

Concerns on MRSIS

- Third party billing
 - Availability of Technical assistance from Harmony
 - *Harmony will train Division staff, who will work with providers. There will also be a number of providers trained as “super users” who can provide some technical assistance. Central Office will have expert staff who will man a help desk. If these staff cannot answer a question they will refer it to Harmony.*
 - Availability of Technical assistance from Medicaid
 - *EDS will continue to provide assistance as before. However, since the provider will now bill MRSIS, EDS responses will only concern what has come to them from MRSIS.*
 - Liability issues for billing
 - *We do not see any liability issues involved in the billing process. MRSIS will not change any billing data submitted by the provider, so what gets sent to EDS will be what the provider submitted.*
 - Audit trail
 - *The audit trail from the provider to MRSIS to EDS to MRSIS to the provider is more accurate and complete than the audit trail in the current system. We see no issues for providers regarding this topic.*
- Financial impact
 - DMHMR five year cost estimates
 - Staff cost
 - *On average \$164,650 in State funds per year*
 - Equipment cost
 - *\$12,000 over five years*
 - Licensing cost
 - *\$147,400 in State funds per year*
 - Other
 - Provider five year cost estimates
 - Staff
 - *No additional staff anticipated to be needed*
 - Equipment
 - *We have no way at this point to assess this cost. It will vary by provider agency and by how each decides to use the system – some already have sufficient computer equipment, others may need to upgrade. Providers using Two-Part Harmony to bill will only need*

from one to three computers, even if they have to purchase new ones. Case management agencies with full Harmony licenses will need adequate equipment and connectivity for all those who hold the license. This could include every case manager, or a select number, or just the supervisor or intake coordinator. Over a five-year period, most computer equipment will have to be upgraded or replaced, regardless of MRSIS. Finally, the most likely area of expense will be the need to obtain high-speed Internet access.

- Licensing
 - *The Department will pay for a certain number of licenses per contractor, based on the contractor's structure and need. We project one to three Two-Part Harmony licenses per contractor. If a provider wants to buy more licenses, we will have to devise a mechanism for payment of the license fee. The Department intends also to provide a full Harmony license for every case manager who has a computer with high-speed Internet access and submits plans of care, eligibility packets, and quarterly narratives. However, the contract with Harmony calls for a specific number of full licenses, and if the need exceeds the contract, the Department will have to re-evaluate its formula for distribution.*
- Other
- Individualized Budgets
 - State match versus local match for individual
 - Who determines? What if the client uses both state and local funds?
 - *Under the current system, providers typically declare their intent to use local funds. Except for the need to simplify the process over time, by allocating local match to one person and state match to another, we do not intend to remove the choice from the provider. The flexibility will be built into the system to allow "hybrid" funding.*
 - Change in level of need; i.e. who funds it?
 - *To the extent the State now funds such changes, we anticipate continuing. This decision always depends on the fiscal condition of the State's funding. Technically, such changes, if funding is available, are much more simple to make with the new system.*
 - Moving between providers, i.e. process.
 - *Consumers currently move between providers, and it inevitably causes concern. We do not promote such moves, and if coercion or solicitation is involved, we tend to deny such moves. Nonetheless, moving is the person's right under Medicaid rules. We will handle moves the same way in the new system we do in the current system, except that, rather than amending two contracts, we will amend one prior authorization.*
 - DHR – timing of local match sent to Trust fund
 - Will Federal be sent when billed or not until match received?

- *The Community Service Offices approve the plans of care by specific delegation from the Medicaid Agency and under the terms of the Waiver as approved by CMS. The plans of care, as approved, feed the prior authorizations. In addition, Community Service Offices currently approve IRBI rates and contracts under the authority of the Commissioner.*
- Timeliness of said process
 - *If the phrase “said process” refers to the prior authorization process, it will occur within the period of 5 working days, if there is agreement ahead of time to make the change. If there is no prior agreement, approval or denial or request for more information will be made within 30 calendar days. The prior authorization process is effective immediately, once the authorization is entered.*
- Centralized collection of data – send info to Central office to be the most efficient
 - *We disagree with this statement. Most efficient for whom? The Division’s staff is in the Community Service Offices and currently makes decisions on a regular basis that affect providers and consumers, and that are necessary to meet the requirements of our funding source. The Community Service Offices will be able to make these decisions faster, and take action faster, with the new system.*
- Case managers and region office staff do not have financial experience, yet they will be controlling a person’s budget and a provider’s budget.
 - *Case managers will be coordinating a person’s plan of care, in cooperation with the staff of the direct service provider. The services a person needs dictate the “person’s budget”.*
 - *Community Service Offices, contrary to the statement above, actually have considerable financial experience by way of the business managers. Nonetheless, the decisions about what services should be provided, and how much they should be provided, is largely a clinical decision. The Community Service Office is required by the terms of the waiver to approve the plan of care. The approved plan of care will be reflected in the prior authorization, and the rates are pre-determined, so there is not a lot of fiscal decision-making needed beyond the general question of budget capacity.*