MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **JOHN COBB**, on April 5, 1995, at 9:00 a.m.

ROLL CALL

Members Present:
Rep. John Cobb, Chairman (R)
Rep. Beverly Barnhart (D)
Rep. Betty Lou Kasten (R)

Members Excused:
Sen. Jim Burnett
Sen. J.D. Lynch
Sen. Chuck Swysgood

Members Absent: None

Staff Present: Lois Steinbeck, Legislative Fiscal Analyst
Ann Boden, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing: Medicaid contracts with Consultec and ITM
Executive Action: None

{Tape: 1; Side: A; Comments: These tapes were almost impossible to understand because of tape quality and since it was an informal meeting, speakers were not clearly identified.}

HEARING ON CONSULTEC SYSTEM FOR MEDICAID

Nancy Ellery, Administrator, Medicaid Services Division, Department of Social and Rehabilitative Services (SRS), explained Medicaid had contracted with Consultec for fiscal agent services since 1987. Consultec pays the claims involving providers, does provider training, and other functions related to managing the our Montana Medicaid Information System (MMIS). Medicaid is satisfied with Consultec services, but is putting out a Request for Proposals for a new contract. This is because the Consultec contract has been in place almost 10 years and the system has become outdated. Consultec is eligible to respond to the Request for Proposal (RFP). The RFP will go out in May or June, 1995, and the new contract will be awarded in January, 1996. There will be a transition period and the new system is expected to be on-line by January, 1997. Consultec processes over three million claims a year with very good performance standards. Their most

recent report shows a 98% pay rate for clean claims within 30 days and less than 1% of the claims are keyed in error. **EXHIBIT 1, Page 6**

CHAIRMAN JOHN COBB asked what in the system is out of date. **Ms. Ellery** answered the system was set up to pay claims and doesn't have much capability in managing client services information.

Terry Krantz, SRS, said there are more than 100 different items being considered for implementation in the new system. The old system is difficult to update with new programs and part of the requirement for the new system is that it be flexible for modifications.

Issue: Length of time to process errors

Jim Ahrens, President, Montana Hospital Association, said providers are frustrated with the process and length of time it takes to process claims when an error has been made. If an error has been made, the provider can't provide the correction over the phone or by correcting the form. The claims process must be started from scratch.

Ms. Ellery said Medicaid has federal standards that dictate the processing of claims. If there's an error in a claim that is the provider's fault, the claim must be completely refiled because the claim is a signed statement attesting to the truth and completeness of that claim. Consultec can't change a claim that they know is in error. It has to be denied and sent back to be recompleted, it is a requirement for the MMIS system. If Consultec makes the error, it can be corrected over the phone.

CHAIRMAN COBB asked if Montana can ask for waivers in the requirement to have the claim completely resubmitted. **Ms. Ellery** said it may not be in the state's best interest to waive these requirements, since it is one way to cut down on potential fraud and abuse, by making the person who's completing the claim responsible for their own mistakes.

Jim South, Consultec, said from a legal standpoint Consultec can't make changes to the document over the phone because if it goes to court, the provider's document and Consultec's document may say different things. The system is old and isn't really set up to do rejection reports electronically, but it is being considered and would be one way to shorten the time frame.

Lori Ericson, Consultec, said resubmitting electronically to correct an error means there isn't the audit trail the federal government requires. What is really needed is a faster notification of rejection. Since Medicaid has changed to an every-other-week payment status, there can be up to a month before the claim can be resubmitted and paid. Consultec has done a lot of work to try to get claims in from the hospital, but the mainframe computer system doesn't allow the ability to send

claims with errors back electronically. Consultec is working on developing an electronic remittance device to be stored on a network.

Ms. Ellery said the RFP will request requirements for electronic filing and resubmissions. To change the current system to address this issue may not be cost effective. One change that is being implemented is for managed care and hospital outpatient reimbursement, which is a major project.

CHAIRMAN COBB asked if there is anything Consultec could do now to speed up the response to rejected claims. **John Chappuis, Medicaid Services Division, SRS,** answered this enhancement could be put into virtual medical systems if it is cost effective.

Ms. Ericson said one factor that slows down the response time is the adjudication cycle. The system requires an adjudication cycle in order to determine if the state will accept the claim. This is a very time consuming process and is done overnight twice a week, not daily. SRS already has a request in process through Montana State University and the Virtual Medical Network to do some of this electronically, but it still won't be a next-day turnaround.

Mr. Chappuis said SRS will explore using budget money in this biennium to enhance this system and cut the time down from two weeks to a few days. There probably will be money left over in the biennium and the system may not cost more than $50,000.

Fran ?, from **St. Patrick's Hospital, Missoula,** said when the hospital transfers claims electronically to Consultec it cannot tell if the claims were received. Some transmissions have been lost. **Ms. Ericson** said Consultec makes immediate confirmation of received claims over the modem to the intermediary. It is up to the intermediary to verify these claims match what the provider transmitted.

Ms. Ericson said an enhancement Consultec is considering is a remittance advisory with a confirmation of every claim received whether it is paid, denied or suspended for an error. This is information providers need to know to get their claims processed in an appropriate time frame. When Consultec processes claims it has to look at all claims for that recipient to see if the service has been paid for in other ways. It's an automatic and lengthy process, which identifies errors on the claim.

CHAIRMAN COBB asked if the new system will be able to have nightly cycles. **Mr. Chappuis** said Medicaid used to have a weekly cycle but SRS, in conjunction with the Governor's office, looked at the cost versus benefit issue and determined a biweekly cycle was more cost efficient. This saves on postage and increases the cash balance for interest earnings. The new system will not be specifically requested to do nightly cycles, but if a cost

benefit analysis shows the need for nightly cycles, it will certainly be considered.

Lee Roath, Montana Deaconess Medical Center, Billings, said providers are not as concerned with the two week payment cycle as with the slowness of the acceptance and rejections process.

Issue: Hospital access to eligibility system

Mr. Roath said access to the eligibility system - TEAMS - is hit or miss for providers. Every Medicaid recipient is supposed to carry a card, which would be effective if happened, but the recipients don't all carry cards, particularly in emergency room trauma situations. Medicaid has developed a 24-hour Fast Fax system where the provider can get eligibility information, but only if the patient's Social Security number is known. The reason it's important to know if an client is a Medicaid recipient is that advance approval is required for most services or the provider must go through the whole certification process on the assumption that the patient is going to be Medicaid eligible. On-line access to eligibility is important to hospitals.

Ms. Ellery said it is a problem that Medicaid clients don't always carry their cards. Clients are told they must have their card or they could be held liable for all costs. In September, 1994, daily updates of TEAMS was implemented. This has helped determine eligibility much more quickly.

Mr. Roath said providers need a simple method to access eligibility information 24 hours a day, seven days a week without having to know the Social Security number. One of the concerns with allowing better access to on-line search is the issue of confidentiality.

Mr. Chappuis said SRS is about to start a pilot project with Lewis and Clark County that will have a microchip with all the provider information embedded in the eligibility card.

Issue: TPL unit (third party liability)

Mr. Roath said if there is no third party liability it seems to take forever to get that out of the system, often four or five claims after TPL has been determined, will still be rejected for TPL reasons. There needs to be a better way to update the TPL information.

Ms. Ellery said Medicaid depends upon the client and the insurance companies to provide accurate TPL information. If there are any changes in TPL it does take a while to get corrected. That's an area Medicaid is trying to improve.

Sheila Foos, City Cab Inc., Billings, said when providers do provide information about TPL it is not acceptable without

written confirmation from the insurance company. Medicare has developed a program which allows providers to take on the responsibility of verifying TPL. She asked if Medicaid could do this also.

Ms. Ellery said if this were something providers are willing to do, it can be considered.

Issue: Sterilization or hysterectomies

Mr. Roath said there is a requirement for the physician and the patient to complete sterilization and hysterectomy paperwork 30 days in advance. If the paperwork is not done the hospital loses its reimbursement. This puts the hospital in the position of being a watchdog over the physician.

Ms. Ellery explained federal regulations are very strict that Medicaid cannot accept sterilization and hysterectomy claims without the paperwork. It is unlikely that federal regulations will change, so this is an issue hospitals will have to work out with physicians.

Issue: County eligibility system

Mr. Roath said there are a lot of problems with counties getting the eligibility process done on a timely basis. Counties have 30 days to approve or deny an applicant, but often these claims take up to 200 days.

Ms. Ellery said the counties are in the high 90% compliance with the 30-day requirement. The claims that have longer periods are for disability determination, which is allowed up to 90 days. Consultec is supposed to be the first line of inquiry if providers have any questions about delays. If that initial search doesn't prove satisfactory, the provider should approach the county directly. If there are still problems, the provider should contact the state Medicaid department. It is the responsibility of the county directors to be sure claims are being processed in accordance with the time frame of the regulations.

REP. BEVERLY BARNHART asked if hospitals could take the eligibility applications. **Mr. Roath** said the hospitals have been told there is a conflict of interest in taking applications. **Ms. Ellery** explained there is not a conflict of interest for hospitals to take Medicaid applications, but the processing of the application must be done through the Medicaid office. If hospitals and other health care providers are willing to initiate the application process, Medicaid can work with these providers on that issue. Currently there are some hospitals that are presumptive eligibility providers to get pregnant women on the system sooner.

{Tape: 1; Side: B}

Issue: Changing of fiscal intermediaries

Mr. Roath said when a provider changes intermediaries it typically means an immense amount of slowdown in processing the change. It would be helpful if the contract for intermediaries ran a minimum of ten years, rather than the current five year contracts.

Issue: Software

Another issue was discussed by an unidentified speaker, which was that Consultec software is designed to reject duplicate claims. This is a problem when a hospital submits several claims for an individual patient in a short time frame, such as a cancer patient who may be using regular out-patient oncology services but also may have emergency room visits.

Mr. South said the software can be manipulated to deal with that problem, but the hospital must notify Consultec of the situation so that process can be accomplished. Consultec will look at the instructions they have for multiple claims and see if they can make them more clear.

Issue: Mental health claims processing

The woman who spoke about the software said mental health in-patient claims processing is probably the most problematic. The state has contracted with the Montana/Wyoming Foundation to pre-authorize in-patient admissions. It is very time consuming and costly for the hospitals to go through both SRS and the Foundation and doesn't seem cost effective. While claims haven't been denied, some claims have been out more than 120 days.

Ms. Ellery explained that in the past SRS tried to authorize all hospital admissions, which was not cost effective at all. Subsequently it was determined that only high cost services needed prior authorization, which means now only rehabilitation, psychiatric and out-of-state hospital admissions. One solution being considered is to allow hospitals that have a stable record of no denials to have a more limited review process. If hospitals will contact SRS with claims that are outstanding, such as the 120 day claim, it will be looked into. There has been a change in the contract recently and some claims have been held up in the transition.

Issue: Ambulance authorization

Sheila Herman, St. Peter's Hospital, Helena, spoke about the process of getting ambulance claims paid. **EXHIBIT 2**

Ms. Ellery said SRS has been working on these problems and just recently have met with hospitals to streamline the process. There is still a problem in the client education phase of the program. Recently, UNISYS Corp. has been contracted to work with

clients after they're enrolled on Medicaid to explain the Passport program. The particular problem as it relates to hospitals is in connection with the COBRA laws which sometimes run contrary to the Passport program. COBRA requires the hospitals to first do an exam to determine if the patient is an emergency and if it's not an emergency then the hospital is relieved of their requirements under COBRA. There is still a problem of clients using the emergency room for non-emergency care, so Medicaid will pay for the initial exam that determines if the patient needs emergency care. If it's not an emergency, the hospital is required to get authorization from a Passport provider before proceeding with care.

Issue: Grouper process

Mr. Roath reported Consultec is running three DRG groupers behind. A grouper is a process of how to pay a DRG - Consultec is at grouper 9 while current standards are at grouper 12. Consultec is not funded for yearly updates. When providers send in group 12 codes they are rejected because group 9 doesn't recognize the codes. Then these claims must get manual approval.

Ms. Ellery agreed that funding was the problem in getting the group codes up to date. The legislature has approved funding to rebase the system which will be done in 1996. It is recommended the grouper be updated every two to three years.

Issue: Medicaid system doesn't stay up with Medicare updates

Trudy ? said the Medicaid system doesn't necessarily keep up with the Medicare updates. Separate codes need to be used to bill for Medicare and Medicaid. This should be addressed.

Mr. Krantz responded that sometimes Medicare doesn't follow national guidelines and Medicaid is careful to follow national guidelines. SRS/Consultec stays as consistent with Medicare as possible.

Issue: Third party insurance and Medicare rejections

Trudy ? discussed concerns about rejected Medicare claims and **Mr. South** responded, but the response was inaudible because someone was coughing and a truck (or airplane) was going by.

Issue: How often SRS and Consultec meets with providers

CHAIRMAN COBB asked how often Consultec and SRS meet with providers. **Ms. Ellery** answered Consultec and SRS are open whenever a provider requests a meeting. Consultec regularly does on-site visits with providers. In 1994 there were nine training visits made. SRS also goes on-site if there are programmatic issues. Consultec and SRS makes a point of attending as many provider association meetings as possible.

{Tape: 1; Side: B; Approx. Counter:42}

HEARING ON ITM SYSTEM FOR MEDICAID

Ms. Ellery gave an overview of ITM, which began on contract with SRS in September, 1994. This contract is a response to problems that were occurring in the transportation program, such as rapidly increasing costs and abuse of the system around the state. Prior to ITM, authorization for transportation was made through the county Medicaid office. Some counties were very conscientious in making sure the requested transportation met the Medicaid guidelines of being the least expensive and/or only means of transportation to a Medicaid covered service. Other counties in effect signed blank checks without verifying the need. The system was inconsistent and some clients took advantage of this by using transportation for other than Medicaid services.

To manage the program appropriately, in terms of cost and access, there needed to be one central source that would prior authorize non-emergency transportation. ITM doesn't provide transportation, they prior-authorize and arrange transportation. ITM is staffed 24-hours a day, 7 days a week with medically-trained people who understand varying needs of clients. ITM helps ensure one consistent policy is followed. As with Passport, ITM is a very dramatic change in how services are delivered and with all changes there have been problems which weren't anticipated. SRS is working with providers to solve the problems and is committed to making this program work. It's accomplishing it's goals, which is to better manage the program and contain some of the costs in the transportation area.

Issue: Increased cost to providers

Lisa Morris, Mission Valley Medicab, said in theory the ITM program sounds good, but it isn't really working. Often the provider is sent on authorized trips for clients that don't need rides. When there is no rider, Medicaid doesn't pay and the cost of the trip is absorbed by the provider. This has happened more frequently since ITM came on board than when it was with the county Medicaid office. These mistakes may be because the client cancelled an appointment or gave the wrong date, or may be that ITM gave the wrong date or address. It is difficult to track where the mistake was made, but regardless it is always the provider who has to absorb the cost. Local providers see the clients and personally know their needs, while ITM is an office in Billings that has no face-to-face contact with clients. Mission Valley Medicab has had to hire office help to get the ITM program on computer, so state billing is accurate, which increases costs plus stress and frustration with the inability to get paid on time due to the amount of paperwork that's been created.

Issue: Delay in claims processing

Jim Morin, Great Falls Capital Comp, complimented SRS, Consultec and ITM for working with Great Falls Capital Comp in the past few months to answer questions and resolve some issues. One issue that has not yet been addressed is how ITM and Consultec relate. Providers can't submit claims to Consultec until ITM has provided proof listings, which in some instances are 90 days past due. The question is, where are these proof listings being held up - at Consultec or ITM or somewhere in the transmittal between the two.

Jo Guy, ITM, answered it depends on the authorization. ITM submits authorization reports to Consultec twice a week. Consultec responds within two-three business days. There is some question as to the accuracy of the report back from Consultec, which has not yet been resolved. One hold-up may be that prices were not submitted to ITM from the provider.

{Tape: 2; Side: A}

Mr. Krantz asked providers to contact him with specific problems, since he has authority over the ITM and Consultec contracts.

Issue: Incorrect dispatching

Mr. Morin said another issues is in case of ITM error in making dispatches. An example is an authorized transfer from ITM that is faxed to the provider after the pick-up time. Also when the authorization is incorrect and the client does not need transportation, the provider must pick up the cost of trying to make the pick-up.

Ms. Guy said when ITM is told about these mistakes a majority of them are client error, when the client gives the wrong date or address.

Trudy ? said ITM is not notifying the providers when client errors have been made. Her company encounters two-three errors a week. When ITM doesn't notify the provider, it leaves the perception that it is an ITM error.

Jim Michaels asked if ITM could provide phone numbers for clients so the provider can call in advance to verify the pick-up.

Ms. Guy said this could probably be done.

Mr. Morin said one thing that this process completely misses is that providers really get to know clients on a personal basis. This knowledge allows the provider to be aware of which clients are likely to have made mistakes in time or dates of pick-ups. Perhaps the providers can give ITM an "alert" list and ITM in turn can flag dispatches with these "alerts."

Ms. Ellery said that is a very good idea that will be explored. She also asked providers to alert SRS if there is know, deliberate abuse of the system so appropriate action can be taken with that client.

Trudy asked how the provider can be reimbursed for making the transportation effort when the client does not need service.

Mr. Krantz answered that when the party responsible for the error can be identified, that is who will be held responsible for reimbursement. If it is client error, they should make the payment. If it is ITM's error, the contract can be modified to make them responsible for errors, beyond a certain acceptable "margin or error" rate.

CHAIRMAN COBB asked ITM, SRS and the providers to develop a system within the next six months to address a way to have provider-client contact to confirm services.

Ms. Ellery reminded providers they have the right to refuse service to Medicaid clients if they know the clients are abusing the system.

Issue: Ambulance transfer

Ms. Herman Referred to process of getting ambulance authorization. **EXHIBIT 2, Page 3** She asked if these process could be refined from the 12 steps. If prior authorization wasn't needed, the medical information would come through the normal coding billing cycle and a case manager wouldn't be needed at all. It's also a double approval process, waiting for the Mesa, AZ, office to approve what ITM has already approved.

Ms. Guy explained the ITM process, saying that sometimes the claim does get bogged down when there are confusions between Medicare and Medicaid claims.

Mr. Krantz said it is necessary to make the initial phone call to ITM to verify clients are eligible and save unnecessary paper work. There probably isn't a way to work around the requirement for clinical information. There probably are not any changes that can be made to reduce the 12-step process.

Ms. Herman asked if this might be considered like the psychiatric admissions, that if there aren't any denials in a several year period, the pre-authorization would waived.

Ms. Ellery agreed to consider that possibility. Statewide, one of three requests are denied. The process is getting better because providers are paying more attention to the documentation required to support an ambulance call.

Laura Sherry, R.N. said there are problems with certain patients. In particular, it is often difficult for head-injury patients to

distinguish between emergency and non-emergency situations. Many of them have learned to call 911 with medical problems and that is all they are capable of remembering. When an ambulance service takes a non-emergency patient to the emergency room, it is the ambulance service that doesn't get paid. Also head-injured people often don't remember to contact ITM with transportation needs. It's a duplication of service for the case-worker to spend 10-15 minutes on the phone with ITM when all these information has been given to the transportation provider. Also ITM, which is supposed to be able to call up patient information with a Social Security number, frequently asks the caseworker to provide all the information because "the computers are down."

Ms. Guy said properly trained 911 operators can determine that a caller does not need an ambulance and call ITM for alternative transportation. There have been computer difficulties and programmers will be correcting the problems within the next two-three weeks. The essential problem is that the date base is too large for the system.

Ms. Morris said many of their clients are set up beforehand and are in the habit of calling Medicab rather than ITM. Also with some of the clients that are on Medicab's calendar, and have called ITM, Medicab does not get dispatches from ITM. When ITM is questioned about these dispatchers, several times the response has been "I remember the call, I don't know why the dispatch wasn't made." Other taxi cab companies probably don't have these calendars, so if they don't get the dispatch the client doesn't get picked up at all.

Ms. Ellery said she can't respond to individual cases without more information. SRS's goal is to try to get providers the most cost effective transportation and make sure limited Medicaid dollars are spent appropriately. That will take some changes in peoples behavior - the clients and the providers. This is a system that can flux and change and can be made to work.

CHAIRMAN COBB asked how large the staff is, is there much turnover, are many calls being put on hold. **Ms. Guy** said there isn't much turnover. The staff is nine dispatchers and nine data entry staff. Day hours are well staffed and putting callers on "hold" because of low staffing has not been a problem.

CHAIRMAN COBB asked if waivers could be made for situations such as the brain injury patient who calls 911. **Ms. Ellery** said she would look at waivers but is concerned about giving out exceptions because then it has a domino effect. It would be better to try to make the system work without creating exceptions.

<u>Issue: Accuracy of data flow from ITM to Consultec</u>

Mr. Morin said in his perception there are problems in data flow from ITM to Consultec.

Mr. South responded there is a tremendous amount of information flow between the two companies. The situation is in constant flux to ensure all areas are covered as far as authorization. The concerns that information doesn't always get from ITM to Consultec are being addressed.

Ms. Morris said providers aren't allowed to bill until forms are received from Consultec. These forms were generated from ITM provided information and are often inaccurate or incomplete. She suggested the provider only have to file paperwork with ITM rather than both companies.

{Tape: 2; Side: B}

Mr. Krantz said the top priority issue for SRS/Medicaid division is to address the issue of prior authorization being made through ITM but not getting to the provider. After that, issues has been addressed, the next priority will be the area of having complete data shared between ITM and Consultec.

The meeting ended with **Ms. Ellery** reiterating that it is important for clients to understand the system and the SRS Medicaid division is committed to continuing and strengthening client education.

ADJOURNMENT

Adjournment: 12:07 p.m.

JOHN COBB, Chairman

PAULA CLAWSON, Recording Secretary

JC/pc

EXHIBIT 1
DATE 4/5/95
SB

HUMAN SERVICES
SUBCOMMITTEE ON APPROPRIATIONS

Room 312-1

April 4, 1995 -- Tuesday

10:00 a.m. - noon Welfare issues

April 5, 1995 -- Wednesday

9:00 a.m. Consultec

10:00 a.m. ITM

April 6, 1995 -- Thursday

8:00 a.m. Reorganization -- SB 345

8:45 a.m. Medical savings potentials

9:45 a.m. Dentists

10:45 a.m. WestMont -- personal care

reorganization questions

1. how is reorganization going to take place. What are the time tables.

2. There is suppose to be a Task Force , When will this be created. How will the membership be determined. Will organized labor be members of this Task Force.

3. What are the main goals of the reorganization. How will we know that they have been met.

4. What plans have been formulated as of now for reorganization. Are there going to be any management changes. When will employees know if they are going to be moved, etc.

5. Are area of local offices going to be consolidated. When will people know that.

6. How are the computer systems, central services going to be consolidated. Who will be in charge of such consolidation.

7. Are there any plans or discussions to add on to the SRS building or build any other building.

8. How are the budgets going to be consolidated in House bill 2.

9. If the reorganization is not to take place for some time, are the divisions suppose to continue operation as they are now.

10. When the fiscal note for the reorganization said that there would be a reduction of about 25 FTE where will those FTEs come from and from which area of the budget.

11. Is the reorganization going to affect any of the expansion of programs that were authorized by the legislature- child support, welfare reform, etc.

12. Are there going to be deputy directors under the director. How is the management structure going to be developed and implemented.

13. Will reorganization start at the top in Helena or at the bottom - out in the field.

14. Is there any draft organizational chart prepared. When will it be prepared.

15. How will we know if reorganization is affecting existing programs or making it more difficult in the transition to continue to do existing work.

16. Where are you going to get the money to move offices around in the tight budget.

EX 1
4-5-95

17. Has the administration seen the proposal developed by Jani McCall. Is it a worthwhile outline with which to begin this effort of reorganization. What parts do you like or dislike.

18. How will the dept. determine which services are appropriate for regionalization/contract and which are appropriate for centralized delivery.

19. Will the dept. make any effort to standardization or rationalize the way in which it deals with its various non profit providers- dd, vr, child care, big brothers and sisters.

20. Will the dept. make any effort to develop a current level budget methodology per the lois steinbeck report for these non profit providers.

21. How will mental health services be integrated into other programs. - managed care, state hospital, community programs, children services.

EX 1
4-5-95

Dental issues.

1. how will the survey be conducted so that there is accurate fee information.

2. can the dentists be compensated for additional time, skill and effort required to manage difficult patients either less than three years old or with documented disabilities.

3. can a toll free line be established so that a medicaid administrator thoroughly familiar with the dental program can be readily available during normal working hours to answer questions and authorize treatment in all but the more complicated cases.

4. can you establish program effectiveness wherein 70% of eligible children 3-12 years old will be examined and the recommended treatment initiated within two years of enactment of these reforms

5. can a meeting of the medicaid section chief and representatives of the Montana Dental association and Montana academy of pediatric dentists every six months to evaluate program progress and further devise ways to eliminate obstacles to patient access.

6. will the department investigate and combat program abuse in the treatment of pediatric dental cases.

7. will the program be put into passport or managed care and what is the time table if so.

8. how will be know of the effectiveness of the program expansion in payments. when will we know of it working.

9. what complaints or concerns have been voiced by dentists besides the low payments and how has this been taken care of.

Westmont. new personal care system

1. How is the new system going to work beginning July 1, 995. When will this new provider system be up and running. What rules need to be changed. When will the rules be written and open for public comment.

2. What qualifications will be needed to be a provider.

3. What were the complaints if any against Westmont and the dept. concerning personal care.

4. Are any audits needed in this area.

5. What investigations if any has the Dept. conducted concerning any problems with Westmont.

6. What does the dept. expect as results going to a new system concerning more providers. How will this be measured.

7.

EX 1
4-5-95

Medicaid savings

1. What is the dept. going to do about the medicaid federal audits that said they possible could save money.

2. What is the dept. doing now about saving dollars under passport after the audit. When will we receive results about the savings.

3. when will the HMOs be up and running. When will we know if they are saving money. Are there going to be any stop losses or ways for HMOs to make the state pay cost increases above a certain level.

4. what is the dept. doing right now to buy more insurance for those who are eligible for insurance now.

5. What are other states doing to save dollars that we are not.

6. What is the growth rate for medicaid right now for most states and especially those states next to Montana.

7. Why were those particular cuts in medicaid picked by the dept. out of all other possible cuts in the medicaid budget in the March 2, 1995 letter sent to providers. What other cuts did the dept. consider before they arrived at those cuts. Are those still the same cuts that the dept. will make if the medicaid budget goes up higher than budgeted.

8. How often does the dept. make formal meetings with the providers or clients to find out if there are any problems. When will be the next meetings. Can we get copies of the meetings and what was discussed and when any proposals for changes will be implemented.

9. Will the reorganization affect the meetings and moving to save medicaid dollars.

10. On the Cobb savings cuts, are there any savings.

11. What do the new growth rates for the last month show in the increase in medicaid costs.

12. The dept. had asked for additional staff for MEDSTATT, why did you not ask for them in the committee.

13. What other possible savings has the dept. looked at concerning savings and why were they rejected.

EX 1
4-5-95

Consultec. and SRS

We have heard the following concerns. Please address them. There will likely be additional questions during the hearing.

1. Problems with electronic billing directly to consultec.

2. example- sometimes claims are pended for 4 times which ends up to be 2 months and then they are denied. Shortly thereafter, eligibility is approved and then we have to rebill. More timely applications need to be done or more updates.

3. incorrect 3rd party information on Medicaid cars. If we had correct information insurance response would be faster.

4. Co pay exemptions on UB92 are often missed, causing a rebill or adjustment.

5. Following through with over the phone adjustments.

6. Very often the patient does not bring in their medicaid card when receiving services and we are not aware that they have medicaid until months down the orad. Make clients more aware of the responsibility to take the medicaid card with them for all medical visits.

7. The teams program updates more often than Consultec causing denial of claims if sent in to early.

8. how often does SRS and Consultec meet with providers to find out if their are any problems. When was the last meeting and what was discussed. When will there be another meeting.

9. What complaints if any has SRS and Consultec have had from providers.

EXHIBIT 2
DATE 4/5/95
~~SB~~ J.S. HUMAN SERV.

ST. PETER'S COMMUNITY HOSPITAL
(406) 442-2480 • 2475 Broadway, Helena, Montana 59601

Medicaid Claims Processing Concerns

4/5/95

Good morning I'm Sheila Herman representing SPCH here in Helena. Our concern, like yours, is to accomplish a correct, accurate, and timely Medicaid claim processes. I would like to briefly identify some areas that cause the greatest number of delays and some potential solutions.

Attached is an an outline of four specific areas that have a significant impact on our Medical claim processing.

PASSPORT

The Passport system as a Managed Care Model has yet to be embraced by the clientele that it is to serve. Prior approval for services rendered in the Emergency room is a concept that we support for appropriate use of medical services.

The client frequently presents for services without their card or knowledge of who their passport physician might be. If they have been assigned a physician that they have never seen, there is a reluctance on the part of the physician to authorize treatment for a patient for whom he has never rendered care. In turn the patient may be seeing a physician that is not their passport physician but definitely is their primary physician.

One out of six passport patients presenting to the emergency room this past weekend had prior authorization for treatment. How can the hospital be reimbursed for the other five?

Solution: Continued patient education starting at the county level with emphasize on patient liability if not consulting with passport provider. Requesting the patient to followup with passport provider after being seen at a hospital as a requirement for continued eligibility.

PREGNANCY CLAIMS

Frequently an obstetric patient will come to the hospital in early labor, be observed and go home. This same patient may come in

later in the same day and deliver. This patient has had two services, an out patient for observation, an inpatient for delivery.

The first bill to reach Consultec will be the outpatient so when the inpatient bill accesses the system, it is automatically rejected as a duplication of services. In order to have the inpatient stay ultimately paid, the bill has to be to combined into one bill. Each time the claim has to be handled by the hospital staff and then the Medicaid staff multiple days are incurred.

SOLUTION: Consultec to have an identification between inpatient and outpatient services being rendered a client on a given service date.

THIRD PARTY LIABILITY

Medicaid may be a secondary insurance to Medicare or other third party payer. Third party payment may not be made promptly which in turn can put Medicaid billing well beyond the 90 day period.

SOLUTION: Medicaid to flag automatic denials of other third party liability that would allow them through the system.

AMBULANCE AUTHORIZATION

Attached is the process we must follow to bill for Medicaid ambulance services. As you can see by this flow chart a call is initiated to ITM (Integrated Transport Management) of the patient use of the ambulance and the clinical need for ambulance transfer.

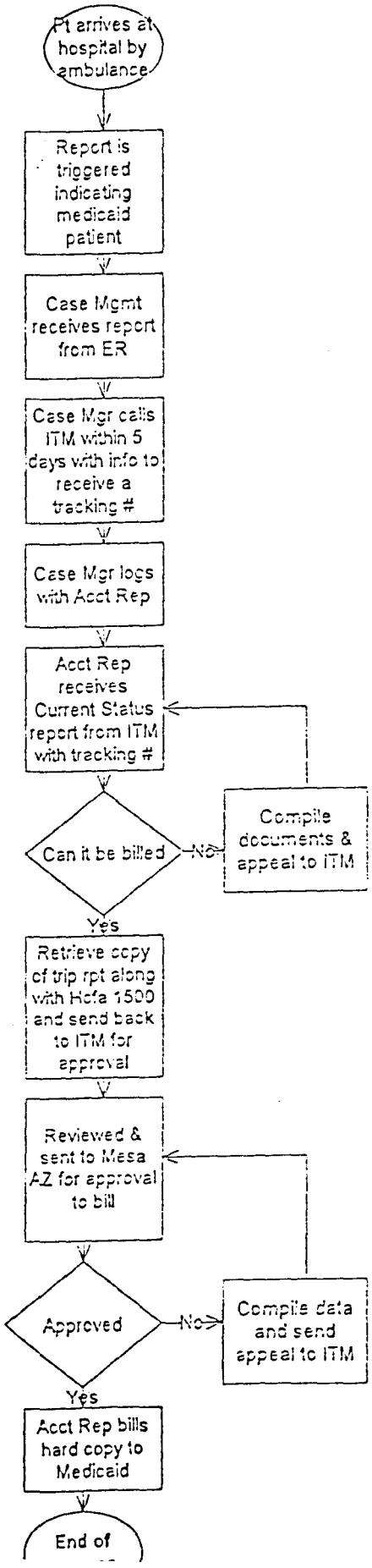
A tracking number is generated that is given to the account representative. If the current status of the claim indicates the claim can be sent, the HCFA 1500 and the trip report are sent back to ITM for approval. It is reviewed by ITM and then sent to Mesa AZ for approval to bill. If Mesa Az then approves it the account representative bills it hard copy to Medicaid. If there is a glitch at the key points additional steps must be taken.

The system that we are working with as demonstrated above is cumbersome, time consuming, labor intensive and frustrating. Potential solutions involve dialogue and evaluation of processes from both the hospital and the Medicaid services. The common goal is appropriate health care delivery to an identified population in a cost effective mode.

Thank you for the opportunity to share our concerns with you this morning.

EX 2
4-5-95

TopChart
Tuesday, April 4, 1995
12:51 PM



Note: Most are approved after appealed with documentation

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services Sub COMMITTEE BILL NO. _____

DATE 4/5 SPONSOR(S) _____

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H-LEE POTTS	MONTANA DEAC		
Jackie [illegible]	MDMC GF Falls		
James Marquard	Kalispell Taxi		
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Terry Krantz	SRS		
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