

STATE OF HAWAII
**NOTICE OF AND REQUEST FOR EXEMPTION
 FROM CHAPTER 103F, HRS**

*07 SEP 21 24:04

ADMINISTRATIVE
 PROCUREMENT OFFICE

To: Chief Procurement Officer

From: Health/ Developmental Disabilities
Department/Division/Branch or Office

Pursuant to § 103F-101(a)(4), HRS, and Chapter 3-141, HAR, the Department requests a procurement exemption to purchase the following:

1.	Title and description of health and human service(s):	
	<p>Services performed under the 1915c federal agreement for the Medicaid Developmental Disabilities/Mental Retardation (DD/MR) Home & Community-Based Waiver Services (HCBS) Program.</p> <p>This request is for exemption for services identified in the approved Federal Medicaid Waiver DD/MR HCBS agreement (Attachment A) that authorizes the State to purchase under the approved Federal Medicaid Waiver DD/MR HCBS agreement with the Center of Medicare/Medicaid until June 30, 2011 (letter to Lillian L. Koller, Esq., Director for the Department of Human Services (DHS), is attached and identified as Attachment B).</p> <p>The unique nature of the relationship that exists between DHS and the Department of Health (DOH), Developmental Disabilities Division (DDD) (Attachment C), is due to the billing process that was created to address issues cited in SCR 106 (Attachment D). Because of the unique circumstances of the billing process, DOH-DDD uses the Department of Accounting and General Services (DAGS) as the mechanism to pay providers versus DHS's Fiscal Agent, Affiliated Computer Systems (ACS).</p> <p>Until such time that DOH-DDD is able to go back to the DHS billing process, DDD will need to continue to make timely payments to these Medicaid eligible providers via DAGS.</p>	
2.	Provider Name and Address:	Various Medicaid Eligible Providers
3.	Total Contract Funds:	\$0
	Contract Funds per Year (if applicable):	\$0
4.	Reference number of Previous Request for this Service (if applicable):	
5.	Term of Contract:	Start: 1/1/08 Per Attachment B End: 6/30/11

STATE OF HAWAII
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EXEMPTION FROM CHAPTER 103F, HRS

6. Describe how procurement by competitive means is either not practicable or not advantageous to the State:

All eligible Medicaid providers are able to participate. In order for DOH-DDD to get federal reimbursement for services rendered under the Title XIX Medicaid HCBS, participating providers must be eligible Medicaid providers.

NOTE: Item No. 3, Funding level is based on program allocation for Title XIX Medicaid HCBS Waiver Program each fiscal year and per CMS Agreement (see Attachment for A & B) and pre-authorization for services by a State DOH-DDD case manager.

7. Describe the reason for the selection of the provider including a description of how the procedure ensured the maximum fair and open competition practicable:

Provider is selected from a list of Medicaid eligible providers who have gone through the requirement that DHS imposes to become an eligible Medicaid provider. Selection of the provider is also by client choice based on this listing. In order for the State of Hawaii to recoup federal funds for the Medicaid HCBS services, provider must be an eligible and active Medicaid Provider, if not 100% general funds need to be used. Under the recent lawsuit settlement agreement that the DOH-DDD was involved in, only individuals deemed ineligible to participate in Medicaid or if Medicaid does not pay for identified needed services can 100% State funds be utilized.

8. Describe the state agency's internal controls and approval requirements for the exempted procurement:

All Medicaid claims processed for federal reimbursement dollars must be provided by an eligible Medicaid provider and based on waiver agreement between the federal government and the State of Hawaii, the services being provided under the Medicaid HCBS Waiver program needs to be pre-authorized by a DOH-DDD case manager.

9. List the state agency personnel, by position title, who will be involved in the approval process and administration of the contract:

Department of Human Services
Director, Lillian L. Koller

10. Direct questions to (name & position):

Trudy Murakami, PHAO VI

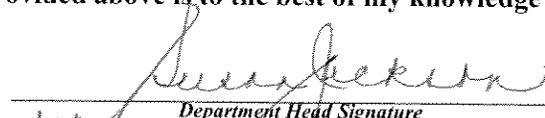
Phone number:

586-5842

e-mail address:

trudy.murakami@doh.hawaii.gov

I certify that the information provided above is to the best of my knowledge true and correct.



Department Head Signature
Chiyome Leinaala Fukino, M.D.

Typed Name

12/21/07

Date

STATE OF HAWAII
NOTICE OF AND REQUEST FOR
EXEMPTION FROM CHAPTER 103F, HRS

NOTICE

The chief procurement officer is considering this request for exemption and, if there is good cause, the state intends to exempt the purchase as described in the request. Any inquiries regarding the purchase shall be directed to the contact person noted in item 10 of the request. Any concerns regarding the exemption shall be in writing and received by the chief procurement officer within seven days of the date the notice was first posted. Concerns shall be mailed to: Aaron Fujioka, Chief Procurement Officer, State Procurement Office, 1151 Punchbowl St., #230A, Honolulu, HI 96813.

FOR CHIEF PROCUREMENT OFFICER USE ONLY

Chief Procurement Officer's Comments:

APPROVED DISAPPROVED NO ACTION



Chief Procurement Officer Signature

12/28/07

Date

Please ensure adherence to applicable administrative requirements.

**Medicaid Waiver Services
DD/MR Waiver Services
Schedule of Rates**

HPMMIS Provider Number:

Name of Agency							
Address:							
Geographical Service Area:							
Effective Date:		July 1, 2006					
Event Type	Place of Service	Procedure Code	Modifier	Type of Waiver Service	HPMMIS Procedure	Unit	Rate
HH	12, 99	T1019	52	Personal Assistance/Habilitation - (PAB) Level 1	Personal Care	15 Minute	\$6.54
HH	12, 99	T1020		Personal Assistance/Habilitation - (PAB) Level 1, Daily	Personal Care	Daily	\$460.42
No HPMMIS					Personal Care, Consumer Directed	Hour	\$11.80
HH	12, 99	T1019	U1	Personal Assistance/Habilitation - (PAB) Level 2	Personal Care	15 Minute	\$7.25
HH	12, 99	T1019	U2	Personal Assistance/Habilitation - (PAB) Level 3	Personal Care	15 Minute	\$8.58
CS	12, 99	S5120	UB	Chore Services Agency	Chore Services	15 Minute	\$3.38
No HPMMIS				Chore Services	Chore Services, Consumer Directed	Hour	\$9.00
HR	12, 33, 35, 99	T2016	U1	Residential Habilitation Level 1	Habilitation, Residential, Waiver	Daily	\$45.00
HR	12, 33, 35, 99	T2016	U2	Residential Habilitation Level 2	Habilitation, Residential, Waiver	Daily	\$61.52
HR	12, 33, 35, 99	T2016	22	Residential Habilitation Level 2A	Habilitation, Residential, Waiver	Daily	\$90.00
HR	12, 33, 35, 99	T2016	U3	Residential Habilitation Level 3 - Behavioral	Habilitation, Residential, Waiver	Daily	\$187.50
HR	12, 33, 35, 99	T2016	UB	Residential Habilitation Level 4 - Childrens TLP	Habilitation, Residential, Waiver	Daily	\$294.00
HR	12, 33, 35, 99	T2016		Residential Habilitation Level 5 - 24/7	Habilitation, Residential, Waiver	Daily	\$485.28

Name of Agency							
Address:							
Geographical Service Area:							
Effective Date:		July 1, 2006					
Event Type	Place of Service	Procedure Code	Modifier	Type of Waiver Service	HPMMIS Procedure	Unit	Rate
HB	99	T2019		Habilitation Supported Employment	Habilitation Supported Employment	15 Minute	\$6.54
OH	12, 99	T1005	22	¹ Respite Services - Agency, Daily	Respite Care - Agency	Daily	\$142.60
OH	12,99	T1005		¹ Respite Services - Agency, 15 Minute	Respite Care - Agency	15 Minute	\$3.15
No HPMMIS				Respite Services, Hour	Respite Care, Consumer Directed	Hour	\$10.40
PD	12, 99	S9123	UB	Skilled Nursing (RN)	Nursing care in home by Registered Nurse	Hour - Single Client	\$45.12
PD	12, 99	S9123	UB	Skilled Nursing (RN), Couple	Nursing care in home by Registered Nurse	Hour - Client Couple	\$63.08
PD	12, 99	S9124	UB	Skilled Nursing (LPN)	Nursing care in home by Licensed Practical Nurse	Hour-Single Client	\$34.76
PD	12, 99	S9124	UB	Skilled Nursing (LPN), Couple	Nursing care in home by Licensed Practical Nurse	Hour- Client Couple	\$44.89
FOR NHWW ONLY:							
PD	12, 99	T1002		Skilled Nursing	RN Services, up to 15 minutes	15 min.	
PD	12, 99	T1002	UD	Skilled Nursing Couples	RN Services, up to 15 minutes	15 min.	
PD	12, 99	T1003		Skilled Nursing (LPN)	LPN/LVN Services, up to 15 minutes	15 min.	

Name of Agency:							
Address:							
Geographical Service Area:							
Effective Date: July 1, 2006							
Event Type	Place of Service	Procedure Code	Modifier	Type of Waiver Service	HPMMIS Procedure	Unit	Rate
PD	12, 99	T1003	UD	Skilled Nursing Couples (LPN)	LPN/LVN Services, up to 15 minutes	15 min.	
AI	99	S0215		Non-Medical Transportation, mile	Non-emergency transportation mileage, per mile	each mile	\$0.83 per mile
AI	99	T2004		Non-Medical Transportation, round trip	Non-emergency transportation commercial carrier, multi-passenger	round trip	\$4.92
AD	99	S5102	U1	² Adult Day Health - Level 1	Day Care Services, Adult (Level 1)	Daily	\$65.88
AD	99	S5102	U2	² Adult Day Health - Level 2	Day Care Services, Adult (Level 2)	Daily	\$82.00
AD	99	S5102	U3	² Adult Day Health - Level 3	Day Care Services, Adult (Level 3)	Daily	\$117.52
AD	99	S5101	U1	² Adult Day Health - Level 1, Half-day	Day Care Services, Adult (Level 1)	Half-day	\$33.44
AD	99	S5101	U2	² Adult Day Health - Level 2, Half-day	Day Care Services, Adult (Level 2)	Half-day	\$41.48
AD	99	S5101	U3	² Adult Day Health - Level 3, Half-day	Day Care Services, Adult (Level 3)	Half-day	\$59.28

Name of Agency							
Address:							
Geographical Service Area:							
Effective Date:		July 1, 2006					
Event Type	Place of Service	Procedure Code	Modifier	Type of Waiver Service	HPMMIS Procedure	Unit	Rate
* EA	12	S5165		Environmental Accessibility Modification/ Adaptations, Evaluation/Assessment	Home Modifications; per service	per service	
* EA	12, 99	T2028		Specialized Medical Supplies	Specialized Medical Supplies, not otherwise specified, waiver	per item	
* ER	12	S5161		Personal Emergency Response System service fee	Personal Emergency Response System; service fee, per month (excludes installation and testing)	per month	DHS contract
* ER	12	S5160		Personal Emergency Response System installation and testing	Personal Emergency Response System; installation and testing	per purchase and installation	DHS contract
* ER	12	S5160	TN	Personal Emergency Response System installation and testing (Molokai, Lanai)	Personal Emergency Response System; installation and testing (Molokai, Lanai)	per purchase and installation	DHS contract
* ER	12	S5162		Personal Emergency Response System purchase	Personal Emergency Response System; purchase only	per purchase	DHS contract
* VM	12	T2039		Vehicular Modifications	Vehicular Modifications, waiver	per service	
* EA	12, 99	T2029		Specialized Medical Equipment	Specialized Medical Equipment, not otherwise specified, waiver	per purchase	

Name of Agency							
Address:							
Geographical Service Area:							
Effective Date:		July 1, 2006					
Event Type	Place of Service	Procedure Code	Modifier	Type of Waiver Service	HPMMIS Procedure	Unit	Rate
CT	11, 12, 99	S9131	52	Training and Consultation for caregivers, PT	Physical Therapist - on island	per hour	\$87.92
CT	11, 12, 99	S9131	52	³ Training and Consultation for caregivers, PT, NI	Physical Therapist - flying to NI	per hour	\$162.92
CT	11, 12, 99	S9129	52	Training and Consultation for caregivers, OT	Occupational Therapist-on island	per hour	\$87.92
CT	11, 12, 99	S9129	52	³ Training and Consultation for caregivers, OT, NI	Occupational Therapist-flying to NI	per hour	\$162.92
CT	11, 12, 99	S9128	52	Training and Consultation for caregivers, Speech	Speech Therapist - on island	per hour	\$87.92
CT	11, 12, 99	S9128	52	³ Training and Consultation for caregivers, Speech, NI	Speech Therapist-flying to NI	per hour	\$162.92
CT	11, 12, 99	S9445		Training and Consultation for caregivers, Behaviorist	Behaviorist-on island	per session	\$87.92
CT	11, 12, 99	S9445		³ Training and Consultation for caregivers, Behaviorist, NI	Behaviorist-flying to NI	per session	\$162.92
CT	11, 12, 99	S9128	52	Training and Consultation for caregivers, Audiologist	Audiologist	per hour	\$87.92
CT	11, 12, 99	S9128	52	³ Training and Consultation for caregivers, Audiologist, NI	Audiologist - flying to NI	per hour	\$162.92
CT	11, 12, 99	S9470		Training and Consultation for caregivers, Dietician	Dietician	Visit	\$58.08
CT	11, 12, 99	T1003		Training and Consultation for caregivers, LPN	LPN	15 Minute	\$8.69
CT	11, 12, 99	S5109		Training and Consultation for caregivers, MD	MD	per session	\$120.00

Name of Agency							
Address:							
Geographical Service Area:							
Effective Date:		July 1, 2006					
Event Type	Place of Service	Procedure Code	Modifier	Type of Waiver Service	HPMMIS Procedure	Unit	Rate
CT	11, 12, 99	S9445	UB	Training and Consultation for caregivers, Pharmacist	Pharmacist	per session	\$92.12
CT	11, 12, 99	S5109	22	Training and Consultation for caregivers, Psychiatrist	Psychiatrist - on island	per session	\$150.00
CT	11, 12, 99	S5109	22	³ Training and Consultation for caregivers, Psychiatrist, NI	Psychiatrist - flying to NI	per session	\$225.00
CT	11, 12, 99	S9445	22	Training and Consultation for caregivers, Psychologist	Psychologist	per session	\$104.28
CT	11, 12, 99	S9445	22	³ Training and Consultation for caregivers, Psychologist, NI	Psychologist - flying to NI	per session	\$179.28
CT	11, 12, 99	T1002		Training and Consultation for caregivers, RN	RN	15 Minute	\$16.17
CT	11, 12, 99	S9127	52	Training and Consultation for caregivers, SW	Social Worker	per hour	\$43.64
CI	12, 99	T2034		DD/MR Emergency Shelter		Daily	\$504.80
CI	12, 99	T2034	22	DD/MR Emergency Respite		Daily	\$223.20
CI	12, 99	T2034	52	DD/MR Emergency Outreach		Hour	\$79.20
¹ Respite per diem rate reflect twenty-four (24) hours of service provision. Respite services, 15 minutes, shall not exceed a total of eleven (11) hours per day.							
² Adult Day Health rates reflect service provision for full day: six (6) or more hours per day; or half-day: three (3) or more hours per day.							
³ Provider shall be authorized for maximum of four (4) hours at NI rate. Additional hours shall be authorized and provided at non-NI rate.							
Place of Service Codes:		(11) Office (12) Home (31) Skilled Nursing Facility (32) Nursing Facility (33) Custodial Care Facility (35) Adult Living Care Facility (54) Intermediate Care Facility/Mental Retardation (62) Comprehensive Outpatient Rehab Facility (99) Other unlisted fac					
Rates are inclusive of all applicable taxes.							

Name of Agency							
Address:							
Geographical Service Area:							
Effective Date: July 1, 2006							
Event Type	Place of Service	Procedure Code	Modifier	Type of Waiver Service	HPMMIS Procedure	Unit	Rate
Any and all expenditures and services to clients beyond the Department of Health case management authorization are subject to non-payment.							
Medicaid waiver services are not billable during periods of client hospitalization, long-term institutionalization or periods of suspension of the waiver.							



C1488

**DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
REGION I)**

75 Hawthorne Street
Suite 408
San Francisco, CA
94105

JUN 20 2006

DEVELOPMENTAL
DISABILITIES
DEPARTMENT OF HEALTH
HONOLULU, HAWAII

JUN 26 A 11:19

Lillian L. Koller, Esq.
Director
Department of Human Services
P.O. Box 339
Honolulu, HI 96809

Dear Ms. Koller:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request received April 4, 2006 to renew Hawaii's Medicaid Home and Community-Based Services (HCBS) waiver for individuals with developmental disabilities/mental retardation (DD/MR) as authorized under Section 1915(c) of the Social Security Act. This waiver has been assigned CMS control number 0013.90.R4. This waiver program provides HCBS as an alternative to institutional care for persons eligible for ICF/MR placement. The effective date of this renewal is July 1, 2006.

As part of this renewal, you requested permission to make the following changes in this waiver program: 1) to provide necessary supports to an additional 150-200 persons with developmental disabilities each year to maximize their independence and support their participation in their communities, 2) to establish a Quality Management (QM) system to comprehensively evaluate and continuously improve the quality of services participants receive, 3) to expand the waiver's coverage area to the entire State, 4) to increase public input into the development of the waiver and its QM systems, 5) to increase anticipated waiver enrollment by approximately 50% to fully meet anticipated demand for services, and 6) to expansion of services covered to include chore services, training and consultation, specialized medical equipment and supplies, vehicular modifications, assistive technology, and personal emergency response systems.

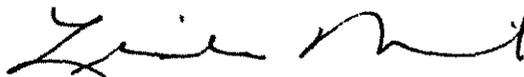
This approval is subject to your agreement to provide services for no more individuals than the number listed in column "C" below. "Total" amounts reflect slight rounding as exhibited in Appendix J-2 of the State's approved waiver renewal.

<u>WAIVER YEAR</u>	<u>FACTOR C</u>		<u>FACTOR D</u>		<u>TOTAL</u>
July 1, 2006 - June 30, 2007	2584	x	\$37,242	=	\$96,234,067
July 1, 2007 - June 30, 2008	2,784	x	\$38,414	=	\$106,943,960
July 1, 2008 - June 30, 2009	2,934	x	\$39,578	=	\$116,121,274
July 1, 2009 - June 30, 2010	3,084	x	\$40,783	=	\$125,776,235
July 1, 2010 - June 30, 2011	3,234	x	\$42,021	=	\$135,896,355

Page 2 – Lillian L. Kohler, Esq.

With a satisfactory showing, the waiver may continue to provide services and be renewed at the end of this five-year period. We appreciate the cooperation provided by you and your staff during the renewal process. If you have any questions, please contact Rick Spector at (415) 744-3592.

Sincerely,



Linda Minamoto
Associate Regional Administrator
Division of Medicaid & Children's Health

cc: Gale Arden, Director, DEHPG, CMSO
Chiyome Fukino, M.D., Director, DOH
Mary Rydell, CMS Pacific Representative
Cheryl Young, CMS, Region IX
Debra Baumert, CMS, Region IX
Ellen Blackwell, DEHPG, CMSO
Patty Johnson, Director, DHS, ACCSB
Dr. David Fray, Chief, DOH, DDD
Eddie Martin, CMS, Region IX

CMISB

PHAO, DDD

Comp. Offer, DDD

LINDA LINGLE
GOVERNOR



MARK J. BENNETT
ATTORNEY GENERAL

LISA M. GINOZA
FIRST DEPUTY ATTORNEY GENERAL

STATE OF HAWAII
DEPARTMENT OF THE ATTORNEY GENERAL
HEALTH & HUMAN SERVICES DIVISION
465 S. King Street, Room 200
HONOLULU, HAWAII 96813
(808) 587-3050

To: Sheila Walters
DAGS, Pre-Audit

From: Martha C. Im/Jill T. Nagamine
Deputy Attorneys General

Date: August 29, 2006

Re: Relationship between the Departments of Human Services & Health and DD/MR
Provider Agreements

This memo is in response to a request explaining the relationship between the Departments of Human Services and Health in relation to payment to Developmental Disabilities/Mental Retardation Medicaid Waiver (DD/MR) providers.

The Department of Human Services (DHS) is the single State agency designated to administer the Medicaid program under Title XIX of the Social Security Act, 42 C.F.R. §431.10, through the authority of §346-14, Hawaii Revised Statutes, and is therefore responsible for securing the federal matching funds for Medicaid Waiver programs. The DD/MR Medicaid Waiver program contracts with providers for the provision of services to the Department of Health (DOH), Developmental Disabilities Division clients.

Thus, although DHS normally processes invoices and claims for Medicaid waiver providers, DOH developed a payment system, linked to the DHS claims processing system, to ensure more timely payment to providers servicing the DD/MR population. DOH pays the DD/MR waiver provider directly upon the provider's submission of claims. These claims are based on prior authorizations. The claims processing and provider invoices are submitted through the Department of Accounting and General Services (DAGS), DAGS produces a check, and the provider is paid.

DOH then submits appropriate information to DHS' payment system in order to receive the federal matching funds for this waiver population. Once DHS verifies eligibility for the claims submitted, DHS secures the federal match for the DD/MR waivers and, in turn, reimburses DOH. The Centers for Medicaid and Medicare Services, the federal agency that

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DEVELOPMENTAL
DISABILITIES DIVISION
DEPARTMENT OF HEALTH
HONOLULU, HAWAII

Ms. Sheila Walters
August 29, 2006
Page 2

administers Medicare, Medicaid, and Child Health Insurance programs, is aware of the payment process established by DOH and has not indicated that this is problematic.

An overview of the claims payment process for DD/MR waivers is attached. If you have any questions, please contact me at 586-3983.

CC: Dr. David Frey, DOH/DDD
Trudy Murakami, DOH/DDD ✓
Patty Johnson, DHS/SSD
Lois Lee, DHS/SSD

Attachment

LINDA LINGLE
GOVERNOR



LILLIAN B. KOLLER, ESQ.
DIRECTOR
HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P.O. Box 339
Honolulu, Hawaii 96809-0339

August 13, 2004

MEMORANDUM

TO: The Honorable Linda Lingle
Governor of the State of Hawaii

ATTENTION: Linda Smith
Legislative Coordinator
Office of the Governor

FROM: Lillian B. Koller, Esq., Director
Department of Human Services 
Dr. Chiyome Fukino, Director
Department of Health 

SUBJECT: Report to the Legislature Requested by SCR 106, 2004 Legislature

Enclosed is a copy of a report to the Legislature requested by SCR 106 adopted by the 2004 Legislature.

Also enclosed are transmittal letters to the Senate and House, which have been prepared for your signature. When these letters are returned to us, we will forward them to the respective offices with the report.

Enclosures

STATE OF HAWAII

**DEPARTMENT OF HUMAN SERVICES
DEPARTMENT OF HEALTH**

**REPORT TO THE HAWAII STATE LEGISLATURE PURSUANT
TO SENATE CONCURRENT RESOLUTION 106 - REQUESTING
AN INQUIRY INTO THE DELAYS IN PAYMENT TO
DEVELOPMENTAL DISABILITY PROVIDERS.**

SUBMITTED TO THE TWENTY-THIRD

STATE LEGISLATURE, 2005

AUGUST 20, 2004

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

I. BACKGROUND

On November 1, 2002, the Department of Human Services (DHS), Med-QUEST Division (MQD), transitioned its Medicaid fiscal agent services and claims processing system from Hawaii Medical Services Association (HMSA) to a new fiscal service arrangement with Affiliated Computer Services and the Arizona Medicaid Agency, Arizona Health Care Cost Containment System.

- Affiliated Computer Services (ACS) is the fiscal agent for Hawaii's Medicaid program. The Medicaid program consists of the fee-for-service (FFS) program and the QUEST program, which provide medical assistance to eligible individuals under Title XIX of the Social Security Act.
 - The FFS program is a State administered program that receives funding for approximately 56% of its expenditures from the Federal Government, i.e., from the Centers for Medicaid and Medicare Services (CMS).
 - The FFS program includes acute care services (including hospitalization and nursing homes) as well as "waiver" services which are non-institutional home and community-based care. Waiver services are defined as those services provided in a home and community-based setting.
 - The majority of recipients eligible for FFS are Aged, Blind, or Disabled (ABD) who are currently not eligible for enrollment in QUEST managed care plans.
 - The "waiver" services for individuals with developmental disabilities or mental retardation, who require non-acute care support, are administered by the Department of Health (DOH). Services for all other "waiver" clients are administered by the Department of Human Services, Social Services Division (SSD).
 - Dental services previously provided through separate dental plans are also offered through the FFS program to all eligible Medicaid FFS and QUEST recipients.
 - Under the current FFS program, including waiver services, payments are made to Medicaid providers in arrears based on the services rendered and

are subject to prior authorization. This means that the services must be authorized before they can be rendered in order for the provider to get paid in a timely manner.

- The Social Services Division (SSD), a sister agency to MQD in DHS, serves as administrator and fiscal accountant for the State's Medicaid Waiver and the Pre-PACE services, which are non-acute, non-institutional home and community-based.
 - The following home and community-based waiver programs are in place: Nursing Home Without Walls (NHWW), Residential Alternative Community Care (RACC), Developmental Disabilities/Mental Retardation (DD/MR), HIV Community Care (HCC), Medically Fragile Community Care (MFCC), and Program of All-Inclusive Care for the Elderly (PACE).
 - SSD either provides case management services directly or designates outside agencies to provide case management services for all waiver recipients except those who are in the Developmentally Disabled/Mentally Retarded (DD/MR) waiver program. The DOH provides the direct case management services for the DD/MR waiver program recipients (see below).
- The Department of Health (DOH), Developmental Disabilities Division (DDD), provides case management and State match funding for the Developmental Disabilities/Mental Retardation (DD/MR) Medicaid waiver program.
 - DOH case managers develop the plan of care or individualized service plans (ISP), which defines the service(s) each individual may receive and which are the basis for the prior authorizations for the individual's services.
 - Notices of prior authorization function as a written notification to providers to verify units that the provider is authorized to provide as well as the dates of service.
 - DD/MR waiver services include personal assistance, adult day health, habilitation, habilitation-supported employment, respite, specialized services, specialized environmental accessibility adaptations, and non-medical transportation.
- The Arizona Health Care Cost Containment System (AHCCCS) manages and operates the Medicaid automated information system that supports the MQD's QUEST managed care and FFS programs.

- This system, the Hawaii Prepaid Medical Management Information System (HPMMIS), was developed through an inter-state agreement between the State of Hawaii MQD and the State of Arizona AHCCCS.
- Under this partnership, AHCCCS is responsible for system operations, system change requests, reports, and ongoing support.
- MQD and SSD are responsible for provider contracting, business policies and claims processing rules, reference tables, and user acceptance and systems testing.
- HPMMIS operates on an Arizona mainframe computer located in Phoenix, Arizona.

SCR 106 focuses on payments to Medicaid providers who offer waiver services to individuals with developmental disabilities/mental retardation (DD/MR).

All services are paid through the HPMMIS system.

Although there are 3,200 individuals receiving case management services from DOH, only 1,987 individuals receive DD/MR waiver services. SSD has contracted with 49 providers to service these individuals.

On April 13, 2004, ACS offered help to DD/MR waiver providers to identify outstanding claims for dates of service from October 2002 through December 2003. Specific instructions were provided to expedite the review and processing of claims. Providers were requested to provide an estimate of the total amount owed and submit associated claims to ACS.

- The due date for submitting estimated amounts and claims was April 26, 2004.
- This date was extended to May 26, 2004 since only 27 of the 49 DD/MR providers had submitted claims by April 26.

II. SCR 106 PAYMENT AMOUNT

The discrepancy in the amount of unpaid billings reported in SCR 106 and the amount providers estimated individually creates a different perspective of the payment issue.

- Total payments for DD/MR waiver services in 2003: \$60 million
- SCR 106 estimated unpaid billings: \$7,000,000 to \$8,000,000
- Actual estimated outstanding amount submitted for payment as claims but not verified and approved: \$1,898,011.77
- SCR 106 estimated unpaid percentage: 10-15 %
- Actual estimated outstanding percentage: 3%

There appears to be a significant overstatement of amounts due to DD/MR providers. Further, comparatively speaking, the \$1,898,011.77 estimated outstanding amount due to

providers is approximately 0.22% of the total \$868 million paid through HPMMIS to all Medicaid providers during this time period. Please refer to Findings 1 and 3 for details of the discrepancy.

III. PRIOR AUTHORIZATIONS (PA) AND THE PA PROCESS FOR DD/MR PROVIDERS

A. Prior Authorizations

1. Before providing services, providers are contractually required to contact and obtain approval/prior authorization from the individual's case manager.
2. Prior authorization activities are supported by both DHS and DOH systems, policies, and procedures.
3. These policies and procedures ensure that each client receives needed services.
4. HPMMIS, as well as DHS and DOH policies and procedures, incorporate features to identify and prevent possible Medicaid fraud as required by CMS.
5. HPMMIS currently does not allow inputting of prior authorizations if the system finds that the client is Medicaid ineligible. Communications regarding Medicaid eligibility reviews for clients with DD/MR may be delayed as clients depend on others to assist them with correspondence and applications.

These processes ensure that submitted claims match the services and units of service (i.e., number of 15-minute units, hours, days) documented in each client's ISP. These services are billed at rates designated in each provider's contract.

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

B. The Prior Authorization (PA) Process

When HPMMIS was implemented for DD/MR services starting October 1, 2002, PA input was labor intensive, requiring staff to manually input PAs into HPMMIS from a paper report. In the fall of 2003, DOH developed an access database to create a "flat file" to electronically load PAs into HPMMIS. While this was an improvement over the initial manual process, it still required manual creation of the file and significant work for DOH case managers. In October 2003, DOH implemented its new client information system, DDCARES. Since June 2004, DOH case managers are able to modify service information at their computers and DOH fiscal staff are able to generate reports of services changes and input directly into HPMMIS. DDCARES is also now able to produce the monthly "flat file" electronically instead of manually for input directly into HPMMIS.

Each of the system improvements described above have significantly enhanced the efficiency, accuracy, and speed of payments to DD/MR providers.

Currently, the following improved policies and procedures are in effect:

1. Providers are contractually required to contact and obtain approval/prior authorization (PA) from the client's DOH case manager before providing services.
2. Approval is documented in a PA approval letter generated through HPMMIS and sent to providers prior to the month in which services are rendered. If a change in the PA is needed, a new letter is generated and sent within two days of entering the PA changes into HPMMIS.
3. Each month, DOH staff creates a disk of PA data downloaded from DDCARES which is transported to ACS for uploading into HPMMIS. All new PAs for the upcoming month are input into HPMMIS by the 16th of the month. HPMMIS then generates PA approval letters for providers which are mailed by the third week of each month for the next month of service. As of July 2004, with DOH's direct access to HPMMIS, any PAs that previously could not be inputted from the disk as well as any PAs that need changes from now on can be expeditiously inputted/modified directly by DOH staff into HPMMIS.

Occasionally, prior authorizations cannot be inputted into HPMMIS because the client's Medicaid eligibility has been flagged as "ineligible" principally due to the delay in response to requests for Medicaid eligibility reviews. DOH and DHS are addressing the inability to input prior authorizations due to Medicaid "ineligible" edits resulting from pending eligibility reviews. We are considering the implementation of "passive renewal" for DD/MR clients.

4. Providers are instructed to provide only those services authorized in the PA letter and bill accordingly. Only one claim per client per provider can be submitted each month.
5. Occasionally, approved services are revoked and HPMMIS generates a letter to the provider indicating the PA is no longer valid. PA revocations can occur for a number of reasons, such as the case manager's determination that services are no longer needed or the client requests services from a different provider. At any time prior to the month of service, a PA letter could be received revoking a previously issued prior authorization. When this occurs, providers are not authorized to provide the service and associated claims will be denied.
6. Often service needs change during the service month, in which case, the providers must contact the client's case manager, who authorizes or denies the request based on the client and/or guardian's approval and the ISP for that client.

7. The plan of care or action plan is updated as part of the Individualized Service Plan (ISP). A prior authorization input report is created for entry into HPMMIS and a revised PA letter is sent to the provider within two days.
8. Providers are instructed to wait for PA letters authorizing new/additional services before submitting claims for new/additional services.
9. Each approved change, whether initiated by the provider, case manager, or client, requires the case manager to modify the client's ISP for his/her supervisor to electronically authorize through DDCARES.
10. Twice a week DOH fiscal staff generate the prior authorization input report with the changes and enter the appropriate changes into HPMMIS. A new PA letter is generated and sent to the provider so that rejected claim submissions are reduced and a claim submitted can be paid timely.
11. ACS data enters all claims within 5 business days. Payment cycles are run every Saturday. Claims and their corresponding PAs can be entered until 6 PM on Friday to get paid in the next week's payment issuance cycle. Checks are mailed the following Friday.
12. If a request for additional units of service is denied, the provider should not provide these services because the agency will not be paid for these services.

IV. FINDINGS

Finding 1: Significant Improvements In Claim Payments Have Been Made.

A. Improvements To Address Payment Crisis

The new HPMMIS claims processing system was first activated for dates of service starting October 1, 2002. For the first four months, from October 1, 2002 to January 31, 2003, only 10% of the volume of claims submitted by waiver providers were paid by the new HPMMIS. In 2002 and early 2003, a number of initial system-related problems caused payment delays. At the same time, however, billing errors by providers were common, which also contributed to payment delays.

In February 2003, the Director of DHS authorized over \$4.5 million in estimated payments to waiver providers to relieve the financial burden caused by system problems and billing errors.

- In February of 2003, the Director of DHS issued estimated payments totaling over \$4.5 million to waiver providers for services not yet reimbursed to all waiver providers to compensate for system-related delays.

- Estimated payments were offset by actual claims submitted later by the providers to verify the services rendered, as required by CMS.
- Some providers did not realize that they had to submit claims correctly to offset payments made to them and to reconcile their accounting records to the payments made. Many of those providers continue to complain that they have never been paid for services but they have, in fact, simply failed to submit correct claims and to reconcile their accounting records.
- Significant recordkeeping by ACS was required to monitor this process and ensure full recoupment of estimated \$4.5 million payments to waiver providers, as required by CMS.
- Full reconciliation of the estimated payments (with one exception) could not be completed until September 2003.
- One provider no longer provides waiver services so recoupment was not completed. MQD is pursuing a collection action for the overpayment to this provider.

B. Current Situation

Today, all areas are significantly improved. Still, there is a common perception that HPMMIS is not able to process claims in a timely manner.

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

- HPMMIS supports the processing and payment of all Medicaid claims.
- From October 2002 to December 2003, over \$868 million dollars were paid through HPMMIS for QUEST and Medicaid FFS, including waiver, services. **The delayed payment problems still being reported by waiver providers represent only \$1.9 million, or approximately 0.22% of the total \$868 million amount paid through HPMMIS.**
- Payments were made on 2 million claims from the October 2002 to the December 2003 time period for all Medicaid claims.
- DHS, DOH, and ACS continue to work with AHCCCS to identify system issues to correct errors and minimize the need to manually process or special handle categories of claims.
- SSD, with support from MQD, developed business rules for all waiver claims processing for payment and budget integrity to prevent Medicaid fraud as required by CMS.

- The system will pay only the amount of the service level authorized by the matching PA. A claim submitted with additional services or service units beyond what is authorized by the PA will not be paid in full until the additional services are authorized by the case manager and a revised PA is issued and entered into HPMMIS.
- This system provides Medicaid fraud and abuse protection. Waiver services are required by contract to be prior authorized by a SSD or DOH DD/MR case manager to ensure that services comply with the client's ISP.
- The system correctly denies claims submitted with errors, (e.g., duplicate claims for same dates of service, invalid recipient ID, service code, missing "W" indicator for waiver claim) or claims for which the recipient has an eligibility or suspension problem.

If a provider submits a "clean" claim and a corresponding PA was entered into the system, the claim will pay during the next weekly billing cycle.

For providers submitting electronically, data entry errors and the five (5) day data entry time are eliminated.

- SCR 106 requested consideration of "immediate advance payment to those developmental disability providers whose claims are still unpaid". Given the small number of providers experiencing persistent problems, the low outstanding dollar volume, improvements in current payments, and the difficulty of reconciling estimated unsubstantiated payments with later claim submissions, releasing estimated payments is unjustified and inappropriate at this time.

Further, CMS does not allow "advance payments" unless the payments are for substantiated services rendered. **If SCR 106 means for the DHS to release payments in arrears in the amount contended but not substantiated by these DD/MR providers for past services, this is not possible. DHS is not allowed to pay unsubstantiated claims. The amount contended is grossly unsubstantiated and it would be fiscally irresponsible for the DHS to pay them.** See Section II, page 3, for details of overstated amounts due to DD/MR providers.

Finding 2: Providers Vary In Ability And Organizational Resources To Manage The Claims Billing And Payment Reconciliation Process. Provider Training Sessions Have Been Conducted But Provider Billing Errors Still Occur.

A. Billing Errors by Providers

Approximately 39% of payment delays are caused by provider billing errors on the claim form.

Common errors are listed below:

(a) Billing errors in specific data fields, e.g., invalid recipient ID number, invalid procedure code.

(b) Billing errors in procedure fields, e.g., not circling the changes on a resubmission, putting previously paid amount in cost share field, billing for same procedure on two lines, billed charges not matching number of units and unit charge.

(c) Billing errors caused by specifics of a case, e.g., not billing around a suspension period, dates of service not matching prior authorization dates of service.

Electronic claims submission will eliminate some, but not all, of these errors. Provider billing staff must still submit accurate claims, especially adjustment (resubmission) claims.

Claims with missing data are Returned To Provider (RTP'd) by ACS for correction and resubmittal. Claims with invalid data are denied payment by HPMMIS.

The turnaround time for payment of a "clean" claim with matching PA is 2-3 weeks, depending on when the claim was entered into HPMMIS or processed electronically. Two DD/MR providers are submitting claims electronically and getting over 90% of their claims paid within 30 days.

B. Remittance Advice to Manage Claims Billings

Providers are required to use their weekly Remittance Advice to manage their claim billing and reconciliation procedures.

The purpose of the Remittance Advice is to document the action and status of each claim processed by HPMMIS during the previous week. Providers should reconcile their accounting records with the Remittance Advice as soon as it is received.

- Reconciliation of a Remittance Advice requires attention to detail. Remittance Advices contain payment and denial information at the claim and line item level. For each claim that pays, either in full or in part, providers should post the information to their internal accounting ledger.

- Claims that do not pay (are denied) should be researched and, if applicable, corrected and resubmitted as a new claim (unless the one-year filing deadline has passed).
- Claims that did not pay in full should be researched and, if applicable, corrected and resubmitted as an adjustment claim, referencing the original claim number.
- If additional PA units are required, communication with the SSD or DOH case manager is required.

Providers who do not use the Remittance Advice and subsequently, their accounts receivables, to reconcile payments continue to be mistaken about the status of claim payment. ACS, DHS, and DOH continue to offer additional support to providers in this area to help providers accurately do their recordkeeping, claims submissions, and adjustment submissions.

C. Provider Accounting Procedures and Staffing

Providers are required to have the necessary internal accounting and recordkeeping procedures in place to run their business. Providers should ensure billing staff are capable of complying with claims submission and payment accounting requirements.

Providers who experience persistent problems typically depend on staff who do not have adequate business or accounting experience to effectively manage billing and reconciliation activities.

- Approximately 20%-40% of providers do not perform payment reconciliation from the Remittance Advice.
 - These providers are unable to identify specific claims attributable to outstanding payment amounts.
 - Providers who are not able to submit accurate, claim-specific, substantiated dollar figures for what is “outstanding” are not using their Remittance Advice to track payment and claims status information.
- Providers are required to check eligibility of clients before rendering service.
 - If a client was suspended from the waiver program during the month, the provider must bill around the suspension period, i.e., providers cannot be paid for services rendered to the client during the suspension period.
 - If a suspension is incorrect, providers should contact SSD to fix the error, e.g., this occurs when short-term suspensions are not closed.

D. Provider Training

The summer before HPMMIS was implemented, Medicaid Waiver Program staff provided training statewide to orient and prepare providers on the use of new claim tools, the new claim forms, and the use of prior authorizations. ACS held three rounds of targeted training sessions for waiver providers to explain detailed billing instructions and provide sample claim forms. Special mailings and instructions are periodically sent to providers to help with reconciliation.

- ACS meets individually with providers who continue to have payment problems to discuss specific claim issues and provide detailed analysis of common errors.
- SSD's fiscal and information staff provide technical assistance to individuals and groups to assist providers who are having problems with their claims.
- DOH staff likewise provide training, assistance, and support to individual providers.
- Provider Bulletins contain information specific to waiver providers.
- The DHS Director, Lillian Koller, personally held frequent meetings (at first weekly, then semi-monthly and later monthly) from February to November 2003, to allow providers to express their concerns with the State's progress in solving payment or PA problems and to develop workable solutions. These meetings provided clarification of billing requirements and instructions for specific situations.
- ACS continues to meet with providers to address payment issues as necessary.
- The Hawaii Waiver Providers Association met with ACS in March 2004 for a refresher training session. ACS also fully described the claims status information available on the MQD's web site.

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

Finding 3: Payments Are Made To Providers With Verifiable Claims

Based on ACS' analysis of claims submitted by providers for the reconciliation project initiated as a result of SCR 106, payment concerns continue to exist with some providers.

- Claims were submitted by 31 of 49 DD/MR waiver providers (63%).

- 17 providers reported no significant outstanding payments.
- 2,729 claims were received; over 55% of these claims were submitted by two providers.
- 367 claims submitted by one provider (34% of all outstanding payments) were properly denied by DOH DD/MR case managers. This means that the DOH DD/MR case managers did not authorize the services rendered prior to the services being rendered and they do not wish to authorize them after the fact because the services exceed the amounts authorized in the client's ISP.
- One provider submitted 298 claims and an estimate of \$100,000 in payment outstanding. These claims were received after the May 26, 2004 deadline so neither these claims nor this amount were included in our findings.
- One provider did not submit claims to the ACS project team but instead submitted these claims in April with their regular claims. As a result, we are unable to analyze these claims to include them in this report. This provider's estimate of the outstanding payments that these claims represented was \$80,000. We have, however, determined that 18%-20% may have already been paid and 70%-75% may require DOH DD/MR case manager modifications to the PA for additional service units.
- The total amount estimated by providers for payments owed is \$1,898,011.77.
- 39% of these claims were returned to providers for provider billing errors.
- 22% of the claims were re-processed after determining that an updated PA had been entered into HPMMIS after the claim was denied. This means that providers are submitting claims for payment before they receive written confirmation from ACS that the updated PA entered into HPMMIS, which is contrary to our payment process instructions.
- 39% of the claims were sent to DOH for review.
- Of the claims submitted to DOH for review, 60% were approved by DOH for PA update and reprocessing.
- 35% of the claims submitted to DOH for review were properly denied by DOH for unapproved units/services, meaning that the providers exceeded the services prior authorized without consent by the DOH to do so and they will not be paid for such services in excess of the client's ISP.

Finding 4: Payment Delays Due To The PA Process Continue To Be Addressed.

A. Frequent Changes To Authorized Services Contribute to Payment Delays

Each month, approximately 20% of DD/MR waiver services are modified to accommodate a variety of changes to client's ISPs.

Some change requests to the Individualized Service Plan (ISP) are client requested, such as "client wants to have services on different days and different times."

- Some change requests are provider requested, such as "provider believes client is agitated so requests an extra half hour of service."
- Some change requests are related to provider capacity, such as "provider received approval to provide RN-based services but used LPN-based service instead."
- Some change requests require significant internal discussion because they require analysis of contract terms and conditions, such as the case of a foster parent (and provider) staying home because the client is sick and requesting additional compensation for home care.
- Change requests are reviewed by the DOH DD/MR case manager with the individual client and/or client's guardian; as a result, some are approved and some are denied based on needs and available resources.
- Providers report that prior authorization letters for changes are not always received in a timely manner. Providers want to submit claims within the first two weeks of the month following the provision of services, including those services that were increased or changed during the previous month. This is what is expected and this is what we are trying to achieve.
- Providers report they occasionally discover that a PA has been updated or changed; yet they did not receive a PA letter. Providers are instructed to call ACS to verify that a prior authorization has been entered into HPMMIS before submitting a claim for payment.

B. Changes to Streamline the PA Process

Management of the PA process at DOH has been difficult until July 2004 due to DOH's previously limited access to information in HPMMIS and inability to transmit data between its internal system and HPMMIS. At that time, DOH's internal system,

Our findings confirm that up to 25% of the updates and changes approved by DOH case managers are not entered into HPMMIS in a timely manner.

DDCARES, was being developed and an interface with HPMMIS was explored but was not viable due to HIPAA requirements.

As of July 1, 2004, DOH staff have direct access to HPMMIS and are able to input PAs and PA changes directly into HPMMIS which significantly improves efficiency, accuracy, and speed of payment.

- Access to HPMMIS enables DOH staff to input PAs and PA changes directly into HPMMIS which will speed up the payment process.
- With HPMMIS access, DOH staff now have the capability to respond more quickly to PA requests and questions from case managers and providers. DOH will also have the tools to generate HPMMIS reports and reconcile service utilization data on the claims side with DOH's DDCARES. This will help DOH staff to authorize changes in services more timely with budget integrity.
- A significant improvement in the PA process occurred in September 2003 when ACS implemented a direct data entry application via electronic interface for DOH and SSD for new PAs only. Updating of existing PAs requires an existing HPMMIS PA number and requires manual keying into the system by DOH staff for changes in existing PAs for DD/MR providers.
- See Recommendation No. 1 for additional capabilities offered by HPMMIS access.
- DOH has also streamlined its PA approval process by eliminating one level of supervisory review.
- DHS and DOH continue to look for automation tools, system capabilities, and procedural changes to improve payment turnaround time for waiver providers.
- DOH and DHS are addressing the inability to input prior authorizations due to Medicaid "ineligible" edits resulting from pending eligibility reviews. We are considering the implementation of "passive renewal" for DD/MR clients.

C. Outstanding Claims Between DOH and DD/MR Providers

In the past, management of the PA process has not dealt effectively with PA discrepancies between DOH and its DD/MR providers. This was due to DOH's limited access to HPMMIS and expenditure reports. However, with current connectivity, DOH hopes to minimize this problem.

- To minimize disagreements, SSD and DOH are clarifying circumstances for provider-initiated changes and emphasizing provider responsibility for billing only approved authorized services.

- The frequency of times where providers have increased or modified services and submitted claims before seeking or confirming authorization from the DOH case manager has created the perception among case managers that some providers are taking advantage of the system.

Providers continue to submit claims for additional service units that have been properly denied.

- Recently, one provider submitted over 1,000 claims; 34% were properly denied.

- When HPMMIS was first implemented for dates of service starting October 1, 2002, DOH case managers were unable to monitor the submission and resubmission of invoices for denied services. As of July 1, 2004, with new connectivity to HPMMIS and access to data, DOH has the ability to change PAs in a more timely manner.

Finding 5: All Components of Claims Processing Must Work Together To Ensure Timely Payment of Claims.

A. HPMMIS Meets Medicaid Management Information System Standards

HPMMIS is a more complex system for users than the payment system previously used by waiver providers.

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

- Each claim must be correctly completed with valid data, such as recipient ID, provider ID, tax ID, diagnosis code, service code, place of service, total charges, and waiver indicators. In total, over 25 fields are required to be completed in order for a claim to process correctly. This is standard billing practice for all Medicare/Medicaid services.
- For waiver services, only one claim per recipient can be submitted each month per provider; each claim may have more than one detail line if more than one type of service is provided.
- Each claim must have a matching prior authorization already in HPMMIS in order to pay.

HPMMIS is designed to provide Medicaid fraud protection.

B. Obligation of Providers

- Providers are required to implement business and accounting procedures to ensure that services are authorized and that only authorized services are performed.
 - Providers must verify Medicaid eligibility before providing services.
 - DD/MR providers are instructed to ensure that a DOH case manager has approved the service before providing the service and that an approved prior authorization letter for those specific services has been received by the provider before providing the service.
 - Providers must also verify that services were actually provided before submitting claims. For example, in one instance, the provider billed to the PA without verifying that the client had moved and was no longer receiving the services on the PA. This case has been referred to the Medicaid Fraud Investigations Unit in the Office of the Attorney General.
- Providers can call ACS anytime to determine if a prior authorization is in HPMMIS so that a claim for the service can be submitted, cleared, and paid.
- Services listed on the PA letter should be consistent with each client's Individualized Service Plan and provider contract.
- If a PA letter contains incorrect information or if a PA letter has not been received, DD/MR providers are required to contact the DOH case manager to resolve this problem as soon as possible.

Finding 6: Alternative Methods Of Speeding Up The Processing Of Claims Within 30 Days Is Unnecessary.

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

- “Clean” claims with matching PAs are paid within two to three weeks of submission, meeting the requirement for “timely” payment.
- ACS data enters all claims within 5 business days. Payment cycles are run every Saturday. Claims and their corresponding PAs can be entered until 6 PM on Friday to get paid in the next week's payment issuance cycle. Checks are mailed the following Friday.
- Improvements in the processing of PA changes are ongoing. For accurately submitted claims, 90% are currently being paid within 30 days.

- **Providers submitting electronic claims experience the timeliest payment of claims.**

- **DHS has approved a contract amendment with ACS to expand its provider services and promote electronic claims submission. The cost of this contract amendment is \$2.5 million for the time period April 2004 through June 2007. This contract amendment allows ACS to hire three Provider Relations Field Representatives and two Business Analysts, and also provides for the implementation and ongoing support of its new electronic data interchange (EDI) package, WINASAP2003, which DHS is offering to providers free of charge.**
 - **Field Representatives will meet with providers on a regular basis to assist in all aspects of interaction to identify issues that prevent timely payment for providers. Resolution of the problem may involve multiple approaches, depending on the cause.**

 - **Field Representatives often work with Business Analysts to identify the reason(s) for payment delays and to develop and execute plans to resolve the problem. This could involve additional training of provider staff to submit a "clean" claim, which results in payment without manual intervention (automatically process through the system). Follow up action could also result in additional training of provider staff to read and understand the remittance advice (RA) in order to initiate actions to resolve "problem" claims, and to assist provider staff in reconciling claims payments.**

 - **Provider Relations Field Representatives will play an important role in assisting providers with the transition to electronic claims submission via WINASAP2003. ACS staff will assist providers in the set-up of WINASAP in their offices and train provider staff on the use of the system.**

 - **ACS Business Analysts will assist Field Representatives in researching claims problems and identifying issues requiring technical interaction with DHS or AHCCCS.**

 - **WINASAP2003 is being provided free of charge to providers and is ideal for DD/MR waiver providers. It can be installed on a personal computer and requires only a modem to connect to ACS' EDI Gateway operation. Installation, training, and on-site support is provided under this contract amendment. Providers will be able to load client and procedure code data to streamline the submission of monthly claims and virtually eliminate the potential for errors.**

Finding 7: Alternatives To HPMMIS Are Being Explored.

- A joint Request for Information (RFI) for the states of Arizona and Hawaii to procure a new information system to replace HPMMIS in two to three years is currently underway. The Federal Centers for Medicare and Medicaid Services (CMS) has approved this undertaking. The RFI is expected to be released by the end of September 2004.
- There is no alternative of returning to the prior manual invoicing process. First, and most importantly, a separate payment system for waiver services was cited in a CMS audit as non-compliant with Federal requirements. Secondly, the previous manual invoicing approach requires significant State oversight and resources which are neither available nor warranted given that HPMMIS is working well for over \$767 million paid annually (July 1, 2003 to June 30, 2004) to all Medicaid providers. This is in comparison to only the small fraction of DD/MR providers who continue to have difficulty getting timely payments for all the reasons discussed in this report.
- Under the prior invoicing system, the State was required to “fix” all errors and discrepancies manually. Under the current system, discrepancies are more easily, consistently, and reliably identified through an automated Remittance Advice system. DOH is responsible for PA-related errors, SSD for suspension-related errors, MQD for code-related errors and reference table updates, ACS for data entry errors, and providers for billing errors.

Our requirement for billing waiver services on a CMS 1500 claim form is also consistent with claims submission requirements in all 50 states.

CMS requires that states use a single, integrated claims processing system for all Medicaid provider payments to provide Medicaid fraud protection.

V. RECOMMENDATIONS

The Department of Health, Department of Human Services, and Affiliated Computer Services have undertaken the following five tasks to improve the billing and payment process for the DD/MR waiver provider community:

- 1. Improve Timeliness of PA Processing in DOH.*
- 2. Disseminate Contract and Billing Guidelines to Providers.*
- 3. Provide Outreach and Targeted Training to Waiver Providers with Claim Error Rate Exceeding 20 Percent.*
- 4. Conduct General Training for Waiver Providers and Waiver Provider Associations.*
- 5. Offer Cost-Free Electronic Billing Software to Waiver Providers.*

The Department of Health (DOH), the Department of Human Services (DHS), and Affiliated Computer Services (ACS) have collectively determined that overall improvements in the billing and payment outcomes for waiver services can be achieved with the roll-out of the five projects listed above.

Recommendation 1: Improve Timeliness Of PA Processing In DOH.

The goal of this effort is to improve the timeliness of PA processing in DOH.

To achieve this goal, DOH and DHS have initiated the following tasks:

- **Review and streamline DOH policies and procedures**
- **Provide HPMMIS access and training to DOH staff at DOH offices**
- **Modify HPMMIS to allow DOH to correct PA mismatches and update PAs on a timely basis**
- **Continued exploration of technological alternatives to streamline PA process**

A. DOH Policies and Procedures

DOH will review its policies and procedures to ensure that its case managers and fiscal staff have the tools, guidelines, contractual rules, and training to efficiently process prior authorizations for waiver services.

This review includes:

- DOH and SSD prepared and distributed guidelines to all Medicaid waiver providers and case managers, including those who serve DD/MR waiver clients, on August 2, 2004.
- Guidelines will clarify standards related to preparing and changing prior authorizations.
- Guidelines will require DOH staff to remind providers that claims should not be submitted unless the service has been approved and entered into HPMMIS. Approval means that the provider has received a prior authorization letter from HPMMIS for the service.

B. HPMMIS Access and Training

DHS has recently provided HPMMIS access to DOH management and fiscal staff. In August 2004, HPMMIS access will also enable DOH to compare claims with prior authorizations in HPMMIS and match this information with internal case management data.

- SSD fiscal and information staff are providing technical assistance to DOH staff on HPMMIS navigation and the claims processing subsystem. Training for eleven DOH staff was recently conducted on June 28, 29, and July 1, 2004.

Training prepares staff to carry out the following:

- Review of PAs in HPMMIS
- Make changes to the PAs directly in HPMMIS

- DOH staff will be able to look at claims with no PA and determine if the service was approved. If so, DOH can enter the PA directly.
- DOH staff can look at claims with a PA mismatch (i.e., different services in the PA and the claim) and determine if the problem is the PA or the claim. If the problem is the PA, DOH can fix the PA directly.
- DOH staff can enter and update PAs, including changes expeditiously. For example, if 25 units of a service have been approved prior to the month of service and a provider requests an additional 5 units and the case manager has approved this change but the update was not made to HPMMIS, DOH can modify the PA to show 30 units of service approved. Similarly, if the additional 5 units is denied, DOH can modify the PA to show 25 units approved and 5 units denied.

DOH will have the capability to quickly determine if a prior authorization in HPMMIS is missing or incorrect, or if additional services or units should be added.

C. Modify HPMMIS for Efficient and Timely Approval

The Department of Human Services (DHS), Med-QUEST Division (MQD) will work with Arizona Health Care Cost Containment System (AHCCCS) to modify HPMMIS to support this new process.

- The system will be modified to “pend” claims with a prior authorization mismatch (same recipient and provider, but different services) instead of denying them.
- The system will also “pend” claims with no prior authorization.
- A new “pend” location will be created for DOH. All claims “pended” for PA will be sent to this DOH location.

- DOH will be instructed on how to pull up these claims, complete a review, and take appropriate corrective action.
- Training will be provided by DHS on working the "pend" location and reprocessing claims quickly for payment.

D. Benefits of New "Pend" Location on HPMMIS

This new process will enable DOH to replicate the manual review they performed with the previous invoicing system.

- Claims with no PA will no longer be automatically denied. If a provider receives a claim denial for no prior authorization, the denial reason is printed on the Remittance Advice.
- Claims with a matching PA will not require review. These claims will be approved for payment automatically by HPMMIS.
- Claims with a PA mismatch will be reviewed by DOH. The review process is as follows:
 - DOH case managers determine if billed services were approved.
 - If the PA needs to be updated, DOH can do the update directly in HPMMIS.
 - If the PA is correct and the provider billed for unauthorized services, the claim can be denied by HPMMIS automatically.

Recommendation 2: Disseminate Contract and Billing Guidelines To Providers.
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The goal of this effort is to ensure that waiver providers, including DD/MR, clearly understand the terms and conditions of their contract with the Social Services Division. SSD is developing detailed contract and billing requirements for all waiver providers. These requirements will be presented as guidelines to stipulate provider qualifications for administrative and fiscal operations of programs and services delivered to Medicaid recipients by the third quarter of FY 2005 before the new contracting period begins.

- Assistance will be offered to providers who need special help to meet these requirements.
- Audits may be required.

- Contracts may be revoked or suspended for providers who do not meet requirements, are in continuous violation, or are unable to achieve compliance in their operations.

Recommendation 3: Provide Outreach and Targeted Training To Waiver Providers With Claim Error Rate Exceeding 20 Percent.

The goal of this effort is to identify providers needing additional help with the billing and reconciliation of claims. In the recent reconciliation project, thirteen providers had a claim error rate over 20 percent. These providers have been scheduled for a site visit and targeted training by ACS.

Training will include:

- Review of training materials and billing instructions
- Analysis of common errors
- Hands-on instruction for fixing errors
- Special handling of corrections and resubmitted claims

DOH and SSD will participate in this outreach to ensure that SSD contractual requirements and billing guidelines, as well as DOH case management activities, are accurately presented to these providers.

Providers have publicly stated their willingness to acknowledge staff deficiencies and accept State recommendations to upgrade training or replace staff unable to meet requirements for accurate billing.

Recommendation 4: Conduct General Training For Waiver Providers and Waiver Provider Associations.

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

The sessions will include:

- HIPAA 101
- Submitting claims electronically and payments through electronic funds transfer
- Introduction to Claims Problems
- Basic Billing and Prior Authorization
- Remittance Advice Reconciliation

Recommendation 5: Offer Cost-Free Electronic Billing Software To Waiver Providers.

The goal of this effort is to provide waiver providers with a cost-free method of submitting electronic claims. ACS is rolling out an electronic billing system in July 2004. *WINASAP2003* is a stand-alone billing system designed for providers submitting fewer than 300 claims per month. This threshold makes it an ideal product for most waiver providers. It is being offered free of charge to providers. It requires only a modem to connect with the ACS electronic data interchange gateway. This distribution of the free electronic billing software is part of the new contract with ACS which includes hiring new provider staff to help providers as stated in Finding 4, Section B.

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- (3) Affiliation agreements with hospitals and other health care providers required for University of Hawaii clinical programs; and
- (4) Services of psychiatrists and psychologists in criminal and civil proceedings when required by court order or by the rules of court.

* (b) Certain federally funded contracts.

Contracts for health and human services that are wholly or partly funded from federal sources shall be exempt from chapter 103F, HRS, when:

- (1) The source of the federal funds imposes conditions on the receipt of the federal funds that conflict with the procedures and requirements established by chapter 103F, HRS, and its implementing rules; or
- (2) The contract is to provide health and human services to implement a federal program that
 - (A) Identifies a target class of beneficiaries;
 - (B) Defines the requirements for a provider to be qualified to participate in the federal program; and
 - (C) Has the price of the provided health and human services dictated by federal law.

(c) Further exemptions by the chief procurement officers. Chief procurement officers may for good cause, upon their own initiative, or upon application by the head of a purchasing agency, exempt additional transactions. Before granting an exemption under this subsection, a chief procurement officer shall consult with the administrator. [Eff JUN 19 1999] (Auth: HRS § 103F-106) (Imp: HRS § 103F-101)