

MINUTES  
Stakeholder Conference Call  
February 10, 2006

Attendees: Stakeholders, Regional Community Services Staff, HarmonyIS Milestone Oversight team, HealthCarePerspective LLC team, Mrs. McIntosh-Wilson, Fordyce Mitchel, and Daphne Rosalis

1. Two of the four planning sessions known as JAD sessions have been completed.
  - a. The first two JAD sessions focused on the design for the Plan of Care and Prior Authorization components of MRSIS.
  - b. The third JAD will focus on claims.
  - c. The “go live” date for the billing (claims) component has been postponed to January 1, 2007.
  - d. The waiting list functionality has been moved from phase 2 to phase 1.
2. The third JAD will focus on claims, payment and the general ledger interface.
  - a. A draft Business Analysis Document will be submitted to DMR after the conclusion of this JAD. This document is the map for the design of the MRSIS system.
  - b. DMR will review the BAD for accuracy and will or will not sign off on the document.
  - c. Prior Authorizations will be generated from an electronic Plan of Care which will come from the case management agency. Some flexibility will be built into this business flow but for the most part case managers will submit the Plan of Care.
  - d. The Plan of Care will be submitted to the Regional Office and a prior authorization will be generated from the plan.
  - e. There is flexibility being built into the prior authorization work flow that will allow unencumbered units to be moved around so that no one is denied services.
3. Business Flow as conceptualized using MRSIS.
  - a. Starting with the point that anyone going into services is coming off of the waiting list, waiting list data has already been submitted by the case manger and the only documentation outstanding is the Medicaid Waiver paperwork.
    - Some of the Medicaid Waiver paperwork can be submitted electronically. Some of the information already exists in MRSIS. There will continue to be documents that require original signatures and will need to be submitted via hard-copy in addition to electronically. The Plan of Care is one such document.
    - The Plan of Care is submitted to RCS.
    - The RCS staff will review the plan based on appropriateness and the regional budget.
    - The plan is either approved and a prior authorization generated or the plan is not approved and sent back for revisions.
    - Once the prior authorization has been generated and approved the person may begin services.

- There will also be a way to auto enroll consumers into Medicaid but this functionality has not been finalized.
4. Providers will have two ways of billing.
    - a. Direct entry into Two-part Harmony or sending a HIPAA compliant 837 to MRSIS.
    - b. Providers that bill via 837 will get an 835 from MRSIS to reconcile records.
    - c. There will be up-front edits built into MRSIS to mimic EDS's CSR report functionality. The CSR report will be going away once EDS completes their upgrades. It is our intent to catch as many common mistakes as possible in order to send EDS the cleanest claim possible.
    - d. All errors will need to be corrected in Two-part Harmony or re-billed through an 837.
    - e. Beginning January 2007 the 1/12<sup>th</sup> payment will go away and the state and federal dollars will be sent to providers in one check.
  5. End of JAD sessions will be in March.
    - a. Screen validation will begin in April.
    - b. User expectants testing will begin in July.
    - c. Training for end-users will be the month of September.
    - d. Plan of care and prior authorization will go live November 1, 2006.