180 Day Delayed

- Patient or provider files *Bona Fide* application or claim with one of the following §31-3505(5)(a)(i-v): Social Security, Supplemental Security income, third party insurance, Medicaid, Medicare, crime victims' compensation, and/or worker's compensation
- Proof of filing should be attached to the application or within 45 days of filing the delayed application
  - File with county within 180 days of the first date of the initial services
  - Must have a reasonable expectation of eligibility and resource will cover the requested dates of service
- Applicant must complete application process with the above resources including appeals or it will result in a denial of county assistance. §31-3505(5)(b), 31-3505(6)

180 Day Delayed Example:

- James, a 33 year old employed male, who has an insurance card in his wallet, has a heart attack on March 23, 2011. The facility checks with the insurance on April 10, 2011 and is told James has insurance. On May 15, 2011 the hospital bills the insurance company. On June 1, 2011, the insurance company denies the claim based upon the individual has reached the yearly allowed maximum. The facility files a county application on June 20, 2011.
- Can the (county) applicant or hospital file a 180 day delayed application? A Bona Fide application to insurance was filed and actively pursued by the facility. County should process as 180 day delayed application.
Board of County Commissioners: Suspensions

• Applicant deemed eligible for resource:
• If notified that patient is subsequently determined to be eligible for a pending resource, notify the providers listed on the application. This would be communicated in the form of a suspension the patient is eligible for the resource on the date specified and that the county no longer is the last resource. §31-3505C (2)(e)
• (See Sample Suspension Letter)
• If there is another resource, the county must exhaust all efforts to check that resource, including contacting Social Security and staying in contact with the provider facility.

Board of County Commissioners: Suspensions

• Creates process for pending resources §31-3505C(2)
• Pending resources must be sole basis for holding up an application from full approval. The application/applicant meets all other criteria for county medical assistance.
• Other forms of public assistance
  • Crime victims
  • Worker’s comp
  • Veterans
  • Medicaid or Medicare
  • SSI
  • Third party or other insurance
• Application suspended – tolls all time limits §31-3505C(3)

Necessary Medical Services

• “Utilization management” may also include the amount to be paid based on the application of the reimbursement rate to those medical services determined to be necessary medical services.
• Pay for necessary medical services for the medically indigent residents of their counties as provided in this chapter and as approved by the county commissioners at the reimbursement rate, or in contract for the provision of necessary medical services.
• Pay for the cost of necessary medical services for a medically indigent resident, as provided in this chapter, where the cost of necessary medical services,
• The governor of the state of Idaho or his or her designee is empowered to negotiate reciprocal agreements with other states for the provision of necessary medical services for residents of this and other states.
• Follow-up necessary medical services based on a treatment plan,
• ... shall have a priority date as of the date the necessary medical services were provided.
• Upon payment of a claim for necessary medical services pursuant to this chapter, the obligated county shall:...
Necessary Medical Services

- Defined in §31-3502(18)A
  - In accordance with generally accepted standards of medical practice
  - Provided to a person for prevention, evaluation, diagnosis or treatment of illness, injury, disease or its symptoms
  - Are clinically appropriate and effective
  - Not provided for convenience of patient or providers
  - Are the most cost effective services or supplies.
- Medical Necessity shall be determined by a physician.

Necessary Medical Services

Medically Indigent Program Excludes Some Services:

- Organ or bone marrow transplants
- Elective, or cosmetic or experimental procedures
- Services provided by residential, skilled nursing, assisted living and shelter care facilities
- Normal uncomplicated pregnancies, excludes caesarean section and childbirth well baby care
- Drugs, devices or procedures primarily used for weight reduction or complications
- Medicare/Medicaid co pays and deductibles
- Services provided by state, federal or local health programs

Food for Thought

- Can I make changes to the determination after it’s been signed by the BOCC?
- What’s an amended approval? I can’t find that in statute.
- Does a provider have to be listed on the application if they are listed on the treatment plan? One of the other...right?
- Do I have to send a med review order for records to every provider on the app.? Some of them weren’t even involved in the emergency.
Collections By Hospitals and Providers

• Payment by an obligated county or board shall be considered payment in full and restrict billing an applicant or obligated person for such services. §31-3509(1)
• Once provider is notified another resource is available, provider must submit or resubmit bill to resource within 30 days notification §31-3509(2)
• Such resources include: third party insurance, Medicaid, Medicare, supplemental security income, crime victims compensation, workers compensation, other insurance, other third party sources or section 1011 funds.

Collections By Hospitals and Providers

Example:
• Bengal county paid $6,800 to RST Facility on behalf of Sarah Sue. Sarah Sue was later determined to be eligible for Medicaid for the approved dates of service. Bengal county has repeatedly made attempts to recoup the payment, to no avail. Bengal County has now approved Daisy Duke who is a new applicant for $6000 to RST Facility. Doglife County notifies RST Facility that no payment will be forth coming and RST still owes the county an additional $800 on the next claim. Bookkeeping nightmare, but it usually only takes once and the providers are willing to reimburse.
  • Note: This doesn’t work if it’s a CAT payment

Right of Subrogation §31-3510

The county and CAT based on their subrogated interest shall be subrogated to all rights of the hospital, other providers, and medically indigent person against any third parties who might be the cause of or liable for such medical services.

You have the obligation both to the taxpayer and the patient to attempt to gather all available funding for the medically indigent program.
Right of Subrogation §31-3510

- Civil Suit: Ask for attorney contact information.
- Attorney’s costs & fees shall not exceed 25% of the subrogated interest unless previously agreed (Previously agreed to is rare)
  - Be sure they itemize attorney’s fees in settlement documents w/ 25% amount

Suggestions...Ideas.....Thoughts.....

- The providers receive insurance funds and rarely if ever notify the county of those funds. Notify the providers in your approvals that you are attaching all outside funds.
- One county uses this disclaimer: The county has first claim to any funds you may or may become entitled to, including but not limited to insurance awards or settlements, lawsuit judgments, victim’s compensation, worker’s compensation, inheritance, lottery winnings or any other funds.
- Another has this... if the patient is approved for Medicaid covering any services that already paid for by the county/CAT program, providers are required to reimburse the county/CAT in the full amount received by the county/CAT and collect payment from Medicaid for those dates of service.

Reimbursement

- Applicant may increase reimbursement on an ongoing basis payment – if BOCC determines a substantial change in circumstances has occurred
- BOCC may review a petition from applicant to reduce order of reimbursement on substantial change in circumstances
- Some counties use collection agencies for past debt collection.
- Others have in house staff who coordinate the effort.
Violations and Penalties §31-3511

- County may deny application IF:
  - False and misleading information by applicant
  - Does not disclose insurance, worker’s comp, other resource or benefits; failure to disclose assets that may render them not medically indigent
  - Failure to cooperate
  - If applicant divests themselves in order to qualify
  - If sanctioned by a state program they are also ineligible for county assistance for the same time period

DID YOU KNOW………

- 31-3511. VIOLATIONS AND PENALTIES (4) If the county commissioners fail to act upon an application within the timelines required under this chapter, the application shall be deemed approved and payment made as provided in this chapter.

CAT YEAR….Say what...???

- A CAT year is defined as one year--less one day from the first date of service of the first episode of care that has been approved by the BOCC. A CAT year is very important because it regulates the counties $11,000 deductible. After a county has paid $11,000 in eligible payments on a patient, the remainder of eligible medical claims may be submitted to the CAT program for the one year timeframe. This can include more than one county case, to get to the full $11,000 spent by the county.
Jail Medical

Is county indigent responsible for jail medical expenses?

Medical expenses can be priced at the Medicaid rate for payment to providers by the county. They are not indigent patients and do not fall under the county clerk’s responsibility for payment. However, some counties choose to allocate clerk’s funds for payment of these bills in anticipation of stopping the payments at $11,000 and sending the remainder of the bills to the state CAT fund for payment. The state CAT program will not pay the excess of $11,000 for those applicants who are in the custody of the county sheriff when treatment occurs.

Jail Medical

• It is the expressed opinion of the each county’s Sheriff and County Commissioners as to which department’s budget gets to pay for health care for inmates in their custody.

• The CAT Board’s attorney has given opinion that the CAT Board will not pay the excess of $11,000 for those applicant’s who are in the custody of the County Sheriff.

• Does the Custodial County have responsibility to pay the medical bills? Yes

• Does the Inmate’s county of residence indigent department have responsibility to pay the medical bills? No as long as the inmate was in custody of the Sheriff and was not released solely for medical treatment.

Pre-litigation Screening Panel

• Pre-litigation was developed to provide guidance in contested resource availability cases §31-3551

• An advisory panel is formed to act as a special civil grand jury and provide a procedure for pre-litigation

• The panel consists of three (3) members – all serve under oath they are without bias or conflict of interest §31-3552

• Chairman – representing and appointed by Health & Welfare

• One (1) Member – representing and appointed by the Idaho Association of Counties

• One (1) Member – representing and appointed by the Idaho Hospital Association.
Pre-litigation Screening Panel

- The pre-litigation panel meets about 4 times per year and typically reviews 8-10 cases to initiate a panel meeting.
- Pre-litigation precedes any court action and is non-binding.
- All panel meetings are recorded and minutes created. Minutes are sent to all participants for review after conclusion of the case.
- The panel will consider the eligibility of the applicants on claims referred to them and render a written decision based on an analysis of the resources available to the applicant.