SELECT COMMITTEE ON EFFICIENCY IN GOVERNMENT

Proposed Changes to Medicaid Laws and Rules

Prepared by Sue O'Connell for the Medicaid Subcommittee
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Background

The Medicaid Subcommittee of the Select Committee on Efficiency in Government decided in November 2011 to obtain more information on Medicaid laws or administrative rules that stakeholders believe are unnecessary or overly burdensome. The subcommittee agreed to ask stakeholders to identify specific changes to the Montana Code Annotated (MCA) or the Administrative Rules of Montana (ARM). They also agreed to ask the Department of Public Health and Human Services (DPHHS) to respond to the suggestions.

This briefing paper summarizes the suggestions submitted by stakeholders. It groups the suggestions into:

- specific changes to identified Medicaid laws and rules; and
- recommendations that offer general suggestions on a specific topic, that do not identify specific laws or rules to be changed, or that make general recommendations for the Medicaid program.

The briefing paper also presents options for subcommittee consideration.

Stakeholder Recommendations Related to Specific Medicaid Laws and Rules

Suggestion 1: Amend state law and administrative rules to allow mental health centers operated by tribes to act as Medicaid providers before obtaining state licensure.

Montana Medicaid law allows reimbursement for mental health center services provided under a program authorized by Title 53, chapter 21, part 10 of the MCA. The definitions section of that part — 53-21-1001, MCA — defines community mental health centers and mental health centers as those facilities licensed by DPHHS. Licensure can take a period of time, and services provided by a tribal mental health center may not be reimbursed by Medicaid until the licensing procedure is complete.

The suggested change would amend 53-21-1001, MCA, and perhaps require other changes to Title 53, chapter 21, part 10, MCA, to indicate that a tribal mental health center does not have to be licensed in order to receive Medicaid reimbursement if it is employing mental health professionals as allowed by federal law.

Reason for Change: The federal government pays the full cost of mental health services provided by a tribal entity; the state pays about 34% of the costs that are provided through non-tribal mental health centers. Stakeholders says this change could reduce the amount of state money required to pay for Medicaid mental health services if the state is currently paying for services for a tribal member who could otherwise be served by a tribally operated mental health facility that is not yet licensed. It also would allow tribal mental health centers to become Medicaid providers before the state licensing process is complete.

Suggestion 2: Amend 53-6-101 and 37-1-305, MCA, to allow Medicaid reimbursement of mental health professionals who are under contract with a tribal mental health center regardless of the person's licensure status. The first statute allows Medicaid reimbursement for care provided by "licensed practitioners within the scope of their practice as defined by state law." The second statute allows state professional licensing boards to issue temporary practice permits to people licensed in another state.

The suggested changes would amend 53-6-101, MCA, to allow Medicaid reimbursement for services provided by a mental health professional who is unlicensed or licensed in another state if the person is employed by or under contract with a tribal health program. The change to 37-1-305, MCA, would allow the issuance of temporary practice permits to people eligible for licensure, even if they're not licensed by another state.

Reason for Change: The federal government pays the full cost of mental health services provided by a tribal entity; the state pays about 34% of the costs that are provided through non-tribal mental health centers. This change could reduce the amount of state money required to pay for Medicaid mental health services if the state is currently paying for services for a tribal member who could otherwise be served by a tribally operated mental health facility that employs or contracts with a mental health professional who is not yet licensed or is licensed in another state.

Suggestion 3: Amend administrative rules to eliminate unit billing for mental health services. Stakeholders cited as examples of this requirement two administrative rules related to targeted case management for seriously emotionally disturbed youth — 37.87.808, ARM, and 37.87,809, ARM. Stakeholders suggest that the state use a case reimbursement method, rather than requiring providers to bill in 15-minute increments.

Reason for Change: Stakeholders say the requirement for unit billing creates a large amount of unnecessary paperwork. They also say that use of a case rate reimbursement system may allow for a greater focus on outcome measures.

Suggestion 4: Amend 37.82.204, ARM, to limit the timeframe for determining Medicaid eligibility for nursing home care. This administrative rule requires that a person's eligibility for Medicaid be determined within 90 days of application for people who are applying on the basis of disability and 45 days for all other applicants. It also allows exceptions "in cases of unusual circumstances which are caused by the claimant or which are beyond the department's control." The proposed change would limit the determination period to 90 days.

Reason for Change: Stakeholders say multiple extensions of the determination period are often granted to applicants for nursing home care, even though the person is already receiving the care. They say an applicant's family may be slow to provide the information needed to determine eligibility. Also, a person may stop paying for nursing home care while awaiting a determination on Medicaid eligibility. If Medicaid coverage is denied, the nursing home may not recover the costs of care that was provided while a determination was pending.

Suggestion 5: Amend 37.86.5110, ARM, and revise other procedures related to Medicaid reimbursement for services provided to Passport to Health enrollees. This administrative rule lists the various medical services that Medicaid enrollees in the Passport to Health Program must obtain either directly from or through authorization by the enrollee's designated primary care provider. Stakeholders suggest that preauthorization should not be required for some of the services, because of the nature of the services and the difficulty in determining Medicaid eligibility at the time services are provided. They also note that Medicaid coverage is sometimes retroactive for services provided before a person is found to be eligible for the program.

Reason for Change: Stakeholders say the current procedures for obtaining authorization either before or after services are provided are cumbersome and often delay reimbursement for providers.

Suggestion 6: Amend Title 37, chapter 40, subchapter 4, of the Administrative Rules of Montana to eliminate the requirement that critical access hospitals transfer patients in need of nursing home care. This subchapter sets out requirements for licensed health care facilities that offer so-called "swing beds," which may be used either for acute care or extended skilled nursing care. Medicaid patients who are admitted to a swing bed in one of the designated facilities must be transferred when a bed becomes available in a nursing facility within a 25-mile radius if they are in need of a nursing home level of care.

Reason for Change: Stakeholders say that many critical access hospitals have essentially replaced their skilled nursing facilities by expanding the number of swing beds in their facilities. Stakeholders also say that excluding these hospitals from the transfer requirement would give the hospitals more flexibility to manage their services and facility.

Suggestion 7: Amend 2-15-2230, MCA, which requires dispute resolution for contracts for human services. Stakeholders suggest specific language that would require a neutral third party to issue a final decision in instances where a developmental disabilities (DD) provider requests that a contract dispute be resolved by the third party. The third party could meet with DPHHS and the contractor informally in meetings that would not be subject to state laws on administrative procedures, rules of civil procedure, or rules of evidence.

Reason for Change: Stakeholders provided specific language for legislation but did not provide additional information on the reason for the requested change.

General Suggestions Related to Medicaid

Suggestion 8: Allow a 2-year eligibility period for a person who qualifies for Medicaid. This suggestion did not identify the law or rule that needs to be changed. It did note that the 2-year eligibility period may need to include an exception that requires youth to reapply when they turn 19 years of age if their 2-year eligibility period has not expired.

Reason for Change: This change would reduce the amount of time that DPHHS spends on processing applications. It also would reduce the amount of time that applicants spend collecting documents, traveling to appointments, and completing the application process, because they would apply less frequently.

Suggestion 9: Require the Department of Labor and Industry (DOLI) to provide DPHHS with verification of a provider's licensure status upon request of the provider. This suggestion did not identify a law or rule that needs to be changed. It may require legislation.

Reason for Change: Stakeholders say DPHHS requires providers who want to participate in the Medicaid program to provide a copy of their professional license. DOLI licenses health care professionals. Stakeholders say requiring DOLI to provide the licensing information directly to DPHHS would create efficiencies.

Suggestion 10: Explore the use of value-based payment models and primary care medical homes. This suggestion did not identify the law or rule that needs to be changed.

Reason for Suggestion: Stakeholders suggested the subcommittee review the information on primary care medical homes presented by John Goodnow, Chief Executive Officer of Benefis Health System, at the August 2011 meeting.

Suggestion 11: Undertake a 5-year pilot project to test tort reforms that would protect Medicaid providers. This suggestion would offer medical liability protections to health care providers who serve Medicaid patients. It would require collection and analysis of data, to determine whether cost savings occurred. The suggestion did not list specific tort reforms but did provide a list of bills that the 2011 Legislature considered but did not pass.

Reason for Change: Stakeholders say that tort reform could result in a significant reduction in the number of tests and procedures performed by health care providers.

Suggestion 12: Consider implementation in the Medicaid program of two programs used in Washington state. This suggestion focuses on the Emergency Department Information Exchange (EDIE) and the Consistent Care programs used by some hospitals in Washington state. EDIE allows emergency rooms to share information about patient visits. The Consistent Care program is used by two Spokane hospitals, to provide case management services to patients who overuse hospital emergency rooms. Implementation of these programs could require legislation or Medicaid waivers.

Reason for Change: Stakeholders say these programs could reduce costs by reducing emergency room visits and related costs, including prescription drug costs.

Suggestion 13: Maintain the status quo on hospital and nursing home utilization fees. This suggestion requires no changes to existing law or administrative rule.

Reason for Suggestion: Stakeholders note that the fees help fund the state's Medicaid program.

Suggestion 14: Require DPHHS to create a work group that would include providers as stakeholders, in order to examine issues related to the expected increase in Medicaid enrollees under federal health care legislation. This suggestion requires no changes to existing law or administrative rule. It would require drafting of legislation.

Reason for Suggestion: Stakeholders say the impending expansion of the Medicaid program in 2014 may require changes to DPHHS business processes. Stakeholders want to be included in discussions of emerging issues and program policies.

Suggestion 15: Urge Congress not to shift additional Medicaid costs to the states. This suggestion requires no changes to existing law or administrative rule. It would require drafting of a committee letter or joint resolution.

Reason for Suggestion: No additional information was provided for this suggestion.

Suggestion 16: Suggest that Congress "federalize" the Medicaid program for senior citizens who are eligible for both Medicare and Medicaid. This suggestion requires no changes to existing law or administrative rule. It would require the drafting of a committee letter or joint resolution.

Reason for Change: Stakeholders say that having two programs cover the health care costs of senior citizens is unnecessary. People who qualify for both programs usually use Medicaid to pay for long-term care services, meaning the state pays about 34% of the costs. Having the federal government pay the full costs of these services would reduce Medicaid costs for the states.

Suggestion 17: Amend 37.82.101, 37.83.201, 37.83.501, ARM, and related sections of the Medicaid policy manuals to increase the amount of income and assets people may have when qualifying for Medicaid. This suggestion did not identify specific changes that should be made to the income and resource limits spelled out in the policy manuals, which establish the limits for the family Medicaid and general Medicaid programs. It also did not specify changes to the latter two rules. Those rules specify income and resource limits for people who are eligible for both Medicare and Medicaid.

Reason for Change: The stakeholder who proposed this change said current income and resource limits are not realistic.

Suggestion 18: Direct DPHHS to amend its Home and Community-Based Services waiver for DD services to allow for use of a daily reimbursement rate system for congregate services. Stakeholders say that before the current hourly billing system was put in place, providers generally could bill for 100% of their costs. That allowed them to base their budgets on a known and stable stream of revenue. Stakeholders suggest that DPHHS review waiver language in other states and develop amendments that would give nonprofit providers greater autonomy in billing.

Reason for Change: Stakeholders say they are unable to bill for services if a client isn't in attendance for a scheduled service or staff is not available to provide the support needed. These variables can affect the provider's budget. They also say that changing the billing system would reduce DPHHS administrative time and costs.

Suggestion 19: Require DPHHS to review the language in its contracts with DD providers to standardize the language and include specific dates for the initiation of contract negotiations. Stakeholders suggest that negotiations must begin by at least April 1 in legislative years and by March 1 in non-legislative years.

Reason for Change: Contracts could be simplified by using standard language and requiring attachments for any items specific to a particular contract or DPHHS program.

Suggestion 20: Require state agencies to review the state and local inspection requirements for DD group homes. Stakeholders say that the agencies should identify and eliminate duplicative reviews.

Reason for Change: Group homes are subject to yearly inspections by various state and local agencies, including state licensing entities and local health and fire departments.

Suggestion 21: Require DPHHS to review the federal and state audits required for DD services, eliminate duplicative audits, and reduce Surveillance Utilization and Review Section (SURS) audits under certain circumstances. DD providers undergo several federal audits for Medicaid, labor, and Social Security issues, as well as audits by DPHHS and other state agencies for compliance with Medicaid, workers' compensation, transportation, and other laws. Stakeholders say duplicative audits should be eliminated, including federal audits if necessary. They also suggest that DD providers work with DPHHS to develop a procedure in which providers could be exempted from SURS audits if they have successfully passed specific federal audits within the past year. Recommending the elimination of any federally required audits would require drafting of a committee letter or joint resolution.

Reason for Change: Stakeholders say elimination of some of the audits would reduce costs to providers, resulting in better efficiency.

Suggestion 22: Require DPHHS to review state laws and administrative rules to see how they could be changed to reduce costs of complying with a Request for Proposal. Stakeholders suggest that the review also indicate the appropriate duration of contracts and that the Legislature waive the RFP process for DD providers when the contractor has met all contract and quality assurance measures. Changes to RFP requirements may require changes to the Montana Procurement Act (Title 18, chapter 4, MCA).

Reason for Change: Stakeholders say that the RFP process takes a significant amount of time, resulting in a waste of money for contractors who are meeting quality assurance reviews.

Suggestion 23: Require DPHHS to work with DD providers, clients, and their families in several areas to determine more efficient processes. Stakeholders suggest that the Legislature require DPHHS establish work groups to help it review:

- all rules in Title 37, chapter 34, ARM, to reduce duplication in paperwork, compliance reviews, and quality assurance, as well as streamline critical incident investigative authority within DPHHS;

- the personal transportation services policy, to develop changes that better reflect the actual costs of providing transportation and related meals and lodging; and

- the invoicing procedures and methodology for transportation services.

These recommendations also say the Legislature should require that each review be completed within 1 year.

Reason for Suggestion: Stakeholders say that simplifying paperwork and compliance and quality assurance reviews would create efficiencies and possibly save money for the state.

Options for Subcommittee Consideration
Based on the information gathered in the course of its work, the subcommittee may want to recommend that the full committee:

1. Find that stakeholders identified statutes and administrative rules that create inefficiencies in the Medicaid program.

2. Approve the drafting of legislation for some or all of the changes suggested by stakeholders.

3. Ask DPHHS to review and amend some or all of the rules that stakeholders identified and notify the committee by June 2012 if the changes would also require legislation.

4. Find that the laws and rules identified by stakeholders are necessary, reasonably efficient, and not in need of change.

5. Find that stakeholders identified federal issues of concern and approve drafting of letters or joint resolutions to address those concerns.

6. Find that stakeholders identified strategies in other states that may improve the Montana Medicaid program.

7. Approve the drafting of legislation to implement in Montana programs that are used in other states.

8. Ask DPHHS to review programs used in other states and notify the committee by June 2012 about whether it plans to pursue similar programs and whether legislation is needed.

9. Make no findings or recommendations.

10. Pursue other options identified by the subcommittee.

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