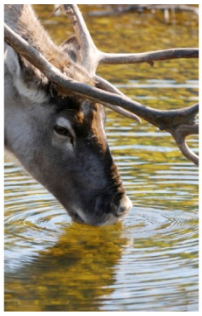
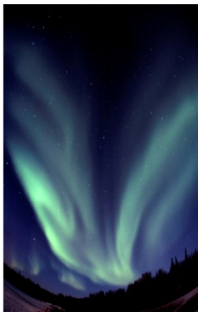
Impacts of the Health Enterprise MMIS Conversion on Home & Community Based Service Providers





SEPTEMBER 26, 2014

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Introduction

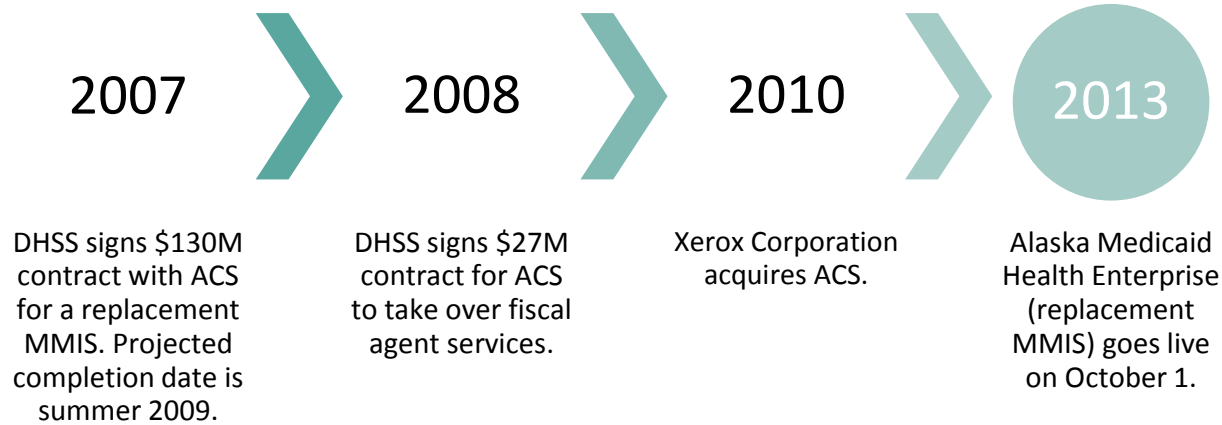
OVERVIEW OF THE MMIS REPLACEMENT PROCESS

Medicaid Management Information Systems (MMIS) are owned and operated at the state level to process Medicaid claims. These systems are vital for ensuring health services reach Medicaid beneficiaries, payments for those services reach Medicaid providers, and sound management, oversight and reporting take place at the state and federal levels. Many states have replaced or are in the process of replacing legacy systems no longer capable of meeting the functions required. With an aging MMIS not designed for the volume or complexity of Medicaid claims processing faced in the mid-2000s, the Alaska Department of Health and Social Services (DHSS) began the process of replacing its legacy MMIS. In 2007, DHSS signed a contract with Affiliated Computer Services, Inc. (ACS) for the design, development, and operation of a web-enabled MMIS (ACS, 2007). The following year ACS became Alaska's fiscal agent, meaning that ACS assumed operation of the legacy MMIS and would oversee the transition to the new system, called Alaska Medicaid Health Enterprise (Alaska Department of Health & Social Services, 2008). In 2010, Xerox acquired ACS and, with it, responsibility for completing development of the new MMIS.

The replacement MMIS was not completed by summer 2009 as projected. Instead, Xerox went live with the Alaska Medicaid Health Enterprise system in October 2013, three and a half years later than expected. The primary reason for this delay as described by DHSS was that ACS/Xerox did not have a core system that could be deployed for Alaska and drastically underestimated the amount of time it would take to develop one (Brodie, 2014).

As the Alaska Medicaid Health Enterprise system neared completion, Xerox undertook user and system testing, went live with specific system components, and required Medicaid service provider re-enrollment.

FIGURE 1: KEY DATES IN MMIS REPLACEMENT PROCESS



In addition, Xerox and DHSS took specific steps to address issues raised by providers (Brodie, 2014):

ADVANCE PAYMENTS: A month prior to the conversion, Xerox identified providers heavily reliant on Medicaid payments. DHSS sent out advance payments in the expectation that delays would occur immediately after the Enterprise system went live. Providers identified for advance payments were limited; they included assisted living homes and Home and Community Based (HCB) service providers that operate on a day-to-day basis. Larger providers with a more diverse client base, such as hospitals, dentists, and physicians, were not included in this initial group. By February 2014, DHSS notified providers that advance payments would be offered to those impacted by delays in claims processing and payment. The notification also laid out repayment options (Brodie, 2014).

BILLING PROBLEMS: DHSS offers Medicaid providers one-on-one assistance to work through billing issues. DHSS maintains the majority of billing issues have been resolved and claims are being paid, despite the fact that over 500 errors ranging from minor to major are still known to exist in the Enterprise system (Brodie, 2014).

COMPARISON OF PRE- AND POST-CONVERSION CLAIMS PROCESSING

The startup of complex information systems rarely goes smoothly. At startup on October 1, 2013, Xerox identified 44 known problems with the system. Soon after, the number of problems grew to 546. Xerox maintains that the performance of the Health Enterprise system is improving. However, not all service providers agree that things are getting better.

Information Insights analyzed Medicaid claims payment information for HCB service providers before and after conversion to the Enterprise MMIS. The pre-conversion period was from January 1 to June 30, 2013; post-conversion was from October 1, 2013 to June 30, 2014. Payment information from eight providers (48,203 claims) was used for the analysis.

Results of the analysis are summarized in the table and charts below. The data confirm that the percentage of claims approved and average amount paid are still well behind pre-conversion levels. In addition, service providers now wait seven weeks for payment rather than just over four weeks.

TABLE 1: CLAIMS PROCESSING PRE VS. POST CONVERSION

	Average Amount Billed (Thousands)	Average Amount Paid (Thousands)	Average in Unpaid Claims (Thousands)	Average Amount Paid as Percent of Total Billed	Average Days from Last Date of Service to Payment
Pre-Conversion	$8,235.8	$7,548.1	$687.7	91.8%	30
Post-Conversion	$11,463.2	$9,579.7	$1,883.5	82.0%	49
% Change	39.2% ↑	26.9% ↑	173.9% ↑	10.7% ↓	63% ↑

Figure 2 shows the percent of claims paid, by month, for each of the study periods. The pre-conversion mean is 92.5 percent of claims paid while 7.5 percent were denied. Claims paid dropped in the post-conversion period to an average of 71.9 percent, with 28.1 percent of all claims denied. The average number of days between last day of service and claim payment increased from 30 days pre-conversion to 49 days post-conversion. The average amount paid for claims also dropped between the pre- (91.8 percent) and post-conversion (82.0 percent) periods.

FIGURE 2: CLAIMS PAID AS PERCENT OF TOTAL SUBMITTED

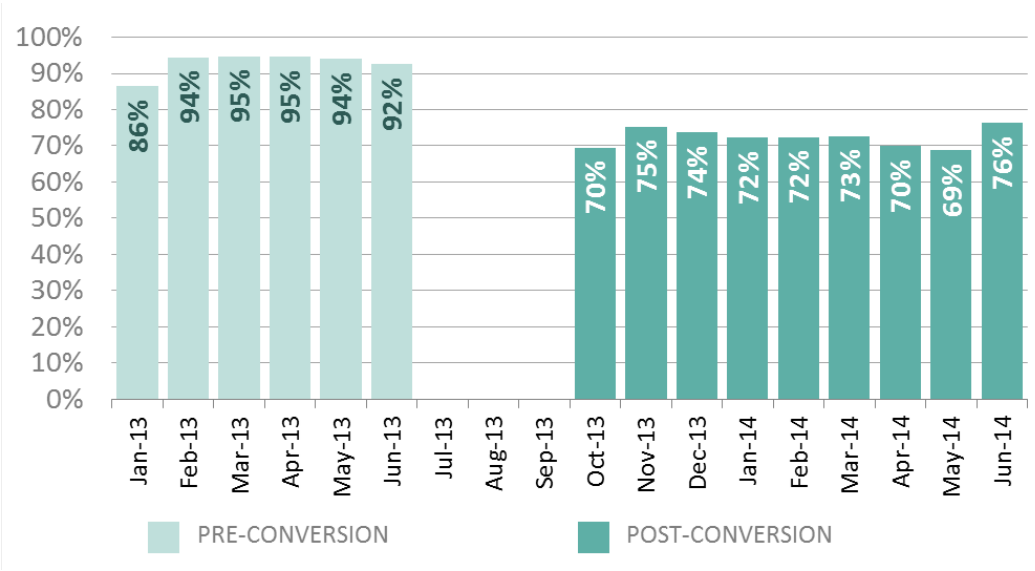


FIGURE 3

Average Days from Last Date of Service to Date Paid

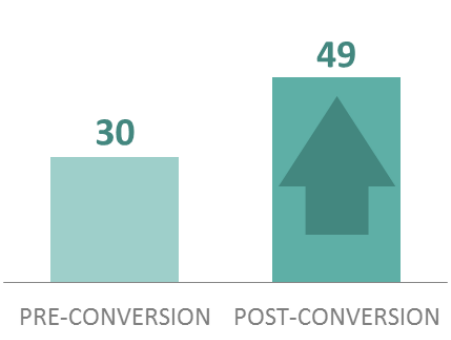
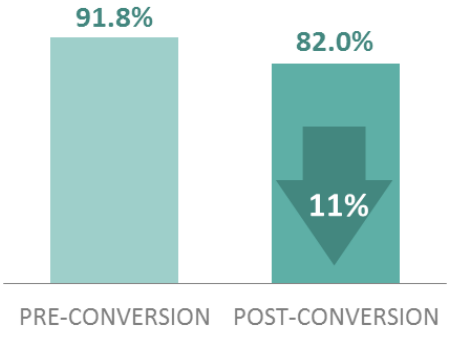


FIGURE 4

Average Amount Paid as Percent of Total Billed



Tables 2 and 3 provide pre- and post-conversion claims and payment information by month.

TABLE 2: NUMBER OF CLAIMS PAID PRE VS. POST CONVERSION

Last Date of Service	Total Billed*	Claims Paid	Claims Denied	Claims Paid As Percent of Total
PRE-CONVERSION				
Jan-13	48,585	41,996	6,589	86.4%
Feb-13	41,316	38,999	2,315	94.4%
Mar-13	43,780	41,456	2,324	94.7%
Apr-13	42,289	39,971	2,318	94.5%
May-13	35,282	33,150	2,132	94.0%
Jun-13	11,284	10,437	847	92.5%
POST-CONVERSION				
Oct-13	13,452	9,351	4,093	69.5%
Nov-13	11,671	8,793	2,878	75.3%
Dec-13	12,100	8,923	3,176	73.7%
Jan-14	12,228	8,841	3,386	72.3%
Feb-14	11,781	8,526	3,254	72.4%
Mar-14	12,691	9,222	3,467	72.7%
Apr-14	11,807	8,261	3,546	70.0%
May-14	11,401	7,834	3,567	68.7%
Jun-14	2,894**	2,208	686	76.3%

* During the pre-conversion period, each service on a claim had a Transaction Control Number (TCN). After conversion, multiple services were included under one TCN. ** June 2014 only includes claims submitted through June 21.

TABLE 3: CLAIMS PAID PRE VS. POST CONVERSTION (DOLLARS)

Last Date of Service	Total Billed (Thousands)	Total Paid (Thousands)	Total Unpaid (Thousands)	Total Paid as Percent of Billed	Average Days from Last Date of Service to Payment
PRE-CONVERSION					
Jan-13	$10,777	$9,141	$1,637	84.8%	35
Feb-13	$8,990	$8,446	$544	94.0%	33
Mar-13	$9,666	$9,081	$585	94.0%	31
Apr-13	$9,075	$8,524	$551	93.9%	29
May-13	$7,911	$7,378	$533	93.3%	23
Jun-13	$2,995	$2,719	$276	90.8%	28

Last Date of Service	Total Billed (Thousands)	Total Paid (Thousands)	Total Unpaid (Thousands)	Total Paid as Percent of Billed	Average Days from Last Date of Service to Payment
POST-CONVERSION					
Oct-13	$13,271	$11,290	$1,981	85.1%	84
Nov-13	$23,837	$22,251	$1,586	93.4%	71
Dec-13	$13,401	$11,341	$2,060	84.6%	68
Jan-14	$11,761	$9,443	$2,318	80.2%	58
Feb-14	$9,599	$7,310	$2,288	76.2%	47
Mar-14	$10,437	$8,095	$2,342	77.6%	40
Apr-14	$8,484	$6,462	$2,023	76.2%	31
May-14	$7,276	$5,484	$1,792	75.4%	22
Jun-14	$5,103*	$4,541	$561	89.0%	16

* June 2014 only includes claims submitted through June 21.

Experience of HCB Providers

Nine HCB service providers were interviewed about their experiences with the conversion to the Alaska Medicaid Health Enterprise system. The purpose of the interviews was to gather information on the impacts of the new MMIS on their operations. Finance directors or CFOs were interviewed from all providers, as well as some executive directors, program administrators and billing staff. In addition to providing data about their Medicaid claims and billing processes, interviewees provided insight into how the conversion to the Xerox MMIS has affected program staff, finances and business relationships.

Interviews took place onsite with the exception of one, which was conducted by teleconference. Though organizations differed in size, budget, operations and services offered, there were many common themes. This section provides a compilation of the issues raised by service providers during the interviews. The first flow chart at the end of the section illustrates the claims and payment processes DHSS and HCB service providers follow under the Health Enterprise system (see page 14). A second flow chart shows the similar process for Personal Care Assistance (PCA) services.

SERVICE AUTHORIZATIONS

Service Authorizations (formerly Prior Authorizations) present an ongoing problem for providers. Service Authorizations (SAs) are the result of a three-step process. First, the consumer is determined to be income eligible by the DHSS Division of Public Assistance. Then the Division of Senior and Disability Services (SDS) approves a Plan of Care (POC), which outlines the services and units of service the individual is eligible to receive. The POC is then transmitted to the MMIS.

The legacy system sent out paper copies of SAs as they were issued. The Xerox MMIS does not do this but will provide a list if one is requested by the service provider. It is also possible to look up individual SAs on the Medicaid Portal, though this requires more time and effort than paper copies took.

Providers also report having trouble tracking progress towards completion of SAs. The information is available through the Medicaid Portal, but finding it is time consuming and some providers have difficulty accessing the Portal.

SDS sometimes gives providers verbal SAs, which helps with billing. However, the current process is cumbersome and inefficient. Service providers report that they submit SAs multiple times before they are approved. Some are holding off on submitting claims due to service authorization problems, which they believe are being mishandled or lost by SDS and the Enterprise system. One program has between $350,000 and $400,000 in outstanding claims that were denied or pended.

UNPAID/DELAYED CLAIMS PAYMENTS

Claims may be denied or suspended due to an invalid SA or for many other issues: eligibility issues, duplicate claims issues, provider certification, etc. Enterprise matches a submitted claim with an SA already in the system and approves or denies it for payment through a complex process of adjudication based on a host of business rules. Some business rules in the MMIS are still not working and have been flagged as known issues.

Delayed payments impact all of the providers interviewed. Many of the providers have had to scramble to cover personnel and program costs. Supported Employment Group Services and Day Habilitation Group Services became Medicaid billable in July 2013. Service providers did not receive payments until May 2014. The unpaid claims for group services reported by providers ranged from $200,000 to $800,000 through May 2014.

Most of the remaining unpaid claims for group services were originally billed to the legacy MMIS between July 1 and September 30, 2013. Service providers rebilled for services during the pre-transition period. Most of the claims are being paid, but one or two are being denied for known issues. Xerox has told service providers the denial code for “consumer not eligible” is a known issue, but because they’ve rebilled, the providers run into timely filing issues, which could result in the claims never being paid.

Another service that has been problematic is Nursing Oversight, which became unbillable when Xerox changed the billing code without notifying providers. Service providers also experienced problems billing for Plan of Care and Care Coordination services. These issues have been resolved and most of the claims paid.

RESUBMITTING CLAIMS

Providers have experienced a larger volume of denied claims with Xerox. They believe the MMIS randomly drops or changes enrollment, service codes and contract end dates. They also note that it was much easier and efficient to track and resolve denials in the legacy system. They used to be able to follow up on all denials. Now there are too many to follow up on. When they do, it takes more time and effort to make progress on an issue.

All of the providers interviewed face challenges with resubmitting billings. In many cases, they have found that resubmitting claims is not the most effective thing to do. One provider stated that not resubmitting results in a faster payment. Others have decided not to resubmit claims denied because of known issues or errors in the MMIS. They have found it better to wait until the errors are fixed by Xerox before resubmitting a billing. In the same vein, providers express frustration that Xerox sometimes says an error code is fixed and they should resubmit, but when they do the claim is denied again.

Service providers say it is difficult to identify reasons why some claims go through and others do not. Denied claims must be researched to determine if the denial is due to an error that is the fault of the service provider or a known issue in the MMIS. If it is the provider’s mistake, they typically correct and resubmit it. If it is a known issue, they may wait for Xerox to fix it before resubmitting, and then track it to make sure it eventually gets paid. While it may appear that providers have few

resubmittals, many providers are prioritizing resubmittals and only submitting the claims most likely to be paid. One provider referred to these claims as the "low hanging fruit."

CLAIMS ADJUSTMENTS

Providers submit claims adjustments for a number of reasons. Adjustments are often needed when more than one person provides services to an individual. If one person submits his or her time after the billing cycle closes, the original claim has to be voided and resubmitted. Two service providers noted that there can be problems when submitting claims adjustments. In one instance, the system paid the new claim, but voided out claims for the same person two or three years back. This resulted in the provider receiving notice that it owed $200,000. Another provider submitted a claim adjustment and was told that it owed over $300,000. It took more than six months for the program to resolve the issue and receive payment.

The new MMIS gives one transaction control number (TCN) per claim, a change from the old system that assigned one TCN per claim line. This causes problems with submitting claims adjustments. When submitting an adjustment for a claim with multiple lines of service, all lines need to be on the claim—not just those being adjusted. To make it less confusing, one provider is billing one line per claim, which makes it easier to track services being denied. Although this method makes it easier to adjust, track, and rebill, it greatly reduced the time billing staff have to perform other tasks.

One service provider notes an ongoing problem with tracking recoupments. The Remittance Advice (RA) is the file that shows how claims have been treated and what will be paid. The RAs that included adjustments have sometimes showed multiple recoupments as well as denials of lines that were not being adjusted. The provider is still working with Xerox to have multiple recoupments fixed.

IMPACT OF UNPAID/DELAYED CLAIMS PAYMENTS

All the providers interviewed say they have struggled financially since the conversion to Xerox's MMIS. The lack of payment for Supported Employment/Day Habilitation Group Services impacted providers the most. Providers report that their unpaid claims for group services ranged from $200,000 and $800,000 through May 2014. The problem has been resolved and most of the claims were paid in May and early June.

The increase in Accounts Receivable (AR) has impacted providers' relationships with banks and vendors. One program recently learned that taxi cab companies in Seattle (which Medicaid beneficiaries use when traveling for medical treatment) were no longer accepting Medicaid vouchers because payment is so slow. AR has doubled for most providers, and many are concerned about how the dramatic increases in AR will be interpreted in upcoming annual audits. Wells Fargo sent an auditor to verify one program's AR. The auditor spent a week onsite. The audit cost the agency $8,000 plus staff time to prepare files and support the auditor.

Many providers have dipped into reserves that took years to accumulate. Others have focused their efforts on income from non-Medicaid services. All of the providers interviewed are watching cash flow on a daily basis. The Boards of Directors, which have fiduciary responsibility for their organizations, have been alarmed, one to the point of discussing legal counsel.

The advance payments provided by the State helped many providers get through the first eight months after the MMIS conversion. Without the advances, most of the providers would not have been able to pay staff. The State agreed to let the providers pay back the advances in installments. Each provider negotiated a payment plan with the State. Then in June 2014 providers received letters from the State telling them to repay the advances by the end of the month. The letter was sent in error, and providers were able to resume the established payment plans.

A number of providers described the post-conversion period as "harrowing." Nonprofits operate on thin margins and with limited reserves. Even with advances provided by the State, a number of providers depleted their reserves and sought loans to help meet payroll. One HCB provider came within two days of not being able to pay its employees.

The problems with the MMIS affected the accounting and billing staff most. The transition to a new billing or information system always requires extra time for users to become accustomed to the system. Unfortunately, the Enterprise system continues to require extra staff and time. HCB service providers are dealing with this in a number of ways:

- The smallest agency used existing staff to deal with the increased workload, prioritizing claims and only working on those most likely to be paid.
- One organization is paying overtime to existing staff.
- Three providers lost staff in their billing departments and had to recruit and train replacements.
- Two providers added new staff to deal with Accounts Receivable.
- One provider lost its CFO at about the time the Xerox system launched. They hired a new CFO who also left. They are working to build an administrative team focused on billing, but at this point, they are only resubmitting the denials most likely to be paid.

All of the providers interviewed say their accounting/billing staffs are disillusioned and tired. Hard work and long hours are not making a difference. There are continuing billing problems, and when one issue is fixed, something new comes up.

KNOWN ISSUES

Service providers say DHSS has done a good job bringing providers and Xerox together. Service providers have regular meetings with state and Xerox staff. However, when providers raise an issue, they are advised to call Provider Inquiry, the Xerox help line. All of the service providers interviewed say they are usually put on hold for 45 to 60 minutes. When they finally get a Xerox representative on the phone, the representative does not know how to resolve the problem.

ERROR/DENIAL CODES

Many of the calls to Provider Inquiry concern error and denial codes. Table 4 lists the 10 most frequent error and denial codes received during the post-conversion period. The totals are for eight months of claims. The three rows highlighted are codes that providers find took the most time to correct. Providers have asked for a fix for error code 4418, which occurred over 30,000 times from

October 1, 2013 to June 30, 2014 (the post-conversion period for which data was analyzed), but it has not been addressed by Xerox yet.

TABLE 4: MOST FREQUENT POST-CONVERSION ERROR/DENIAL CODES

Code	Description	Frequency
4418	Provider code is in conflict with the submitted claim. There is a conflict between the Procedure Code and Provider Specialty submitted on the claim.	31,059
5140	Service Authorization submitted on the claim is not on file	24,050
4125	The Diagnosis Code has been reviewed and it has been determined that payment cannot be made.	10,856
4419	There is a conflict between the Procedure Code and Provider Type submitted on the claim	10,427
8040	The Number of Units on the Claim have exceeded the Service Authorization Approved Number of Units.	7,492
2040	The Date of Birth on the claim does not match DOB on file	7,211
3832	Medicaid Coverage - Waiver Claim excluded	6,849
6600	Exact duplicate	6,676
3810	The submitted service on the claim is not covered by the Benefit Plan for this member	6,312
9095	No Fund Code assigned for To Be Denied Claim	6,111

Other codes that providers said were problematic are listed below:

3305	Rendering provider is not enrolled on DOS
3800	Rendering provider not in any network associated to any of the benefit plans for the member.
5090	The billing modifiers submitted on the claims do not Match the modifiers specified on the SA
5220	Service authorization is pended with errors – header
5221	Service authorization is pended with errors – line
8050	Service authorization unit of measure mismatch
8904	In Home Habilitation vs. Personal Care

FIGURE 5: FLOW CHART FOR HCB SERVICE CLAIMS UNDER THE ENTERPRISE MMIS

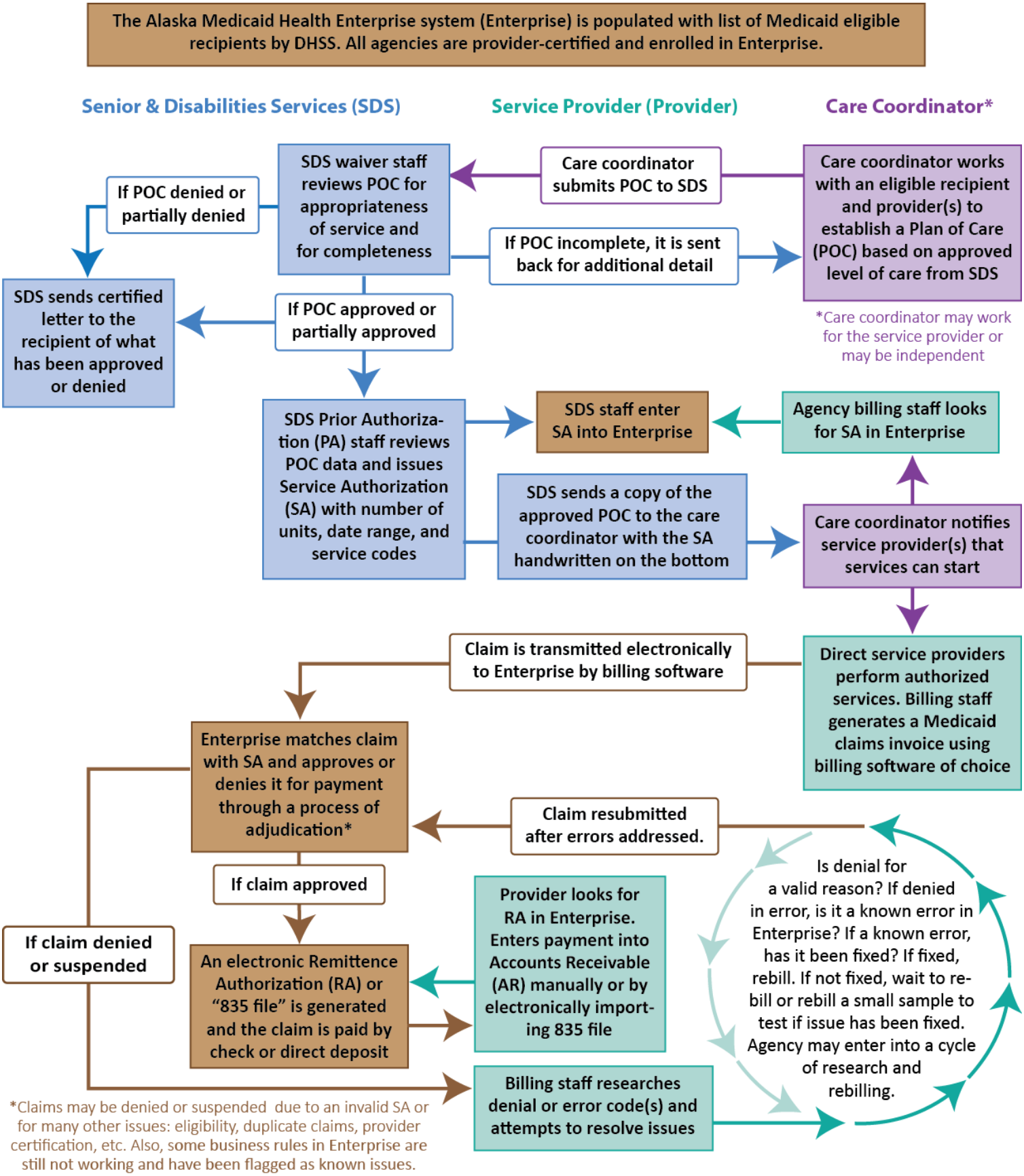
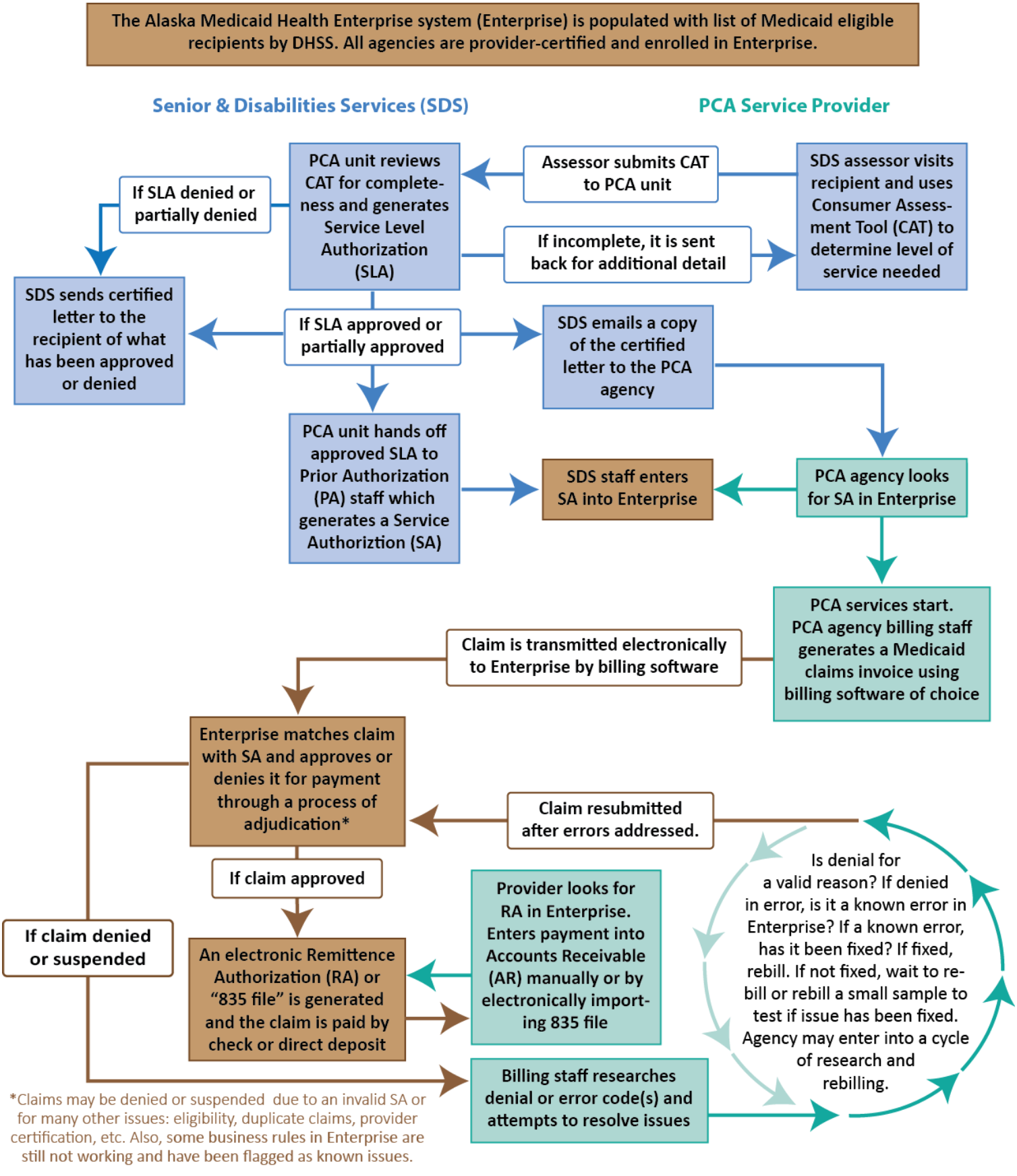


FIGURE 6: FLOW CHART FOR PCA CLAIMS UNDER THE ENTERPRISE MMIS



MMIS at the National Level

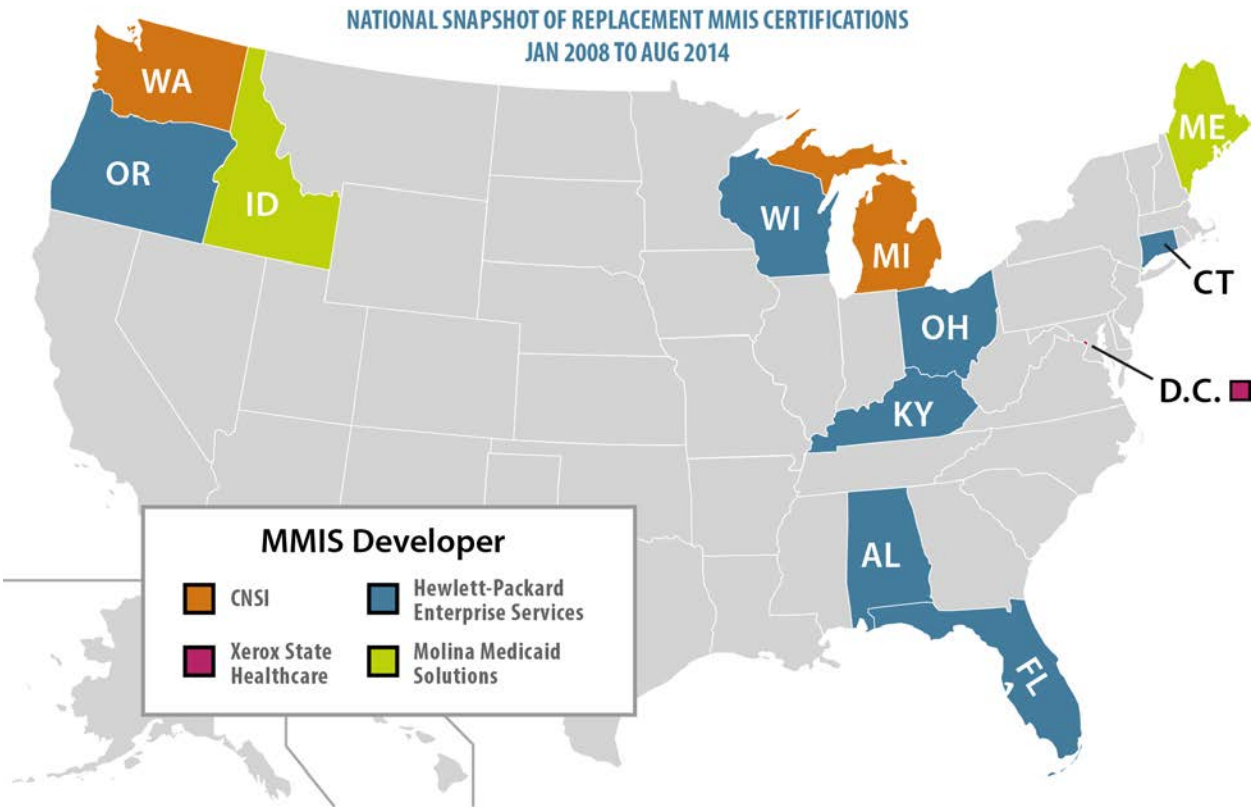
State Medicaid programs are complex, multibillion dollar enterprises. For most states Medicaid is the largest or second largest budget item, and MMIS contracts (whether for operation, design, or both) is typically the largest services contract awarded by a state. As initially designed, the MMIS was a financial and accounting system for paying provider claims and retrieving information. However, as state Medicaid systems have expanded, the demands on the MMIS have grown. In the Medicaid Information Technology Architecture developed by the Centers for Medicare and Medicaid Services (CMS), the MMIS is described as the "central information nervous system" and is expected to support Medicaid Enterprise systems by enabling all Medicaid systems to communicate directly with each other (Centers for Medicare and Medicaid Services).

At present all states have an MMIS, but these systems run the gamut from legacy systems running on platforms designed 15 to 30 years ago to a cloud-based MMIS based in Michigan and shared with Illinois that is still in development. Currently only 13 states operate their own MMIS; the rest contract with a fiscal agent. All states currently in the process of redesigning their MMIS have contracted with a private firm for Design, Development, and Implementation (DDI). The number of private contractors taking on these roles is limited. Companies offering MMIS services often take on the role of fiscal agent in one state and that of DDI in another, or they may do both in the same state. The largest firms (those taking on fiscal agent and/or DDI contracts for multiple states) include HP Enterprise Services, Xerox State Healthcare, Molina Information Systems, CNSI, and CSC (Centers for Medicare and Medicaid Services, 2013).

The map on page 17 provides a snapshot of states with replacement systems certified by the Centers for Medicare and Medicaid Services from 2008 to August 2014. The certification of a MMIS is only done when the existing MMIS is turned off and wholly replaced; upgrades or enhancements to subsystems within the MMIS do not require a new certification (Meacham, 2014). CMS certification is of primary importance, because without it a state will not qualify for the full federal financial participation that covers 90 percent of development and 75 percent of operations costs for the MMIS.

Xerox's only certified MMIS is in the District of Columbia (D.C.) and is the result of the company's acquisition of ACS in 2010 (Department of Health Care Finance, 2012). Designed by ACS, the MMIS went live in December 2009 and was certified in December 2011. The District of Columbia continues to enhance its enterprise system (Department of Health Care Finance-Strategic Plan, 2012).

FIGURE 7



Source: Meacham, 2014

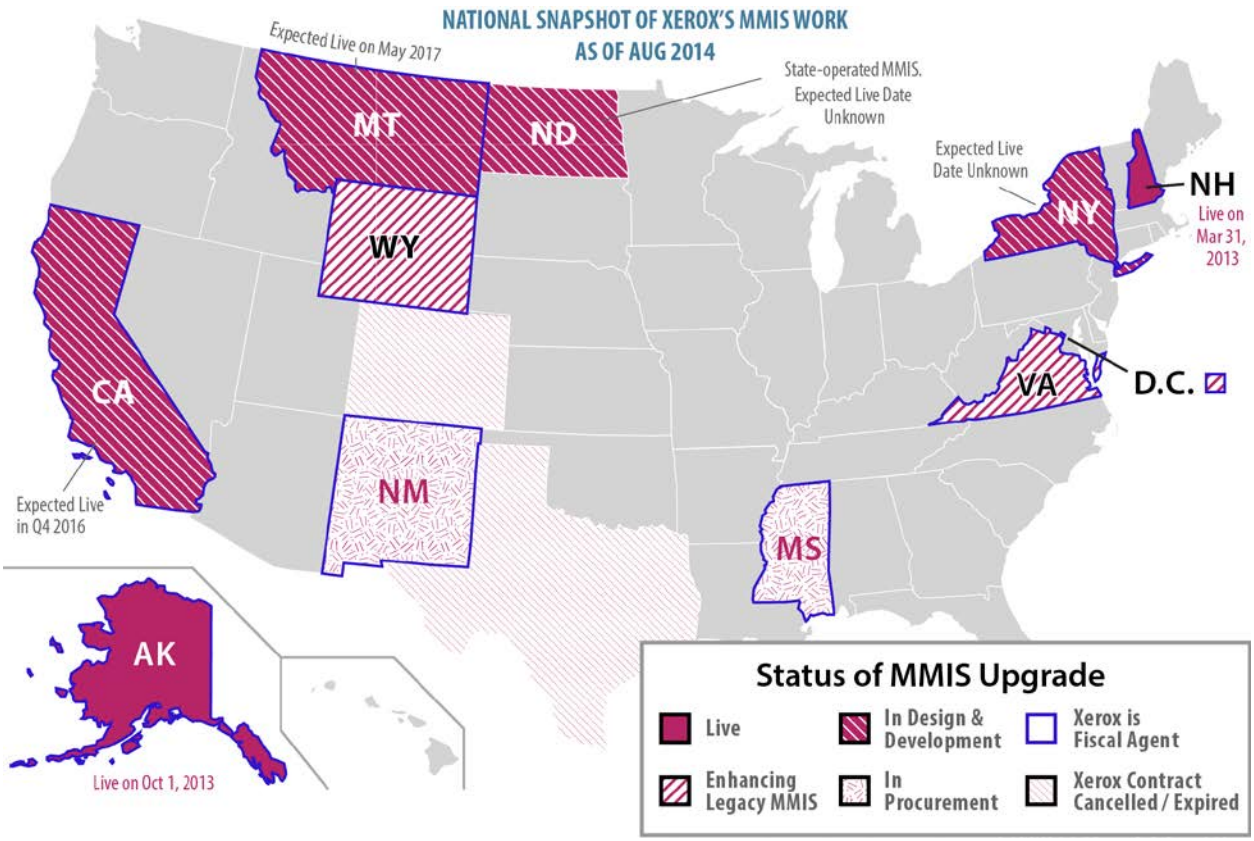
ROLE OF XEROX IN MEDICAID MANAGEMENT INFORMATION SYSTEMS

Though its number of state MMIS certifications is low, Xerox is a major contractor for Medicaid systems. The map on page 18 highlights the states in which Xerox works either as a fiscal agent or as the MMIS developer or both. The only other state to go-live with a Xerox-developed MMIS is New Hampshire.

The states in which Xerox is acting as the developer of a replacement MMIS—California, Montana, New York, and North Dakota—are in different stages of the DDI process. California, Montana, and North Dakota are well into design and development and have all experienced delays in system deliverables. New York only recently signed a contract with Xerox (in July 2014) for the development of a replacement MMIS. Other states that have had prominent disputes with Xerox over Medicaid systems, such as Texas, are not replacing their MMIS.

A more detailed look at New Hampshire's experience with Xerox is informative because the state's replacement MMIS has now been operational for a year and a half. Like Alaska, New Hampshire has a small population, participates in the Medicaid waiver program for Home and Community Based Services, and was engaged in both development and operation of a replacement MMIS in the same time period.

FIGURE 8



Source: Centers for Medicare and Medicaid Services, 2013, updated from other sources

NEW HAMPSHIRE'S EXPERIENCE

The New Hampshire Department of Health and Human Services (DHHS) offers services to individuals with developmental disabilities (DD) and acquired brain disorders through the Bureau of Developmental Services (BDS). BDS is made up of a main office and 10 designated nonprofit area agencies representing geographic regions of New Hampshire. Area agencies function at a quasi-governmental level with contracts from BDS, either acting as direct service providers or contracting with vendors to provide services. Information Insights staff interviewed an administrator from BDS, an area agency executive director, an area agency director of finance, and the lead data systems technician from the Community Support Network, which provides administrative and financial service to the ten area agencies.

All those interviewed identified post-conversion problems similar to those faced by Alaska DD providers. These included significant delays and process disruptions in prior authorizations/service authorizations, delayed payments, incorrect or missing provider IDs and service codes, and inability to generate reports or conduct queries at the area agency level.

Nearly a year and a half after the April 2013 conversion, state and area agency staff familiar with the new MMIS report that many of the problems have been resolved or the impacts on providers of

on-going problems have at least been minimized. Three post conversion actions taken by New Hampshire's DHHS and Xerox stood out as critical in easing the impact of conversion on providers, according to those interviewed:

- **STRONG WORKING RELATIONSHIP BETWEEN BDS AND AREA AGENCIES:** BDS staff meets regularly with area agency executive directors, financial officers, service coordinators and benefit providers as part of normal operations. The strong working relationship between BDS and area agency management and staff made it possible for BDS to identify the top problems for agencies and advocate for change through the New Hampshire Office of Information Technology.
- **CONTINGENCY PAYMENTS:** New Hampshire's DHHS planned for advance transition payments during the legacy MMIS blackout and quickly set up a formal request process for contingency payments for providers experiencing billing or payment delays after the conversion. Those interviewed reported that this system worked and that despite the delays and backlogs significant problems with unpaid claims did not develop. BDS continued to offer contingency payments through August 2013 and the repayment schedule is flexible and on-going.
- **CLAIM PROCESSING AND SERVICE AUTHORIZATIONS:** Delays in claim processing and payment have been resolved. A primary cause of the delay was the backlog in SA data entry. The fix to the backlog has been Xerox's dedication of staff and space for entering SAs into the new MMIS. Area agencies and BDS do not see this as a true solution, but it has reduced the service authorization backlog.

Even with the resolution of the most pressing post-conversion issues, both BDS and area agencies made clear that the new MMIS is not as efficient or functional in meeting the needs of providers, especially DD providers, as it needs to be. Still unresolved are issues related to reporting and query access, efficient electronic interface between the new MMIS and area agency service authorization system, and recognition of area agencies as distinct operators (different from medical or dental offices) due to their size, range of long-term care services provided, and large number of Medicaid beneficiaries.

Recommendations

1. **CONTINUE MAKING ADVANCES/CONTINGENCY PAYMENTS TO SERVICE PROVIDERS UNTIL THE HEALTH ENTERPRISE MMIS IS PERFORMING AT PRE-CONVERSION LEVELS**. We encourage the State to set up a formal request and re-payment process for contingency payments to providers who are continuing to experience payment delays.
2. **RETURN TO ONE TRANSACTION CONTROL NUMBER (TCN) PER CLAIM LINE**. The new system of one TCN for each claim makes it difficult and time consuming to adjust claims with multiple lines of service.
3. **PROVIDE THE SERVICE PROVIDERS WITH REAL TIME ACCESS TO SERVICE AUTHORIZATIONS (SAS)**. Prior to the Xerox MMIS, providers received paper copies of SAs and were able to track service units. Currently, the Xerox MMIS system does not include this function. A stop gap measure is to again provide Medicaid service providers with paper copies of SAs.
4. **INCREASE THE NUMBER OF CALL CENTER STAFF WHO UNDERSTAND THE SYSTEM**. Service providers said they are often on hold for 45 to 60 minutes before they are connected to customer support. When they finally get a Xerox representative on the line, the representative often does not know how to resolve the problem.
5. **INFORM MEDICAID BILLING SOFTWARE DEVELOPERS BEFORE CHANGES ARE MADE TO THE MMIS**. Currently, there is little communication between Xerox and billing software developers (such as Payerpath and MediTrack) who provide the bridge between service providers and the MMIS. Changes are made without warning, forcing developers to scramble to make changes so providers can bill.
6. **REVISE THE MMIS TRAINING VIDEOS SO THAT THEY REFLECT THE CURRENT SYSTEM**. Program billing staff said that they learned how to use the system through experience on the job. Service providers said that the training videos didn't help and didn't appear to be the same system.
7. **WORK WITH HCB PROVIDERS TO DEVELOP A SCHEDULE FOR ADDRESSING AND FIXING THE MOST COMMON ERROR CODES**, beginning with 4418, 8040 and 3810.

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