**Iowa State Association of Counties**

**Operations Subcommittee**

**Thursday September 1, 2016 10-3pm**

**Meeting Minutes**

**Members Present:** Brandi Kanselaar, Karen Dowell, Susan Duhn, Kris Gardner, Julie Davison, Sara Lupkes (partial), Maria Walker, Ami Anderson (partial), Justin Schieffer and Julie Albright

**Members Absent:** Lisa Kempf, Suzanne Watson, and Jennifer Vitko

**Staff Present:** Jeanine Scott, Laz Schreck, JD Ricklefs, Dylan Young, and Chris Schwebach

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| --- | --- | --- |
| **Task** | **Due Date** | **Person Responsible** |
| Polk Revisit Budget Structure vs. Planning Tool needs | 9.26 | Sara/ Ami |
| Screen Mockups for Expenditures Budget Entry/Edit Screen | 9.26 | JD |
| Write up I & R allocation idea – Send to Members | 9.15 | Karen |
| Review 11 + Column Grids and bring recommendations to next meeting | 9.26 | All |
| Proposition to Advisory for more Voting Operations Members | TBD | Jeanine |
| Add new DG dropdown value to stage | 9.16 | Chris |
| Test ramifications of using new DG value (warehouse, claims, budgets, etc) | 9.26 | Brandi/ALL |
| Archive Providers based on discussion and send the remaining out to expert users for cleanup | 9.26 | Chris/Laz |
| Update Paid Date/Check Date for Auditor Integration | 10.31 | Dylan |
| Respond to Sara Berndt with decision on Jail Diversion Entity | 9.16 | Jeanine |
| Set up Expert User Call | 10.15 | Brandi |
| Update members on OCR response to Health Plan Question & direct entry idea | 9.26 | Beth |

10:03 – Meeting called to order and introductions of the committee. Sara Lupkes brought Ami Anderson (PCIT PM), Justin Wilcox (PCIT DEV), and Maria Walker (PCHS) with her.

10:05 – Justin Schieffer motioned to approve the agenda and Kris Gardner seconded, the agenda was unanimously approved

10:06 – Karen Dowell motioned to approve the Operation meeting minutes from June 30 and July 1 and Julie Davison seconded, the minutes were unanimously approved

# 10:07 – Polk County Gap Analysis

Sara Lupkes explained that a project team has been performing a gap analysis between PCHS current MIS system and CSN over the past 5 months. The project team consisted of Polk County Health Services, Polk County IT, Brandi & Karen and ICTS. The group went on to discuss some of the more significant gaps between CSN and PCHS.

## Level of Support

One of the main gaps discovered was the use of Level of Support (LOS) to identify what services the client is allowed to have. After discussions with Operations and CEO subcommittee regarding the statewide usage of Level of Support data Polk took a look at their FY16 authorizations to determine long-term viability of using the LOS model. Of the approximate 12,000 authorizations only 1,300 were Level 3 support (LOS scale 0-5) or above. Based on this information Polk decided that while they would still need to track a client’s Level of Support it is not necessary to build this into the funding authorization and service framework within CSN.

#### **Decisions**: Level of Support will not be built into CSN 3.0

## Provider Integration

Providers are fully integrated into the PCHS MIS system. They can access remittance documents, enter contact information, and check on funding authorizations. The group agreed that giving providers the ability to access Notices of Decision and Remittance Documents would be very helpful and increase security. They would like to incorporate this functionality into 3.0 *(out of scope)*

Polk also allows providers to enter contacts in their system. Brandi mentioned that Providers can enter contacts in the Case Manager area and they can also bill this way. Polk also allows their Providers to upload contacts into the system. The group discussed this functionality and Jeanine said it will be something that needs to be revisited in early 2017 when we look at the functionality of entering client contacts for case management and mental health advocates.

#### **Decisions**

#### Add the ability for providers to access documents into CSN 3.0 scope

#### Revisit providers entering contacts into CSN in early 2017

## Business Intelligence

Sara explained how the BI (Business Intelligence) system PCHS has created and supported can be beneficial to CSN. The BI system is a reporting tool built with the primary purpose of flexibility and transparency. Polk County uses it currently to help their providers access Outcomes data in real-time and make adjustments or improvements based on the data provided. The system can be extended to include Jail and Crisis metrics. PCHS would like to keep this system intact utilizing it for regional dashboards and state-wide reporting. PCHS specific reporting would be done in IZENDA just as the other entities are doing today. Jeanine brought up to the group that it takes a high-level skill set to manage a BI platform and developers with specific skills would need to be hired to support it. However, with the investment PCHS has made into this system and the benefit it has been to their providers she felt that it would be worthwhile to continue utilizing it as Sara has suggested if their current vendor can continue support and development for the next year. Jeanine will recommend to the Advisory committee that a BI position be filled within ICTS in FY18. In the meantime, Brandi will be working part time for ISAC and will familiarize herself with the BI structure and work with the current vendor

#### **Decisions**

#### No formal decisions made. Recommendations will be made to Advisory when presenting the FY18 budget.

## Financials

Polk budgets by Fund, COA, DG and Provider while all other regions budget by Fund, COA and DG. Karen (CSS) and Julie (ECR) explained that their regions went away from budgeting at this level of detail several years ago and do not desire to go back. Sara explained Polk uses this approach to allow an in-depth review of their Providers and the services they are offering to determine if efficiencies or changes can be made at the provider level. Polk County IT is currently building a tool that can be used the help Polk drill down at an even more granular level as they are doing budget analysis for the coming fiscal year. The group was not in favor of adding either the additional detail structure to CSN since it could delay the launch of the system and no other region would use it. Sara asked if the group would approve the addition of this functionality if Polk County IT would build it. Jeanine pointed out that it would be difficult for Polk County to only build a piece of the financials area but could utilize Polk County IT in building other components.

The discussion then transitioned to the new budgeting tool PCHS is developing. It was explained the tool will allow a user to designate an inflation/deflation percentage that could be applied to budget line items to determine how the bottom line would be affected within certain scenarios. It will also have the ability to ‘class’ line items (similar to COB) so segments of a budget can be prioritized and adjusted easily. Sara mentioned she often needs to itemize and prioritize services, for example, if revenues are cut she can quickly determine which services they can no longer fund based on the new information. It was suggested to structure the Expenditure Budget screen by accommodating Core/Additional Core as well as priority and non-priority populations. Kris built on this idea and said it would be very helpful to have multiple grouping options like in Excel. Another idea was brought up to have a fly out showing the current budget and then a budget planning tool/phase. The financial analysts could use the supporting screen to shift amounts based on specific scenarios such as when a Provider moves multiple clients to another region and money may need to be shifted away from other services to compensate.

Jeanine suggested that all of this functionality being discussed seemed to be around forecasting and financial tools rather than the actual budget structure the regions need to track expenses and revenues. The group agreed and were in favor of adding a Financial Planning module that would incorporate many of the ideas discussed here. The one exception to this that the group would like to model the expenditure budget screen after the DHS worksheet and not how it was re-designed to work within the current 3.0 specifications. *(NOTE: do we really want to do this? What if DHS changes their requirements or worksheet at some point?)*

Brandi suggested to table this discussion and final decisions until the September 26 meeting. She suggested that Sara send screen shots of what is being built by Polk County IT to Operations members prior to that meeting so they can have a better understanding. JD will also create some mockups of a new expenditures budget screen that will incorporate some of the drill down features discussed (core, core +, etc).

#### **Decisions**

#### Add a Financials Planning module to CSN 3.0 (timing for this TBD)

#### Revisit Expenditures screen design in Sept 26 meeting

# Clients Served

The group discussed how each region represented is administering the number of clients served initiative (allocating non-direct costs back to clients) and if a best practice could be recommended for all regions. PCHS is getting monthly reporting from Providers of clients being served. CSS workers track their clients using Outlook journal capabilities then Karen enters those into an eClaim and uploads the claims into CSN quarterly. She is considering switching to monthly allocations to allow for a more current accounting of these costs. NWICC has their social workers enter contacts in both CSN and on paper (duplicative tracking) then she pulls a report of the number of contacts and allocates back to the client. ECR is allocating based on the number of clients – not on the number of contacts workers have had with those clients. They are entering their allocations monthly. Sioux Rivers is not yet allocating expenses. Justin didn’t know what Rolling Hills is doing. Based on the discussion the group is not prepared to offer a standard business practice recommendation at this point.

Several asked how others are handling Information and Referrals – when there is no client for which to allocate the expense. These ‘touches’ are not reported anywhere. Since this makes up a lot of what the regions do Karen asked if there is a way to enter all the I & R contacts as a claim and then select a ‘Warehouse Exception’. Karen will write up her idea and send out to the members to take to their CEOs and then discuss at the September 26 Operations meeting.

#### **Decisions**

#### Wait until FY18 to make a best practice recommendation on client allocation

#### Revisit Information and Referrals entry in Sept 26 meeting after members discuss with their CEOs

# CSN 3.0 Data & Design

## 11:39 – Legal Status/Legal Issues

During the last meeting ICTS was asked to do some analysis regarding the usage of the legal status and legal issues fields. The legal status field has about 80% usage currently while the legal issues field is only used about 1.5% of the time. Members strongly felt the only reason the Legal Status field is being used is because it is on the old CPC application. However, all agreed it is not useful because no one keeps it updates after the person is accepted for services.

#### **Decisions**

#### Do not build the functionality to collect either legal status or legal issues in 3.0. Current data will be retained.

## 11:43 – Roommate Field

During the last meeting ICTS was asked to do some analysis regarding the usage of the roommate field. The roommate field is only used for about 9% of the clients. It was thought that this was originally added for case managers. Justin said case managers do not need the field.

#### **Decisions**

#### Do not build the functionality to collect roommate information in 3.0. Current data will be retained.

## Client Diagnosis Notes

#### **Decisions**:

#### 3.0 Leave the notes field within the diagnosis area.

#### 3.0 Add a new drop down called ‘diagnosed by’ having the options of Self, Medical, and Mental Health as options

## 11:45 – Display Grids

Working through the design of 3.0 the developers have discovered the current number of columns within display grids breaks the new design. It would be optimal to reduce the number of columns in each grid to 5. If absolutely necessary additional columns could be ‘stacked’ under the first 5 bringing the total number of columns allowed in any grid to 10. The first 5 columns would be displayed with a “+” icon next to the line that, when clicked, would display the second row of columns underneath the first. A report was handed out containing all grids in CSN having 11 or more columns, the screen on which the grids appear, and data elements. Members will review the report and come back to the September 26th meeting with recommendations on the columns necessary for each grid.

## 12:00 – Misc.

##### Merging Clients

Default the claims checkbox to checked to avoid the situation of merging a client without their claims.

##### Expert User Plus

Add another level of expert user that can edit claims data at any time. This would allow power users the ability to fix warehouse type issues without having to wait for IT.

#### **Decisions:**

#### 3.0 Auto-check the claims option when merging clients

#### 3.0 Add a new expert user type that can edit all claim data at any time.

# 12:35 – Open Operations Position

The committee wants to give Polk a voting position however it needs to be confirmed how many appointments can be made to the sub-committee. Brandi and Jeanine thought it was 7 (including the chair). In the last Advisory meeting the recommendation to add a regional representative from each region to this committee was not approved. This group strongly feels each region should have a representative. Jeanine and Brandi are going to work on a proposal to take back to Advisory to request the expansion of voting members. Regardless of the decision committee members expressed that the discussions are important for everyone to take back to their CEOs and for members to bring discussion to this group from their regions.

#### **Decisions**

#### Take recommendation back to Advisory to expand this committee to full regional representation.

# 12:47 – HD/PD Clients without Mental Illness

Justin Schieffer brought up that there is no clear DG to assign clients that fall into elderly, children or other categories. How should this be handled? Because the DG options are mandated by DHS the members suggested leaving the DG blank if there is no qualifying DG associated. Maria Walker from Polk mentioned that they created CBCM for all various waivers their CM’s now have through AmeriHealth Caritas. They use this category if clients are not eligible for MI or DD/ID.

Jeanine said that they would add a value of Physical Disability to the DG options and then this group can test to see if there are any adverse effects to this throughout the system (i.e. warehouse reports, claims, etc).

#### **Decisions**

#### 2.0 Add and test addition of physical disability DG code in stage.

# 12:55 – Residency Changes (Address changes and Funding Request)

Brandi wanted to re-discuss this topic, to confirm the group agreed with the decision documented in the last set of minutes to not close Funding authorizations when a client’s residency change is approved. It appeared to be a misunderstanding on the discussion. The group was referring to the status of the funding request – not the functionality. Once the residency change (address) is approved the system is to populate all open/approved funding requests with the end date of the previous address and NOT change the status. Additional functionality was requested to alert the user via a modal that there are [x] number of open funding authorizations associated with the current region/residency that will be closed as a result of this action. The system will NOT add new funding authorizations in the new region.

The reason this functionality is being added is because users will not end requests when residency changes. When this happens claims erroneously adjudicate against the old requests.

We also revisited why the address approval step is needed. It was felt that adding this approval step will cut down on (or eliminate) the issue of someone changing a client’s address to a jail or P.O. box.

Maria Walker asked if regions were considering offering 30-day grace period when a client moves regions. All agreed this would be ideal but only if all regions follow the rule. If only some honor it the other regions will end up paying both when the client comes into their region and after they leave. Karen said the CEOs are deciding if there will be a 30-day coverage rule. If a 30-day coverage rule is revisited the group will need to decide if the end date of the old funding requests should be 30 days after the end date of the previous address. This topic will be re-visited when Funding Request development begins.

Currently the system populates the payer options based on the client access records. This will not be possible in 3.0 since client access will not be needed. Brandi suggested populating based on past address residency records.

#### **Decisions**

#### 3.0 Address approval is required when residency changes.

#### 3.0 Open funding requests associated with the old address will be ended using the address end date once residency is approved by the new region.

#### 3.0 New funding authorizations will not be created for the new region when residency is approved

#### 30-day coverage rule will be revisited when funding request development begins.

#### Revisit payer options when funding request development begins.

# 1:09 – Funding Authorizations / NODs

In the last meeting it was asked if the system could email NODs to providers. Due to security risks this is not a good approach. However, because it was decided that NODs and Remittance documents will be accessible in the portal emailing will no longer be necessary.

# 1:10 – Provider Cleanup

Chris distributed the results of the report listing providers associated with host entities of ISAC, Out of State, and State of Iowa. Karen suggested further reducing the result set by pulling out providers not having claims paid in the last fiscal year. ISAC will do this and send the new report out to the expert users to re-assign these providers to the correct host entity.

Laz worked through over 10,000 providers and found 669 having some type of an indicator that they are “Bad” or to “Delete” in the provider name. It was suggested that the system have some type of archiving ability so the providers do not show as options when searching or selecting providers throughout the system. Delete providers without associated claims, rates or funding authorizations. Archive the remaining providers meeting the ‘bad’ definition.

In 3.0 it was requested that providers be auto-archived if no claims were paid within a certain time frame. When new providers are added check for matches in archived providers and present those providers as options versus adding a new provider.

#### **Decisions**

#### 3.0 Add the ability to archive a provider.

#### 3.0 Do not show archived providers as options or in search results.

#### 3.0 Add nightly job to auto archive providers 3.0 Check for duplicate providers when new providers are entered.

#### Send the host county provider list out to the expert users after removing providers having claims paid within the last fiscal year.

# 1:29 – Auditor Integration

Auditor integration was designed based on the rule that an auditor would not be sending partial payment batches back to CSN. During testing it was found that some regions send their auditors claims to ‘hold’ until they are ready to pay them. It was determined that the scenario of an auditor deciding to pay late or holding claims doesn’t make sense. The members expressed that the auditors are expected to pay exactly what was on the bill/claims. If an auditor decides to not pay a claim, the workers would have the ability to use the auditor denied functionality and mark the claim as denied. It was determined that IT needs to update the logic to update the paid date with the check date that comes back from the auditor.

#### **Decisions**

#### Partial batches will not be reconciled. (no change)

#### Update the paid date with the check date during reconciliation

# 1:36 – Jail Diversion

Sara Berndt sent in a request to add a new entity for the Southeast Iowa Link region to manage their Jail Diversion program. She would like to utilize the case management module in much the same way the advocates are using it today. After much discussion a decision was made to not add a new entity but add the individuals doing jail diversion in as regional employees and give them the case management function. The entity would also need to have the case management module flag checked. The reason for using the regional entity is because jail diversion is a community services program as opposed to Advocates who are not community service department employees. Julie mentioned that they pay for their sheriff’s office to do jail diversion services for them. If this was the case and the sheriff’s affiliate wanted to utilize CSN they would be considered a separate entity from Community Services. We will need to revisit the need for regions to stand-up new programs quickly to avoid the recreation of data systems outside of CSN to track these types of programs.

Jeanine mentioned that new jail diversion functionality will initially be modeled off Polk’s existing system with the end goal being to tap into the statewide CEGIS data exchange which would eliminate the need to get separate feeds from each jail or require manual data entry of this information.

#### **Decisions**

#### Do not add new entities for community based programs.

#### Revisit how to create a process by which regions can dynamically add new programs with a set of common data elements that can be tracked across programs. (program type, dates, etc.)

# 1:44 – Release Discussion

Julie Davison discussed her situation in which a claim was paid on a client her region did not have access to and it was actually paid under the wrong client because full access was not granted to the client’s record. In another instance employee in the CSS region were attempting to get rid of duplicate client records but could not cleanup because the region associated with one of the duplicate client’s old address records would not grant access to that cleanup.

Client access requests are being ignored even when there is a valid release present or the reason for access is necessary for the payment of claims.

A call to the Expert Users will be done in order to discuss why access is not being granted and what can be done to allow regions to work together to serve these people until 3.0 is in place.

# 2:00 – Atypical Providers/Fair & Appropriate/Release

Beth presented her research findings on the topics above. The situation regarding if regions are considered Health Plans has been submitted to the OCR anonymously by legal counsel to get a definitive answer. If regions are determined to be health plans they must be Federally certified.

A billing provider could be considered both atypical or typical because they provide both types of services. All non a-typical providers are required to either submit their claims via direct data entry or an 837. There was discussion about whether or not the eClaim process could be considered direct data entry. Beth will research this and report back to the committee at the next meeting.

In a previous meeting it was asked if a CSN release could be uploaded and activated before all signatures are received. As new signatures are received the new document would be uploaded over the original document. Beth said each iteration of an active CSN release needs to be kept as a standalone document. If a new release is received after the previous release has been determined active, even if it is just additional signatures, the previous release must be revoked and the new one uploaded. This becomes difficult to manage because many times a client has several individuals who need to sign the release for them and rarely are they all in a room at once. In this case a release can be uploaded with a signature and left in a pending status. Once the next signature is received a new document would be uploaded with the additional signature and so-on until all the required signatures are received. Once the release has all the signatures the release can be activated. Once activated if additional information is received the current release must be revoked. The system must not allow a user to upload a new release on top of an existing release document if the release status is active. It was agreed this is going to be an important training point since there will be no way for the system to know if a release is complete.

NOTE: This release discussion only applies to the CSN release. External releases can be replaced or overlaid as needed.

#### **Decisions**

#### 3.0 Do not allow release documents to be overlaid unless the release is in a submitted status.

#### 3.0 Add a revoked status to the release status types and logic that supports the new status.

# 2:35 – MHA Report

Gina presented some data she has been working with to determine if advocates are using CSN. The point of this research is to figure out how to get a baseline to determine if and how Advocates are utilizing CSN because we know they will have to produce reports for DHS in FY18. Attempting to determine usage based on committal claims is difficult because there is no direct correlation between committal claims, committal records or advocate contact records. Justin asked if there is a way to track how many times Advocates log in, and Julie wants to have Advocates in the system and see their contacts for billing purposes. It was agreed that meaningful reports are difficult to produce without committals being associated with both claims and contacts. In lieu of this it was suggested to run the reports based on client advocate association. If there is an Advocate assigned to a client, then check if contacts have been made. EDMS Data Exchange is the key to solving this issue, by tapping into their system to get committals.

The group would also like to see a filter on the contacts screen so uses only see contacts entered by their own entity type.

The committee would like to eventually see all advocates utilize the CM module so standardized billing reports could be run and eventually auto allocate the client cost to the regions. This will likely not be included in 3.0 but could be considered an initiative for the next fiscal year.

#### **Decisions**

#### Create a report based on client / advocate association

#### 3.0 require advocate contacts be tied to a committal record [in 9.26 meeting]

#### 3.0 require committal claims be tied to a committal record (confirm in 9.26 meeting)

Next Operations Meeting Scheduled for **September 26, 2016 8:30am – 3:30pm**

3:16 – Meeting adjourned