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<b>Agency:</b>	<b>107 Health Care Authority</b>
<b>Decision Package Code/Title:</b>	<b>PL-IM ProviderOne Phase 2 Project</b>
<b>Budget Period:</b>	<b>2013-15 Biennial Submittal</b>
<b>Budget Level:</b>	<b>PL –Performance Level</b>

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## **Recommendation Summary Text - Placeholder**

The Health Care Authority (HCA) requests funding to complete the ProviderOne Phase 2 Project and provide for ongoing operations and maintenance costs once the project has been completed. HCA's original proposal anticipated completing the project in SFY13; implementation of the project was delayed which is reflected in this request.

## **Package Description**

The ProviderOne Phase 2 project consolidates \$2 B in DSHS Medicaid expenditures for home and community based services with approximately \$5 B in Medicaid expenditures currently processed by ProviderOne, the state's federally certified Medicaid payment and decision support system.

The 2012 legislature provided \$10,537,000 for SFY12 and \$13,933,000 for SFY13 to complete the ProviderOne Phase 2 project. HCA's proposal originally anticipated a funding decision would be finalized sooner than it was; consequently project implementation was delayed. Until funding was approved, HCA minimized expenditure commitments thereby under spending the allotment for FY12. However the amount now required in FY14 to complete the project exceeds the amount underspent in FY12. Fortunately, the total project cost will still be within the amount of federal funding approved at 90% FFP.

Ongoing costs are also requested for the incremental cost to maintain and operate ProviderOne once Phase 2 is implemented. The amounts needed for operations costs are unknown at this date. An additional five staff are also necessary to support the new functionality within the system by providing ongoing support of systems operations, which includes system testing when modifications or change orders are implemented, to serve as business experts, to address system configuration issues and to serve as data warehouse experts.

This request addresses system costs for the state's Medicaid Enterprise System to perform social service payments by leveraging and enhancing existing ProviderOne functionality in conjunction with interfacing with a separate vendor to provide payroll like services that are consistent with the Collective Bargaining Agreement (CBA) with SEIU. In a separate decision package, DSHS is requesting the on-going cost for the payroll like services.

The funding for implementation costs are eligible for an enhanced match rate of 90 percent Federal Financial Participation (FFP) and the ongoing costs are eligible for enhance match rate of 71 percent FFP. DSHS will be submitting a separate decision package for their anticipated costs.

Below is the revised implementation of social service Medicaid programs that will occur in two (2) groups as follows:

1. Approximately 3,200 residential facilities who receive a 1099 tax form will be implemented in the Fall of 2013; and
2. Approximately 35,000 individual providers who receive a W-2 tax form will be implemented in the Winter of 2013.

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Questions related to the fiscal portion of this decision package should be directed to Stacy Crawford at (360) 725-1884 or [stacy.crawford@hca.wa.gov](mailto:stacy.crawford@hca.wa.gov).

Questions related to the programmatic portion of this package should be directed to Cindy Davidson, MMIS Federal Liaison, at (360) 725-1236 or [cynthia.davidson@hca.wa.gov](mailto:cynthia.davidson@hca.wa.gov).

### **Fiscal Detail/Objects of Expenditure**

To be determined.

### **Narrative Justification and Impact Statement**

#### **What specific performance outcomes does the agency expect?**

Consolidation of remaining Medicaid payments onto the state's federally certified Medicaid payment and decision support system achieves the following results:

1. **Least costly option for meeting requirements of CMS and SEIU #775:** As the state's federally certified Medicaid system, ProviderOne qualifies for 90/10 FFP for one-time enhancements and 75/25 for on-going operations, including staffing costs. SSPS qualifies for 45/55 FFP. Continuing to invest in SSPS or investing in a new system to meet CMS and SEIU requirements for home and community services are more costly options with less federal participation.
2. **Greater administrative efficiencies by consolidating \$7 B in Medicaid expenditures:** A primary goal for HCA management is to consolidate Medicaid payments processed by two (2) separate systems into a single payment system. This goal is supported by the federal CMS, the Joint Legislative Administrative Review Committee (JLARC), and state executives.
3. **Improved coordination of care for over 1 million needy clients and potentially higher federal match:** By consolidating client information into a single payment system, state staff will be able to coordinate care across program areas and funding sources. Besides improving the experience of clients, the Medicaid system will be programmed to select the best federal match when the client is eligible for the service under more than one program/funding source.
4. **Improved payment integrity and accountability:** The single Medicaid system will include payment checks and verification not implemented today. Client eligibility, provider credentials, and payment rules (such as duplicate checks and fraud detection rules) will be validated before payment occurs, addressing many audit findings associated with home and community based services today.
5. **More flexibility to respond to evolving healthcare initiatives:** ProviderOne is a highly configurable system that allows the state to more easily make modifications to respond to policy changes at the state and federal levels.

#### **Performance Measure Detail**

##### **Activity Inventory**

H003 HCA Information Technology

**Is this decision package essential to implement a strategy identified in the agency's strategic plan?**

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Yes, this decision package supports several aspects of the strategic plan. In particular, consolidating Medicaid supports evidence based medicine (EBM) objectives by including the full spectrum of services a client receives. Similarly, Phase 2 supports the chronic care management objective by including a broader range of services for clients. In both instances, ProviderOne expands the data used to support these two (2) objectives to include mental health, substance abuse, and community based services to name a few.

The Strategic Plan also notes that when complete, ProviderOne will:

- Support better decision making through consolidated payment data.
- Establish greater system flexibility for adapting to policy changes.
- Increase quality of client services through a more holistic approach to service delivery.
- Enhance customer service through more on-line/self-service features.
- Improve payment and cost avoidance processes through improved data integrity.

**Is this decision package essential to implement a strategy identified in the agency’s strategic plan?**

Yes. This request supports the Governor’s priority: Improve the health of Washingtonians. Implementation of Phase 2 expands ProviderOne support of the Governor’s healthcare initiatives by expanding services to include all Medicaid programs. By adding home and community based services to ProviderOne, the new Medicaid system will be able to support the following:

- Use evidence based medicine (across *all* programs).
- Expand chronic care management (across *all* programs).
- Emphasize health promotion and prevention (across *all* programs).
- Increase data transparency (across *all* programs).

By expanding the client services addressed in ProviderOne, the governor’s healthcare priorities of government will be expanded to address home and community based services, mental health, and chemical dependency.

**Does this decision package provide essential support to one of the Governor’s priorities?**

Yes. Consolidating Medicaid payments supports the Governor’s Priorities of Government (POG), especially the priority to improve the health of Washingtonians. Through greater flexibility to respond to evolving health care initiatives, improved administrative efficiencies, improved data and decision making, and expanding evidence based medicine and chronic care to address a broader spectrum of service, the next phases of ProviderOne support the governor’s priorities for healthcare.

**Does this decision package make key contributions to statewide results? Would it rate as a high priority in the Priorities of Government (POG) process?**

Consolidation of Medicaid expenditures will realize the goals identified or endorsed early on by many stakeholder groups including CMS, JLARC, SEIU, OFM, and Information Systems Board (ISB). Additionally, Phase 2 addresses many audit findings from the State Auditor’s Office (SAO) around payment integrity and accountability.

**What are the other important connections or impacts related to this proposal?**

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Two (2) organizations representing providers (SEIU and WSRCC) are stakeholders to this request as well as DSHS and the OIG who has filed non-compliance findings that could result in disallowance of \$19M.

**What alternatives were explored by the agency, and why was this alternative chosen?**

Two alternatives were considered:

- 1) **Upgrade SSPS:** Upgrading SSPS to meet CMS and SEIU #775 requirements is more costly and subject to a lower federal match than investing in the state’s already established and federally certified Medicaid payment and decision support system.
- 2) **Develop a new payment system:** To invest in a new payment system would require another large IT project, which would be costlier and qualify for a lower or no federal match.

Instead, decision makers chose the option of using the state’s Medicaid system to address home and community based services. Shifting SSPS programs to ProviderOne has the following benefits:

- Leverages existing technical infrastructure and previous investment
- Maximizes enhanced FFP for remaining Medicaid programs
- Capitalizes on the expertise of an experienced team who successfully implemented Phase 1

To delay implementation to a future Biennium would result in:

- Missed opportunity to reverse 30 years of “siloesd” data
- Increased costs long term compared to short term savings
- Lost federal revenue
- Non-compliance with federal and JLARC recommendations
- Non-compliance with audit findings
- Inability to respond to SEIU CBA requirements

**What are the consequences of not funding this package?**

1. CMS requests refund of enhanced match

With approval of the ProviderOne Advanced Planning Document, CMS has been paying an enhanced match for all project costs since January 2011. With no benefit being realized for Phase 2, CMS can request the federal portion of the project costs be re-paid.

2. SEIU 775 CBA articles relating to the “Modern Payroll System” are not realized

The union has been requesting a “Modern Payroll System” since 2007 due to the difficulties SSPS has in satisfying bargained items. Phase 2 is scheduled to implement this “Modern Payroll System” through the Provider Compensation Subsystem (PCS) of ProviderOne. In the last Arbitrator Award, DSHS was given a “pass” on this issue because progress was being made on the acquisition of a modern payroll system through ProviderOne Phase 2. Without Phase 2 and PCS, there is a risk that the Arbitrator will dictate the solution and timing for implementing this requirement.

3. SAO and OIG Audit findings against ADSA are not corrected

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ADSA has received repeated audit findings from SAO due to the inability to capture time at the required quarter hour increments by date of service. ADSA also has an OIG finding related to clients/providers not having timesheets that show time by date of service. The corrective action plan for these findings is the implementation of ProviderOne Phase 2. With Phase 2, providers will be required to provide the hours worked for a client in quarter hour increments by date of service. The OIG audit identified \$19.4M in disallowances. If DSHS does not correct the problem, OIG is recommending the state payback the \$19.4M.

4. SSPS Must Remain Fully Operational and incorporate costly changes to address audit findings and SEIU requirements

The most significant risks to SSPS are with development and operations staff. The SSPS technical team contains 11 developers and 1 manager. Of these 12, nine have relatively recent Unisys Cobol experience. Of these nine, eight are eligible to retire now. There are two mainframe database administrators, both are eligible to retire. Of the five SSPS Program Managers, three are eligible to retire. With the dying SSPS technology, it is very difficult to find people willing to fill these positions. There is a real risk that two-thirds of the SSPS development and maintenance staff could leave through retirement within the next several months leaving the state unable to properly maintain the system or enhance it to meet future requirements.

Additionally, the experienced team who implemented Phase 1 and are working on Phase 2 would be disbanded and momentum lost, making it unlikely that the state will ever succeed in consolidating Medicaid payment data into a single payment and decision support system.

**What changes would be required to existing statutes, rules, or contracts, in order to implement the change?**

No changes to existing statutes, rules, or contracts are required.

**Expenditure and Revenue Calculations and Assumptions**

*Revenue Calculations and Assumptions:*

Revenue assumes that the majority of costs for this project will qualify for 90 percent ffp for DDI costs and 71 percent ffp for operations and maintenance.

*Expenditure Calculations and Assumptions:*

The ProviderOne vendor, Client Network Services Incorporated (CNSI), will be responsible for the implementation of changes necessary to support Phase 2. Additional FTEs will be necessary to support the ongoing maintenance and operations once Phase 2 is implemented.

**Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?**

*Distinction between one-time and ongoing costs:*

One-time system development costs are expected while on-going operations costs will continue.

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*Budget impacts in future biennia:*

Annual ProviderOne operations costs will continue into future biennia.