Finance Workgroup Minutes
8/2/06

Purpose of the teleconference meeting is to review issues associated with coordination of benefits for clients billed to DMH and develop recommendations for the SRI meeting in September.

- Overview of issues and meeting handouts (attached) was reviewed by Randy Pletcher. Issues included:
  - Definition of usual and customary charge, whether it is based on the provider's fee schedule or the Rule 132 rate schedule, and how the resulting amount is entered into ROCs
  - Principle of equity between MCD and NMCD clients in planning for DMH fee for service structures to protect access for all clients, reduce/eliminate any financial incentives for preferring one type of client over another, and encourage application for MCD, where appropriate.
  - HFS parameters—Medicaid payment is payment in full, and consistent treatment of MCD and NMCD facilitates billing to CMS as clients' eligibility change.
  - If Rule 132 rate is payment in full several issues exist from the providers' perspective, including:
    - Providers' financial incentives to seek third party payments is reduced,
    - Provider's revenue from DHS and other payers could be reduced, and
    - Timing is problematic since eventual collections may be different from amounts billed. Mechanisms to true-up actual calculations are complex.

- Provider discussion of issues:
  - Discrimination against MCD clients not a big issue due to provider struggling to meet MCD targets. The impact of MCD/NMCD targets depends upon each provider's particular situation.
  - Number of MCD clients with TPL is very low, but much larger volume of NMCD with small self pay amounts
  - Technical issues for retroactive MCD eligibility are complex—example of need to refund client payments if client eligibility changes from NMCD to MCD.
  - If coordination of benefits is based on provider's fee schedule, the amount paid to each provider could be different.
  - Provider's rate schedule should be usual and customary charge and that amount should be defensible based on a variety of factors.
  - Proposed calculations, which will reduce MCD/NMCD billable amounts by TPL and client payments, will result in fewer resources available in the community for mental health services.
  - Rates do not cover the costs of service, which is why the incremental reimbursement from third parties/clients payments should be available to providers.

- MCD or NMCD eligibility not specified in ROCs until after the claim is processed.
- Providers will admit MCD clients from out of area, but not NMCD
- Is an incentive from the 718 fund possible?
- All agree that MCD COB must begin with the Rule 132 rate
- The critical issue is whether the NMCD COB calculation begins with the Rule 132 rate, the provider's fee schedule or another amount.
- Timing is important for cash flow, so if final payment is required prior to filing, cash flow will be delayed. Also, if claims can be filed based on expected amounts and the actual collection is different, how can a true-up be claimed?
- Is there an impact on access to service? Is there an impact on the dollars available for services?

Next meeting to review preliminary recommendations Monday, August 8, 1:30 – 3:30 PM.

Meeting participants:
Doug Kolasinski, Randy Pletcher, Susan Parker, Tim Sheehan, Teresa Goode, Brittan Harris, Kelly Schuler, Mike Bach, Wanda Burnett, Gongmin Mou, Rich Murphy, Heather Eagleton, Candace Clevenger, Robert Lesser, Frederica Garnett, Tom Frederick, Kathy Roberts

Background for the Coordination of Benefits for Community Mental Health Services
Third Party Liability

A. How does the current system work for considering third party liability in determining the payable amount? – Part Deux

The provider has this information:

1	DHS rate	$ 71.52
2	Provider's usual and customary charge	$ 85.00
3	Contributions from third party payers	$ 42.50

- Provider sums total payments from other parties = $ 42.50
- Provider deducts total payments from other parties from the lower of the usual and customary charge =$ 85.00 - $ 42.50
- Provider bills DHS for the remaining portion of the bill = $ 42.50

The adjudication system sees this:

1	DHS rate	$ 71.52
2	Provider's usual and customary charge	$ 42.50
3	Contributions from third party payers	$ 00.00

- The system sees the provider charge is lower than the DHS rate
- The payable amount is the full charge from the provider = $ 42.50

Background for the Coordination of Benefits for Community Mental Health Services
Third Party Liability – Current Processing

A. How does the current system work for considering third party liability in a payable amount?

1	DHS rate	$ 71.52
2	Provider's usual and customary charge	$ 85.00
3	Contributions from third party payers	$ 42.50

- Sum total payments from other parties = $ 42.50
- Deduct total payments from other parties from the DHS rate = $ 71.52 - $ 42.50
- The remainder is the payable amount = $ 29.02

B. Why is this the way the current system works?
For Medicaid recipients the system is set up this way to meet the federal requirement that payment from Medicaid is payment-in-full. This means that any provider willing to receive reimbursement for a Medicaid recipient agrees that the Medicaid rate for the service will be the full amount of payment from any and all sources.

For non-Medicaid recipients the system is set us this way to conform with the general premise that the state will have a single system of care for both Medicaid and non-Medicaid recipients and will not establish different policies for the different populations. Therefore, the policies and procedures for non-Medicaid recipients are set up the same as they are for Medicaid recipients. This is intended to maintain equity and avoid discrimination that could lead to service access problems for one consumer group or the other.

C. Is this a new policy for FY2007?
No, this is the way the system has always worked to determine the payable amount for non-Medicaid recipients, which began in FY2005. If the provider reported third party payments on ROCS for either a Medicaid or a non-Medicaid recipient, the calculation of the payable amount would have been made the same way.

D. What would be an alternative to this approach?
The most commonly expressed alternative would be determining the payable amount differently for non-Medicaid recipients. If the DHS payment was not considered payment in full for non-Medicaid recipients the calculation of the payable amount could be as follows:

- Sum total payments from other parties = $ 42.50
- Deduct total payments from other parties from the usual and customary charge = $ 85.00 - $ 42.50
- The remainder is the payable amount = $ 42.50

Issues for Discussing the Coordination of Benefits for Community Mental Health Services

Third Party Liability

What are the implications of having the same payment and reimbursement policies for Medicaid and non-Medicaid consumers of mental health services?

1. The State needs to maintain access to services for non-Medicaid consumers. In many states resources for non-Medicaid consumers have eroded because the services are not an entitlement.
2. The State needs to maintain provider incentives to serve Medicaid recipients. If a provider could receive more revenue for serving a non-Medicaid consumer, as compared to a Medicaid consumer, there would be incentives to discriminate against Medicaid recipients.
3. The Department needs to control costs under fee-for-service. If DHS payment for non-Medicaid consumers was accepted as payment-in-full, the State's average payment per consumer would be less than if the DHS payment was not considered payment-in-full.
4. The Department wishes to maintain provider advocacy in assisting consumers to obtain public benefits. If providers have the opportunity to receive more revenue for non-Medicaid consumers as compared to Medicaid consumers, the providers will have no financial incentive to assist consumers to become Medicaid recipients.
5. It is poor public policy to have different state reimbursement methods for the same services.
6. Having the same reimbursement policies for Medicaid and non-Medicaid consumers facilitates State claiming of Medicaid for recipients with retroactive eligibility.
7. Third party reimbursement policies for non-Medicaid All Kids enrollees will be the same as they will be for Medicaid recipients, and the State should not have different policies for non-Medicaid consumers that could lead to discrimination.

What are the implications of having the different payment and reimbursement policies for Medicaid and non-Medicaid consumers of mental health services?

1. If DHS payment for non-Medicaid recipients is considered to be payment-in-full, providers will have no financial incentive to seek payment from third parties.
2. If DHS payment for non-Medicaid recipients is considered to be payment-in-full, providers will experience a reduction in revenue both from the State and from other liable payers.
3. If DHS applies Medicaid policies to non-Medicaid payments, providers could face delays in submitting correct bills to DHS for non-Medicaid consumers with third party coverage. In order to know the third party payments, providers might have to wait for an Explanation of Benefits (EOB), which could take 30 days or more from the date of service.

Basic Concepts for Discussing the Coordination of Benefits for Community Mental Health Services

Third Party Liability

Third Party Liability
A third party is an individual, institution, corporation, public or private agency, trust, estate, insurance carrier, employee welfare benefit plan, health maintenance organization, health service organization, preferred provider organization, governmental program such as Medicare, CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the medical costs of injury, disease, or disability of a recipient.

Medicaid Policy on Third Party Liability (IDHFS, Chapter 100, Topic 120)
The Illinois Department of Public Aid is, by federal and State law, the payor of last resort. Payment can be made through the Department's Medical Programs only after all other known resources for payment, both private and governmental, have been explored and exhausted. Examples of third party resources include Medicare, private health insurance, liability insurance, Workers' Compensation, Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), Veterans Administration benefits, Black Lung benefits, etc..

It is the responsibility of the provider to ascertain from each patient whether there is a third party resource that is available to pay for the services rendered. In an effort to aid providers in situations where a third party resource is known to the Department, the third party liability (TPL) resource coverage code is printed on the MediPlan or KidCare Card (see Topic 108); however, providers retain the responsibility for determining the status of a patient's eligibility for third party coverage and benefits prior to making charges to the Department.

Medicaid Policy on Medicaid Payment as Payment-in-Full (IDHFS, Chapter 100, Topic 101.1)
To be approved for participation, a provider must agree to…

- Provide services and supplies to patients in the same quality and mode of delivery as are provided to the general public, and charge the Department in amounts not to exceed the provider's usual and customary charges;
- Accept as payment in full the amounts established by the Department, except in limited instances involving allowable spend-down or co-payments, as described in Topics 113 and 114:

DHS/DMH Premise About A Single System of Care
The Department of Human Services adopted the principle in the beginning of the transition from community mental health grant payments to fee-for-service that policies

for non-Medicaid consumers would be the same as policies for Medicaid consumers. These are the reasons for that choice:

- It would permit providers to serve all consumers in the same manner,
- It would avoid discrimination between Medicaid and non-Medicaid consumers, assuring the same access and quality of services for all clients funded by DHS,
- It would permit centralized Medicaid claiming for consumers with retro-active Medicaid eligibility