



MRSIS Implementation: Regional Provider Meetings

State of Alabama

Department of Mental Health and Mental Retardation

Division of Mental Retardation

June 14 and 26-28, 2006



Agenda

- Today's Objectives
- Background
- Project Timeline
- Implementation
 - Business Model
 - Transition and Operational Issues
 - Technical Requirements
 - Training Approach
- Q & A



Today's Objectives

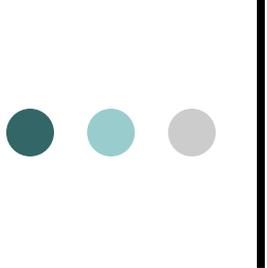
- Share with Providers Key Information on Business Model
- Communicate Project Milestone Dates and Current Status
- Provide Opportunity for Questions and Discussion on Provider Implementation and Operational Issues
- Identify Issues to be Addressed



Background

Primary Reasons for Change

- Waiting List Lawsuit
 - Incorporate changes in proposed settlement
- Replace the Current Contracting Process
 - Cumbersome paper-based system creates delays when changes are needed in client service plan
- CMS Quality Framework
 - Need system to collect and manage information at the client, provider and state level



Benefits of New Information System – Phase I

- Smoother, integrated process to manage applications and enrollments
- Integrated Waiting List functionality
- Ability to more quickly change plans of care and prior authorizations
- Integrated Case Manager data
 - Progress notes
 - Quarterly narrative (Phase II)



Benefits (continued)

- Clean audit trail of payment for Federal Review
 - Combine the federal and either state or local match into one check
 - Integrated management of local match received and disbursed
- Reporting capabilities
 - At state, regional office and provider levels



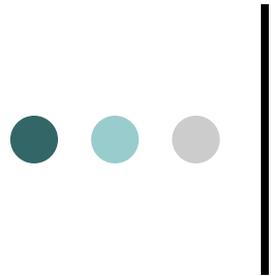
Client Centered System

- Focus shifts to consumers and client specific data around services and outcomes.
 - Who is being served
 - Where are they being served
 - What services are they receiving
 - What outcomes are being obtained
 - Are the clients satisfied with the services being provided.



Project Timeline

- **Requirements Definition** Jan 2005 – Apr 2006
- **Set-up and Configuration** Apr – Oct 2006
- **Internal Testing and Training** Aug – Nov 2006
- **Provider Testing/ Training** Oct 2006 – Feb 2007
- **Deployment/Go-Live** Jan - Feb 2007



Major Milestones/Key Dates

2006

- 1/5 - Project Kick-off
- 4/25 - JAD (Joint Application Design) Sessions Complete
- 4/26 - Business Analysis Documents Approved
- 7/28 - Harmony Claims Manager Delivered – Testing Begins
- 9/20 - Pilot Site Claims/Finance Training
 - Testing complete by 10/31
- 10/16 - Harmony Case Management Module Delivered
- 11/1 - Pilot Site Case Manager Training
 - Testing complete by 11/17

2007

- 1/1 - Regional Office Go Live
- 1/2 - Provider Claims/Finance Training Begins
- 1/22 - Case Management Training Begins
- 2/1 - Claims Processing Go Live
- 3/1 - Case Management Go Live



Business Model

- Electronic data submission through MRSIS
 - Case Management Agencies
 - Criticality and Eligibility for Waiting List
 - Waiver Enrollment and Redetermination Documents
 - Plans of Care
 - Quarterly Narratives (Phase II)
 - Direct Service Providers
 - Claims for services delivered
- Prior authorization system
 - Prior auth # will be issued by MRSIS for waiver services based on an approved Plan of Care and available funding
 - Prior auths will be approved by Regional Offices
 - Claims to be billed through MRSIS rather than directly to EDS



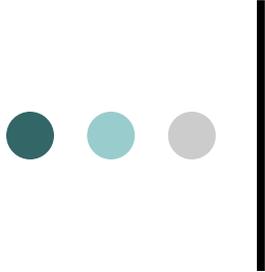
Business Model

- State match will be paid with the claim
 - 1/12th of state contract will be paid through January 2007 for December services
 - Beginning February 2007, state match will be paid based on claims submitted for service dates beginning January 1, 2007
- Local match must be received by the state in order for claims relying on local match to be paid
 - Local match will continue to be received and disbursed to providers as is currently done, but there must be sufficient match credit on file in MRSIS or the claim will hold until the match amount is met



Claims/Remittance

- Claim Submission Options
 - Direct Data Entry (DDE) into Two-Part Harmony
 - Electronic Data Submission – 837
- Claim Remittance Options
 - Electronic Remittance – 835
 - 835 will designate funding sources for paid claim
 - Online reporting through Two-Part Harmony
 - Will also show funding sources



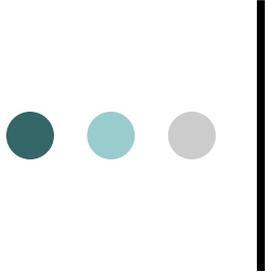
Impact on Provider Billing and Remittance

Providers currently using Medicaid PES system

- Claims will be entered into Two-part Harmony
 - Extensive use of drop downs and validations to minimize data entry errors

Providers using internal system to generate 837

- **Minor changes in 837 billing format**
 - Will use current EDS format with addition of SSN and NPI (National Provider Identifier)
 - Authorization number must be on the claim
- Electronic remittance file (835) will be created – providers will be able to match payment to submitted claim via the claim control number



Impact on Provider Billing and Remittance

All Providers

- System generated reports
 - Remittance Advice – equivalent to current “Green Bar Report”
 - Claims Error Reports – equivalent to current “CSR Report”
- Additional reporting capabilities will be available through Two-part Harmony
 - On-line reports through Crystal Reports
 - Can download results to Word, Excel, etc.



Provider Choices

- Billing Choices
 - Submission method –
 - 837 or direct entry
 - Frequency –
 - Claims will be evaluated against billing rules every day
 - Payment cycles will remain unchanged
 - Corrections –
 - Can be done online or through 837



Technical Requirements

- Harmony and Two-Part Harmony are both web-based applications
- Workstation
 - Need computer capable of running Internet Explorer 5.0
- Connectivity
 - Need high speed internet access
- User License
 - Each individual user requires a Named User License
 - Every record is logged with the user id who created, modified, and viewed the information
 - HIPAA regulations prohibit users from “sharing” user license
 - Case Managers will require a full Harmony License
 - Direct Service Providers will require a Two-part Harmony License



Training Approach

- Role-based , Hands-on, End User Training
- ALL INDIVIDUALS ASSIGNED A USER LICENSE MUST BE TRAINED
- Claims Entry – ½ day session
 - Two-part Harmony claims entry, voids and corrections, and claim status/verification
- Financial Processing – ½ day session
 - Submission and retrieval of electronic files, remittance processes, and financial reconciliation
- Case Managers – 2 full consecutive day sessions
 - Accessing client information, adding new clients to waiting list, waiver and non-waiver programs, development of plans of care, eligibility and criticality summary assessments, and other case management tasks



Provider Transition Issues

- Workstations & Connectivity
 - Who needs to work in MRSIS and do they have the right computer and connectivity to the internet?
- User License Assignment
 - How many people need licenses and which type do they need (two part or full)?
 - Understand there are a limited number and you may need to rethink your workflow to utilize the licenses you can get.
 - We believe that direct service providers will need one, or more likely two Two-part Harmony licenses to do their billing and receive remittance advices, unless they submit 837s directly. In that case they will only need one Two-part Harmony license, so they can look up the prior authorization numbers.



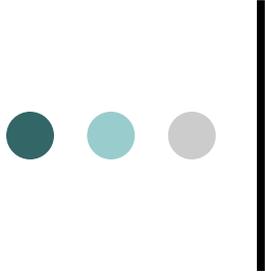
Provider Transition Issues

- Large agencies may need three Two-part Harmony licenses.
- Case Management agencies will have full licenses, which can also handle billing and remittance.
- Workflow Planning
 - How is data gathered by the billing person to construct the claim?
 - Does another party review the claim before it is submitted?
 - Who makes changes if errors are received?
 - Who receives and reviews the remittance advice – in MRSIS the RA will be electronic?



Provider Transition Issues— workflow planning continued

- The MRSIS system will have an up-front adjudication process, which will return any errors to the billing provider within 24 hours to be corrected and re-billed.
 - How will you adjust your billing activity to incorporate the 24 hour turnaround of errors?



Provider Transition Issues— More to think about

- In February, providers will need prior authorization numbers for existing MR clients. Two-part Harmony users will have those numbers already assigned. 837 submitters will have to look up the numbers – or more likely the Division will prepare an initial listing for them.
- Testing
 - Pilot sites will test: 837 submission and Two-Part submission
 - Pilot sites will test remittance advice and report writing
 - Pilot sites will test case management: billing through the SPES system's new 837
 - And ALL 837 submitters will test sending a week's worth of claims prior to go-live.
- Training
 - Claims Entry and Financial Reconciliation
 - Case Manager Training



Communications

- **MRSIS Website**
 - www.mh.alabama.gov/mr/mrsis.htm
- **Bi-Weekly conference calls**
 - 1 888 776-3766, passcode: *2626217*
 - Set agenda with opportunity for Q&A
- **Regular updates at existing forums**
 - Coordinating Subcommittee

Closing Comments and Q&A

