MINNESOTA DEPARTMENT OF

Children, Families & Learning

State Billing Process for Optimizing Third Party Revenue to Special Education

Report to the Legislature

May 2002

As required by Laws of Minnesota 2001, Special Session, Chapter 6, Article 3, Section 19

A Report to the 2002 Minnesota Legislature

State Billing Process for Optimizing Third Party Revenue to Special Education

Prepared by the
Minnesota Department of Children, Families & Learning
in consultation with the
Minnesota Department of Human Services

May 2002

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A Report to the Legislature:
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Legislative Charge

The following report was written at the direction of the 2001 Legislature. The request is found in 2001 Special Session Laws, Chapter 6, Article 3, Section 19:

> (STATE BILLING PROCESS) The commissioner of children, families, and learning, in consultation with the commissioner of human services, shall develop and recommend a billing process consistent with Minnesota Statutes, sections 125A.21 and 125A.744, for school districts to use to optimize processing third-party bills, including medical assistance. The commissioner of children, families and learning shall report to the legislature by February 1, 2002 on recommendations for a billing system.

Cost to Prepare Report

The 1994 Legislature enacted the following provision: A report to the Legislature must contain, at the beginning of the report, the cost of preparing the report, including any costs incurred by another agency or another level of government. (Minn. Stat. § 3.197.)

The following provides an estimate of the costs incurred to prepare this report about third party billing. This report provides information the Department of Children, Families & Learning already collects as part of its normal business function. The cost information below does not include the cost of gathering and analyzing data, but rather is limited to the estimated cost of actually preparing this document.

Funding for this report: No special funding was allocated for this report.

Cost to the Minnesota Department of Children, Families & Learning: $5,414

Other Agency Costs: $1,340

Total estimated cost of preparing this report: $6,754

Note: *In this report, use of the phrase "public health plans" means two programs: Medical Assistance (MA) and MinnesotaCare (MC). These are the two public health plans in Minnesota that reimburse school districts for health-related services identified on an Individual Family Service Plan (IFSP), Individual Education Plan (IEP) or Individual Interagency Intervention Plan (IIIP). Both MA and MC reimburse school districts for health-related services in the exact same manner. Therefore, during this report we refer to these two programs collectively as public health plans or Minnesota Health Care Programs (MHCP).*

Executive Summary

Beginning July 1, 2000, Minn. Stat. § 125A.21, subd. 2, mandated districts "seek reimbursement from insurers and similar third parties for the cost of services provided by the district whenever the services provided by the district are otherwise covered by the child's health coverage." In response to these statutes, the Department of Human Services (DHS) and the Department of Children, Families & Learning (CFL) cooperated to develop and implement by July 1, 2000, a process for school districts to bill Minnesota Health Care Programs (MHCP).

Districts are at various stages of implementing the mandate:

- As of February 25, 2002, 299 districts had enrolled as an IEP provider with MHCP.
- During calendar year 2001, 119 districts billed MHCP for at least one student.
- Payments to the 119 districts from MHCP for calendar year 2001 were approximately $1.2 million.

There have been significant revisions in how districts access revenue for health-related services from MHCP. DHS continues to work together with CFL and local districts on the process of understanding and developing the "expedited system" used by districts to obtain third party revenue from MHCP.

This report closely examines three important areas of function in the current MHCP state billing process for school districts:

- informed consent;
- MHCP reimbursement rates calculation and payment; and
- billing administration.

In each area, this report reviews background, issues, a goal and recommendations.

Overview to Current State Billing System

History and Status

Beginning July 1, 2000, Minn. Stat. § 125A.21, subd. 2, mandated that school districts "seek reimbursement from insurers and similar third parties for the cost of services provided by the district whenever the services provided by the district are otherwise covered by the child's health coverage." With this mandate, certain provisions were made in statute to assist schools in accessing revenue from Minnesota Health Care Programs (MHCP) and to protect the levels of medically necessary health and support services available to children who rely on MHCP to live in the community.

In response to these statutes, the Department of Human Services (DHS) and the Department of Children, Families & Learning (CFL) cooperated to develop and implement by July 1, 2000, a state billing process for school districts to bill MHCP.

District Enrollment

As of February 25, 2002, 299 districts had enrolled as an Individual Education Plan (IEP) provider with MHCP.

District Training

Over 80 publicized training sessions have been held since Spring 2000. Topics have included billing, program policies, rates, overview, train the trainer and special topics designated by specific schools, districts and professional groups. These sessions have been sponsored and provided by DHS, CFL, Minnesota Administrators for Special Education (MASE) and local school districts. In 2001, DHS and CFL staff have responded to more than 4,000 phone calls and e-mails regarding IEP services.

DHS developed and distributes an IEP Services Technical Assistance Guide used by schools to assist them with the policies and procedures related to billing IEP services to MHCP. In addition, DHS provides a "contact" sticker with the names and numbers of DHS staff who can help with questions and a brochure entitled "Medical Assistance and School Health Services – Information for Families" written in English and translated into nine different languages. DHS has recently made a Web site available that provides the IEP Services Technical Assistance Guide and other helpful information online.

DHS monitors the claim activity of the schools and provides them with technical assistance. The Surveillance & Integrity Review Section (SIRS) at DHS has audited about 15 districts to date.

District Revenue

During calendar year 2001, 119 districts billed MHCP for at least one student. Payments to districts from MHCP for calendar year 2001 were approximately $1.2 million. Medical Assistance (MA) and MinnesotaCare (MC) are funded approximately 50 percent by the federal government and 50 percent with local dollars. Typically, providers enrolled in MHCP receive payments that include the federal share and the local match which comes from the DHS budget. Per Minn. Stat. § 125A.744, subd. 3, districts receive only the federal portion of the payment less a five percent adjustment (not to exceed $350,000 per year). For IEP health-related services paid by MHCP to districts, the match does not come from DHS's budget. The match is provided by the district from educational dollars obtained through state and/or local education revenue sources.

The final amount of reimbursement from MHCP to districts for school year 2000-2001 will not be known until the annual settle-up occurs sometime after July 5, 2002. The cost-based rate formula establishes an interim rate for each district for each of the six service categories. The interim rate is used to pay districts for daily services provided to each eligible child. The district bills MHCP for an encounter each day the district provides a covered service to an eligible child.

At the end of the school year, DHS requests districts to report the total number of encounters the district has billed to DHS for each service and the total number of minutes of qualified service by category. This report can be filed anytime the district chooses, but it must be to DHS by July 5th of the following year. Based on the data submitted, DHS will recalculate all of the payments to determine if the district was overpaid or underpaid for services billed. If the district was underpaid, MHCP will issue an additional payment. If the district was overpaid, MHCP will adjust future payments to the district until the overpayment is recouped.

Continuous Improvement

There have been significant revisions in how districts access revenue for health-related services from MHCP. Listed below are some of the revisions that occurred. DHS continues to work together with CFL and local districts on the process of understanding and developing the "expedited system" used by districts to obtain third party revenue from MHCP.

- Billing MHCP is now done per encounter, instead of by a fifteen (15) minute unit as previously required.
- Billing MHCP is now done using eight special codes only available to schools.
- Rates are established based on direct costs to a specific district as reported in the Electronic Data Reporting System and Uniform Financial Accounting and Reporting Standards reports to CFL (reports that districts have always done) and in an annual report to DHS including the number of encounters and the total number of minutes per category of service. Because rates are specific to a district, DHS has established about 2,500 rates.

- Coverage for speech therapy services was expanded to include individuals who are licensed by the Board of Teaching as an educational speech-language pathologist with a Master's in speech and the equivalent work experience to qualify for their Certification of Clinical Competence (CCC) from the American Speech-Language-Hearing Association (ASHA).
- Physician orders are now only required for personal care and nursing services. Previously, they were required for all services every 60 days. Orders are now valid for up to one year.
- When districts are reimbursed for services that are also being provided by other providers, such as rehabilitation agencies or home care providers, thresholds and authorizations are no longer affected.
- Parental fees are not affected when districts receive reimbursement for services when a child's eligibility is established under the TEFRA Option (Tax Equity Fiscal Responsibility Act of 1982) or a home and community-based waiver.

Issues and Recommendations

Introduction

Minnesota school districts receive the majority of their third party revenue from claims to Minnesota Health Care Programs (MHCP) through the current state billing process. This report closely examines three important areas of function in the state billing process:

- informed consent;
- MHCP reimbursement rates calculation and payment; and
- billing administration.

In each area, the report reviews background, issues, a goal and recommendations.

To determine the current issues in the three areas indicated above, a survey was sent to local school districts. The following issues and concerns for improvement were identified:

- Eliminate the requirement for school districts to obtain informed consent from the parent to bill MHCP. Instead, utilize a notification of intent to bill MHCP and obtain a release of information within the context of the Individual Education Plan (IEP) process.
- Relieve schools from obtaining denials or determinations from private health plans before accessing reimbursement from MHCP.
- Review MHCP rate-setting for school districts to:
  - ensure all actual costs are considered, including administrative costs;
  - eliminate any duplicate reporting requirements; and
  - consider all possible payment options.

Informed Consent

Background

A number of state and federal regulations (e.g., Minn. Stat. § 125A.21, Minn. Stat. § 13.01 and Family Education Right to Privacy Act) require districts to get informed consent from the parent to share educational records and to bill public or private health plans. This is accomplished through signed permission from a child's parent or legal representative. This appears to be a reasonable and prudent requirement. However, districts cite obtaining informed consent from parents as one of the largest barriers to obtaining third party revenue.

Issues

- Informed consent is dictated by complex and overlapping federal regulations and state statutes.

- Although the intent is to protect children and families of children in special education, the recommended forms are overly complex and daunting.

- Districts report that some medical providers, advocates, private health plans and county staff tell parents to "just say no" to third party billing.

Goal

Permit Minnesota's consent process to be consistent with the Individuals with Disabilities Education Act (IDEA), thereby giving districts more potential for success at accessing third party revenue from public plans.

Recommendations

- The Legislature should amend Minn. Stat. § 125A.21 to eliminate the requirement that school districts obtain approval to bill MHCP. Replace informed consent with parental notification and annual release of information. This amendment was passed and is effective March 27, 2002.

- CFL should redesign consent information and forms for maximum readability, informational content, understandability and administrative utility. This redesign is planned for Spring 2002. It includes the recent legislative changes and is in progress.

MHCP Reimbursement Rates Calculation and Payment

Background

Through legislative initiatives, stakeholder collaboration and intense work by DHS, the process of submitting claims to MHCP got much simpler. School districts have dubbed this revised process as "Expedited MA." Districts use only eight (8) special codes that are only available to schools, claim forms do not need ICD-9 codes and each district is reimbursed based on actual cost of staff providing the service.

However, many districts are still confused about how MHCP establishes rates and they find it difficult to plan and promote third party billing because of the length of time between service delivery and actual knowledge about or receipt of the "payoff."

Issues

- Districts believe costs other than direct service provider salary and benefits need to be included in a cost-based payment methodology.

- Many districts do not understand the rate-setting methodology and are not sure how to determine if their individual rates are acceptable or how to revise them if they are not.

- The length of time that passes before establishing revised rates and the settle-up is too long.

- Districts are required to do some duplicative reporting for settle-up purposes.

Goal

Establish an equitable rate methodology that will be acceptable to the Centers for Medicare and Medicaid Services (CMS) and fair to districts.

Recommendations

- CFL should work with school districts to identify as many costs associated with the provision of health-related services as possible (including administrative costs such as supervisory and support staff, office supplies, etc.), and recommend to DHS the possible methods of incorporating those costs into MHCP reimbursement rate-setting calculations.

- CFL and DHS, together with stakeholders, should explore alternative rate-setting methodologies to improve the process and payment system.

Billing Administration

Background

The potential for some districts to access additional funding is substantial. While there is incredible potential for additional funding, there are also substantial administrative demands involved in establishing a billing infrastructure within a district. Some districts have suggested it would be best to have one billing agent provide billing services for all districts. There are other districts that believe CFL should provide claims processing services. CFL is not currently staffed nor does it have the resources to become the state centralized billing agent for schools.

Issues

- There is limited time available for local district staff to effectively implement a third party billing system.

- There are limited staff and resources at state agencies to provide technical assistance and support to local districts during development and implementation of a state centralized billing agent.

Goal

Promote district access to all third party revenue to which they are entitled.

Recommendations

- CFL and DHS should integrate current and future educational documentation requirements with certain billing requirements, to the extent possible, so that staff time is efficiently utilized and the same or similar information does not need to be provided in multiple formats.

- CFL should continue to review existing data systems, such as the electronic Services Program (eSP) for the Individual Interagency Intervention Plan *(*IIIP), to gather and store data that can be retrieved for multiple purposes, such as claims processing, and examine methods for eliminating redundant data entry.

- CFL should review the component tasks of third party billing in an effort to determine what, if any, portions of the process may be done more efficiently at a regional or state level. The Third Party Leadership Committee and other advisory groups should be organized at the local and/or regional level to facilitate this effort.

Summary

In the past two years, school districts have increased their access to revenue from public programs for health-related services. Districts continue to ask questions and challenge the system leading to better understanding and use of the system. Stakeholders continue to identify issues and recommend strategies.

The opportunity for state agency staff and districts to meet in formal and informal situations has provided a unique opportunity for everyone involved in the state billing process to learn from each other. It is not unusual for those who provide the training, technical assistance and surveillance to discover additional areas that need more clarification or revision. Quality improvement is an ongoing function on all levels.

Minnesota has a system in place to access revenue for health-related services from public programs. We now need to focus the same kind of attention on accessing revenue from private health plans.

A public policy discussion needs to occur about how private health plans are to participate in the process of providing payment for health-related services provided as part of an Individual Family Service Plan (IFSP), Individual Education Plan (IEP) or Individual Interagency Intervention Plan (IIIP) developed under special education.

Appendix

Historical Summary of Third Party Regulations

1975
Congress passed Public Law 94-142 authorizing the Education for All Handicapped Children Act which obligated schools to provide comprehensive services. The 94th Congress explained that the school district's obligation to provide special education and related services at no cost to the parents of a child with a handicapping condition "…. is not construed to prohibit charges by the education agency to insurers, public programs, and others for hospital care, health services, rehabilitation, and other non-educational services. States are encouraged to utilize all sources of support for comprehensive services for handicapped students."

1986
In Public Law 99-457, Congress provided further clarification regarding the fact that education funds may not be used to "satisfy a financial commitment for services which may have been paid for from another public or private source," if special education was not available. It further declared that services provided under special education do not "permit the State to reduce medical or other assistance available or to alter eligibility under Title V of the Social Security Act (Maternal and Child Health) or Title XIX of the Social Security Act (relating to medicaid…)" within the state.

1988
Public Law 100-630 made it clear that Medicaid funds are available for the payment of "related services" in a school-aged child's Individualized Education Plan (IEP).

1989
The Minnesota Legislature enacted the enabling legislation allowing use of Medical Assistance (MA) funds to pay for medical services in an IEP if the services were otherwise covered by Minnesota's State Plan. In addition, legislation was passed permitting districts to enroll with public and private health plans as providers and that receiving revenue from public and private health plans would not reduce the educational funding received by a district.

Districts were able to bill MA and/or private health plans like any other "medical" provider. Third party billing was done at the option of the district. Only a few districts attempted to access third party revenue. Several had some success. The districts that were successful typically found one or two services to bill that worked for them. With the advent of Prepaid Medical Assistance Plans (PMAP), even the districts that had some success were accessing less funding from MA or had given up all together in their attempt to access funds. One of the ongoing debates was who was "payor of last resort" with both Medicaid and education claiming the title.

Many states seized the opportunity to bring in additional funding by overhauling their Medicaid programs to add special services that could be billed only by schools, expanding the types of credentials recognized under their State Plans and streamlining

the manner in which districts access Medicaid funding. Minnesota chose to allow all districts to bill Medicaid if they followed all the same rules regarding covered services, documentation, credentials, physician orders, prior authorization and medical necessity.

1997

The Individuals with Disabilities Education Act (IDEA) Amendments of 1997 added a number of significant provisions to the law. One very important provision required states to identify a method to define the financial responsibility for public agencies regarding education that ensures a free appropriate public education to children with disabilities. The law explained that the financial responsibility of the "….State Medicaid agency and other public insurers of children with disabilities, shall precede the financial responsibility of the local education agency…" This resolved, once and for all, the dilemma of payor of last resort. Knowing there was clear direction to use MA funds before spending education dollars, Minnesota began to move in a new direction.

1998

During the 1998 legislative session, districts were mandated to seek reimbursement from third parties when the services identified in IEPs were otherwise covered by a public or private health plan. This mandate was effective July 1, 1999.

1999

It was apparent in the 1998 legislation that in order for the mandate to be effective, it would be necessary to make changes regarding schools' access to third party revenue. The main concern was to develop strategies around MA because MA funds are designated to be used before educational funds. The strategies were aimed at protecting benefits for children who are eligible for MA, carving out IEP related services from the PMAPs and streamlining the requirements to be met in order for districts to bill. In addition, districts requested the mandate be delayed until July 1, 2000. This would provide the time necessary to develop a hybrid system. Some of the major revisions that were enacted during the 1999 session relating to districts billing MA are:

- Many MA enrolled providers must obtain an authorization to provide services. However, an IEP team authorizes covered MA services. No additional authorization is required.
- DHS budget expenditures will not increase because districts receive only the federal financial participation. (This amount is currently 50 percent.) The local match comes from the district.
- DHS may receive up to $350,000 annually from the federal payments to districts to cover any additional administrative costs resulting from this process. The revenue is obtained through a 2.5 percent reduction in the amount of the federal reimbursement before it is paid to districts.
- Schools bill DHS directly under fee for service even if the child is eligible for services under a PMAP.
- Instead of obtaining physician orders every 60 days for services, districts were permitted to obtain orders no more than once a year.
- DHS was required to develop a cost-based reimbursement system.
- Services reimbursed to districts by DHS could not count against any service thresholds for that child.

- DHS is required to explore the expansion of provider types that may provide IEP related services and receive reimbursement.

With the tools provided by the 1999 Legislature, DHS, CFL and the Minnesota Department of Health, together with stakeholders including schools, providers, advocates, parents and other state agencies, developed and implemented what became known as “Expedited Medical Assistance.”