Appeals
5. Inquire about Member Eligibility
6. Develop/maintain Benefits Package and
7. Claims payment

A template was developed, and interviews were conducted with District agencies during August and September 2008. The following agencies were interviewed:

1. Office of the State Superintendent of Education
2. District of Columbia Public Schools
3. Department of Disability Services
4. Child and Family Services Administration
5. Department of Child Protective Services
6. Department of Youth Rehabilitative Services
7. Department of Mental Health
8. Charter Schools represented by the DC Special Education Co-operative

External Stakeholders were interviewed to gain their perspective on billing-related issues, including the Quality Trust for Individuals with Disabilities, Healthy Families/Thriving Communities Collaborative, DC Fiscal Policy Institute, the Children's Law Center, and the DC Primary Care Association.

A list of stakeholders who participated in individual interviews and/or stakeholder meetings appears in the Appendix.

III. Assess the District's Current Capabilities

Each process was then evaluated using the MITA framework Business Capabilities Matrix to evaluate and designate a business capability level for the process. This capability level designation will become the baseline against which future improvement is measured by business process.

For each business process, agencies identified the way the business process is currently being implemented. This is the “as is” description. In addition, the groups identified achievable improvements, which is the desired “to be” state. These were incorporated into a template. The “as is” description appears in Appendix C. This is the description of the current level of implementation of the business process. Appendix D includes the “to be” description; that is, the level of development of the particular business process that the District wishes to achieve over time. Appendix E is the assessment of the current MITA maturity level of the business processes and the level to be achieved. Ultimately, the roadmap for change is the plan to move each of these business processes from the “as is” level of business capability to the “to be” level.

IV. **Determine the District’s Target Capabilities**

Participants identified a target capability for the business process being evaluated using the MITA Business Capabilities Matrix, the District’s goals and objectives and the “as is description”. This “to be” target capability for each business process represents the desired approach to implementing this business process within the District’s fiscal and operational parameters. The result of the effort to describe the current and target capabilities is documented in the following Self-Assessment Profile, which is intended by the District to become one of the bases for planning, prioritizing, and requesting funding for business process and system improvements.

V. **The MITA Maturity Model**

The MITA Maturity Models identifies five levels of maturity. The District of Columbia assigned one of the 5 maturity levels as defined by MITA to the “as is” and “to be” descriptions. Briefly, these levels can be described as follows:

1. At Level 1, the agency focuses on meeting compliance with the thresholds for state and federal regulations, primarily targeting accurate enrollment of program eligibles and timely and accurate payment of claims for appropriate services.
2. At Level 2, the agency focuses on cost management and improving quality of and access to care within structures designed to manage costs (e.g., managed care, disease management). The focus on managing costs leads to program innovations.

3. At Level 3, the agency is focused on adopting national standards, collaborating with other agencies in developing reusable business processes, and promoting one-stop-shop solutions for providers and consumers. The agency also encourages intrastate data exchange.
4. At Level 4 the agency benefits from widespread and secure access to clinical data and focuses on improvement of healthcare outcomes, empowering public and private enrollees and provider stakeholders within the state, measuring objectives quantitatively, and ensuring overall program improvement.
5. At Level 5 the agency has optimized program management, planning and evaluation, to take advantage of national and international interoperability, and has made improvements that maximize automation of routine operations.

Appendix C: As-Is Administrative Services¹

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
Administrative Claims Processing				
OSSE does not submit administrative claiming.	Care management staffs do time studies quarterly, updated yearly. a new process is being considered	Although CFSA has claimable administrative costs, does not submit administrative claiming.	DCPS does not submit administrative claiming.	DMH submits claims for Medicaid administrative activities – Access helpline, discharge planning.
Administrative Functions Method of Finance				
	\$1.7 m in federal funds annually			\$3-4 m in federal funds annually
Administrative Documentation and Billing				
Administrative Cost Allocation Plan Compliance and Documentation				
	Staff are trained in completing time study forms which are submitted to OCFO			Schedule A, lists all positions and % Medicaid, is submitted to OCFO
Administrative Claims Submittal to DHCF				
	Separate MOU with DHCF on administrative claiming cost allocation.			
Administrative Audit				
Administrative Claims Payment				
Administrative Financial Oversight				
	OCFO prepares reports			
Administrative Fully Utilizing Medicaid Funding				
	During preparation of new waiver, agency went through services across the agency to look for services to be federally matched. Working on getting			

¹ The Department of Youth Rehabilitation Services (DYRS) was not included in these tables as it does not currently bill MAA for Medicaid services.

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	out-of-state placements back to DC to leverage Medicaid.			
Administrative Budget Review with DHCF				
	DDS meets with the CFO weekly and works with DHCF on changing policies.			

Appendix C: As-Is Direct Services

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
Provider Enrollment				
<u>Licensure and Certification</u>				
<p>OSSE verifies provider licenses.</p> <p>Current CSA policy requires all CSAs to have a child psychiatrist employed – creates barrier for specialty care agencies to become established as a DC provider.</p> <p>The current rehab option provided by DMH is geared towards adults versus children.</p>	<p>DDS certifies HCBS waiver providers on an annual basis and sends quarterly reports to DHCF as part of quality assurance reporting</p> <p>Provider must be certified and Medicaid enrolled before human care agreement can be written.</p> <p>License checks and site visits used to verify provider credentials.</p>	<p>CFSA rehab facilities which provide Medicaid services. Others are licensed by state of Maryland.</p> <p>No requirement that they be Medicaid enrolled.</p> <p>No other agencies rely on CFSA licensing.</p>	<p>OSSE verifies provider licenses.</p> <p>The District licenses Medicaid providers other than school psychologists</p>	<p>Prior to moratorium on new providers, DMH approved certifications of CSA providers – reviewed application, site visit, assessed services, clinical, billing, HR, etc., talked to consumers, looked at licenses, checked with OIG, etc.</p> <p>Certifications are for 2 years. 40 types of certifications – depending on mix of services provided.</p>
<u>Providers</u>				
	<p>87 DDS case manager staff provide case management services – claimed through administrative match.</p> <p>All other DD services provided by community providers.</p> <p>Rates were not the issues so much as providers being tired of court monitoring.</p>	<p>CFSA is a provider for targeted case management and MRO (other than contracted residential services).</p> <p>Rehab providers are on varied contract monitoring cycles.</p> <p>CFSA, in role as parent, chooses providers for children in the system</p>	<p>Most providers are DCPS employees and some are contractors.</p>	<p>DMH is a direct provider – one of 20 CSA providers – providing services in 5 locations</p> <p>DMH oversees other providers with whom the agency competes as provider.</p> <p>Current moratorium on new CSA providers.</p>
<u>Provider Enrollment</u>				
<p>Charter schools have a hard time enrolling as providers</p>	<p>DD waiver providers submit a Medicaid provider enrollment</p>	<p>34 rehab providers are enrolled under one provider number with CFSA.</p>	<p>DCPS enrolled with Medicaid as 7 provider numbers – 1 for fee-for-service</p>	<p>Each of 20 Core Service Agency (CSA) providers has own provider number.</p>

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	<p>application with DD waiver addendum to DDS.</p> <p>DDS reviews provider application in two step process</p> <p>Is provider fit and qualified – financial solvency, personnel qualifications, criminal background checks, history in other states, etc.</p> <p>Does provider meet administrative rules for services they wish to provide – full review of applicant’s policies and procedures</p> <p>Applications for providers who pass the DDS two step process are forwarded to Office of Program Operations (OPO) in DHCF for enrollment as a Medicaid provider.</p> <p>OPO does the data entry and issues Medicaid provider number</p> <p>All DD providers should be Medicaid providers</p>	<p>Some are also enrolled with DHCF and others are not.</p>	<p>network, 1 transportation, and 5 special education centers (get global rate).</p>	

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	<p>Some (out of state providers, some ICF providers, some respite providers) may not be waiver providers.</p> <p>Initially, with new waiver, some trouble getting providers to enroll.</p> <p>DDS is bringing in new providers to improve care.</p> <p>DDS has a provider relations office with only a couple staffers. . DDS Technical Assistance Team (5 staff)- helps providers with application process. DDS holds provider orientation sessions for waiver providers and other DDS providers together.</p> <p>Providers can access same information as consumers through consumer portal</p> <p>Provider applications with instructions are on-line</p> <p>Human care agreements to contractors with waiver provider status.</p> <p>Some providers are also providers with other state agencies.</p>			

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	<p>DDS intends to become a Medicaid provider by next April. The department wants to provide home modification, vehicle modification and one-time transition coordination.</p>			
<u>Provider Contracts</u>				
	<p>DDS also holds direct contracts with service providers for individuals who are not Medicaid eligible.</p>			<p>Contracting process through human care agreements. State contracts with agencies – agency uses subcontracted providers.</p>
<u>Provider Capacity</u>				
<p>Day treatment providers are needed as well as service providers with flexible hours:</p> <p>The 30 day “day treatment” threshold creates a barrier for serving and keeping children within the District. Once they reach the threshold, treatment options are limited; usually results in the placement of a student in a non-public school or PRTF.</p>	<p>Need specialized providers for persons with dual diagnosis.</p>			
<u>Provider Education/Training</u>				
	<p>DHCF Provider bulletins are on web and hard copy – may not be up to date.</p>		<p>Service provider training is done by PCG – trained on Easy IEP, Medicaid billing.</p>	
<u>Provider Directory</u>				
	<p>DDS Waiver Unit</p>			<p>DMH maintains</p>

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	maintains provider directory.			provider directory on web.
Audit of Claims and Encounters				
			Cost settlement that occurs after payment is more difficult for agency staff than is billing and getting paid.	
Service Authorization				
<u>Prior Approvals</u>				
Each student's Individualized Education Plan (IEP) constitutes prior authorization and parental consent.	<p>MCIS system auto feeds prior approvals to the ACS interface (Delmarva)</p> <p>All prior approvals are determined based on plan of care.</p> <p>Need to get initial PA closed when new PA authorized. It does not always happen so it appears as a duplicate.</p>	CFSA decides if specialty foster care or residential treatment facility care is appropriate based on clinical practice.		eCURA holds prior approvals (eCURA is maintained in DMH with InfoMC contracted to assist in "getting bumps out".)
Service Plans/Level of Care Determinations				
	<p>DDS does ICF placements. Delmarva completes LOC for ICF.</p> <p>DDS does LOC determinations for waiver enrollees.</p> <p>SPA in works to have both use similar criteria and perhaps combine functions.</p> <p>Planning meeting held with client, client chooses</p>			<p>Treatment plans are created in eCURA.</p> <p>Discharge planning by DMH staff, hospital staff assign patients to CSAs, is claimed as administrative services.</p>

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	<p>services and providers from menu of providers. If housing support is needed referrals are made to providers with available openings if new funds are not available.</p> <p>Service plan meeting with Service Coordinator determines what services are needed/requested by client.</p> <p>Annual plan of care lists all services, providers, frequency of service, etc. Plans are in MCIS.</p> <p>Service Coordinator meets with client and provider to update plan of care.</p>			
Manage Provider Grievance and Appeal				
<p>OSSE gets call from provider about not being paid.</p> <p>OSSE can not look up and explain denial.</p>	<p>DHCF, helps providers with rejected claims re-bill.</p>	<p>Because of contracted rates, few providers appeal payment.</p>	<p>The school district is the provider; therefore there are no additional providers who would call to inquire about denied claims.</p>	<p>Only one service denial appealed since 2002.</p> <p>Plenty of grievances – same as other non-Medicaid provider relations.</p>
Resources for Member Eligibility Inquiry				
	<p>DDS MCIS system includes eligibility information for Medicaid and non-Medicaid enrollees.</p> <p>DDS has a web-based consumer information portal.</p> <p>DDS determines</p>	<p>Query MMIS system</p> <p>Read-only access to IMA's system</p> <p>Dial up electronic verification is available.</p> <p>A Claiming</p>	<p>Global match of DCPS rolls with District eligibility roster.</p> <p>IMA Automated Client Determination System (ACEDS) one query at a time.</p>	

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	<p>individual's level of care.</p> <p>After verifying individual's Level of Care need, DD sends form to IMA to indicate person is waiver enrolled.</p> <p>DDS provides enrollees with free choice of institution versus non-institutional care (ICF-MR or HCBS)</p> <p>DDA explains the benefits provided under HCBS and determines the individual budget</p> <p>Cost neutrality is based on aggregate versus individual comparison to facility placement</p> <p>DDS establishes treatment plan based on assessment and create prior approvals (automatic) base on treatment plan</p> <p>Some problems with IMA exist – Sometimes the ICF/MR code is not closed even after individual has left ICF/MR and is on waiver. Thus the waiver can't be opened or paid</p>	<p>Specialist in CFSA Medicaid Claiming Unit checks why children are not eligible for Medicaid at the time of services so that eligibility is established before invoice comes in.</p>		
Develop/Maintain Benefits Package				
	DDS program staff	The Medical Unit in		Services determined

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	<p>work with DHCF to develop state plan and HCBS waiver amendments.</p> <p>DDS is going to add peer counseling and enhanced primary care coordination to the waiver (to be submitted in Dec.)</p> <p>Case Management is now administratively claimed and DDS wants to bring it into the waiver to get enhanced funding.</p>	<p>the Office of Clinical Practices determines services to purchase.</p>		<p>by state plan and budget restrictions. DMH looks at population needs and develops program.</p>
Claims Payment for Medicaid and non-Medicaid				
<u>In General</u>				
<p>OSSE does not currently process claims from providers for non-Medicaid.</p> <p>OSSE wants to make changes to allow for Medicaid billable services at schools . Problem of teachers and parents using special education to get EPSDT services to kids during the school day (for example mental health and speech services) because kids can't get MCO services at school. School based services is often best for children. .</p>	<p>DDS does not submit claims for Medicaid program services – DD providers submit Medicaid claims for Medicaid eligible clients to DHCF for approval and payment.</p> <p>DDS processes claims from non-Medicaid providers – DD providers submit claims and or invoices for non-Medicaid services and non-Medicaid clients to DDS for approval and payment pursuant to human care agreements.</p>	<p>CFSA submits targeted case management and Medicaid Rehab Option (for foster children) claims to DHCF.</p> <p>CFSA processes claims for non-Medicaid services – IV-E claims and or invoices for foster care (room and board), adoption maintenance and administrative claims.</p>	<p>DCPS currently submits claims for Medicaid program services.</p>	<p>DMH submits claims for Medicaid program services – standard counseling, Community Based Intervention (ACT for kids), Assertive Community Treatment (ACT), Medication Management.</p> <p>DMH processes claims and or invoices from providers for non-Medicaid.</p>
<u>Billing System</u>				
OSSE will use Easy IEP (PCG) system	Paper non-Medicaid claims for payment	Claims are submitted and paid	No billing MCOs - IDEA services are	eCURA includes enrollment, prior

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
<p>for this billing until ASO decision is made.</p> <p>OSSE will need to unbundle and make timely payment within 30 days of receiving invoices from non-public schools.</p> <p>Provider has 6 months to submit claim plus 1 year to pursue denials</p> <p>DHCF has two years plus one month to claim FFP</p> <p>CMS wants District contracts with non-public schools for IEP services that are Medicaid billable (currently through DCPS). Contracts would include definition of services, rates, contract terms, etc</p>	<p>are keyed into MCIS and into PAS (procurement system).</p> <p>All invoices go to DDS CFO for approval in the PAS system, then to Treasurer for payment.</p> <p>District Quick Payment Act requires 30 days payment standard from CFO to issued check.</p> <p>MCIS system contains services, client, billing information and auto feeds prior approvals to the ACS interface (Delmarva)</p> <p>Providers directly bill ACS.</p> <p>Remittance advice goes back to provider and to DDS.</p> <p>The new waiver uses HCPCS codes, not local codes.</p> <p>For non-Medicaid services - contract information entered into MCIS. MCIS calculates amount invoice should be. If invoice submitted amount matches MCIS amount, invoice is paid. If it doesn't match, the</p>	<p>electronically in most cases, in FACES</p> <p>FACES reports number of days and Medicaid portion of claims to ACS.</p> <p>Each placement is identified by FACES and reported as a group to ACS with claim.</p> <p>Providers enter data into FACES – little chance for provider to manipulate billing – occasionally pay for days after child has left placement.</p> <p>Invoiced amounts are almost always the amount paid. There are few cross checks.</p> <p>Exacta-Med is company that transmits claims from FACES to ACS.</p> <p>TCM is billed monthly for each child based on number of days.</p> <p>Claims go from CFSA to ExactaMed by 837 transactions and from ExactaMed to ACS. More claims are lost in the first step, but 90% of claims are paid.</p>	<p>carved out of the MCO contracts.</p> <p>Fee for service claims are generated in a HIPAA compliant manner by the Easy IEP feature of the new Special Education Tracking System (operated by PCG). This proprietary system generates the claim, includes all Medicaid required edits.</p> <p>Easy IEP system changes can be done in an hour. Easy IEP has secure log in and role-based access – only providers who are licensed to provide a certain service can enter that service.</p> <p>Providers contracted via blanket purchase agreements are paid when Easy IEP documentation is complete.</p> <p>New system does not interface with ACS. Claims are first generated in Easy IEP and sent to DHCF.</p> <p>New system has some imaging ability, but hard copies are still kept of all imaged documents.</p>	<p>approvals, 511,000 claims and \$45 m.</p> <p>Of \$45 m, \$31 m goes to ACS by 837 and 835 transactions.</p> <p>CSAs are given licenses to access eCURA, additional licenses available for a fee.</p> <p>eCURA provides canned and written claims management reports and reports for the court monitor.</p> <p>Claims go to eCURA first because ACS can not accept PAs electronically.</p> <p>DMH wants claims to go through eCURA in order to have access to clinical information</p> <p>ACS pays CSA with local share coming from DMH budget.</p> <p>DMH pays out of local funds for non-Medicaid services.</p> <p>Claims process for Medicaid and non-Medicaid services is the same up to point when Medicaid claims data sent to ACS.</p> <p>For Medicaid services, providers get RA from ACS.</p> <p>MMA is upgrading MMIS. new version in October 2009.</p>

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	<p>invoice goes to a Provider Management liaison for review.</p>	<p>Medicaid pays 70% of the rate to CFSA. This takes time, may improve in FY08.</p> <p>Claims documentation is received monthly.</p> <p>CFSA works with fiscal to ensure services billed match services received. New initiative to get this done before 3 year audit.</p> <p>To allow for only one Case Management service – if child getting 2nd service from another provider – first claim in gets paid.</p> <p>CFSA works with Medicaid Fraud Unit to avoid duplicative payments, to address problems like incorrect Medicaid number for child.</p> <p>CFSA has considered having each of the 34 providers bill Medicaid separately. They have been unsuccessful in getting providers to do this.</p>	<p>Remittance Advices are web-based, go to DCPS and PCG.</p> <p>PCG has contract for system project.</p>	<p>Currently it can't handle place of service code. New system should avoid school and provider office services looking like duplicates.</p>
Denied Claims				
			When necessary,	Staff work unpaid

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
			<p>DCPS completes research to resubmit claims.</p> <p>15% of claims are kicked back from ACS, about half of these will eventually be paid. Most of the time denied because child was not Medicaid eligible on the date of service.</p>	<p>claims and re-bill through eCURA.</p> <p>eCURA checks proper authorizations, eligible consumer, etc. Sends claim back to provider if diagnosis is missing, bad client identification number or no prior authorization.</p> <p>eCURA sends approved claims to ACS.</p> <p>DMH assists CSA to get paid if ACS denies claims. DMH gets 835s from ACS, posts them on eCURA, keeps data for review.</p>
<u>Rates</u>				
	<p>Waiver providers are paid fee for service.</p> <p>Fees paid to providers for the same services do not vary by whether or not the client is Medicaid.</p> <p>DHCF sets rates and pays ICF providers.</p> <p>DDS hired consultant in 11-07 to help establish waiver rates. Consultant used current rates and best practice to set rates.</p> <p>Waiver rates will be reviewed.</p>	<p>Provisional rate cost settled at end of year.</p> <p>CFSA Contracts and Procurement Unit sets MRO rates for 34 providers.</p> <p>The difference between provisional rate and the cost settled MRO rate is large.</p> <p>Different rate for each provider negotiated by Contracts and Monitoring Unit.</p> <p>Interim rates with cost settlement.</p> <p>For TCM,</p>	<p>Fee for service claims interim rates have not changed in many years</p> <p>Typically DCPS owes DHCF after cost settlement.</p> <p>Global Methodology – bundled per diem rate paid for 5 schools that serve high need children.</p>	<p>Different rates are paid for Medicaid and non-Medicaid services.</p> <p>Rate development has not been done since 2002.</p> <p>In process of reviewing rates. Hired individual to look at similar jurisdictions, cost of living, and unit size and gather comparable data.</p>

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	<p>ICF/MR rate reviews are underway for October 1.</p> <p>Waiver rates pay better than past practices in Medicaid program.</p> <p>Complaints that ICF/MR rates are low relative to costs.</p>	<p>personnel and non-personnel costs are allocated based on sampling – results reported quarterly.</p>		
<u>TPL</u>				
<p>Current Medicaid Recovery Unit in DCPS does good job but should improve.</p> <p>District bill to require insurance companies to pay for habilitation services for severely disabled kids should increase TPL.</p>				<p>DMH migrated “pay and chase” to ACS in November. There have been complaints.</p>
General Information				
<u>Services</u>				
<p>OSSE is in the process of transitioning the bill payment function for transportation services and services provided by non-public schools. Medicaid reimbursement is through the DCPS Medicaid process at this time.</p>	<p>With the new waiver, there are 26 waiver services, some are capped.</p> <p>District also has a Money Follows the Person grant that DDS will administer with DHCF.</p>	<p>Targeted case management</p> <p>Medicaid Rehabilitation Option services</p>	<p>Transportation by trip ticket</p> <p>Fee for Service – OT, PT, psychological counseling, evaluation and re-evaluations</p>	<p>Medicaid enrollees receive standard licensed counseling through Medicaid MCOs.</p> <p>Medicaid HMOs reimburse DMH for medication and counseling</p> <p>Medicaid enrollees who are SED or SPMI are not in Medicaid</p>

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
Care Center Part C evaluation centers – federally and locally funded, use MCOs, use Medicaid providers but don't bill Medicaid.				MCOs – instead are assigned to a CSA
FFP				
	<p>The first \$2.9 m local share of DDS Medicaid services comes from DHCF budget</p> <p>Annually \$80-90 m in total DDS Medicaid claims paid.</p> <p>Total local share \$24 to \$27 m annually.</p>	Medicaid federal share \$36-\$38 m annually.	DHCF pays DCPS FFP portion only (70%) – budgeted at \$18 million per year. (About \$3.5 m transportation, \$2 m fee for service, and \$12.5 global methodology). Was higher in 2003 - \$20 m.	\$28 m in federal Medicaid dollars for CSA payments.
Organization/Persons Served				
	<p>Two sides to DDS: Developmental Disabilities Agency (DDA)</p> <p>Rehabilitation Services Agency (RSA) Voc Rehab – federally funded, no Medicaid</p> <p>DDA serves 1990</p> <p>1200-1300 of the 1990 are on the waiver</p> <p>Another 500 are in ICF?MR</p> <p>Several of the 1990 are out of state</p> <p>Some are foster or</p>	<p>2300 kids in foster care, on average per month.</p> <p>All foster children are eligible for Medicaid, although some are not properly enrolled.</p> <p>Information should be submitted to IMA within 5 days in order to initiate Medicaid enrollment.</p> <p>By law, Medicaid children who enter the foster care system go from managed care to fee for service coverage within 30 days.</p>	<p>75% of children have health related services in IEP</p> <p>75% of these are Medicaid eligible.</p> <p>Medicaid eligibility numbers are declining.</p>	55% of DMH clients are Medicaid.

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	respite and not Medicaid	30-40% of foster care children are in MRO placement.		

Appendix C: As-Is Medicaid Relationship

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
Agency Integration of Medicaid Policy				
	<p>In the past, communication between DHCF and DDS has been poor. It is better now with DHCF/DDS Liaison's help and with weekly meetings.</p> <p>Medicaid unit in DDS keeps up with Medicaid changes through weekly conference calls with DHCF and by word of mouth.</p> <p>Example of problem - DD was not notified of transportation changes by DHCF. Difficult roll out – problems with DD persons using public transportation.</p>	<p>CFSA keeps track of Medicaid policy changes with new DHCF/CFSA liaison, CFSA External Affairs person and through DHCF, APHSA, NASMD.</p>	<p>Good relationship with DHCF, has improved over last two years.</p>	<p>DMH Office of Strategic Planning responsible for all policy development. DMH tracks Medicaid changes through DMH legal, web and from DHCF.</p> <p>DHCF update process could be improved.</p> <p>Example of problem - DHCF responsible for coding standards but provides no coding books or online access to codes.</p>
Claims Processes Trend Monitoring				
	<p>DDS monitors trends with provider calls, weekly reports, what DHCF/DDS Liaison hears and weekly calls with DHCF.</p> <p>Also, DHCF was maintaining a written list of MMA issues and due dates – not sure if this continues.</p>	<p>Agency identifies trends by looking at remittance advices and working denied claims.</p> <p>Centralization may disadvantage working exception reporting.</p>		<p>DMH fiscal services looks at claim reports and trend numbers, looks for utilization trends to evaluate costs and rates.</p> <p>DMH talks with DHCF by phone – not formal process.</p>
Fully Utilizing Federal Medicaid Dollars				
	<p>Majority of local dollars are for room and board, out-of-</p>	<p>No Medicaid payable services CFSA would like to add. Can't get</p>	<p>Did an analysis of ways to fully utilize federal</p>	<p>Should be a more formalized process – do review</p>

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	<p>state services, residential, vocational, and day services. Also for nursing either for non-Medicaid eligible, service beyond amount, duration and scope, or the provider has not gotten enrolled in Medicaid yet.</p> <p>Local dollars also pay for medical and pharmacy bills if individual can't pay copays (see court order)</p>	<p>Medicaid to cover clinical psychiatric services to in-home population.</p> <p>Problems with moving children from MCO to FFS when come to CFSA.</p>	<p>reimbursement about 7-8 months ago which indicated there might be more that can be done.</p> <p>Agency is looking at additional services that should be reimbursable (nursing and case management).</p> <p>DCPS develops an annual cost allocation plan. A new comprehensive compliance plan has been implemented to meet compliance and documentation requirements.</p>	<p>annually.</p>

Appendix C: As-Is MMIS Vendor Interaction

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
MMIS Vendor Interaction				
	DHCF/DDS Liaison works with providers on billing issues.			Agency uses weekly eCURA match with Medicaid system to identify claims paid, going to daily match.
MMIS Denials and Information Requests				
	Weekly DDS gets information from ACS about payments to waiver providers - \$ amount paid, # approved, # denied, service codes, provider name, etc.			
MMIS Payments Accounting				
	Use ACS report to keep track of 30% state share to be paid by DDS, utilization management, what providers are providing. Hard to match payments to Prior Authorizations because ID numbers are different. Want to make sure consumer is getting services they need but hard to match what is authorized to services provided and paid.			835s loaded into eCURA.
Cost Allocation Plan Compliance and Documentation				
Audit				
	Currently plan to do more auditing. Want to pull random samples of claims and services.			Department of Accountability does regular audits of provider files – some unannounced.

As Is OSSE	As Is DDS	As Is CFSA	As Is DCPS	As Is DMH
	<p>DDS is uncertain if services above the PA level don't get paid, and currently there is no way to check whether services provided are below the PA level.</p> <p>DDS does quality oversight through quality assurance with DHCF doing quarterly chart audits.</p> <p>DHCF checks for fraud and abuse and conducts financial audits.</p>			

Appendix D: To-Be Administrative Services

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
<p>Administrative Claims Processing</p>	<p>The ASO will receive appropriate data or claims, and prepare and submit administrative claiming to the Fiscal Agent.</p> <p>The ASO will receive and generate any attachments necessary for administrative claiming submissions.</p> <p>The ASO will be responsible for maintaining administrative claiming history; Partner Agencies will be able to inquire about all pending, paid and denied history from the ASO.</p>	<p>OSSE will work with ASO to identify potential administrative claiming opportunities.</p> <p>DDS will continue to submit administrative claiming directly to DHCF through a separate MOU. DDS will receive assistance from ASO to develop an alternative process for case management staff submitting their time studies or claims in the future.</p> <p>CFSA has identified administrative claiming opportunities and will work with the ASO to develop the billing process.</p> <p>DMH will work with ASO to submit administrative claiming, these do not flow through the eCURA system.</p>	<p>Work in cooperation with partner agencies to develop claims processing work flows (claim track) for all claims that may be eligible for Medicaid reimbursement, and those that may require tracking to coordinate with Medicaid billings. The claim track will include analysis of documentation requirements, methods of claims preparation, methods of claim submission, hardware and software requirements, and communication requirements.</p> <p>For each claim track, create or employ systems, communication links, methods, data repositories, document management, claims submission paths, and reconciliation procedures. When appropriate, the ASO will create service authorization systems and procedures that will control referrals, line item authorizations, and plans of care authorizations.</p> <p>Based on the claim tracks, create and operate systems and interfaces to facilitate the creation of claims and the recording of documentation necessary to support the claims. Operate a web portal, electronic claims receipt and generation facility (clearinghouse), paper claims processing facility, document management system, transaction processing system, and data reporting system to handle all aspects of claim information receipt, claim generation to multiple payors, claim coordination of benefits, third party liability, claim processing reporting and auditing.</p> <p>For each claim track, create and record editing, auditing, coordination</p>

<p>1 Related MITA Business Processes</p>	<p>2 To Be Recommended Functions for ASO for All Agencies</p>	<p>3 To Be for IMA, DHCF, and Partner Agencies</p>	<p>4 Mandatory Requirements for ASO</p>
			<p>of benefits rules, authorization streams, and documentation requirements (rules). Deploy the rules in as part of the automated system.</p> <p>Develop reports for each claim track and for each partner agency to evaluate the effectiveness of claims submission and processing.</p> <p>For each claim track developed under Develop/maintain Benefits package, develop a standardized billing process and template. The claim track may be different for each partner agency, and the claim track may offer multiple options for the claim submission method.</p> <p>Create interfaces to receive claims information and all documentation from each partner agency to conform to the claim tracks.</p> <p>Operate a web portal, electronic claims receipt and generation facility (clearinghouse), paper claims processing facility, document management system, transaction processing system, and data reporting system to handle all aspects of claim information receipt, claim generation to multiple payors, claim coordination of benefits, third party liability, claim processing reporting and auditing.</p> <p>Create interfaces to receive information on direct-billed claims; store the information in the data warehouse for use in coordination of benefits, determining claims priority, history and longitudinal reporting.</p> <p>Submit claims to all payors in the order of priority determined by the claim track. Coordinate claims payments from multiple payors as appropriate to coordinate benefits</p>

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
			<p>and manage third party liability.</p> <p>Integrate service authorizations into the claim tracks and claims processing.</p> <p>Create reports and maintain data for ad-hoc reports in the data warehouse to report on the effectiveness and use of service authorizations.</p>
Documentation and Billing	The ASO will receive and generate any attachments necessary for administrative claiming submissions.		<p>Receive, process and maintain all information described under claims processing to document and properly bill all eligible claims submitted.</p> <p>Deploy a document management system or equivalent to provide access to DHCF and partner agency staff to submit and view claims documentation.</p> <p>Generate any required attachments or other documentation necessary to support claims submission or to defend a claim in an audit or dispute.</p>
Cost Allocation Plan Compliance and Documentation	The ASO will manage the cost allocation plan compliance and documentation for the Partner Agencies.	DDS performs quarterly cost allocation and an annual update.	<p>Create a draft Cost Allocation Plan for DHCF approval and submission.</p> <p>Revise and resubmit the plan at the direction of DHCF.</p> <p>Prepare monthly and quarterly reports based on the Cost Allocation Plan to report actual allocations to DHCF and the federal Centers for Medicare and Medicaid Services (CMS).</p>
Claims Submittal to DHCF	The ASO will receive appropriate data or claims, and prepare and submit administrative claiming and attachments to the Fiscal Agent.	All Partner Agencies will provide the ASO with appropriate information to accurately submit administrative claiming.	Submit claims in order of priority to the various funding sources.
Audit	The ASO will receive all RAs from the fiscal agent and will provide these to all Partner	The Fiscal Agent will continue to prepare RA Reports for providers.	Receive and reconcile all 835,837. 997, TA1 and 277U transactions, remittance advice and other documentation from the fiscal agent

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
	<p>Agencies.</p> <p>The ASO will assist Partner Agencies with reconciliation of administrative claiming based on pending, paid and denied history.</p>	<p>DHCF will manage all settlement agreements due to reconciliations, audits, etc.</p>	<p>and other payers.</p> <p>Claims payments will be made directly to the partner agencies or designated payee, but the ASO will receive the remittance information and prepare accounting reports.</p> <p>Report on claims processing, denials, history, and trends to DHCF and each partner agency.</p> <p>Assist the partner agencies in the reconciliation of claims processing and audit reports.</p>
Claims Payment	<p>The ASO will be responsible for maintaining administrative claiming history; Partner Agencies will be able to inquire about all pending, paid and denied history from the ASO.</p>	<p>Fiscal Agent will:</p> <ul style="list-style-type: none"> • be responsible for maintaining claims history, and • recoup any provider overpayments. 	<p>Maintain status and accounting record of all claims payments, including paid amount, denied amount, funding source, third party liability amount, recipient share of payment, and amount billed.</p> <p>Create standard reports and generate by claim, by week, by month, by quarter, by fiscal year, and by calendar year for each claim track, each partner agency, and in summary.</p> <p>Create and produce trending and effectiveness reports.</p>
Financial Oversight	<p>The ASO will prepare budget and spending reports as directed by the Partner Agencies.</p> <p>The ASO will prepare financial reports as directed by the Partner Agencies.</p>		<p>Create and prepare standard weekly, monthly, quarterly, fiscal year and annual reports of budgeting and spending for both program costs (claims billed and paid) and administrative costs (amounts paid to the ASO for processing and operations.)</p>
Fully Utilize Medicaid Funding	<p>The ASO will assist the Partner Agencies in identifying administrative claiming opportunities as needed.</p>	<p>DDS will continue to look for administrative claiming opportunities in the waivers and throughout the program. DDS will continue to work through the CFO and</p>	<p>Create the Cost Allocation Plan to fully utilize the Medicaid funding available.</p> <p>Create claim tracks and submit claims in a manner that fully utilized Medicaid funding available.</p> <p>Report on FFP trending.</p>

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
		DHCF to revise policies as needed.	Participate with DHCF and partner agencies in Process Improvement activities to determine improved efficiencies and to fully utilize Medicaid FFP when appropriate and valid.
Administrative Budget Review with DHCF	The ASO will assist the Partner Agencies in the Administrative Budget Review process with DHCF as directed.		Participate as directed by DHCF in budget preparation, budget review, and auditing.

Appendix D: To-Be Direct Services

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
<p>Provider Enrollment</p>	<p>The ASO will have the capability to authorize, enroll and disenroll providers as determined by the Partner Agencies.</p> <p>The ASO will be responsible for maintaining and updating this information, which may include provider or specialty type, service and billing locations, etc.</p> <p>The ASO will respond to inquiries regarding provider/contractor/business associate information as directed by Medicaid or the Partner Agencies.</p> <p>The ASO will be responsible for provider communication information as directed by DHCF and the Partner Agencies.</p>	<p>Recruitment of new providers will remain the responsibility of the Partner Agencies.</p> <p>Medicaid and Partner Agencies will award contracts for providers within the scope of their responsibilities.</p> <p>OSSE will delegate functions of licensure verification for therapists and psychiatrists to the ASO.</p> <p>DCPS uses the OSSE approved school psychiatrists. DCPS will continue to issue licenses for other providers.</p> <p>CFSA will continue to license facilities but only for their own purposes will not have to be accessed by others.</p>	<p>Develop and operate interfaces with the fiscal agent to receive provider file information.</p> <p>Create, maintain and operate a provider database of authorized providers.</p> <p>Maintain multiple identifiers for providers and complete financial, medical license, ownership, credentialing and demographic data to track and maintain them according to Medicaid ID, National Provider Identifier (NPI), Medicare ID, group affiliations, practice addresses, owners and managers.</p> <p>Create interfaces with each partner agency to exchange data on providers participating in Medicaid and partner agency programs.</p> <p>Provide assistance to enrolled providers or those seeking enrollment to participate by operating a provider enrollment web portal and a provider enrollment telephone help desk. Provide an on-line application function and provider information update function, enrollment forms, and general information.</p> <p>Create and maintain interfaces to validate providers against the NPI database, Medicare/Medicaid proscribed provider lists, and other disciplinary action files to assure that ineligible providers are not allowed to provide services to Medicaid recipients.</p> <p>Create, maintain and operate electronic and paper claims administrative files to include trading partner agreements, electronic data exchange agreements, business associate agreements, HIPAA privacy, security, code set and NPI agreements, contract and credentialing documentation that may be required to support claims.</p>

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
			<p>Store provider data in a flexible data warehouse to be used in the creation of financial, compliance, fraud-control and health outcome reports.</p> <p>Create and produce provider manuals, including policy manuals, billing manuals, HIPAA companion guides, electronic submission manuals or guides.</p> <p>Solicit enrollment and reenrollment information from providers as requested by DHCF and record enrollment/reenrollment information in the data warehouse.</p>
<p>Audit of Claims and Encounters</p>	<p>The ASO will receive all RAs from the fiscal agent and will provide these to all Partner Agencies.</p> <p>The ASO will assist Partner Agencies with reconciliation of claims based on pending, paid and denied claims history.</p>	<p>The Fiscal Agent will continue to prepare RA Reports for providers.</p> <p>DHCF will manage all settlement agreements due to reconciliations, audits, etc.</p>	<p>Receive HIPAA X12 835, 997, TA1, and 277U transactions from the fiscal agent for all claims submitted on behalf of participating providers and partner agencies. (Claims data)</p> <p>Store claims data in a flexible data warehouse to be used in the creation of financial, claims management, compliance and health outcome reports.</p> <p>Use claims data to reconcile billings for each agency and to measure trends in the amount and percentage of services for each partner agency covered by Medicaid.</p> <p>Use claims data to resolve billing errors and to develop improvement plans to assure that all eligible services are being accurately billed to Medicaid.</p> <p>Provide claims data reports to assist in policy determination and to support audit and fraud-control activities.</p>
<p>Service Authorization</p>	<p>The ASO will interface with the agencies to maintain treatment plans, referrals and service authorizations only for billing purposes.</p> <p>The ASO will check claims against PA as</p>	<p>Only the Partner Agencies approve service authorizations in accordance with their policies and procedures.</p>	<p>Work in cooperation with partner agencies to develop claims processing work flows (claim track) for all claims that may be eligible for Medicaid reimbursement, and those that may require tracking to coordinate with Medicaid billings. The claim track will include analysis of documentation</p>

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
	<p>well as do back end audits. Will monitor claims against authorization for under and over utilization.</p>		<p>requirements, methods of claims preparation, methods of claim submission, hardware and software requirements, and communication requirements.</p> <p>For each claim track, create or employ systems, communication links, methods, data repositories, document management, claims submission paths, and reconciliation procedures. When appropriate, the ASO will create service authorization systems and procedures that will control referrals, line item authorizations, and plans of care authorizations.</p> <p>Integrate service authorizations into the claim tracks and claims processing.</p> <p>Create reports and maintain data for ad-hoc reports in the data warehouse to report on the effectiveness and use of service authorizations.</p>
<p>Manage Provider Grievance and Appeal</p>	<p>The ASO will be responsible for tracking provider grievances and appeals related to claims payment.</p> <p>The ASO will manage a provider call center to field questions and will assist the providers using a comprehensive claims history database.</p>	<p>The responsibility for resolution of provider grievances and appeals will remain with IMA, DHCF and the Partner Agencies.</p> <p>DDS providers will continue to appeal directly to DHCF for claims-related complaints.</p>	<p>Maintain a method for grievance receipt, tracking and reporting. This will include the ability of providers to initiate actions on a web portal, through a telephone call center, or by submission of paper forms or letters.</p> <p>The Grievance procedures will be handled by automated or highly regulated manual procedures to assure that all required actions are taken within specified timeframes.</p> <p>Maintain all data and documentation necessary to record and resolve grievances.</p> <p>The grievance resolution procedures will record and allow decisions from the ASO and from MMA and the partner agencies.</p> <p>Issue regular reports to DHCF and the partner agencies on the status of all grievances filed, including timeliness of resolution, resolution results and trending.</p>

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
<p>Inquire Member Eligibility</p>	<p>The ASO will maintain an eligibility file that has the capability to add, delete or update member demographic information as directed by the Partner Agencies.</p> <p>The ASO will maintain current member information which will be reconciled with the Fiscal Agent's eligibility file.</p> <p>The ASO will develop and maintain a standardized process for agencies to confirm eligibility (such as a Web Portal).</p> <p>The ASO will have the capability to communicate with members of the Partner Agencies, as directed by DHCF or the Partner Agencies.</p> <p>The ASO will have the capability to track member grievances and appeals.</p>	<p>IMA will maintain the current Medicaid eligibility determination processes.</p> <p>Each Partner Agency will determine eligibility specific to their program and benefits.</p> <p>All Partner Agencies will utilize the ASO Member Eligibility in the same manner.</p> <p>The responsibility for resolution of member grievances and appeals will remain with IMA, DHCF and the Partner Agencies.</p> <p>DDS uses MCIS to maintain eligibility information for Medicaid and non-Medicaid enrollees.</p> <p>CFSA and DCPS accesses eligibility through IMA Automated Client Determination System (ACEDS) one query at a time.</p>	<p>Create and maintain an interface with the fiscal agent to regularly verify Medicaid eligibility for participants in partner agency programs. The interface will use HIPAA X12 270/271 transactions in batch mode on a daily basis for all new participants. The interface will regular verify the continuing eligibility for existing participants. The ASO will use HIPAA X12 270/271 real-time individual transactions and automated voice response inquiries as necessary to update or resolve individual cases.</p> <p>Store participant data in a flexible data warehouse to be used in the generation of claims, claims resolution, third party responsibility determination, eligibility verification to partner agencies and providers, compliance, longitudinal and program management reports, health outcome and ad-hoc reports.</p> <p>Create interfaces specific to each partner agency to receive information on new participants and updates on existing participants. Create methods to record participant information that may affect continuing eligibility, such as birth and death information, income, family composition, income, assets, identification and demographic information. Record all information in the data warehouse.</p> <p>Create systems and interfaces to record participant eligibility in other federal and District of Columbia programs. Create methods to determine priority of claims submission (primary, secondary and tertiary payor)</p> <p>Make eligibility verification available to partner agencies, providers and other authorized users, to report eligibility for all programs based on priority. Make eligibility information available via a web portal, via and Automated Voice</p>

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
			<p>Response System (AVRS), via a call center, via Medicaid Eligibility Verification System (MEVS) vendors, and via a web service that handles direct 270/271 transactions (TCP/IP and batch).</p> <p>Maintain a method for recipient grievance receipt, tracking and reporting. This will include the ability of recipients to initiate actions on a web portal, through a telephone call center, or by submission of paper forms or letters.</p> <p>The Grievance procedures will be handled by automated or highly regulated manual procedures to assure that all required actions are taken within specified timeframes.</p> <p>Maintain all data and documentation necessary to record and resolve grievances.</p> <p>The grievance resolution procedures will record and allow decisions from the ASO and from DHCF and the partner agencies.</p> <p>Issue regular reports to DHCF and the partner agencies on the status of all enrollee grievances filed, including timeliness of resolution, resolution results and trending</p>
<p>Develop/Maintain Benefits Package</p>	<p>The ASO will be responsible for maintaining the benefit package including the service/drug formulary for Medicaid and each Partner Agency to ensure appropriate billing.</p>	<p>The Medicaid Program and the Partner Agencies establish the minimum benefit package for Medicaid beneficiaries.</p>	<p>Work with DHCF and each partner agency to determine all possible sources of claim payment for their participants, and determine the priority or order of billing for each. (claim track)</p> <p>Determine for each claim track the claims submission and documentation requirements. Based on the claim tracks, create and operate systems and interfaces to facilitate the creation of claims and the recording of documentation necessary to support the claims. Operate a web portal, electronic claims receipt and generation facility (clearinghouse), paper claims processing facility, document management system, transaction</p>

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
			<p>processing system, and data reporting system to handle all aspects of claim information receipt, claim generation to multiple payors, claim coordination of benefits, third party liability, claim processing reporting and auditing.</p> <p>For each claim track, create and record editing, auditing, coordination of benefits rules, authorization streams, and documentation requirements (rules). Deploy the rules in as part of the automated system.</p> <p>Develop reports for each claim track and for each partner agency to evaluate the effectiveness of claims submission and processing.</p>
<p>Claims Payment</p>	<p>The ASO will receive appropriate data or claims, and prepare and submit claims to the Fiscal Agent, except for DDS direct-billing waiver providers.</p> <p>The ASO will receive and generate any attachments necessary for claims submissions, except for DDS direct-billing waiver providers.</p> <p>The ASO will be responsible for maintaining claims history; Partner Agencies will be able to inquire about all pending, paid and denied claims history from the ASO.</p> <p>OSSE – ASO will develop a standardized billing process for all claims regardless of payer, will include unique identifiers for each group: Special</p>	<p>All Partner Agencies will provide the ASO with appropriate claims data to be used in developing HIPAA compliant claims, except DDS direct-billing waiver providers.</p> <p>All Partner Agencies will provide the ASO with all attachments needed to adjudicate a claim, except DDS direct-billing waiver providers.</p> <p>OSSE will begin using Easy IEP system for billing transportation and day services from DCPS. This proprietary system generates claims information but does not interface with Fiscal Agent.</p> <p>CFSA will:</p> <ul style="list-style-type: none"> Set MRO rates for contracted providers and perform annual cost settlement based 	<p>For each claim track developed under Develop/maintain Benefits package, develop a standardized billing process and template. The claim track may be different for each partner agency, and the claim track may offer multiple options for the claim submission method.</p> <p>Create interfaces to receive claims information and all documentation from each partner agency to conform to the claim tracks.</p> <p>Operate a web portal, electronic claims receipt and generation facility (clearinghouse), paper claims processing facility, document management system, transaction processing system, and data reporting system to handle all aspects of claim information receipt, claim generation to multiple payors, claim coordination of benefits, third party liability, claim processing reporting and auditing.</p> <p>Create interfaces to receive information on direct-billed claims; store the information in the data warehouse for use in coordination of benefits, determining claims priority, history and longitudinal reporting.</p>

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
	<p>Education, DMH, CFSA.</p> <p>OSSE – New system must establish a link between EPSDT and school-based services to track and verify that services are delivered in the most appropriate setting and are billed accordingly.</p> <p>CFSA – ASO will retrieve and submit claim information from FACES to Fiscal Agent for payment.</p>	<p>on DHCF established provisional rate.</p> <ul style="list-style-type: none"> • Capture encounter information for claims in the FACES system. <p>DDS</p> <ul style="list-style-type: none"> • As direct billing providers, waiver providers will be paid by the Fiscal Agent, not through the ASO. • MCIS system is used to bill non-Medicaid services. MCIS also contains services, client, billing information and auto feeds prior approvals to the ACS interface (Delmarva) <p>DCPS claim information will be available through the Easy IEP feature of the Special Education Tracking System. This proprietary system generates claims information but does not interface with Fiscal Agent.</p> <p>DMH will:</p> <ul style="list-style-type: none"> • Maintain billing information for Medicaid and non-Medicaid services • Continue to pay for non-Medicaid services <p>Fiscal Agent will:</p> <ul style="list-style-type: none"> • be responsible for maintaining claims 	<p>Submit claims to all payors in the order of priority determined by the claim track. Coordinate claims payments from multiple payors as appropriate to coordinate benefits and manage third party liability.</p> <p>Maintain all reference files necessary to properly submit claims, including procedure code files, diagnosis code files, drug files, formulary files, taxonomy files, reference files of proscribed providers, location codes, mailing codes, demographic codes, funding codes.</p> <p>Inventory the systems being used by the Partner Agencies, extract data necessary for claims submission and historical reporting. Assist DHCF and the Partner Agencies in determining systems and processes that can be discontinued or scaled back.</p>

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
		history, <ul style="list-style-type: none"> • recoup any provider overpayments, estate recoveries and TPL recovery efforts, and • manage the drug rebate program. 	

Appendix D: To-Be Medicaid Relationship

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
Agency Integration of Medicaid Policy	The ASO will incorporate Medicaid Policy into systems processes that will accommodate the DHCF/Fiscal Agent and the Partner Agencies needs with the goal of creating a standardized format across the Partner Agencies.	The DHCF and the Partner Agencies will develop Medicaid Policy.	<p>Incorporate Medicaid policy as communicated by DHCF into claim tracks, rules, documentation standards, claims editing and auditing, and all operations.</p> <p>Designate staff and work with DHCF and partner agencies in continued process improvement activities.</p> <p>Make changes in systems and procedures to implement changes agreed in the process improvement activities.</p>
Claims Processes Trend Monitoring	<p>The ASO will be responsible for maintaining claims history; Partner Agencies will be able to inquire about all pending, paid and denied claims history from the ASO.</p> <p>The ASO will generate monitoring reports of claims processing trends as directed by the Partner Agencies.</p>		<p>Provide transaction processing system access to DHCF and partner agencies to allow specific claim and potential claim inquiry; provider information inquiry; participant information inquiry; service authorization inquiry; and reference inquiries.</p> <p>Provide data warehouse access to DHCF and partner agencies to allow generation of standard and ad-hoc reports. Provide an industry-standard or equivalent user interface (such as Business Objects, Cognos, or Crystal Reports) to allow the users to generate their own reports. Provide open-source SQL access to allow DHCF and the partner agencies to interface the data warehouse to their own systems.</p>

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
			Produce regular, standard reports on claims submission and results, including status reports, funding reports, trend reports, claims payment and denial reports and history reports.
Trend Communication with DHCF	The ASO will develop and communicate trend information as directed by the DHCF and the Partner Agencies.		

Appendix D: To-Be MMIS Vendor Interaction

<p style="text-align: center;">1 Related MITA Business Processes</p>	<p style="text-align: center;">2 To Be Recommended Functions for ASO for All Agencies</p>	<p style="text-align: center;">3 To Be for IMA, DHCF, and Partner Agencies</p>	<p style="text-align: center;">4 Mandatory Requirements for ASO</p>
<p>MMIS Vendor Interaction</p>	<p>The ASO will develop and maintain standardized links between the MMIS and the Partner Agencies as directed.</p>	<p>DMH has a direct electronic link with Fiscal Agent and gets a weekly update with Medicaid information. Uses the eCURA system.</p> <p>DDS would also request such access.</p>	<p>Create and maintain interfaces with the fiscal agent, partner agencies, providers, clearinghouses and vendors necessary to support all operations.</p> <p>Provide system access to DHCF and partner agencies (DC users) via a web-based system application that requires only an Internet connection for each DC user. Maintain systems to grant and control system access based on user ID and password for all users authorized by DHCF.</p> <p>Maintain role-based security to allow authorized users to access only those parts of the system and data warehouse that are necessary for the accomplishment of their authorized responsibilities, as determined by DHCF.</p>
<p>MMIS Denials and Information Requests</p>	<p>The ASO will be responsible for maintaining claims history; Partner Agencies will be able to inquire about all pending, paid and denied claims history from the ASO.</p> <p>MMIS denials and information requests will be received, researched and coordinated with the specific Partner Agency by the ASO.</p>	<p>All the Partner Agencies will have access to and take part in the response to MMIS information requests.</p>	<p>Receive and process HIPAA X12 835, 997, TA1 and 277U transactions, remittance advice from the fiscal agent and other payors, and other information to account for and reconcile all claims submitted.</p> <p>Record and track all denied or partially paid claims.</p> <p>Research all denied or partially paid claims in coordination with partner agencies to determine if the errors can be corrected, if the claims should be submitted to an alternate payor, or if the claims should be written off.</p> <p>Correct and resubmit claims to the appropriate payors to assure payment of all valid claims.</p> <p>Create and produce regular, standard reports on all claim denials, the result of research, and the results of resubmission, including trending</p>

1 Related MITA Business Processes	2 To Be Recommended Functions for ASO for All Agencies	3 To Be for IMA, DHCF, and Partner Agencies	4 Mandatory Requirements for ASO
			reports. Develop Process Improvement Plans to reduce the number of denials and improve the efficiency of claim processing.
MMIS Payments Accounting	The ASO will develop and maintain summary reports for each of the Partner Agencies to show the federal/state payment split and reconcile with the DHCF reports.	DHCF will report federal/state participation for all service and administrative claims for each of the Partner Agencies.	Develop an absolute accounting system that accounts for every potential claim submitted at every stage. Determine and record in the data warehouse the disposition of the claim, claim lines, claim line amounts, third party liability, patient responsibility, funding source, billing status, payment status, denial status, resubmission status. Create and produce standardized weekly and monthly accounting reports, reconciliation and trend reports.
Cost Allocation Plan Compliance and Documentation	The ASO will work with CFOs, MMA and the fiscal agent to modify the District's Medicaid Cost Allocation Plan to accurately claim the maximum allowable Federal Financial Participation (FFP) for ASO operations.		Create a draft Cost Allocation Plan for DHCF and CFO approval and submission. Revise and resubmit the plan at the direction of DHCF.
Audit	The ASO will assist Partner Agencies with reconciliation of claims based on pending, paid and denied claims history. The ASO will coordinate any audit requests with the Partner Agency as needed.	Each Partner Agency will notify the ASO of specific data requests related to audits in sufficient to research claims history and prepare response.	Produce all standard accounting and auditing reports necessary to comply with any authorized auditor. Provide system access as directed by DHCF and CFO to any authorized auditor. Produce ad-hoc reports to assist in the audit process as directed by DHCF. Provide knowledgeable staff to assist in the reconciliation and explanation of any reports produced by the ASO, MMA or partner agencies.

Appendix E: District of Columbia Medicaid Information Technology Architecture (MITA) Maturity Level Analysis

This report is a limited self-assessment based on certain MITA business processes that are recommended to be performed by the ASO. The report team assessed and assigned maturity levels to the functionality of the As Is business processes between the Medicaid fiscal agent and the Partner Agencies. The To Be business process functionality is based on the recommended activities to be performed by the ASO and how those activities enhance the fiscal agent's performance. The descriptions and charts below will not address all the MITA business processes only those in the Business Areas of Member Management, Provider Management, Operations Management and Program Management that are recommended to be performed by the ASO.

The interview teams found that communication and transfer of information between the Medicaid fiscal agent and the Partner Agencies is difficult and inconsistent. Proprietary programs are being used by each of the Partner Agencies to maintain eligibility files, provider files and claims submission information. The business processes associated with these activities function at a maturity level 1, which means that the District is focused on compliance with State and Federal regulations with little or no standardization. The recommended activities for the ASO will function at a maturity level 2, which means that the District will now be better able to focus on cost management and improving quality of and access to care within structures designed to manage costs.

Member management and provider management process will be enhanced through the development of a web portal by an ASO. This will achieve standardized outbound communications from the Medicaid fiscal agent to the Partner Agencies such as policy transmittals, eligibility files and remittance advices. Direct access to upload claims information, provider complaints, or performance reports will facilitate the standardization of inbound communications from the providers to the fiscal agent.

Operations management will be improved through claims standardization. While the ASO will not pay claims, it will collect claims data and attachment information, convert and submit the data in the Medicaid compliant format and assist the Partner Agencies with reconciliation. The ASO will also maintain the history for all paid, pending and denied claims to further assist the Partner Agencies with provider inquiries or audits of their financial records.

Management of Federal and District funds will be through the Program Management business processes. In managing the benefit packages and monitoring the claims paid according to program policy, the ASO will be able to bill for services in a priority that fully utilizes the Medicaid Federal Financial Participation and use alternate funding sources whenever possible.

The MITA business processes directly impacted by the web portal, claims standardization and the other efforts recommended for development and implementation by the ASO are shown below.

District of Columbia MITA State Self-Assessment

Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
Member Management					
Inquire Member Eligibility	1	2			
Provider Management					
Provider Inquiry Regarding Information	1	2			
Manage Provider Information	1	2			
Manage Provider Grievance and Appeal	1	2			
Manage Information About Provider	1	2			
Operations Management					
Apply Claim Attachment	1	2			
Audit Claim/Encounter	1	2			
Provider Inquire, Payment Status	1	2			
Manage Payment Information	1	2			
Program Management					
Develop and Maintain Benefit Package	1	2			
Maintain Benefits Reference Information	1	2			
Manage Program Information	1	2			
Managed FMAP	1	2			
Managed State Funds	1	2			

NOTE: See the As Is and To Be tables for current and proposed activities that support the maturity level analysis.

Appendix F: Meetings and Attendees

DC ASO Project Interviews

Children and Family Services Agency – August 12, 2008

Agency Attendees:

John Simmons, CFSA
Jim Sprawls, CFSA
Marshall, CFSA Technical Liaison

Project Team Attendees:

Jason Cooke, HMA
Gary Crayton, HMA
Jane Longo, HMA
Patricia MacTaggart, GWU
Richard Jensen, GWU
Melisa Byrd, MAA

Department of Mental Health – August 12, 2008

Agency Attendees:

Michael Neff, DMH Chief Administration Officer
Mel Barry, DMH
Sylvia Mackey, DMH

Project Team Attendees:

Jason Cooke, HMA
Gary Crayton, HMA
Jane Longo, HMA
Richard Jensen, GWU
Patricia MacTaggart, GWU

Department of Disability Services – August 13, 2008 and September 30, 2008

August 13, 2008 Meeting

Agency Attendees:

Brenda Emanuel, DDS

Project Team Attendees:

Gary Crayton, HMA
Kathy Gifford, HMA
Jane Longo, HMA
Melisa Byrd, MAA

September 30, 2008 Meeting

Agency Attendees:

Laura Nuss, DDS
Ken Cabral, DDS

Project Team Attendees:

Theresa Sachs, HMA
Patricia MacTaggart, GWU
Melisa Byrd, MAA

Office of the State Superintendent of Education – August 13, 2008

Agency Attendees:

Kevin Clinton, OSSE Fiscal Agent
Charity Hallman, OSSE Office of Special Education
Yuliana Del Arroyo, OSSE Office of Special Education
Dr. Health McCabe, Office of DC Chief Financial Officer

Project Team Attendees:

Gary Crayton, HMA
Kathy Gifford, HMA
Jane Longo, HMA
Melisa Byrd, MAA

Meeting with Advocacy Organizations – August 21, 2008

Agency Attendees:

Jimi Lethbridge, Public Policy Coordinator, Quality Trust for Individuals with Disabilities
Richard Flintrop, Director of Policy and Planning, Healthy Families/Thriving Communities Collaborative
Jenny Reed, Research Associate, DC Fiscal Policy Institute
Shannon Hall, Staff Attorney, Children's Law Center
Sharra Greer, Policy Director, Children's Law Center

Project Team Attendees:

Theresa Sachs, HMA
Patricia MacTaggart, GWU

Meeting with MMIS – August 26, 2008

Agency Attendees:

Sam Walker
Alex Peralta

Project Team Attendees:

Theresa Sachs, HMA
Gary Crayton, HMA (by phone)
Patricia MacTaggart, GWU
Richard Jensen, GWU
Melisa Byrd, MAA

DC Public Schools - August 26, 2008

Agency Attendees:

Dasarath Kiridena, DCPS Medicaid Unit

Matthew Ginsburg, DCPS Special Education Reform Team
Christopher Edwards, Public Consulting Group
Kevin Clinton, OSSE Fiscal Agent
Charity Hallman, OSSE Office of Special Education
Yuliana Del Arroyo, OSSE Office of Special Education

Project Team Attendees:

Theresa Sachs, HMA
Gary Crayton, HMA (by phone)
Patricia MacTaggart, GWU
Richard Jensen, GWU
Melisa Byrd, MAA

DC Primary Care Association – August 26, 2008

Association Attendee:

Sharon Baskerville

Project Team Attendees:

Theresa Sachs, HMA
Gary Crayton, HMA (by phone)
Patricia MacTaggart, GWU

Charter Schools – September 5, 2008

Schools Attendees:

Laura Loessner, DC Special Education Co-operative

Project Team Attendees:

Gary Crayton, HMA (by phone)
Patricia MacTaggart, GWU
Mark Dorley, GWU
Melisa Byrd, MAA

Department of Youth Rehabilitation Services – September 5, 2008

Project Team Attendees:

Gary Crayton, HMA (by phone)
Patricia MacTaggart, GWU
Melisa Byrd, MAA

ASO To-Be Sessions – September 8, 2008

Agency Attendees:

Michael Neff, DMH
Steve Baron, DMH
Charity Hallman, OSSE
Yuliana Del Arroyo, OSSE
Dasarath Kiridina, DCPS
Matthew Ginsburg, DCPS
Jane Young, CFSA

Ronnie Charles, CFSA
Roque Gerald, CFSA
John Simmons, Jr., CFSA
Jim Sprowls, CFSA
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Appendix G: Recommended ASO Global Requirements

Provide transaction processing system and data warehouse access to DHCF and Partner Agencies (DC users) via a web-based system application that requires only an Internet connection for each DC user. Maintain systems to grant and control system access based on user ID and password for all users authorized by DHCF.

Maintain role-based security to allow authorized users to access only those parts of the system and data warehouse that are necessary for the accomplishment of their authorized responsibilities, as determined by DHCF.

Maintain a security system on web portals to control access to upload or download files, submit claims, verify eligibility, submit grievances, and perform other functions for only those providers and recipients that are pertinent to the user. Issue user IDs and passwords in an approved and controlled manner to a master user for each provider and to each recipient requesting access. Create and deploy a system that allows provider's master users to control access to other members of the provider's staff.

Maintain all HIPAA, agency specific (such as mental health and substance use treatment) and industry-standard security, privacy, confidentiality, encryption and data integrity requirements. All transactions that may affect claims submission or payment, including provider file changes, reference file changes, recipient file changes and claims file changes must be logged and tracked in an auditable method that will identify who made the change, what change was made, and when the change was made.

Maintain the most stringent of HIPAA, federal and District of Columbia record retention policies. Purge data using criteria given by DHCF.

Maintain industry-standard Generally Accepted Accounting Procedures, Generally Accepted Auditing Standards, and comply with all federal Medicaid laws and guidelines.

Call centers should have standardized hours, be operated at locations approved by DHCF and the Partner Agencies, and be toll-free for recipients, providers and member agencies.

Call centers should be sufficiently staffed to meet DHCF customer service standards for promptly answering calls and responding to inquiries.

The ASO must provide web portal services, all hardware, software, facilities, equipment, communications and staff necessary to meet requirements.

The ASO must provide training initially and ongoing to its own staff, to DHCF and Partner Agency staff, and to providers. This will include the creation of training manuals, handbooks, curricula, training courses, web-based help screens and web-based training. This will also

include the delivery of training in classrooms and ongoing technical assistance to DHCF, Partner Agency staff and providers as the discretion of DHCF.

The ASO must analyze existing systems operated by each Partner Agency, create interfaces and convert data as necessary to support operations. Whenever DHCF, Partner Agencies, providers or vendors can support it, the ASO should employ an automated process. When entities outside the ASO control cannot support automation, the ASO will need to develop effective and efficient manual procedures.

The ASO must mail notices to providers and participants as directed by DHCF.

