Case Study: RPA-as-a-Service for Healthcare

Simplifying Texas Medicaid Claims with Robotic Process Automation

Eight managed care organizations implement RPA to comply with evolving regulations and secure their Medicaid contracts with the State of Texas.

The Medicaid program in the United States is administered through the U.S. Department of Health and Human Services through Centers for Medicare and Medicaid Services (CMS). CMS establishes the program requirements and monitors each state's program to ensure their compliance. States are required to follow the CMS protocol for service quality and eligibility standards, a responsibility that most states contract to health insurance companies.

A provision of the Affordable Care Act called for expansion of Medicaid eligibility in order to cover more low-income Americans. With this expansion, the federal government would cover 90 percent of the cost for the state. As part of a Supreme Court ruling in 2012, states could not be forced to expand their programs, and 14 states have opted against expansion.

Texas, one of those 14 states, has the largest Medicaid coverage gap in the country, with roughly 1.1 million residents falling outside of the state's eligibility requirements. In 2011, the state was able to negotiate a Medicaid 1115 waiver, a five-year agreement that secured 25 billion dollars in federal funding, which is set to expire in 2021. The funding has allowed the state to expand Medicaid managed care while preserving hospital

The State of Texas contracts with managed care organizations to process the unique requirements surrounding Medicaid claims, a task that proved challenging for eight of HPA's health plan clients.

Outcomes

- 13 million Texas Medicaid claims processed to date
- More than 500,000 LTSS claims processed, offsetting more than 30,000 manual labor hours for all clients
- 29.48% time savings and $120,000 in labor savings on nursing facility claims, within 18 months for one client
- 99% processing accuracy compliance on drug codes updates within three months for one client

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funding, provide incentive payments for health care improvements, and direct more funding to hospitals that serve large numbers of uninsured patients.

As part of this waiver, the state must adhere to federally-mandated terms and conditions to prove they are working to reform their health care delivery system while also maintaining quality of care. Adherence to these guidelines has proven challenging for the managed care organizations (MCOs) who have contracted with the State of Texas for Medicaid business. To add to the complex requirements, the sheer population size of Texas Medicaid members results in a large volume of claims to be processed, often retroactively. This creates a burdensome operational constraint for MCOs, who need to staff up quickly to process claims within a specific timeframe, or reconfigure their claim management systems to meet these unique requirements as they roll out.

The true impact of non-compliance

If MCOs don't meet state and federal standards, they not only risk losing their Medicaid business, but are also subject to hefty financial penalties. If these plans do not maintain 99% processing accuracy on these claims they risk being fined no less than fifty thousand dollars.

Poor performance can also impact MCOs in other ways. Each plan contracted with the state is graded using a five-star, quality rating system—Texas STAR Medicaid rating, issued by Texas Health and Human Services (HHSC), and the Star Rating System, issued by CMS. Plans are evaluated annually and rated on specific criteria, including member complaints and loss of membership.

HHSC issues a managed care report card to each health plan every year. Report cards are made available to consumers on the HHS website, sorted by service area and by program—CHIP, STAR, STAR Kids, and STAR+PLUS. HHSC also uses these report cards to determine which plans will receive additional funds or be placed on performance improvement plans.

At the federal level, plans with three stars or less for three consecutive years are flagged as poor performers, at which point enrolled members are alerted and allowed to switch plans outside of the enrollment period. Members are also blocked from enrolling in low-performing plans via the online Plan Finder.

The automation potential for MCOs

The nature of Texas Medicaid claims has caused many health plans to seek out robotic process automation to comply with the ever-evolving state and federal requirements while also ensuring their Medicaid business is secure.

Today, HPA is automating Texas Medicaid claims for eight MCOs contracted with the State of Texas. Their automation specialists researched Texas Medicaid requirements and worked with the clients' subject matter experts to build out the process requirements, as well as address the configuration limitations within their claims management system.

- **Long Term Services & Support (LTSS) claims are submitted in both high-volume and frequency, due to the nature of services being rendered.** A state-mandated change in billing requirements shifted each unit of service from one-hour increments to 15-minute increments. On top of this, the contracted pricing of these claims is dictated by the service modifiers and many platforms still do not allow for complete customization on all modifier combinations. One client, in particular, faced a tough decision without automation: hire 19 employees to manually process the claims, or pursue a three-year custom IT solution. Due to the timely filing and minimum processing accuracy requirements, the client couldn't afford the increased cycle time and inaccuracy that comes with manual claims processing. HPA's automation experts built out custom pricing tables so that claims could easily be processed according to the new billing requirements, without customization to their system. HPA was also able to quickly process the client's inventory of 50,000 pended claims, well ahead of the 30-day deadline. Over the last three years, HPA has processed more than 500,000 LTSS claims, offsetting more than 30,000 hours of manual processing tasks.
- **LTSS Electronic Visit Verification (EVV)** – EVV is a computer-based system that verifies the occurrence of authorized personal attendant

service visits by electronically documenting the precise time a service delivery visit begins and ends. As part of the 21st Century Cures Act, CMS requires EVV for all Medicaid personal care and home health services, a responsibility that falls to the MCOs. HHSC negotiated delays to the EVV start date for new programs, services, and service delivery options affected by the Cures Act, meaning more operational changes for MCOs. In order for these payers to process claims for Medicaid services currently included in EVV criteria, additional fields on the claim file were required that did not exist within the claim management system, a change that would require custom configuration. HPA's robots utilize the claim file from the EVV portal to supplement the missing fields and process the claims, allowing clients to comply with new requirements without operational impact or system configuration.

- **With STAR+PLUS nursing facility claims, the MCO receives a daily file from HHSC containing members' level of care and applied income that has to be processed within 10 days of receipt.** Within the claim management system, a field to capture this data, which dictates how the claim should be processed, did not exist. With an average monthly volume of 17,000 nursing facility claims, one client had assigned eight full-time employees to parse the file and manually update claims with member information.
  As a result of automation, the client was able to achieve 29.48% in time savings and more than $120,000 in labor savings over an 18-month period.
- **Texas Health and Human Services has established their own reimbursement criteria for clinician-administered drugs and biologicals.** MCOs are required to adhere to the program-specific formularies for Medicaid and Children's Health Insurance Program (CHIP). Adhering to HHSC's criteria was problematic for payers as it required manual validation against a data crosswalk between National Drug Codes (NDC) and Healthcare Common Procedure Coding System (HCPCS), which is updated quarterly, as well as a fee schedule issued by Texas Medicaid and Healthcare Partnership (TMHP). HPA developed an automated solution to check the claim against the NDC-to-HCPCS crosswalk. If the claim could be paid, the claim is then priced against the TMHP fee schedule, allowing claims to be priced accurately and processed automatically. For one client, after four years at 57% processing accuracy, they were able to achieve 99% accuracy within three months of automating with HPA.

Wins aren't limited to specific processes. As a result of automating Texas Medicaid claims with HPA, one client experienced a dramatic reduction in complaints and an increase in their STAR Rating. Today, the client's auto-adjudication rate rests at 84%. HPA automates an additional 12% of their claims, bringing their total auto-adjudication rate to 96%, a rate that is rare for a plan of its size.

Looking to the future

To date, HPA has helped eight health plans process nearly 13 million Texas Medicaid-related claims quickly, accurately and within program guidelines. HPA's demonstrated expertise in developing automated solutions for evolving Medicaid requirements truly positions health plans to secure their Medicaid business and reduce operational costs, while continuing to deliver excellent service to their members.

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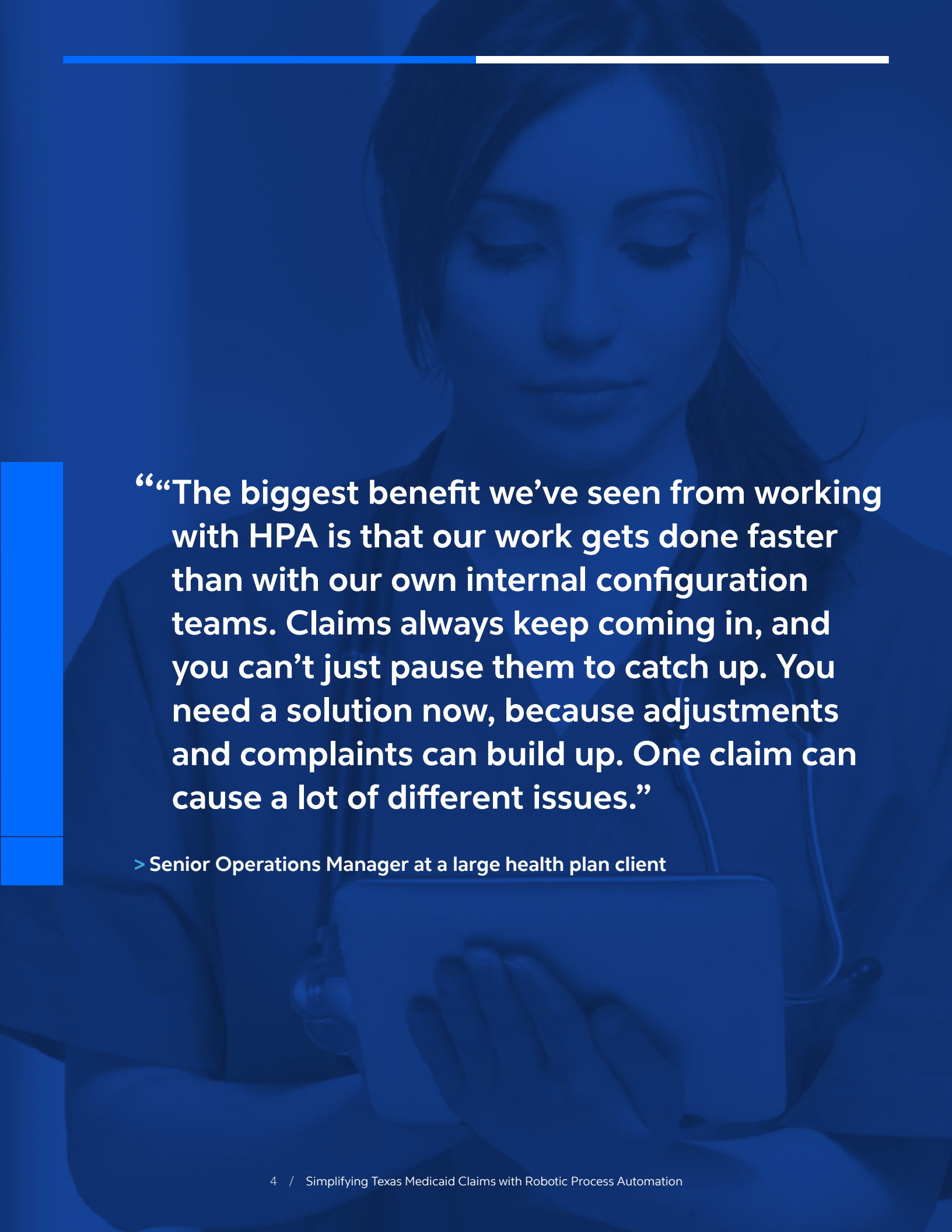

> “The biggest benefit we’ve seen from working with HPA is that our work gets done faster than with our own internal configuration teams. Claims always keep coming in, and you can’t just pause them to catch up. You need a solution now, because adjustments and complaints can build up. One claim can cause a lot of different issues.”
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> > Senior Operations Manager at a large health plan client

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Cognizant's Healthcare Business Unit works with healthcare organizations to provide collaborative, innovative solutions that address the industry's most pressing IT and business challenges—from rethinking new business models, to optimizing operations and enabling technology innovation. A global leader in healthcare, our industry-specific services and solutions support leading payers, providers and pharmacy benefit managers worldwide. Visit us at https://cognizant.com/trizetto.

About HPA, A Cognizant Company

HPA is the leading RPA-as-a-Service provider for health plans seeking secure, reliable intelligent automation solutions. As a proven automation Center of Excellence, we utilize our proprietary technology and extensive reusable code library to deliver scalable RPA programs that accelerate ROI and reduce total cost of ownership.. For more information, please visit hpa.services.

About Cognizant

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