



# **Coordination of Benefits Summary**

DHS/DMH Provider Impact

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## Background and Purpose

The business practices and calculations associated with determining amounts billable to each payer when a client has private resources or private insurance in combination with Medicaid or Non-Medicaid eligibility is known as coordination of benefits. For FY07, the Division of Mental Health (DMH) added coordination of benefits language to Attachment B of the Department of Human Services (DHS) Community Services Agreement to specify how payments from DMH should be coordinated with any other benefits that a consumer receives. The language required that DMH be treated as a payer of last resort for Medicaid and Non-Medicaid, and that these funds could not be used to subsidize any other provider agreements with other payers. Federal law requires that Medicaid be treated in this manner, and other states typically require that general revenue funds be treated as the final payer, behind Medicaid.

### Provider Feedback

The addition of the coordination of benefit language in the DMH Attachment B created significant feedback from a number of providers, who indicated that their organizations would suffer revenue reductions as a result of this change. Several meetings were held with providers via teleconference to understand the impact of the required coordination of benefits, and the primary issues for coordination of benefits and the corresponding DMH billing appeared to exist for Non-Medicaid funds only. All providers on the teleconferences appeared to understand that Medicaid was the payer of last resort and that the Rule 132 rate was payment in full for Medicaid services. If a consumer had another payment source, such as Medicare, the other payer must be billed and any amounts collected from the primary payer should be deducted from the Rule 132 rate for billing to Medicaid. Self pay amounts are also not an issue for Medicaid, since Medicaid consumers cannot be billed for any covered service under current Illinois regulation.

Based on information collected from the provider meetings on this issue, it became clear that provider practices associated with coordination of benefits for Non-Medicaid consumers varied widely. Some providers served very few Non-Medicaid consumers with Medicare, private insurance or any ability to pay, and others treated Non-Medicaid coordination of benefits in exactly the same manner as for Medicaid consumers—the Rule 132 rate as payment in full, resulting in a reduction in the amount billed to DMH for any amounts collected from the consumer or third parties. There was also a group of providers who served significant numbers of Non-Medicaid consumers with insurance or ability pay, and these providers were collecting amounts from other payers and billing DMH Non-Medicaid the full Rule 132 rate up to their agency fee schedule, which was substantially higher than the Rule 132 rate schedule. Providers in this group had worked to develop more diversified revenues, and stated that they were using the larger collections from those with third party coverage and DMH Non-Medicaid eligibility to help subsidize poor Rule 132 rates.

One of the most challenging issues for providers participating in the teleconferences on coordination of benefits was how to handle self pay collections, particularly once fee for service is implemented. While many agencies attempt to establish some responsibility for Non-Medicaid consumers and families to pay reduced amounts for services, these amounts are typically difficult to collect, and collections can extend for months or even years. As a result, providers had many questions about how self pay amounts should be treated. Issues related to whether the assessed fee should be deducted from the DMH Non-Medicaid claims and what would happen if the amount was later found to be uncollectible were discussed, along with the cash flow problems that providers would experience if DMH Non-Medicaid billing had to be

delayed until collection efforts were exhausted. Many providers were also concerned about the high administrative costs associated with attempting to collect small consumer balances.

The provider meetings also yielded extensive discussions about which consumers should be eligible for Non-Medicaid funding. Contractually, DMH expects providers to serve target populations (SMI adults and SED youth), and providers can serve eligible persons to the extent resources are available. Although DMH currently has definitions of target and eligible persons, monitoring of the consistency of the application of these criteria by providers has been extremely limited. As a result, provider practices related to which Non-Medicaid consumers were billed to DMH also varied widely. Some providers referred most consumers with private resources to other community providers, thereby reserving Non-Medicaid funding for those with no other options for services. Other providers had very active lines of business devoted to insurance or self pay clients, and would bill DMH Non-Medicaid if the consumer met criteria for Non-Medicaid eligibility. Several providers noted the importance of further DMH clarity regarding eligibility for Non-Medicaid funding.

### Fee for Service Transition and Medicaid Impact

The issues associated with the coordination of benefits for Non-Medicaid consumers have been highlighted due to the planned transition to fee for service. Under grant reimbursement, providers were not required to bill for Non-Medicaid consumers or services, although the goal was for DMH Non-Medicaid funds to be used for consumers who were very ill or indigent, and who did not have access to Medicaid for some reason. Questions about methodologies for calculations of the amount billable to DMH Non-Medicaid arose during FY05, and DMH had not provided definitive guidance on coordination of benefits until the language in the FY07 Attachment B. The lack of specific DMH guidance allowed providers to develop a range of methodologies for determining the amount billable to Non-Medicaid when a consumer had other insurance or government benefits. Because providers continue to be paid using grants for FY07, a net reduction in revenues will not result from the coordination of benefit policy until the transition to fee for service is complete.

Existing coordination of benefit requirements for Medicaid consumers is a factor in developing requirements for Non-Medicaid consumers. Currently, the Department of Healthcare and Family Services (HFS) relies on consistency between Medicaid and Non-Medicaid consumers in the DMH system to review all DMH claims for possible retrospective identification of Medicaid consumers from Non-Medicaid claims. This retrospective review process allows Illinois to identify additional Medicaid claims from DMH data and to garner the associated federal financial participation. For FY06, the federal funds generated from retrospective review of Non-Medicaid claims by HFS are estimated at \$3.4 million based on nine months of actual data, and those amounts are deposited to the 718 fund. HFS uses a similar process to review SASS claims, and DMH is projected to receive \$1,000,000 for FY06 from HFS for reimbursement for SASS eligible children who become Medicaid eligible retrospectively. If Medicaid and Non-Medicaid coordination of benefit policies for DMH claims are inconsistent, HFS would be forced to discontinue retrospective review of Non-Medicaid claims, and the state would lose the federal share (\$3.4 million) and the DMH service delivery system would lose the total amount (\$4.4 million).

Consistency between DMH Medicaid and Non-Medicaid coordination of benefit practices must also be considered from a mental health policy perspective. As explained in the Findings section below, some current provider practices for Non-Medicaid coordination of benefits result in higher reimbursement for Non-Medicaid consumers than for Medicaid consumers. Throughout the transition to fee for service DMH has attempted to create a single system of care for all consumers, Medicaid and Non-Medicaid, to protect access to care for those most in need of publicly funded mental health services. Allowing different practices for coordination of benefits for Medicaid consumers compared to Non-Medicaid consumers is inconsistent with DMH's goal for a single system of care.

To better understand the range of current provider practices for coordination of for Non-Medicaid consumers, DMH initiated a site visit process to review an agency's policies for determining which consumers are eligible for DMH Non-Medicaid funded services and to review actual practices based on a sample of records. The site visits were also designed to collect information regarding the projected financial impact from the Attachment B language for coordination of benefit. The site visits were completed using teams comprised of Parker Dennison, DMH Central Office and Regional Office staff.

## Methodology

Providers were selected for site visits in a non-random manner. Coordination of benefit reviews were conducted at some providers where site visits had already been scheduled for other purposes in order to use resources efficiently. Other providers were selected based on provider estimates of significant revenue reductions after fee for service implementation due to the DMH Attachment B language for coordination of benefits.

Two types of coordination of site visits were conducted. Comprehensive reviews were completed for five providers, and included review of fiscal policies and practices using a Provider Coordination of Benefits tool developed by Parker Dennison. These reviews were focused solely on Non-Medicaid consumers and measured an agency's policies, procedures and expected business practices against a list of 17 areas that reflect preferred practices for coordination of benefits based on Parker Dennison's experience with nearly 500 providers across the country. Record reviews were also completed as a part of the comprehensive reviews to validate the implementation of fiscal policies and procedures, and to assess the extent sampled records support a determination of Eligible, Target SED (youth) or Target SMI (adult) according to current DMH definitions and standards. The clinical determination was deemed an important part of the review of the use of Non-Medicaid funding to assess whether the funds were being devoted to those clients most in need of publicly funded mental health services. The number of clinical records reviewed ranged from 17 – 50 per agency, with a larger number of records reviewed at agencies projecting substantial financial impact from full implementation of coordination of benefits. Consumer rent payments for residential services were excluded from self-pay amounts for purposes of the financial impact analysis. The site visit tool is attached as Appendix A.

More limited coordination of benefit reviews were conducted for two providers and consisted of a review of business practices without validation through chart reviews. Limited reviews also did not include detailed modeling of the financial impact of the Attachment B coordination of benefit language. Providers were selected for limited reviews based on advance telephone calls that indicated that existing practice and client mix would result in no/very limited financial impact from the Attachment B coordination of benefit language.

The following providers were selected for coordination of benefit site visits:

Comprehensive Reviews	Limited Reviews
Delta Center	The Thresholds
Coles County Mental Health Center	Janet Wattles Center
Kenneth Youth Center	
Stepping Stones	
Heritage Behavioral Health	

# Findings

## General

The providers participating in the site visits fell into two distinct groups. One group, representing five of the seven providers (71%), had very limited Medicare, insurance (private insurance and Medicare are referred to as third party) or consumer billings from consumers who were also billed to DMH Non-Medicaid. The second group, 29% of the providers, had worked to diversify revenues beyond DMH funding and had substantial numbers of insurance consumers and billings. This second group of providers will suffer the greatest negative financial impact from full implementation of the coordination of benefit language in the DMH Attachment B. Based on informal feedback from the provider community since the release of the FY07 Attachment B, the distinct split found from the site visits appears to be consistent with impact on DMH contract providers throughout the state.

The range of coordination of benefit business practices varied widely by provider. Some providers had extensive third party and self pay collections and associated business practices. Other providers served DMH or other governmentally funded clients nearly exclusively, with very little third party and self pay billings and collections. In these agencies, consumers with resources were typically referred to other providers, and very little infrastructure for managing third party and self pay business existed.

## Financial

The following amounts are based on sampled data from FY06, and where relevant, amounts were annualized by provider based upon the sample size for each provider. Each provider received a detailed analysis of its results from the site visit and had an opportunity to make any corrections to its report. Provider specific summary reports have been made available to DMH under separate cover to offer anonymity to participating providers.

- Financial impact—Projected annual financial impact from implementation of the coordination of benefit language ranged from a reduction in DMH Non-Medicaid billings \$0 - \$416,000 per provider, and five of the providers had estimated an annual impact of less than \$1,000.
  - Providers' collections of third party and self pay amounts ranged from 0 – 49% of DMH Non-Medicaid contract allocations and 0 – 14% of total DMH contract, including Medicaid, Non-Medicaid and capacity grant amounts.
- Fiscal policies—On average, providers had 52% of the recommended fiscal practices in place or partially in place. The 17 recommended fiscal practices are detailed in Part A of the site visit tool in Appendix A. These practices include screening for benefits at admission and regularly throughout treatment, application of a means test to determine ability to pay, use of a sliding fee scale to set fees according to ability to pay, and various billing and collection procedures. On an individual basis, providers varied widely in their implementation of fiscal policies from a low of two policies in place to a high of 16 in place or partially in place. Since the coordination of benefits policies and procedures in most instances has not been expressly required by DMH, it was expected that there would be substantial areas of variance.

- Billing Non-Medicaid—The range of practices for billing amounts to DMH Non-Medicaid varied widely.
  - Two providers billed DMH Non-Medicaid in full with no reduction for amounts collected from third parties or consumers/families.
  - Five providers either reduced amounts billed to Non-Medicaid by amounts collected from third parties or had no collections from third parties.
  - One provider is not billing any payer—Medicare, Medicaid or DMH—for physician services, and is using the DMH capacity grant to support physician services. This provider would actually have a small positive financial impact from implementation of coordination of benefits.
- Self pay—Self pay collections were also highly variable. Three providers had no self pay collections, and one provider had collections of less than \$2,000. Three providers had more substantial self pay collections ranging from approximately \$40,000 to \$132,000 for FY06, or 5 – 9% of DMH NMCD allocations for these providers. Two of these three providers demonstrated excellent procedures for collecting sliding fee amounts and were successful 60 – 96% of the time collecting from consumers at the time of service.
- Insurance collections insurance and self pay—Four of the providers were billing third parties when identified, particularly Medicare for adults. Of these four providers, two had developed particular expertise in triaging clients to practitioners with the credentials required for third party reimbursement and had excellent billing and collections procedures for third party balances. The strong performance of these two providers in the area of insurance billing and collections is unusual for public sector community providers.
- Provider fee schedules—Providers typically establish a fee schedule based on prevailing market rates and costs to deliver services. Each provider was able to set its own fee schedule, resulting in a significant range of fees. On the fee schedules examined, fees ranged from \$90 - 130 per hour for individual therapy and \$125 - 260 for an evaluation by a physician. Two providers had no agency fee schedules and claims for these providers are submitted based on the payers' rates.
- Sliding fee scales—Publicly funded mental health providers often establish sliding fee scales that offer reduced fees based on family income for consumers/families without insurance or Medicaid. DMH does not have standards or requirements for the implementation of a sliding fee scale or the income levels that should be used on the scale. In other states, sliding fee scales are often linked to federal poverty limits, and in Illinois, three providers had sliding fee scales that were linked to 100 – 200% of federal poverty limits. A sliding fee at federal poverty guidelines means that consumers were charged full agency fee amounts if they had incomes over 100 – 200% of federal poverty amounts based on family size (\$9,800 – 19,600 for a family of one). Two providers did not have sliding fee scales and the two remaining providers had sliding fee scales that were not linked to federal poverty guidelines. The sliding fee scales that were not linked to federal poverty guidelines were set at a top range of \$65,000 - 85,000 in annual income, or 660 – 867% of federal poverty levels.
- Segregation of third party business—Two organizations, one with substantial third party revenues and one with very limited third party revenues, have established separate cost centers for third party operations and DMH funding is not included in these cost centers. This segregation of third party operations allows these agencies to measure the stand-alone financial performance of those lines of business and to help reduce the use of DMH Non-Medicaid funds for clients not eligible for DMH funded services.

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- Collections in excess of fee schedules—Two organizations have been collecting amounts in excess of their agency fee schedule. Collections above the fee schedule occur when a DMH Non-Medicaid consumer has private insurance and/or is making payments according to a sliding fee scale, and DMH is billed for 100% of the Rule 132 rate. The amount of collections above agency fee schedules was approximately \$3,000 for one provider and \$53,000 for the other provider, or less than 5% of one agency's annual negative impact from implementation of coordination of benefits, up to 13% of the other provider's estimated negative impact. While providers are still paid under grants, providers' DMH collections are not increased by this practice.
- Non-reimbursable insurance services—Some providers' original estimates of the negative financial impact were found to be overstated due to services that are not reimbursable by insurance companies. Insurance companies do not typically cover the range of services reimbursable under Rule 132. Case management, skills training and psychosocial rehabilitation are examples of services that are poorly reimbursed by insurance companies. Where DMH Non-Medicaid consumers have insurance and clinical need for services not covered by their insurance, standard coordination of benefits permits billing of those services to the secondary payer, DMH Non-Medicaid. As a result, providers' estimates of the financial impact of the Attachment B coordination of benefits language were reduced by 20 – 35%.
- Matching staff credentials to payer requirements—Many insurance companies, including Medicare, require independently licensed professionals to provide service as a condition for reimbursement. Rule 132 allows reimbursement for a larger range of practitioners and community mental health agencies typically have difficulties matching staff credentials to payer requirements unless specific procedures are in place at triage and intake.

## Clinical

- Target and eligible persons—Review of clinical documentation supported that Non-Medicaid consumers met target criteria in 69% of the charts reviewed and met eligible criteria in 99% of the charts reviewed on average across all agencies. The range of consumers meeting target definitions was 44 – 100% of the charts reviewed, and the range of consumer meeting eligible criteria was 96 – 100%.
- Screening for target and eligible—In order to assure that DMH funds are used according to contractual requirements, it is necessary to screen for determinations of target and eligible consumers in order to assure use DMH funding for target populations first, and eligible consumers as resources allow. Only one provider was consistently screening for determination of target or eligible status at admission, and no providers were routinely screening for target/eligible on a regular basis throughout treatment to reflect changing consumer circumstances.
- Clinical record findings—For the five providers participating in detailed reviews, a number of recommendations to improve clinical record documentation were made as a part of each provider's onsite visit. These recommendations were offered to providers as technical assistance to improve the quality of the documentation and its compliance with Rule 132 and federal Medicaid requirements. However, these recommendations did not modify the financial impact of the coordination of benefits analyses and will not be addressed in detail in this report.

## Recommendations and Next Steps

The recommendations below are designed to allow the DMH mental health system to retain the estimated \$4.4 million of incoming federal and HFS funding from retrospective review of Non-Medicaid claims. Based on the site visits, these recommendations also appear to be consistent with existing practices for many providers, and would create consistency and equity across the DMH provider network.

- DMH should proceed with implementation of the Attachment B language as written for third party insurance, which requires that the Rule 132 rate be treated as payment in full and billings to DMH Non-Medicaid should be reduced by any amounts collected from third party insurance.
  - If Non-Medicaid consumers receive medically necessary Rule 132 services that are not reimbursable by their insurance carrier, those services should be billable to DMH Non-Medicaid and a denial of payment for these services should be documented as required by HFS.
- DMH should develop a state-wide sliding fee scale that is tied to federal poverty guidelines based on income levels at 100 – 200% of federal poverty guidelines. Existing sliding fee scales that are used by HFS for AllKids and Title XXI eligible persons should be reviewed for applicability to the DMH system.
- In those situations where a consumer qualifies for the DMH state-wide sliding fee scale, providers should be allowed to retain self pay amounts and to bill DMH Non-Medicaid at 100% of the Rule 132 rate. Allowing providers to retain self pay amounts for consumers who qualify for a standard DMH sliding fee scale encourages providers to collect self pay amounts, but recognizes that any collections for this group of consumers will be limited and administratively challenging. This recommendation also avoids any delays in ability to bill DMH while waiting for small consumer self pay collections.
  - When Medicaid eligible consumers are identified through retrospective review of Non-Medicaid claims, providers should continue to refund any self pay collections to consumers back to the date of the retrospective Medicaid eligible. These procedures are currently required for DMH providers.
- Where a consumer has income above the standard sliding fee scale established by DMH, any self pay amounts should be treated consistently with third party collections, with the Rule 132 rate billed to DMH reduced by self pay collections.
  - DMH may wish to implement a sliding fee scale that extends beyond 100 – 200% of poverty to establish standard copays that must be deducted prior to billing DMH Non-Medicaid. Standard copays for consumers with incomes above 100 – 200% of poverty will allow providers to immediately establish the amount billable to DMH, thereby expediting Non-Medicaid billing and improving cash flow after implementation of fee for service. It would also assure DMH that providers are making reasonable efforts to collect self pay amounts from higher income consumers, and that providers do not bill DMH Non-Medicaid the full 132 rate to avoid self pay collection issues. A sliding fee scale above 100 – 200% of poverty is analogous to the premium payment structure for All Kids, where families at 100 – 800% of poverty are eligible for subsidized healthcare premiums.

- DMH should develop specific instructions and guidelines for providers for coordination of benefit requirements and should include this topic in one of the planned provider training sessions in anticipation of implementation of the Revised Rule 132 and fee for service.
  - DMH should address how local government/708 Board funding should be treated for purposes of coordination of benefits.
  - The guidelines should address how DMH should be billed when the third party insurance has a bundled or time-based CPT code that does not directly correlate with the DMH HCPCS codes.
- DMH should consider additional site visits to other providers who have estimated significant negative financial impact from implementation of the Attachment B coordination of benefit language. Providers should be contacted to determine if the planned DMH policies related to self pay amounts and services not billable to third parties will reduce the original financial impact estimates.
- DMH should finalize its policies for coordination of benefits and communicate the information to providers no later than March 1, 2007 to allow sufficient time for providers to make the operational and information system changes that will be necessary for some providers.

## Appendix A—Site Visit Tool

December 1, 2006

DHS/DMH

<b>Provider:</b>	<b>Date:</b>
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<b>PART A: Fiscal Policy Review</b>				
1. Complete and consistent form(s) & filing of consumer financial demographics and benefit verification (third party benefit verification, income determination, responsible person/contact info)?	Yes	No	Yes But	
2. P & P requiring standard sliding scale fee schedule?	Yes	No	Yes But	If yes, attach.
3. P & P requiring means test for under/no funded (including for non-Medicaid billing) individuals?	Yes	No	Yes But	
4. Is the means test or the sliding fee scaled tied to federal poverty level?	Yes	No	Yes But	If yes, what level? 100% 200% 300% higher
5. P & P requiring documentation of compliance with eligible/target definition at admission?	Yes	No	Yes But	
6. P & P requiring documentation of compliance with eligible/target definition at least annually?	Yes	No	Yes But	
7. P & P requiring documentation of all third party benefits at admission (copy of card and benefit verification)?	Yes	No	Yes But	
8. P & P requiring matching of services and credentials to third party requirements?	Yes	No	Yes But	
9. P & P requiring documentation of at least quarterly review of all third party benefits?	Yes	No	Yes But	
10. P & P requiring updating/re-verification of income level for application of sliding fee scale/means test at least annually or upon significant change in living status (job, residence, etc.)?	Yes	No	Yes But	
11. P & P establishing practices for A/R follow-up for amounts billed to third parties?	Yes	No	Yes But	
12. P & P describing copay collection requirements (when, who collects, etc)?	Yes	No	Yes But	
13. P & P describing Coordination of Benefits practice (which payers billed first, balance billing practices, etc)?	Yes	No	Yes But	
14. Produces financial results for third party payer business separately? (payer or total)	Yes	No	Yes But	
15. Does provider routinely use electronic verification of Medicaid eligibility?	Yes	No	Yes But	
16. Does provider routinely use other electronic mechanisms to check for Medicare or other third party coverage (i.e. Medifax)?	Yes	No	Yes But	
17. P & P establishing practices for A/R write-off for amounts billed to third parties?	Yes	No	Yes But	
<b>Fiscal Policy Review TOTALS</b>				