Minutes for SRI Finance Workgroup
Small Workgroup on the Coordination of Benefits
10:00AM Thursday, September 7, Teleconference

Participants included Doug Kolasinski (chair), Randy Pletcher, Susan Parker, Diane Bell, Kelly Schuler, Mike Bach, Wand Burnett, Gongmin Mou, and Kathy Roberts.

Randy Pletcher had prepared a presentation of six options for considering other, non-DHS payers in the calculation of payable amounts to providers for services to non-Medicaid consumers. It was already clear to the members of the group that policies and procedures for Medicaid consumers are well established.

The six options are variations based upon two variables: consumer payments, and the base number to use in calculating payable amounts.

	Consider Consumer Payment	Ignore Consumer Payment
Base calculations on provider-reported usual and customary charge	Option 1	Option 2
Base calculations on a standardized usual and customary charge	Option 3	Option 4
Base calculations on the DHS rate	Option 5	Option 6

Mike Bach suggested that there may be another option, but in discussion the group agreed that this new option was based on the same conditions as Option 1.

Wanda Burnett brought up the issue that the implications of a decision on the coordination of benefits depended very much upon what population DMH expects providers to serve with DMH funding. Others pointed out that sometimes when providers contract with privately funded groups, such as with employee assistance programs, payment rates may be less than DMH rates, and DMH funds end up subsidizing these programs. Randy Pletcher noted that as we have discussed the coordination of benefits, DMH has become aware that it needs to clarify for providers who the eligible consumers are. However, that decision is beyond the responsibilities of the finance workgroup and must involve consumers, DMH, DHS, and the Governor's Office. Randy Pletcher asked the chairman, Doug Kolasinski, if it made sense for the financial workgroup to continue to evaluate and recommend one or more options, or whether the group should wait until DMH has made that determination. Doug Kolasinski indicated that he felt the group could still make a recommendation from the options and, after discussion on the matter, the group agreed.

Kathy Roberts asked about the planned site visits by Parker, Dennison, and Associates to look at details of provider billing when multiple payers are involved. Susan Parker noted that any findings from these visits will be reported to DMH and to SRI. Doug Kolasinski added that the recommendations of this workgroup do not depend upon any findings from P, D & A, so this group can proceed.

The group then turned to the options, with the understanding that the six presented were all the reasonable options to consider. One of the group members asked Susan Parker which of the options was used most frequently in other state-funded programs. She indicated that Option 5 was the most

typical option. A group member observed that that option would be fine if the DHS rate was high enough.

Gongmin Mou noted that any option that considered consumer payments presents many practical difficulties, particularly for very low-income persons with small fees and a low likelihood of payment. Mr. Mou suggested that the group eliminate all of these options (1, 3, and 5). He also explained that ignoring consumer payments in the calculation of payable amounts simplified retroactive Medicaid claiming, because the calculation of payable amounts would be unchanged. Kelly Schuster pointed out that it is still time consuming and costly for providers to seek third party payments, as well. But the group generally favored the options that ignore consumer payments. Susan Parker commented that this was a reasonable choice when consumers have very low incomes and their fees are small, but it is not reasonable for consumer of higher means. After discussion, the group agreed that ignoring consumer payments in the calculation of payable amounts would depend upon DMH implementing some type of income-based limitations on client eligibility or payments, perhaps like that used in other state programs (e.g. DASA).

With options 1, 3, and 5 eliminated from any recommendation, the remaining differences among the remaining options were due to the starting point for the calculation of payable amounts. Most of the discussion focused upon the advantages and disadvantages of using provider-reported usual and customary charges and a standardized statewide usual and customary charge (options 2 and 4). It was clear that the primary implication of the difference between the two was the effect on provider revenue and DMH expenditures. Members pointed out that many providers would use true usual and customary charges in reporting services under option 2, but other providers might take the opportunity to increase their charge artificially to maximize payments from DMH. Several persons observed that since option 2 ignores consumer payments in the calculation of DHS payable amounts, it is possible that total revenue for the service could exceed the usual and customary charge, which presents ethical, if note legal, issues for the provider.

The group also noted that the acceptability of option 4 depends upon the method for calculating the standard “usual and customary charge”. If this value is too low, the method has little advantage over option 6. If the value is high enough, option 4 could offer a reasonable compromise that permits providers to receive total payments in excess of DHS rates, without setting up opportunities for artificial inflation of reported usual and customary charges.

The group decided that their preferences (in order) were option 2 (if the anomaly of total payments in excess of charges can be remedied), Option 4 (with an acceptable method for setting the standard charge), and option 6. The group concluded that this could be presented to the larger financial workgroup to determine the recommendation to the SRI task group.