CAT MANUAL

IDAHO ASSOCIATION OF COUNTIES

EFFECTIVE

MARCH 12, 2021

Catastrophic Health Care Cost Program (CAT) Fund

This manual will explain the Catastrophic (CAT) process from the electronic submission of the case through the CAT Board's approval and payment of the claims by the state controller's office.

The IAC has contracted with Indigent Healthcare Solutions (IHS) to enable counties to electronically submit cases and enable IDHW/CAU to electronically notify counties of denials and upload the applications.

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1 CAT Board Application

1.1 Checklist for Completing the CAT Application

- ☐ CAT Number – numbers assigned through IHS to be used to identify this patient with CAT
- ☐ Submitting county – county that is submitting the CAT application
- ☐ Anniversary date – Determined by the CAT year. Definition in Tab B
- ☐ Documented U.S. Citizenship – indicate if the patient is a documented citizen.
- ☐ Age – age of patient at the time of the first date of service
- ☐ Gender – is the patient male or female
- ☐ Monthly patient income – include all sources of income of patient
- ☐ Monthly household income – include all income patient has access to for living expenses
  - ☐ Major Assets/Equity Item – Do not list liquid assets, i.e. checking/ savings accounts
  - ☐ Value – list current market value of item
  - ☐ Lien Amount – list any liens or loans against the piece of property
  - ☐ Equity – this is the value minus the loan amount
- ☐ Application type – What type is the original combined application? Mark the appropriate box
- ☐ Nature of Emergency and Treatment – State the medical condition and brief summary of the treatment applied for
- ☐ Total medical claims – total billed amount of all the claims related to this application prior to any reductions and pricing.
- ☐ Summary of total medical claims – list each provider with their total eligible claims amount
- ☐ Total medical claims at reimbursement rate – Total amount of the eligible claims priced out so we can see how much the county and the CAT combined will be paying. This amount should match the total of the previous field.
- ☐ Medical review – indicate if a medical review was completed for this application
- ☐ Medical review savings recommendations – indicate any savings that will be used due to the recommendation of the medical review
- ☐ Cost of medical review – total cost of the medical review(s) on the cases related to this CAT Application
- ☐ Medical review and findings – BRIEF summary of medical review findings
- ☐ Medicaid/Medicare/insurance eligible
  - ☐ Indicate if patient was eligible at time of services
  - ☐ Indicate amounts paid by other resources
  - ☐ If retro resources are being applied for partial payment…what is first date of eligibility
  - ☐ If they signed up for YHI (Your Health Idaho - the exchange) when does their coverage start?

1.2 Explanation

The CAT application is a summary of the case for the CAT board to review. It is a document that goes to a public meeting. No identifying information should ever be on the CAT app.

1.2.1 CAT Number

A series of numbers and letters that are assigned through IHS to be used to identify a patient and to warehouse all documents related to the CAT case. These numbers are not the same as the numbers assigned by the combined unit when you first receive an application from the department. The CAT program controls the numbers. All numbers are assigned to the counties for their distribution. Your county license plate designator is the identifying piece of the number. The state fiscal year is the middle number. Each year's numbers become available on July 1st. Each county determines and has control over what CAT number is assigned to each medical review and CAT case.

1.2.2 Submitting County

Include your county name when submitting the CAT application for consideration.

1.2.3 Anniversary Date

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 county's $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 time-frame. This can include more than one county case, to get to the full $11,000 spent by the county.

1.2.4 Documented U.S Citizenship

Was the box on the combined application check marked no? If so, and if during your investigation you determined their presence in this country qualifies them for payment on emergent services to stabilization only. Mark "NO" on the CAT application.

1.2.5 Age

The age of patient at the time of the application for services.

1.2.6 Gender

Indicate if the patient is male or female

1.2.7 Monthly Patient Income

Include all sources of income which you used in determining indigency. Remember to include monthly benefits, like SSI.

1.2.8 Monthly Household Income

Include all income patient has access to for living expenses. This number should also be reflected in your clerk's findings showing indigency.

1. **Major Assets/Equity Item** – List property, real and titled. That includes boats, snow-mobiles, etc. Do not list cash holdings, i.e. checking/ savings accounts.

2. **Value** – List (resale value) of item. If you made them sell it, what would they get for it?
3. **Lien Amount** – List the amount still owing on any liens or loans against the piece of property. This has nothing to do with our type of county lien. Examples would be mortgages, or title loans or a car loan.
4. **Equity** – This is the property's value minus the loan amount. Example: Blue book value on the car is $9,500. Patient still owes $1,500 on the loan. EQUITY equals = $8,000.

1.2.9 Application Type

What type is the original combined application received for this CAT year? Mark the appropriate box.

1.2.10 Nature of Emergency or Treatment

Start with the medical problem. Examples: Heart attack, or MVA or Diabetic seizure. If it is an MVA, list injuries resulting from the accident that are being treated. Head trauma, broken ankle, or intestinal injury for example. Then summarize the treatment. Was there surgery? Is there more than one county case? If so, what's each of them about?

1.2.11 Total Medicaid Claims

Total billed amount of all the claims APPROVED and related to this application prior to any reductions and pricing.

1.2.12 Summary of Total Medical Claims

List each provider with a total of their eligible claims amount.

1.2.13 Total Medical Claims at Reimbursement Rate

As defined in Third Party Applicants Filing Emergent Applications §31–3502(23), I.C.). Total amount of the eligible claims priced out so we can see how much the county and the CAT combined will be paying. This amount should match the total of the previous field. List each provider with their total eligible claims amount that has been approved by the BOCC.

1.2.14 Medical Review

Indicate if a medical review was completed for this CAT Case.

1.2.15 Medical Review Savings Recommendations

Indicate any savings that will be used due to the recommendation of the medical review.

1.2.16 Cost of Medical Review

Total cost of the medical review(s) on the applications related to this CAT case.

1.2.17 Medical Review & Findings

Provide a brief **summary** of medical review findings. If the case is found to be medically necessary and no adjustments are needed state only "medically necessary and emergent" ... (or non emergent on a 10 day)

1.2.18 Medicaid/Medicare/Medical Insurance Eligible

Indicate if patient was eligible at the time of service, or when they will become eligible.

Indicate amounts paid by other resources.

If retro resources are being applied for partial payment ... what is the first date of eligibility?

If they signed up for YHI (the exchange), when does their coverage start?

2 Submitting Cases for Board Approval

Within 14 days after the county payment, any application exceeding $11,000 per resident per calendar year shall be forwarded to the CAT Board. A copy of the Clerk's Findings, the final decision of the BOCC and a statement of costs paid by the county shall be forwarded with the application to the board. §§31–3508A(4) & 31–3519, I.C.

The CAT application and accompanying documentation shall be filed to the CAT Board within fourteen (14) days from the date you pay your $11,000.

TIPS: Something to think about...

Refer to local county internal operation procedure for compiling case for submission to the CAT program. (for example CAI, Stevenson's or local county procedure manual)

If county approval excludes some dates of service which were applied for but after the investigation, including the medical review, the county board did not authorize them for payment, you may need to wait 28 days from the approval date to allow for due process. Statute does not require you to wait 28 days from an approval. However, it is in the best interests of the case to allow for this time before paying your $11,000 and then submit your case to the CAT program.

Each county is required to make payment to the eligible providers on an approved application up to $11,000 before sending the case to the CAT for consideration.

2.1 CAT Electronic Case Submission

2.1.1 CAT Board Application

☐ The CAT Board application should be one page only. If it extends to a second page, change the formatting to force it onto one page.

Scan ONLY one page into this category on IHS.

See Exhibit A – CAT Board Application

2.1.2 CAT Medical Records

☐ As defined by IMR as pertinent to the episode of care, for review. However, if no medical review is conducted, the requirement is to submit relevant medical records. Records fitting that description include, but are not limited to, the following:

- ☑ Emergency room report
- ☑ Consultation notes and reports
- ☑ Operative reports
- ☑ History and physical
- ☑ Discharge summary
- ☑ Lab reports
- ☑ Imaging reports

2.1.3 CAT Request For Payment

- ☐ Use a separate, clean request form each time a new set of claims is submitted.
- ☐ Stack the claims behind it in order as listed on the request form.

  Specific information for CAT request payment sheet

  - ☑ County name
  - ☑ Date sending to CAT
  - ☑ Invoice # of each provider requesting payment
  - ☑ Indigent name
  - ☑ Anniversary date
  - ☑ Date of service for each provider
  - ☑ Provider name (include Company name and doctor name)
  - ☑ Tax ID # of each provider requesting payment
  - ☑ Total billed amount
  - ☑ Amount County paying if splitting payment on the claim
  - ☑ Amount CAT to pay

2.1.4 Commissioners' Decisions

- ☐ Send all determinations relating to the county case(s) you are submitting to the CAT.
- ☐ Listing specifically who and what is covered for payment.
- ☐ Stacked with the newest most recent decision on top.
- ☐ Include the suspension decision if the county suspends a case for a pending resource, and the resource is denied.

2.1.5 Completed Combined Application

- ☐ Completed pursuant to §31–3502(7), I.C.

All applications and additional requests by the time it comes to the CAT Fund. If that was not possible, an explanation must be submitted. (i.e. patient is deceased, incarcerated, etc.) Applicant's signature and any initials required for edits are expected to be on all combined applications.

2.1.6 Signatures

- ☐ Is the application signed by the applicant on page 1, 9 and 10
- ☐ Did the patient initial all blanks on the rights and responsibilities page 10. If not, is there an explanation why?
- ☐ If third party application, did the third party sign page 1 and page 9
- ☐ Stack with the DHW cover sheet on top, making sure the top fax line is legible
- ☐ Nothing else intermingled in the scan. ONLY applications, additional requests in this category

2.1.7 County Payments Summary Form

- ☐ Certification showing payment of qualifying county claims totaling $11,000.
- ☐ "County hereby certifies that, payments listed herein have been made to providers and amount to $11,000, prior to case submission to the CAT Fund."
- ☐ Copies of each paid claim, stacked in order as listed on the county payment summary form, clearly showing pricing used.

2.1.8 Clerk's Findings

- ☐ An explanation/summary provided to your BOCC at initial hearing includes the clerk's recommendations to the BOCC. Including any updated findings prepared for appeal hearings to update BOCC on case status
- ☐ Was there an appeal hearing? If so, scan the resulting Order and Findings of Fact

2.1.9 County Liens

- ☐ The CAT board requires a county recorded lien be on file for every CAT case.
- ☐ Scan in the statutory lien, recorded with your county pursuant to §31–3504(4), I.C.

2.1.10 N-1 (State Lien)

- ☐ Scan in the county Medical-Form N1

2.1.11 Medicaid/SSI/Insurance

- ☐ All Medicaid determinations from the CAU.
- ☐ Any correspondence or decisions from 3rd party payers & verifications from other resources, such as: SSI, Medicare, liability insurance, worker's comp, crime victim benefits, auto insurance, homeowners insurance.

2.1.12 Medical Reviews (When Applicable) Are Scanned In By IMR

- ☐ Do not re-scan the medical review into IHS.

2.1.13 Miscellaneous Documents

- ☐ Any other pertinent documentation pertaining to the case including any correspondence or explanation letters, etc.

2.1.14 Reimbursement agreement

- ☐ Reimbursement agreement signed and scanned in
- ☐ OR –Advise of a time certain when one will be provided to CAT Fund

2.1.15 Treatment Plans

- ☐ Do you have a treatment plan included In this case? If so, scan it here, NOT in with medical records.
- ☐ Does it have all required elements included on it (Listed in IAC manual under treatment plan)

3 Administrative Procedures For The Counties

3.1 Determination of a Case

The CAT Board is responsible for a case upon submission by a county and receipt and acknowledgement by the authorized secure web based system.

3.2 Single Case Processing

Once an application is approved by the county and all claims are received, the application and all relevant documentation are to be scanned into the secure web based system pursuant to statutory timelines.

Applications are reviewed in order of receipt, based upon the scan /submittal date into IHS.

Referring to the list above and on the CAT transmittal form (sample attached herein) the documentation is reviewed for completeness. If documentation, listed above is missing, or incomplete the county is notified to provide the additional information. If the information is not provided before the meeting deadline, the case is held until all documentation needed is received in the program office, reviewed and processed for the next scheduled meeting of the CAT Board.

When a case review is completed and the case is eligible for consideration by the CAT Board, the information is compiled for submission to the CAT Board members for their review.

3.3 Processing Multiple County Cases Into A Single CAT Year

1. Each indigent has one CAT number per 12-month period. However, they may incur several incidents and the county may receive multiple applications on one person during a 12-month period.
2. The county incurs one $11,000 deductible for each 12 months.
3. The following documents must be scanned separately into the same CAT number for each county case.
    A. Each county application not already scanned in
    B. Medical records for each related incident
    C. Each county BOCC decision, listing who and what is being approved
    D. Any updates on lien filings or reimbursement agreements
4. Payment Summary sheet. When filling out the summary sheet to summarize the COUNTY payments that equal $11,000, pay/list all of the first case before starting on the second case. Then pay any of the second county case claims to reach your full $11,000. (Only include those payments that are eligible for CAT approval)
5. Medical reviews are required for individual cases with billed charges over $75,000. If a single additional claim exceeds $50,000 in billed charges then an additional medical review may be required. CAT Year:

Back to Checklist. Back to Anniversary Date

3.4 Reimbursements

The CAT will track cases for reimbursement payments.

The county shares the patients' reimbursement payments with the CAT fund. §31-3510A, I.C. The amount sent to the CAT for each patient is determined by the assignment sent to the county by the CAT program and based on each CAT year.

If you have a frequent participant, you may have 2 or 3 different assignment percentages on one person.

When a patient pays off their account, through settlement, estate reconciliation, the lottery ticket that won big, or by any other means, you must notify the CAT program that no additional payments will be received so we can inactivate the account in our records.

If a patient is deceased, please notify the CAT program office so the records can be adjusted as well.

3.5 Resource Eligibility

If a patient is approved for a resource which covers some of the charges or dates of service, the approval letter from the resource must be scanned into the appropriate CAT case number (examples include worker's compensation, Medicaid (partial dates of service), med-pay insurance). Use the Medicaid/SSI/Ins. category in IHS.

If a patient is denied one of the resources listed in statute, then scan the denial documentation into the system under the Medicaid/SSI/Insurance category.

Suspensions are ONLY used to wait for other resources. Person must be deemed indigent in all other areas for a suspension determination to be appropriate. Residency, obligated county and medical necessity must also already be proven.

Avoid ***denying*** for other resources. If you deny for other resources, you can't suspend at a later date for other resources pursuant to statute. (You can stipulate to something if the provider agrees, however, talk with your prosecutor).

3.6 CAT Board Determination and Payment

The CAT Board meets approximately every 8-10 weeks to review claims.

Approximately, one week prior to each CAT Board meeting you will receive email notice of the cutoff date for cases submitted to the CAT board for consideration at the next meeting. New cases which meet the requirements in this document after that date shall be considered at a later meeting of the CAT Board.

New cases and accompanying claims approved by the Board are given priority for processing. Ongoing requests for payment are paid based on receipt date.

Once a CAT case is approved by the CAT Board, each claim may require up to forty-five (45) days for processing and submission to the state controller for payment.

CAT program office notifies the counties in writing of case disposition after each board meeting.

3.7 Closing CAT Cases

When the processing of a case is complete, it is the responsibility of the county to notify the CAT office of cases being closed on the closing spreadsheet. If you have a frequent client, who has multiple CAT numbers, close them separately, as they expire. To determine when to request assignments; Do so:

- If the CAT year has expired or; before the expiration date IF; The patient is deceased and no further cases will be opened for them and no further claims will be received.
- Upon notification of closed cases, the CAT office will provide the counties with assignments on each CAT number for your commissioners to sign.
- County retains copy of assignment for records
- Scan signed assignments into IHS for the CAT board's files. Remember to change the status to "Closed" after you scan it in

See Exhibit B – Copy of County Cases to close Form

4 Submitting Claims for Consideration of Payment

The goal of sending in forms and documentation for payment by the CAT fund is to secure payment of medical claims by our program. With that in mind, the importance of understanding the claims process itself is important. The focus of the process at the CAT fund level, is that of payment. The services have been rendered, the patient has been treated, now it's time to pay the claims.

Medical Claims: Defined in statute §31–3502(15), I.C. When a provider wants to be paid by the county/state programs for services rendered during an episode of care, which has already been applied for timely, final claims shall be sent to the county for consideration of payment no later than 60 days after the BOCC approval. (Hospital claims likely came in much earlier if an order was sent to the hospital).

4.1 An Eligible Claim §31–3517, I.C.

To insure all claims can be paid by the state CAT fund, we must have all the paperwork authorizing the claim scanned to us. The CAT fund program will review the claim for the following elements:

- ☑ Is the claim presented to the CAT Fund on a CMS form UB04 or a 1500? NO? Payment denied pursuant to statute. Game over. Yes? Continue….
- ☑ Is county date stamp, showing when claim was received, visible on the top of each claim?
- ☑ Was the claim received date no later than 60 days from the approval showing these services listed on the claim?
- ☑ Are any other sources of payment recorded on the 1500 in box 29? If so, did you use this and any other payment information in your pricing calculations?
- ☑ They are more than $25. Singular medical claims when the billed rate for the claim is less than $25.00, shall not be presented for payment. §31–3508(15), I.C. (Individual charges listed on a claim may be less than $25.00 as long as the full payment to be made on the submitted claim is $25.00 or more.)
- ☑ Are dates of service listed on the medical claim included on a completed combined application, treatment plan or additional request that has been approved by the BOCC?
- ☑ Provider on the 1500 claim whom the check will be made payable to was approved by the BOCC and the name of the provider and all dates of service which were approved for payment, are listed on the approval.
- ☑ Show all pricing calculations on the claim form including the amount county is asking the CAT fund to pay. The CAT fund staff does NOT do pricing, we do offer qualified assistance referrals if you need help. Be sure you are pricing from the corresponding interim rates sheet and fee schedule to the dates of service you are calculating.
- ★ When a claim is sent into the CAT fund for payment and all these elements have been included, the last component for the CAT to check on is:
- ★ Did we receive a copy of all related BOCC decisions? Is this claim information listed on an approval?
- ★ Was the date(s) of service(s) rendered, applied for and therefore listed on a combined application; or an additional request as well as any treatment plan?

If these questions cannot be answered affirmatively, there's no need to send the claim to the CAT office for payment.

4.2 Patient/Application

When an applicant, typically the patient, wants to include a provider, on their application (during investigation,) who provided services DURING the applied for time period and same diagnosis, the addition must be initialed by the applicant prior to approval.

The CAT must be able to read the combined application. Any additions should be legible. All criteria for timeliness and submission must be met, as outlined in this manual.

4.3 Third Party Applicants Filing Emergent Applications (See §31–3502(26), I.C.)

The CAT program believes due process is necessary in this portion of the application process allowing the third party applicant, just like the applicant, a way to streamline the process for notifying counties of other providers that were involved in an emergent care situation. This provides a vehicle for this to happen. The CAT fund must have documentation on all providers who are requesting payment.

Outlined below is a process for notifying the county of newly identified provider(s) involved with the care listed on the original application. The county will review all providers with the patient/applicant in order for them to be added to the original application and considered by the board of county commissioners.

Provider Page

You may use the first page of the combined application. (NOT the cover sheet) Or provide the information in a format to include all such information as would be found on the first page of the combined application.

Used by 3rd party applicant/hospitals to inform a county of newly discovered additional providers who were involved in the initial previously applied for episode of care.

- Used as a form of communicating between the third party applicants and the counties.
- NOT considered an additional request.
- ONLY submitted by 3rd party applicant/hospital and must be acknowledged by applicant during interview.
- Services printed on the provider page must be part of the same timely filed dates of service and diagnoses included on a completed application.
- No action will be taken on the additional provider page until a completed application is received.
- Sent directly to the county **after** the county has received the combined application.
  - ★ ***TIPS for providers***: Call your county and see if the application has been received from the department before sending over additional information.
- Can only be considered by a county during the investigatory time frame.

★ The CAT program will not pay for providers who are added with this form, if the form is received **after** the initial determination.

5 CAT Policies

5.1 Additional Requests

The CAT Fund will only accept additional request forms from the counties for services that have been applied for 10-days prior. The linked policy and procedures will outline the guidelines for submitting claims to the CAT for payment and when additional request forms are required for claims payment.

See Exhibit C – CAT Additional Request Policy

See Exhibit D – Additional Requests Procedures

5.2 CAT Board Legal Counsel

The CAT Board has separately contracted for legal representation with an outside firm and is no longer represented by the attorney general's office. For that reason, the CAT board must approve the billable hours spent by our contract law firm.

If a county is engaged in a legal matter regarding a case or otherwise needs legal review of an issue and requests assistance from the CAT program and its legal counsel or for litigation assistance, or to include the CAT fund in proceedings, call the program office to receive instruction on how to proceed.

To consult with our attorney for input, the county shall contact the CAT program office first, to request assistance stating reason for request;

Contact information will be provided by the program office.

See Exhibit E – Legal Counsel Policy

5.3 Medical Review Policy

The purpose of this policy is to clearly specify that the CAT Board has a right of subrogation for cases in excess of $11,000 as specified in Idaho Code. Emergent cases, submitted on 31-day applications, in excess of $75,000 that will be submitted to the CAT program for consideration shall be reviewed:

The CAT Board requires counties conduct medical reviews on all combined applications where indigents'medical expenses are estimated or anticipated to exceed a billed rate of $75,000.

The CAT program will participate and will reimburse the counties for fifty percent (50%) of the costs for reviews IF specific criteria is met. See attached procedures.

Medical reviews must be conducted prior to BOCC final approval.

Individual claims under $75,000 that will ultimately be sent to the CAT for consideration may be reviewed:

If a county makes a decision to conduct a review based on the complexity of a case, for CAT cases that have a billed rate under $75,000, the CAT Program will participate and will reimburse the counties for fifty percent (50%) of the costs for such review.

See Exhibit F – CAT Medical Review Policy

5.3.1 Requesting The Medical Review

When requesting a medical review, or communicating with IMR via email, always put the CAT number assigned to the medical review in the email SUBJECT line.

Scan into IHS the documentation pertinent to the services on the application for the reviewer to access.

Elements needed for the review:

- Combined Application: Scan into "County Application" category
- Medical Claims: Scanned into "Misc." category
- Medical records are scanned into category "Medical Records"

Note: if you have several hundred pages of records to scan, refer to the list of necessary medical records. Frequently, many records we receive are not pertinent to a medical review of this nature. Reviewing hundreds of pages of documents is cumbersome.

5.3.2 Understanding The Recommendations

Any reviewers'recommendations that provide for a reduction SHALL be considered. If the BOCC chooses not to apply a reduction, the BOCC shall explain the choice to pay at the reimbursement rate.

If the reviewer recommends a resource, follow up on it. If it is not a viable resource, document your findings with a written explanation and include when submitting a case by scanning your letter into the MISC. category.

When services are defined in the review as 'emergent'or as 'non-emergent' it is not to be misconstrued as application approval in anyway. Services must always be appropriately applied for pursuant to statute.

If follow up services are indicated in the review as standard treatment, they must still be applied for in order to be considered for payment.

> *Example: A global therapy/ or treatment plan of 60 days would be appropriate. Reviewer is just giving you a 'heads up' that IF you get a request for that particular kind of treatment...it shouldn't be approved for more than 60 days.*

5.3.3 Medical Review Reimbursement Process

To receive the 50% reimbursement from the CAT program, you must submit the Excel spreadsheet/ invoice form provided by the CAT program for this purpose.

Include all data on the spreadsheet for all medical reviews conducted for your county. Even if it's a case the CAT cannot reimburse you for. We need to collect the data.

Provide report to the CAT no less than quarterly. More frequently is also acceptable if you have a high volume.

See Exhibit G – Medical Review Invoice Form

5.4 Settlement Policy

The purpose of having a settlement policy is to clarify that for cases exceeding $11,000 the CAT program shall be clearly named in any lien filed and in any reimbursement agreements with any party. The CAT board has the right to review large settlements being offered on cases that effect the state of Idaho.

- To provide input on a timely basis, a subcommittee of the CAT Board shall be established to review any settlement requests from counties and provide recommendations to the full Board.

- When a county negotiates the settlement of a case that includes CAT payments; and the amount being considered for payment is a difference of twenty-five percent (25%) or more of the current amount due on the account, such county must notify the CAT program office and provide the following:
  - A copy of the recommended settlement amounts
  - Payment history of the applicant and remaining balance due
  - Explanation and reasoning for settlement
  - A description of the situation and source of new funds
- Upon notification by the county, the CAT program office shall provide all documentation to the settlement subcommittee for consideration. Once a decision is reached by the settlement committee, the CAT program office shall immediately notify the county of the decision. If the committee cannot come to a consensus, it will be referred to the full CAT Board for consideration.

See Exhibit H – Settlement Policy

5.5 Non-emergent Cases Filed On 10-day Prior Applications

The CAT Board will require the counties to conduct a medical review on non-emergent cases filed on 10-Day prior applications prior to county approval and submission to the CAT Board. The CAT program will participate and will reimburse the counties for fifty percent (50%) of the costs for such review if it is a CAT case or was likely to have become a CAT case based on estimated billed charges.

The review shall be completed prior to the Board of County Commissioners' determination process and not after an approval.

SUSPENSIONS: If a case is over $75,000 billed amount, a review shall have been conducted before the suspension is issued. (Note: full determination of medically indigent must be reached, including medical necessity, validating the need for a review.)

6 Mental Health & Jail Medical

6.1 Mental Health Coverage

Responsibility for mental health expenses incurred during an involuntary protective hold is ordered by a court and payment is assigned to a county. How a county board of commissioners assigns payment within a county budget is discretionary. In September of 2010 the Attorney General's office, in an informal guideline, advised that claims resulting from a P/C hold are not eligible for payment by the state Catastrophic Health Care Cost Program.

CAT Board Polices attached in supporting documentation.

CAT Board polices are created to streamline processes in the relationship between the counties and the CAT fund.

6.2 Jail Medical

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 claims in anticipation of stopping the payments at $11,000 and sending the remainder of the claims 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. See St. Alphonsus vs. Killeen (1993).

6.3 Medical Expenses Incurred During Incarceration

§20–605, I.C. says that any inmate in need of medical treatment shall receive such treatment and it is the responsibility of the sheriff to pay for the costs, provided they are in their custody.

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. St. Alphonsus vs. Killeen (1993).

A patient under guard at the hospital and not physically within the confines of the jail itself, is still considered in custody for purposes of payment and the CAT program will not cover any medical charges.

The Inmate's usual county of residence indigent department does not have the responsibility to pay the medical claims for as long as the inmate was in custody of another county's jail. The custodial county has the responsibility to pay the medical claims incurred while in the custody of

The county cannot release an inmate from their custody in order to receive medical treatment.

It is the decision of each county's board of commissioners as to which county department's budget gets to pay for health care for inmates in their custody.

The CAT Board's attorney has determined that the CAT Board will not pay the excess of $11,000 for those applicants who are in the custody of the county sheriff. A patient under guard at the hospital and not physically within the confines of the jail itself, is still considered in custody for purposes of payment and the CAT program will not cover any medical charges.

EXHIBIT A
CAT Board Application

CAT BOARD APPLICATION

CAT NUMBER: SUBMITTING COUNTY:

Anniversary Date: Legal US Citizenship: Yes ☐ No ☐

Age: Gender: ☐ Male ☐ Female

Monthly Applicant Income: $ Monthly Household Income: $

Major Assets/Equity

Item	Value	Lien Amt.	Equity
	$	$	$
	$	$	$
	$	$	$

APPLICATION TYPE:
☐ 10 Day Prior ☐ 31 Day Emergency ☐ 180 Day Delayed

Nature of emergency and subsequent treatment:

Claims (Billed Rate): $

Summary of total medical Claims at reimbursement rate (I.C. §31-3502(23))

Total Medical Claims at the Reimbursement Rate: $

Medical Review: Yes☐ No ☐ Cost of Medical Review: $

Medical Review Savings from claims: $

Medical Review Findings Summary:

Medicaid Eligible: Yes ☐ No ☐ Date will be eligible:
Medicare Eligible: Yes ☐ No ☐
Insurance Available: Yes ☐ No ☐ --If Yes --- List Insurance Company:

Reimbursement Agreement: Yes ☐ No ☐ Note Amt.: $
Summary of Agreement: $ Payment amount: 1st Billing Date:

EXHIBIT B
Copy of County Cases to close Form

County		Last name, First	CAT number	Anniversary Date	Total paid by county	Total paid by CAT

EXHIBIT C
CAT Additional Request Policy

STATE OF IDAHO

CATASTROPHIC HEALTH CARE COST BOARD

Policy: Additional Request Policy	Policy Number: 2011-02
Effective Date: May 1, 2016	Date Adopted: March 17, 2016
Annual Review Date:	Date Amended:
Retro for Fiscal Year	

I. AUTHORITY:

Idaho Code Chapter 35, Title 31

II. BACKGROUND:

The goal of sending in forms and documentation for payment by the CAT fund is to secure payment of medical claims by our program. With that in mind, the importance of understanding the claims process itself is imperative. The focus of the process at the CAT fund level is that of payment of timely filed fully documented medical claims.

III. PURPOSE:

The purpose of this policy is to outline the process for the CAT fund when paying medical claims: Defined in statute §31-3502(15) To allow for a provider to be paid by the county/state programs for services rendered during an episode of care which has already been applied for timely, final claims shall be sent to the county for consideration of payment no later than 60 days after the BOCC approval.

The counties must follow the procedures outlined in the *Cat Medical Claims Required Supporting Documentation* for Cat Board consideration.

IV. POLICY:

1. CAT Policy for Submitting Medical Claims for Consideration of Payment

To receive reimbursement pursuant to statute, a medical claim must be timely filed and meet all other statutory requirements.

The CAT fund program will review the claim for the following basic elements.
Check list:

- Is the claim presented to the CAT Fund on a CMS form UB04 or a 1500? NO? Payment denied pursuant to statute. §31-3502(15)
- The CAT Fund is a state agency and as such makes payment requests through the state controllers system. Any vendors wishing to be paid by the state of Idaho shall provide all necessary documentation for payment purposes. To include but not limited to, Federal ID number, known herein as 'vendor number'. Identifying data such as legal name, address, and phone number on the medical claim whom the check will be made payable to and all dates of service with appropriate payment codes listed.
- The county shall show all pricing calculations on the claim form by referencing the pricing manual and interim rates sheet appropriate to the claims, including the amount county is asking the CAT fund to pay.
- The CAT fund staff does not do pricing.
- When a claim is sent into the CAT fund for payment and these elements have been included, the county must refer to the *Cat Medical Claims Required Supporting Documentation* for complete instructions for submission for payment

2. <u>ADDITIONAL REQUESTS -- NON-EMERGENT SERVICES</u>

- ❖ *Additional Services - are unanticipated NON-emergent services.*

This section refers ONLY to unanticipated non-emergent services. The CAT fund will allow additional request forms for those services that need to be applied for under the same course of treatment for the same condition.

Additional requests reflect those non-emergent services that may arise after a combined application and treatment plan have been filed with the county. These non-emergent forms are investigated by the county for consideration of payment and must be received 10 days prior to services being allowed.

- Additional requests are those requests that are not on the treatment plan for follow up services.
- Services can never be added outside of the 6 month time period of the original application.

Necessary documentation requirements are provided in detail in the *Cat Medical Claims Required Supporting Documentation*

V. OUTCOMES AND MONITORING:

- The CAT program will provide information and materials to the counties and provide training to assure the payment of medical claims submitted to the state.

- The result of this policy is to clarify and to improve the process and overall effectiveness of the payment system which is the CAT program's primary focus.

Adopted this _____ day of _____, 2016.

_____
Roger Christensen, CAT Chairman

_____
Richard Armstrong, CAT Secretary

EXHIBIT D
Additional Requests Procedures

ADDITIONAL REQUESTS -- NON-EMERGENT SERVICES

- **Additional Services - are unanticipated NON-emergent services.**
    - **Additional requests are used for those non-emergent services *or* procedures, not already included on a combined application.**

This section refers ONLY to unanticipated non-emergent services. Those services that need to be applied for under the same course of treatment for the same condition. It reflects those services which need to be added (10 days prior) for consideration of payment that arise after an application and treatment plan have been filed with the county.

This type of request does not 'stand alone'. They are related to a full combined non emergent or emergent application for assistance. *NOTE:* An additional request cannot be attached to a denial. A denial is no longer a valid application and therefore the request cannot be considered and must be considered denied. If an application is appealed, additional requests may be also considered at that hearing pursuant to agreement by all parties.

To Be Considered A Valid Additional Request the following criteria must be met

- ✓ Additional requests are filed separately and become part of a complete combined application.
- ✓ Additional requests go directly to the county
- ✓ Additional requests are filed at least 10 days prior to the first date of the scheduled service by an applicant/patient and -
    - Shall include a signed page 1 of the combined application NOT the cover sheet.

- ✓ Are *for medically necessary services* pursuant to statute. §31-3502(18).
- ✓ Are only for services relating to the same condition applied for on the original application.
- ✓ If request was received directly from a provider, clerk has 10 days to contact patient and update the original application including but not limited to financial information. §31-3505A (5)

GUIDELINES:

- ➔ Most claims are related to services already applied for and don't need to have additional paperwork when submitting to the CAT fund.
- ➔ However, when submitting new claims to the CAT program, additional requests shall include the corresponding BOCC approval.
- ➔ Additional requests may only be considered for payment by the CAT fund if they have been approved by the BOCC.
- ➔ Any services on a medical claim not related to the original diagnoses must be applied for separately on a complete application and the proper timelines in statute must be followed.
- ➔ Additional requests are those requests that are not on the treatment plan for follow up services.
- ➔ Services can never be added outside of the 6 month time period of the original application.

EXHIBIT E
Legal Counsel Policy

STATE OF IDAHO

CATASTROPHIC HEALTH CARE COST BOARD

Policy: **Use of Legal Counsel**	Policy Number: 2011-04
Effective Date: July 1, 2011	Date Adopted: July 26, 2011
Annual Review Date:	Date Amended:
Approved Retro for Fiscal Year	

I. AUTHORITY:

Idaho Code § 31-3503A, 31-3518.

II. BACKGROUND:

Historically the CAT Board has had legal representation either through its administrator or through the Attorney General's office. There has been an administrative change in operations, including additional responsibilities of the Board. The recent restructuring of the Attorney General's office has resulted in their inability to continue to represent the CAT Board. The CAT Board has separately contracted for legal representation with an outside firm.

III. PURPOSE:

The purpose of this policy is to limit and control the costs of using the CAT Board legal counsel when providing assistance to counties.

IV. POLICY:

- If a county is engaged in legal action regarding a case or otherwise needs legal review of an issue and requests assistance from the CAT program and its legal counsel, the county shall be required to follow these guidelines:

    1. The county shall contact the CAT program office in writing to request assistance stating reason for request;

    2. The county shall forward all documents for case review to the CAT program office not the office of the law firm, by email and contact the CAT office to confirm receipt.

3. For litigation assistance or other legal consultation, the county shall comply with paragraph "2" of these policies and shall specifically set forth the purpose for which the assistance is needed.

V. OUTCOMES AND MONITORING:

By providing standardized forms and training for county indigent staff it is anticipated that the costs for legal counsel will be reduced.

Adopted this 7 day of 26, 2011.

Roger Christensen, CAT Chairman

Richard Armstrong, CAT Secretary

EXHIBIT F
CAT Medical Review Policy - Amended Sept 2018

STATE OF IDAHO

CATASTROPHIC HEALTH CARE COST BOARD

Policy: Conducting Medical Reviews	Policy Number: 2011-02
Effective Date: July 1, 2010	Date Adopted: September 19, 2011
Annual Review Date:	Date Amended: **September 24, 2018**
Retro for Fiscal Year	

I. AUTHORITY:

Idaho Code § 31-3502(28) 31-3503A, 31-3504, 31-3505A, 31-3518

II. BACKGROUND:

The counties in the state of Idaho and the Catastrophic Health Care Cost Program (CAT) are responsible for paying the medical costs for necessary medical services for those individuals deemed to be medically indigent residents of Idaho. They are also required by state law to be the payer of last resort for financial assistance.

In May 2010 the Idaho Association of Counties entered into a statewide contract, which was renewed and updated in 2016, with a contractor to perform medical reviews on county indigent cases. The implementation of utilization management reviews of indigent cases was to aid in the determination of the emergent nature of case care, the appropriateness of costs and medical necessity, as they pertain to payment by our programs pursuant to Idaho Code.

III. PURPOSE:

The purpose of this policy is to provide guidance to both entities in their decision making regarding the statutory requirement to pay for necessary medical services. Providing this retrospective review of records and hospital claims for medical care assists in assuring accountability by counties and the state for the taxpayer money spent on these claims.

IV. POLICY:

1.) Emergent cases, submitted on 31-day applications, in excess of $75,000 which will be submitted to the CAT program for consideration shall be reviewed for medical necessity:

- The CAT Board requires counties conduct medical reviews on all combined applications where applicants' indigents' medical expenses are estimated or anticipated to exceed a billed rate of $75,000.

- The CAT program will participate and will reimburse the counties for fifty percent (50%) of the costs for reviews IF specific criteria is met.
    - A. Medical review must be conducted prior to BOCC final approval.

2.) Individual claims, that will ultimately be sent to the CAT for consideration may also be reviewed at the counties' discretion:

- If a county makes a decision to conduct a review based on the complexity of a case, for CAT cases, the CAT program will reimburse the counties for fifty percent (50%) of the costs for such review. when it becomes a CAT case.
- If an additional ongoing individual *claim* exceeds $50,000 in billed charges then an additional medical review *may* be requested by the CAT Board.

3.) Non-Emergent requests for treatment. cases filed on 10-Day Prior Applications:

- The CAT Board will require the counties to conduct a medical review on non-emergent cases filed on a 10-Day prior application with a treatment plan if:
    - prior to final county approval
    - If the case appears likely to become a CAT case.

- The CAT program will participate and will reimburse the counties for fifty percent (50%) of the costs for such review **if** the application treatment was likely to have been included in a CAT case based on estimated *billed* charges.

V. OUTCOMES AND MONITORING:

- The CAT program will provide a spreadsheet for counties to complete to assist in tracking the information obtained, and savings resulting from performing these reviews.
- The result of this policy is the collection of information concerning ways to improve the process and overall effectiveness of the program.

Adopted this ___24th____ day of September, 2018.

_____
Roger S. Christensen, Chairman

_____
Russell Barron, Secretary

EXHIBIT G
Medical Review Invoice Form

MEDICAL REVIEW INVOICE FOR PAYMENT									
County _____ County EIN#_____ Date _____									
Case #	Diagnosis	Application Type	Billed Amount	Interim Rate	Med Rev. Recommendations	Med Review reduction taken	Amt county Paid	Amount CAT Pays	Notes

EXHIBIT H
Settlement Policy Executed 2015

STATE OF IDAHO

CATASTROPHIC HEALTH CARE COST BOARD

Policy: **Settlements**	Policy Number: 2011-05
Effective Date: July 1, 2011	Date Adopted: July 26, 2011
Annual Review Date: September 2015	Date Amended: September 28, 2015

I. AUTHORITY:

Idaho Code § 31-3510, 31-3503A, 31-3518.

II. BACKGROUND:

The counties in the state of Idaho and the Catastrophic Health Care Cost Program (CAT) are responsible for paying the medical costs of individuals deemed to be medically indigent. They are also required by state law to be the payer of last resort for financial assistance.

Idaho Code provided for the process in dealing with medical indigency from the filing of an application, recording a lien, investigating an applicant, approval/denial of claims, payment of medical bills through repayment and settlement. The Catastrophic program is involved in these processes when cases exceed $11,000.

Prior to March 2010 few settlement requests were brought before the CAT Board. Since then the counties have been informed to provide specific information for Board approval after review by the BOCC.

III. PURPOSE:

The purpose of this policy is to clearly specify that the CAT Board has a right of subrogation for cases in excess of $11,000 as specified in Idaho Code.

IV. POLICY:

- For cases exceeding $11,000 the CAT program shall be clearly named in any lien filed and in any reimbursement agreements with any party.

- To provide input on a timely basis, a subcommittee of the CAT Board shall be established to review any settlement requests from counties and provide recommendations to the full Board.

- When a county negotiates the settlement of a case which includes full lien release on payments that have been made by the CAT fund; and amount being considered for payment is a difference of twenty-five percent (25%) or more of the current amount due on the account, such county must notify the CAT program office and provide the following:

    - The original balance on the account
    - A reconciliation of the recommended settlement amounts
    - Payment history of the applicant and remaining balance due
    - Explanation for settlement
    - A description of the situation and source of settlement funds

- Upon notification by the county, the CAT program office shall provide all documentation to the settlement subcommittee for consideration. Once a decision is reached by the settlement committee, the CAT program office shall immediately notify the county of the decision. If the committee cannot come to a consensus, it will be referred to the full CAT Board for consideration.
- The only exception to this rule would be if the request is for settlement of an estate for a deceased person where no real property exists. The CAT board recognizes that very little room for negotiation exists in these situations. The BOCC may determine a reasonable settlement on behalf of the CAT fund.

V. OUTCOMES AND MONITORING:

This process requires ongoing training to all counties as settlements are unique. This will be accomplished by providing instruction at various trainings and meetings yearly.

Amended this 28th day of September, 2015.

Roger S Christensen

Roger Christensen, Chairman

Richard Armstrong, Board Secretary