SELECT COMMITTEE ON EFFICIENCY IN GOVERNMENT

Recommendations from the Health Care/Medicaid Subcommittee

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Background

The Health Care/Medicaid Subcommittee of the Select Committee on Efficiency in Government met four times to review health care and Medicaid laws, administrative rules, and programs.

The subcommittee solicited comment from mental health providers in October 2011 and from other Medicaid providers in November 2011. The subcommittee then asked interested parties to identify specific statutes or administrative rules that they considered unnecessary or overly burdensome, along with the changes that should be made to the laws or rules.

The Medicaid suggestions were forwarded to the Department of Public Health and Human Services (DPHHS) in mid-December. At a January 2012 meeting, DPHHS Medicaid and Health Services Branch Manager Mary Dalton responded to each of those suggestions.

The committee also reviewed information and public comment on the Medicaid application and application process; the Children's System of Care Account; the use and promotion of long-term care insurance partnership policies; and the effects of a Washington state law related to the improper transfer of assets by people seeking Medicaid coverage for long-term care.

Recommendations to the Select Committee on Efficiency in Government

On February 1, the subcommittee approved eight recommendations for consideration by the full committee, as summarized below. Five would require the drafting of legislation, two would require letters requesting action by DPHHS, and one involves the 2013 appropriations process.

Recommendation 1: Authorize the drafting of legislation to create a 4-year tort reform pilot project involving Medicaid patients and providers.

Reason for the Recommendation: Stakeholders said tort reform could reduce the use of so-called "defensive medicine" that health care providers say they often practice to protect themselves against medical malpractice claims. Defensive medicine occurs when providers order more tests or procedures than may be needed. The practice is believed to increase health care costs. Stakeholders said a pilot project would allow the state to collect information to determine whether tort reform would reduce the use of defensive medicine.

Elements of the Proposed Legislation: The bill draft would:

- require Medicaid patients who file malpractice claims to meet a higher level of proof than other claimants, if the medical care was provided by a Medicaid provider who had agreed to participate in the pilot project;

- require a participating medical provider to document in a patient's record the tests, procedures, treatments, or other interventions that were omitted and explain why the provider believed a test, procedure, or treatment was unnecessary;

- limit provider participation to family practice, internal medicine, emergency department, and pediatric physicians and to acute care hospitals;

- limit the pilot project to Cascade, Missoula, and Yellowstone counties; and

- require the state to contract with a health care data firm to collect data and monitor the program outcomes.

Recommendation 2: Authorize the drafting of legislation to eliminate the requirement for unit billing of certain Medicaid services.

Reason for the Recommendation: Stakeholders said the requirement to bill in 15-minute increments creates unnecessary paperwork and may not allow providers to focus as much as they should on the outcomes their patients experience. Stakeholders have suggested -- as one alternative -- that the state use a case reimbursement method.

Elements of the Proposed Legislation: The bill draft would:

- eliminate the requirement now in administrative rule that Medicaid providers bill in 15-minute increments for various services; and

- substitute an alternative billing method, which would be selected from among recommendations to be solicited from stakeholders as the bill is drafted.

Recommendation 3: Authorize the drafting of legislation to revise the Medicaid application and eligibility determination process.

Reason for the Recommendation: Sen. Caferro made this recommendation, saying it would improve efficiencies and thus could result in cost savings.

Elements of the Proposed Legislation: The bill draft would require DPHHS to:

- change the Medicaid application to request only the information required under federal law and regulations;

- match an applicant's Social Security number against existing electronic databases to verify as much of the application material as possible;

- use a central intake model for applicants, similar to the model used by the Healthy Montana Kids program;

- use technology to the greatest extent possible, including the use of online applications, electronic data matches, document imaging, and electronic signatures; and

- report to the Legislature on the outcomes of the changes to the application form and the use of electronic databases for verification purposes.

Recommendation 4: Authorize the drafting of legislation to impose a penalty on people who receive assets that were improperly transferred by a person who applies for Medicaid coverage of long-term care costs.

Reason for the Change: Stakeholders said this law would deter people from transferring assets as a way to qualify for Medicaid coverage. They said that people who have the means to pay for their long-term care should do so rather than transfer their assets so that the Medicaid programs covers their costs.

Elements of the Proposed Legislation: The bill draft would be modeled on a Washington state law and would:

- allow the state to fine a person who has received assets from a Medicaid applicant if the assets were transferred so the applicant could qualify for coverage, the asset transfer created a period of ineligibility for Medicaid coverage, and the state provided Medicaid payments during that time because denial of coverage would have created an undue hardship for the applicant;

- require the recipient of the asset transfer to pay the state's court costs and legal fees for any matter taken to court;

- allow the state to petition for return of the asset to the Medicaid applicant; and

- exempt certain types and/or amounts of transfers from the penalty provisions.

Recommendation 5: Authorize the drafting of legislation to revise elements of the 72-hour presumptive eligibility program for mental health crisis stabilization services.

Background on the Program: The 72-hour presumptive eligibility program is not a Medicaid service. The program is paid for by the state general fund, with $1.24 million appropriated in each year of the current biennium. The appropriation pays for mental health services that are provided for up to 72 hours to stabilize a person who is in psychiatric crisis. Participating mental health practitioners may provide the care without verifying a person's insurance coverage. If a person is insured or covered by Medicaid, the provider bills the insurer. The presumptive eligibility program pays the costs for individuals who are uninsured or underinsured.

Reason for the Recommendation: Stakeholders said the proposed changes would ensure that providers would be reimbursed for providing services whenever they're needed and for providing assessments that may better reflect the status of a person's mental health during the 72-hour eligibility period.

Elements of the Proposed Legislation: The bill draft would:

- allow for payment of crisis stabilization services that are provided within 7 days of a previous discharge from crisis services;

- allow for two, rather than one, psychiatric diagnostic interview examinations during the 72-hour period; and

- potentially change the definition of "crisis" to expand the instances in which a person may be eligible for services. Administrative rule currently defines "crisis" as "a serious unexpected situation resulting from an individual's apparent mental illness in which the symptoms are of sufficient severity, as determined by a mental health practitioner, to

require immediate care to avoid:

- jeopardy to the life or health of the individual; or
- death or bodily harm to the individual or to others."

Recommendation 6: Ask DPHHS to put together a stakeholder group to start planning for the expansion of the Medicaid program under the federal health care law.

Reason for the Recommendation: Stakeholders said the expansion of the Medicaid program on Jan. 1, 2014, may require changes to DPHHS business processes. Stakeholders want to be included in discussions of emerging issues and program policies. They also want to make sure the state is taking the appropriate steps now so that it is prepared to meet the requirement.

Proposed Action: This recommendation could be carried out by drafting and sending a letter to DPHHS and/or the governor and asking for a response by a date set by the committee.

Recommendation 7: Ask DPHHS to work with providers toward an outcome-based system of services and to articulate in a measurable form what will be accomplished in three specific areas.

Reason for Recommendation: Rep. Noonan made the recommendation based on the amount of testimony from providers who supported changing from the current fee-for-service payment method to a method that pays providers for certain outcomes or performance measures.

Additional Elements: The request would ask DPHHS to review of the use of validated tools to assess and measure fidelity of Medicaid services to a wraparound philosophy of care; to use validated measures to evaluate the acuity of the children served, the assessment of family functioning, family skill strengths and deficits, and the ability to measure any improvements in services; and track child placement with a goal of creating incentives for community-based treatment and reducing placements in out-of-state facilities, psychiatric residential treatment facilities, and group homes.

Proposed Action: The recommendation could be carried out either by sending a letter to DPHHS and asking for a response by a date set by the committee or by drafting legislation.

Recommendation 8: Recommend that the 2013 Legislature reduce the appropriation for utilization review of certain Medicaid services from $1.7 million per year to $185,000 per year.

Reason for the Recommendation: The full committee heard presentations related to the DPHHS contract with a private company for prior authorization of certain mental health services. Sen. Caferro made this recommendation, noting that federal law requires this review for only two services. She said limiting a contract for utilization review to those two services could save the state more than $1.5 million a year.

Proposed Action: This recommendation could be carried out by preparing a letter for presentation to the members of the House Appropriations Committee and Senate Finance and Claims Committee at the start of the 2013 Legislature.