At its meeting in May, the Select Committee on Efficiency in Government tabled LCSC11, which proposed to streamline the billing for targeted case management services under the Montana Medicaid program. The key elements would cut down on administrative costs and decrease the onerous paperwork that is required under the current 15-minute unit billing.

Many mental health providers had mixed feelings regarding the proposal and conveyed mixed messages during the discussion at the May meeting. This resulted largely from the history of the Department of Public Health and Human Service (DPHHS) of arbitrary rate setting for the reimbursement of services.

Section 53-6-113 (3) MCA requires DPHHS to set reimbursement rates using actual cost as a consideration. A 2008 cost study required of mental health providers by the DPHHS and approved by the Center for Medicaid and Medicare Services found that the cost to provide mental health targeted case management services for children was $18.35 per 15-minute unit. DPHHS ignored and continues to ignore the cost study and reimburses providers at $12.61 per 15-minute unit, well below cost.

Some mental health providers feared the change proposed in LCSC11 because there is very little protection against the Department setting the monthly rate even lower than the current rate.

Interestingly, DPHHS used the results of the 2008 cost study to decrease the reimbursement rate for targeted case management for adults with severe and disabling mental illness. Providers feared that the Department could use the proposed change to set a monthly reimbursement rate that continues to ignore the cost of the services and the average number of hours of service provided per client, thus creating an even greater financial disincentive to provide essential community services.

Recommendation

In establishing the reimbursement levels for Federally Qualified Health Centers (FQHC), state Medicaid agencies and Medicare are required by federal law to conduct an annual actual cost study to ensure that "safety net" providers are fully compensated for their care of the populations covered by State Medicaid or Medicare.

In December 2000, Congress required states to change their FQHC payment methodology from a retrospective to a prospective payment system (PPS). This law established a per-visit baseline payment rate for existing FQHC's equal to 100 percent of the center's average costs per visit incurred during 1999 and 2000 that were reasonable and related to the cost of furnishing such services. The general formula for establishing a PPS rate was to take the average of the total reasonable costs for 1999/2000 and divide by the average of the total visits for those years (total costs / total visits = PPS rate).

Since January 1, 2001, states have been required to pay FQHCs a per-visit rate, which is equal to the baseline PPS payment rate increased each year by a standard medical inflation factor, known as the Medicare Economic Index ("MEI"), and adjusted "to take into account any increase or decrease in the scope of such services furnished by the center . . . during that fiscal year."

This cost-based methodology ensures that the cost of care for Medicaid and Medicare services for indigent and uninsured populations are not shifted.

Mental health providers recommend that the State of Montana adopt this approach to reimburse state licensed mental health centers that provide that same level of "safety net" services to low income and indigent populations. Other mental health providers would continue to operate under the current RBRVS system DPHHS uses for other Medicaid services.

SUBMITTED TO THE SELECT COMMITTEE ON EFFICIENCY IN GOVERNMENT
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