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






MARCH 31, 2015

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INTRODUCTION

Medicaid Management Information System (MMIS) is vital for ensuring Medicaid provider payments, access to services for Medicaid beneficiaries, and program management and reporting at the state and federal levels. The MMIS is owned and operated by the State of Alaska and administered through the Department of Health and Social Services.

In the first phase of the study, Information Insights focused on the MMIS system and recommended ways to improve the invoicing and payment processes.

Phase II looks at the direct and indirect costs incurred by providers as a result of the change to the new system. FOCUS, ResCare, Mat-Su Services for Children and Adults, Hope Community Resources, Frontier Community Services, Assets, and REACH. We surveyed the providers who participated in Phase I about their on billings, revenues and other costs since the conversion. Seven programs provided data, which is summarized in this report. Data are for the period October 1, 2013 to September 30, 2014 unless otherwise noted. See Appendix A for a copy of the Financial Impact Survey tool.

There are a number of limitations to be considered when looking at the data. First, the sample size was small, only 8 of the 40 agencies that provide Medicaid funded Home and Community Based services. Another issue is that some of the questions did not apply to all of the respondents, leaving some questions with only 1 or 2 responses. And finally, all of the financial information was self-reported.

PRE- AND POST-CONVERSION FINANCIAL IMPACTS

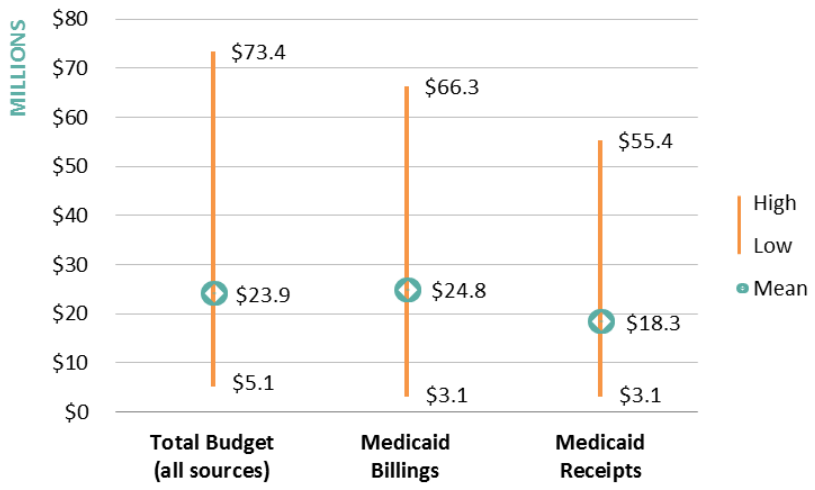
Agencies were asked a number of questions about their Medicaid billings and revenue for the first year under the new Health Enterprise MMIS system. Responses are summarized in Table 1.

Since the State refinanced services through Medicaid, fewer services are supported by the State General Fund. As a result, community-based service providers have relied more and more on Medicaid revenue. The agencies surveyed indicated that Medicaid revenues are now two-thirds (65%) of their total budgets.

The conversion to the Xerox MMIS negatively impacted all healthcare providers who depend on payment for Medicaid funded services. Many of these issues have been resolved. However, Home and Community Based Service providers reported that, while current Medicaid billings are up to date, the previous backlog remains. Much of this is due to a back-log of eligibility determinations by the Division of Public Assistance.

TABLE 1: MEDICAID PAYMENTS AND RECEIPTS AS PERCENT OF TOTAL AGENCY BUDGET

	Total Budget (all sources)	Medicaid Billings	Medicaid Receipts	Percent of Budget from Medicaid Payments
Program 1	$5,070,000	$3,120,000	$3,120,000	62%
Program 2	$33,600,000	$49,509,343	$24,755,070	86%
Program 3	$11,948,971	$9,476,130	$8,808,790	61%
Program 4	$73,352,033	$66,329,856	$55,375,565	90%
Program 5	$10,000,000	NR	$8,500,000	85%
Program 6	$18,210,187	$8,122,298	$9,095,498	48%
Program 7	$15,400,713	$11,853,085	$2,279,692	76%
High	$73,352,033	$66,329,856	$55,375,565	90%
Low	$5,070,000	$3,120,000	$3,120,000	48%
Mean	**$23,940,272**	**$24,800,119**	**$18,275,821**	**65%**
Responses (n)	7	6	6	7



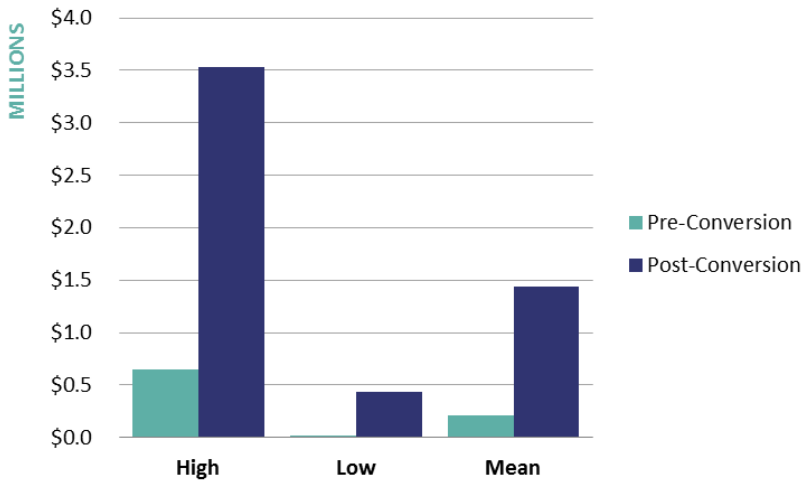
FINDING

MEDICAID PLAYS AN IMPORTANT ROLE IN AGENCY BUDGETS AND THEIR ABILITY TO PROVIDE COMMUNITY SERVICES.

Agencies reported that their total in Medicaid invoices unpaid after 90 days increased over 500% after conversion—from an average of $214,388 before the MMIS conversion to $1,443,881.

TABLE 2: UNPAID MEDICAID INVOICES

	Pre-Conversion: Invoices unpaid (over 90 days) as of 9/30/2013	Post-Conversion: Invoices unpaid (over 90 days) as of 9/30/2014
Program 1	$34,653	$541,000
Program 2	$497,924	$24,755,050
Program 3	$21,094	$1,046,247
Program 4	$650,805	$35,300,284
Program 5	$92,000	$432,000
Program 6	$33,971	$606,374
Program 7	$170,268	$2,279,692
High	$650,805	$3,530,284
Low	$21,094	$432,000
Mean	**$214,388**	**$1,443,881**



FINDING

DUE TO DELAYS AND INCONSISTENCIES IN MEDICAID PAYMENTS, RESULTING IN A OVER A FIVE-FOLD INCREASE IN UNPAID INVOICES, AGENCIES ARE LESS ABLE TO RELY ON MEDICAID REVENUES TO SUPPORT COMMUNITY-BASED SERVICES.

LOANS AND ADVANCES

Agencies were also asked to provide information on loans and advances directly attributable to the inconsistency in Medicaid payments since conversion. Three organizations used their reserves (between $996,654 and $1,410.853) in order to continue to provide Medicaid services. Two of the seven providers participating in the survey reported using bank loans and lines of credit for this reason.

DHSS also provided financial support to providers through advances to be paid back once issues were resolved with MMIS and revenues returned to normal. Five respondents took advantage of the offer and borrowed an average of $2,645,285. All five were still repaying the advance at the time of the survey, with an average owed of $1,656,867 as of September 30, 2014. One service provider noted that they made payments in June and July 2014, but stopped because claims processing continued being inconsistent, making it impossible to predict monthly revenues.

TABLE 3: BANK LOANS AND DHSS ADVANCES

	Agency reserves (reduction for year)	Loans/Line of Credit (highest)	Loans/Line of Credit (as of 9/30/2014)	Advances from DHSS (total received)	Advances from DHSS (owed as of 9/30/2014)
High	$10,000,000		$800,000	$7,845,900	$5,525,800
Low	$445,529		$500,000	$170,000	$103,281
Mean	**$2,670,607**	**$1,150,000**	**$650,000**	**$2,645,285**	**$1,656,867**
No. reporting loans/advances	5	1	2	5	5

ADDITIONAL MMIS CONVERSION COSTS

Agencies were asked to provide information on other annual costs they would not have incurred prior to conversion. For example, in order to qualify for lines of credit, two agencies were required to have audits by their lending institution. Human resources is another area impacted by the conversion. In order to keep up with the increase in billings and re-billings, staff was asked to work overtime, new staff were recruited, hired and trained, and other projects shelved. One agency deferred further development of Electronic Health Record system billing options. The cost of billing system upgrades or increased inefficiencies also increased agency costs.

Service providers made the following comments about the other costs incurred after the MMIS conversion:

- 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.

TABLE 4: OTHER COSTS DIRECTLY RELATED TO MMIS CONVERSION

	High	Low	Total (all agencies)	No. reporting costs
Audits	$13,285	$732	$14,017	2
Temporary employees	$57,756	$10,005	$80,241	3
Recruitment/training	$8,000	$5,700	$13,700	2
Overtime	$18,218	$675	$18,893	2
Lost productivity of billing staff	$109,000	$6,932	$273,812	7
Time of regular staff lost for normal business tasks and other projects	$55,503	$5,000	$135,659	5
Value of claims at risk of non-payment due to Medicaid ineligibility exceeding timely filing rules	$525,000	$46,394	$1,121,394	4
System upgrade research, conversions, deferred projects and opportunities, etc.	$250,000	$10,000	$335,400	4
Total	**$977,711 (single agency)**	**$30,000 (single agency)**	**$ 1,993,116 (all agencies)**	

While not all respondents reported additional costs, in several cases agencies they said they incurred costs but were unable to quantify them. The total of all additional costs reported for the seven agencies was $2.0 million in the first year after conversion. The agency with the highest total reported nearly $1.0 million in additional costs, while the agency with the lowest reported $30,000.

FINDING

DURING THE FIRST YEAR AFTER CONVERSION, HOME AND COMMUNITY-BASED PROVIDERS INCURRED SUBSTANTIAL DIRECT AND INDIRECT LOSSES IN REVENUE, TIME, AND RESOURCES DUE TO THE MMIS CONVERSION, IMPACTING AGENCIES' OVERALL FINANCIAL

CONCLUSION

Home and community-based services began in Alaska more than 20 years ago. The idea was that, by providing services in person's home and community, the need for more expensive nursing home care would be reduced. The home and community-based service system is relied on by adults and children with disabilities.

While Medicaid continues to play an important role in agency budgets and their ability to provide community services, it is clear that during the first year after conversion agencies have been significantly burdened by delays and uncertainties in Medicaid payments and have incurred direct and indirect losses in revenue, time, and resources directly attributable to the conversion.

This has had the effect of reducing agencies' overall financial health and resiliency. As a result, agencies have been less able to rely on Medicaid revenues to support community-based services. Provider agencies have worked hard to insulate consumers and services from the problems with Medicaid billing, although one organization was less than a week away from not being able to pay staff.

Issues are being resolved more slowly than originally hoped for, and the losses during the first year will continue to impede the operation of services in the years ahead. As was noted earlier in this report, there is still a significant backlog of billings for services provided before and during the conversion, which will likely to extend into the third year before providers are fully paid. Service providers continue to rely on their reserves, loans from banks, or advances from the Department of Health and Social Services.

If the Department of Health and Social Services chooses to develop a plan for reimbursement of the additional costs borne by the providers, it is recommended that further funding be made available for audits of Home and Community Service providers to more precisely quantify the direct and indirect financial costs of the conversion. It is most important that the backlog of payments for unpaid claims is expedited. Without that, it will be years until agencies regain some of the financial status they had prior to the conversion.

Appendix A

AADD Financial Impact Survey

Agency: _____

Contact Info (in case follow-up is needed): _____

All questions are for the period **October 1, 2013 to September 30, 2014**

_____ Agency/Organization Budget (including all sources)
_____ Total Medicaid Billings
_____ Total Medicaid Revenues
_____ Total Medicaid invoices that were never paid (need to define)
_____ % of Agency Budget from Medicaid Payments

Loan and advances directly attributable to inconsistency in Medicaid payments

Source	Estimate $	Detail
Agency Reserves		
Bank Loans		
Advances from DHSS		
Other programs within your organization, i.e. employment services		
Other (please describe)		

Costs directly attributable to inconsistency in Medicaid payments

Source	Estimate $	Detail
Audit(s)		
Temporary Employees		
Employee Recruitment and Training		
Overtime		
Other (please describe)		