**** Bill No. ****

Introduced By **********

By Request of the *********

A Bill for an Act entitled: "An Act establishing principles for payments to entities that contract with the department of health and human services to offer community-based services; requiring the department to collect and analyze rate-related information; and amending sections 52-2-112, 52-2-301, 53-6-101, 53-10-201, 53-10-203, 53-10-204, 53-10-211, and 53-10-212, MCA;."

Be it enacted by the Legislature of the State of Montana:

Section 1. Section 52-2-112, MCA, is amended to read:

"**52-2-112. Duty to strengthen child welfare services -- principles for payment**. (1) The department shall make provision for establishing and strengthening child welfare services, including protective services, and for care of children in registered or licensed family foster homes, child-care agencies, group homes, or treatment facilities. Payment provided under this section is made under the provisions of 41-3-115 and 52-2-611.

(2) In making payment for services under this part, the department shall follow the principles for provider reimbursement that are established in [section 7]."

{*Internal References to 52-2-112: None.*}

Section 2. Section 52-2-301, MCA, is amended to read:

"52-2-301. State policy -- principles for payment. (1) The legislature declares that it is the policy of this state:

~~(1)~~ (a) to provide for and encourage the development of a stable system of care, including quality education, treatment, and services for the high-risk children of this state with multiagency service needs, to the extent that funds are available;

~~(2)~~ (b) to serve high-risk children with multiagency service needs either in their homes or in the least restrictive and most appropriate setting for their needs in order to preserve the unity and welfare of the family, whenever possible, and to provide for their care and protection and mental, social, and physical development;

~~(3)~~ (c) to serve high-risk children with multiagency service needs within their home, community, region, and state, whenever possible, and to use out-of-state providers as a last resort;

~~(4)~~ (d) to provide integrated services to high-risk children with multiagency service needs;

~~(5)~~ (e) to contain costs and reduce the use of high-cost, highly restrictive, out-of-home placements;

~~(6)~~ (f) to increase the capacity of communities to serve high-risk children with multiagency service needs in the least restrictive and most appropriate setting for their needs by promoting collaboration and cooperation among the agencies that provide services to children;

~~(7)~~ (g) to prioritize available resources for meeting the essential needs of high-risk children with multiagency service

needs; and

~~(8)~~ (h) to reduce out-of-home and out-of-community placements through a children's system of care account to fund in-state and community-based services that meet the needs of high-risk children with multiagency service needs in the least restrictive and most appropriate setting possible.

(2) In making payment for services under this part, the department shall follow the principles for provider reimbursement that are established in [section 7]."

{*Internal References to 52-2-301:*
*52-2-308** *53-6-402* }

Section 3. Section 53-6-101, MCA, is amended to read:

"**53-6-101. Montana medicaid program -- authorization of services.** (1) There is a Montana medicaid program established for the purpose of providing necessary medical services to eligible persons who have need for medical assistance. The Montana medicaid program is a joint federal-state program administered under this chapter and in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq. The department shall administer the Montana medicaid program.

(2) The department and the legislature shall consider the following funding principles when considering changes in medicaid policy that either increase or reduce services:

(a) protecting those persons who are most vulnerable and most in need, as defined by a combination of economic, social, and medical circumstances;

(b) giving preference to the elimination or restoration of an entire medicaid program or service, rather than sacrifice or augment the quality of care for several programs or services through dilution of funding; and

(c) giving priority to services that:

(i) employ the science of prevention to reduce disability and illness~~,~~;

(ii) services that treat life-threatening conditions~~,~~;

(ii) services to youth, because services provided at an early age, particularly preventive services, may reduce the need for moreintensive services at a later age and reduce long-term costs to the state; and

(iv) services that support independent or assisted living, including pain management, to reduce the need for acute inpatient or residential care.

(3) Medical assistance provided by the Montana medicaid program includes the following services:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) other laboratory and x-ray services, including minimum mammography examination as defined in 33-22-132;

(d) skilled nursing services in long-term care facilities;

(e) physicians' services;

(f) nurse specialist services;

(g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age;

(h) ambulatory prenatal care for pregnant women during a

presumptive eligibility period, as provided in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;

(i) targeted case management services, as authorized in 42 U.S.C. 1396n(g), for high-risk pregnant women;

(j) services that are provided by physician assistants within the scope of their practice and that are otherwise directly reimbursed as allowed under department rule to an existing provider;

(k) health services provided under a physician's orders by a public health department; and

(l) federally qualified health center services, as defined in 42 U.S.C. 1396d(l)(2).

(4) Medical assistance provided by the Montana medicaid program may, as provided by department rule, also include the following services:

(a) medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(b) home health care services;

(c) private-duty nursing services;

(d) dental services;

(e) physical therapy services;

(f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 10;

(g) clinical social worker services;

(h) prescribed drugs, dentures, and prosthetic devices;

(i) prescribed eyeglasses;

(j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;

(k) inpatient psychiatric hospital services for persons under 21 years of age;

(l) services of professional counselors licensed under Title 37, chapter 23;

(m) hospice care, as defined in 42 U.S.C. 1396d(o);

(n) case management services, as provided in 42 U.S.C. 1396d(a) and 1396n(g), including targeted case management services for the mentally ill;

(o) services of psychologists licensed under Title 37, chapter 17;

(p) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C. 1396d(h), in a residential treatment facility, as defined in 50-5-101, that is licensed in accordance with 50-5-201; and

(q) any additional medical service or aid allowable under or provided by the federal Social Security Act.

(5) Services for persons qualifying for medicaid under the medically needy category of assistance, as described in 53-6-131, may be more limited in amount, scope, and duration than services provided to others qualifying for assistance under the Montana medicaid program. The department is not required to provide all of the services listed in subsections (3) and (4) to persons qualifying for medicaid under the medically needy category of assistance.

(6) In accordance with federal law or waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department may implement limited medicaid benefits, to be known as basic medicaid, for adult recipients who are eligible because they are receiving financial assistance, as defined in 53-4-201, as the specified caretaker relative of a dependent child under the FAIM project and for all adult recipients of medical assistance only who are covered under a group related to a program providing financial assistance, as defined in 53-4-201. Basic medicaid benefits consist of all mandatory services listed in subsections (3)(a) through (3)(l) but may include those optional services listed in subsections (4)(a) through (4)(q) that the department in its discretion specifies by rule. The department, in exercising its discretion, may consider the amount of funds appropriated by the legislature, whether approval has been received, as provided in 53-1-612, and whether the provision of a particular service is commonly covered by private health insurance plans. However, a recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage.

(7) The department may implement, as provided for in Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, a program under medicaid for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

(8) The department may set rates for medical and other

services provided to recipients of medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

(9) The services provided under this part may be only those that are medically necessary and that are the most efficient and cost-effective.

(10) The amount, scope, and duration of services provided under this part must be determined by the department in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended.

(11) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

(12) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program after taking into consideration the funding principles set forth in subsection (2)."

{*Internal References to 53-6-101:*
2-18-704 *20-9-501* *33-22-303* *33-22-512*
33-30-1014 *33-31-301* *33-31-301* *50-19-323*
53-2-215 *53-2-215* *53-2-215* *53-2-215*
53-2-215 *53-4-601* *53-6-113* *53-6-116*
53-6-131 *53-6-131* *53-21-139* *53-21-139* }

Section 4. Section 53-10-201, MCA, is amended to read:

"53-10-201. Legislative findings, purpose, and intent. (1) The legislature finds that services provided by the department to persons who are living in a community setting outside of state

institutions and who are persons with developmental disabilities, are mentally ill, or are elderly or very young are essential services and the essential nature of the services is not diminished because the services are provided by contracts. Because the services provided by contracts are many and are important to the well-being of Montana residents who can least care for themselves, the legislature finds that it is necessary to establish a system under which provider services, the costs of providers, and the reimbursement rates paid to providers are analyzed and monitored on a regular basis to ensure that state funding is appropriately expended, that consumers' and taxpayers' expectations are attended to, and that the providers of the services are treated fairly.

(2) The purpose of this part is to provide a regular, predictable, and equitable mechanism under which contracted services, costs, and reimbursement rates are given optimum attention by the department. The legislature does, however, retain its constitutional duty to enact or amend law concerning contracted services, make appropriations for contracted services through funding of department programs, and review department contracted service programs through the mechanism provided in this part. This part is not intended to restrict the legislature in making its appropriate policy and fiscal judgments concerning the value of department programs or services.

(3) It is the intent of the legislature that the department shall conduct a periodic, comprehensive analysis of both existing rates and the factors relevant to provider rates, pursuant to

[section 7].

~~(3)~~ (4) It is the intent of the legislature that to the greatest extent practicable, the commission should:

(a) establish an open and defensible process for conducting its work;

(b) create a set methodology or protocol that uses data provided every four years by the department and through which provider reimbursement rates can be recommended for a service, service level, or population of service consumers served by a provider and the department;

(c) recommend a list of reimbursable expenses for every service and service level based upon the expenses necessary to provide that service or service level and comply with the licensure, contracts, and administrative rules that govern that service or service level;

(d) recommend rate equity among service levels within a group of services and between different groups of services; and

(e) recommend the best and most cost-effective method of regulating and auditing provider services."

{*Internal References to 53-10-201: None.*}

Section 5. Section 53-10-203, MCA, is amended to read:

"53-10-203. Commission on provider rates and services. (1) The department shall form an advisory commission to be known as the commission on provider rates and services to provide information to the department concerning provider services, costs, and reimbursement rates. The commission membership must

include a maximum of 15 individuals representing providers, consumers of provider services, and family members of consumers and is as follows:

(a) at least three providers;

(b) at least three of a combination of consumers of provider services and family members of consumers;

(c) two employees of the department;

~~(d) one representative from the legislative fiscal division~~;

~~(e)~~ (d) one representative from the governor's office on budget and program planning;

~~(f)~~ (e) subject to 5-5-234, one member of the majority party and one member of the minority party of the house of representatives; and

~~(g)~~ (f) subject to 5-5-234, one member of the majority party and one member of the minority party of the senate.

(2) A representative of the legislative fiscal division must be provided with all materials provided to the commission and must be offered an opportunity to comment on matters before the commission.

~~(2)~~ (3) Except as provided in this section, the commission is subject to the provisions of 2-15-122.

~~(3)~~ (4) Except as provided in this section, members shall serve for a term of 2 years and may be reappointed by the appointing authority for one additional term. A member appointed to fill an unexpired term may be appointed for an additional two terms. The appointing authority shall stagger the first terms of

the first board to terms of 2 to 4 years. Members appointed to represent state departments, offices, or other state bodies may be appointed and reappointed as the department determines necessary.

~~(4)~~ (5) The commission shall elect a presiding officer and vice presiding officer and by vote determine its rules of operation. The commission shall meet at the call of the presiding officer, who shall determine meeting times in consultation with the department.

~~(5)~~ (6) The commission is allocated to the department for administrative purposes only as provided in 2-15-121."

{*Internal References to 53-10-203:*
53-10-202 }

Section 6. Section 53-10-204, MCA, is amended to read:

"53-10-204. Duties of commission on provider rates and services. (1) The commission shall conduct an ongoing review of provider services, costs, and reimbursement rates. The review must be made without regard to the source of funds for reimbursement payments.

(2) The commission shall consult with the director concerning provider services, costs, and reimbursement rates subject to its review but shall make independent determinations of those matters within its authority. The commission shall establish a consistent and impartial process for determining the order in which provider services, costs, and reimbursement rates will be reviewed by the commission ~~and the methodology that the~~

~~commission will use in its review~~.

(3) The commission shall establish a methodology for reviewing provider costs and rates that is:

(a) objective;

(b) predictable;

(c) developed in a scientific manner; and

(d) balanced and equitable, as evidenced by consideration of the following factors:

(i) client access;

(ii) quality of services;

(iii) provider networks;

(iv) equitable reimbursement; and

(v) good stewardship of taxpayer resources.

~~(3)~~ (4) The commission shall take into account the work of other advisory groups or councils working with the department on subjects concerning its authority and make recommendations to the director and appropriate members of those groups or councils concerning the subject and timing of the work of those groups or councils that will assist the commission and those groups or councils to exercise their legal or other authority and achieve their purpose.

~~(4)~~ (5) In conducting its review, the commission shall also consider:

(a) the need for the department to limit expenditures to appropriations;

(b) existing and future contracts with the department;

(c) state and federal laws, rules, and regulations; and

(d) the intention of the legislature to live within available revenue.

~~(5) In reviewing existing reimbursement rates and recommending new or altered reimbursement rates to be paid to providers, the commission shall consider the following factors:~~

~~(a) the level of financial risk taken by a provider in providing services;~~

~~(b) the complexity of the provider's services;~~

~~(c) the capital investment made by the provider;~~

~~(d) the administrative overhead in the provider's business; and~~

~~(e) any other matter affecting the cost of the provider's services.~~"

{*Internal References to 53-10-204: None.*}

NEW SECTION. **Section 7. Principles for provider rates.** The commission and the department shall use the following principles in reviewing, recommending, and setting rates for providers:

(1) State agencies shall treat the procurement of services provided to persons living in a community setting outside of a state institution with the same procedures used for the procurement of other government services and goods.

(2) State agencies shall clearly state the regulations and standards by which the services are governed.

(3) State agencies shall fund, to the greatest extent possible, the cost of meeting federal, state, and local regulations.

(4) Rates must be driven by measurable outcomes established by the agency responsible for procuring the services.

(5) The methodology for establishing rates shall take into consideration all costs of providing quality care and services, including but not limited to:

(a) the results of the data review conducted by the department as provided in 53-10-211;

(b) direct costs, such as the cost of providing care that meets a person's basic living needs, physical care, mental health care, education, and family and community integration needs; and

(c) indirect costs, which include but are not limited to:

(i) case management costs;

(ii) facility, property, and operational costs, including administrative overhead in the provider's business;

(iii) capital improvements;

(iv) licensing costs;

(v) the costs of complying with administrative rules; and

(vi) personnel, including professional development and certification needs;

(d) the level of financial risk taken by a provider in providing services;

(e) the complexity of the provider's services; and

(f) any other matter affecting the cost of the providers' services.

Section 8. Section 53-10-211, MCA, is amended to read:

"53-10-211. Department to assist and cooperate with

commission ~~on provider rates and services~~ -- data collection and analysis required -- records privacy. (1) The department shall provide to the commission the maximum assistance that may practicably be made available to the commission and shall provide the commission with the necessary equipment, records, and other material that are both necessary and helpful for the commission to achieve the purposes of this part, including records and other material concerning past, current, and potential provider services, costs, and reimbursement.

(2) The commission and the department shall base rate review and rate decisions on a common set of criteria and data from all providers and populations served in a community setting outside of a state institution.

(3) The department shall develop the common set of data at least every four years by:

(a) requiring all providers to submit audited data on the actual cost of providing the service;

(b) analyzing, and comparing all data available on the actual cost of providing each type of service;

(c) collecting, analyzing, and comparing the rates paid by private purchasers of services that are the same as or similar to those paid by federal, state, or special revenue funds;

(d) conducting cost-of-care analyses for all service types;

(e) collecting and analyzing information on the percentage of total provider revenue that is derived from state, federal, or special revenue funds;

(f) collecting information related to access to and trends

in care; and

(g) assessing the impacts of changes in reimbursement on the use of services and the quality of care.

(4) The department shall report the information and analysis required in subsection (3) to the commission and the legislature by July 1, 2010, and every four years following that date.

(5) As part of the data review process, the department shall establish a process with providers for accountability, performance, and communication purposes.

(6) In providing and considering those records and materials, the department and the commission shall make whatever changes in provider or consumer information that are necessary to comply with lawful requirements for the privacy of the service providers and consumers."

{*Internal References to 53-10-211: None.*}

Section 9. Section 53-10-212, MCA, is amended to read:

"53-10-212. Commission findings, recommendations, and reports. The commission shall:

(1) make recommendations and reports concerning its activities and the results of its review to the director at those times as the commission determines; ~~and~~

(2) make findings and recommendations and prepare a report to the legislature, in the manner provided in 5-11-210, on the subjects of its review; and

(3) report its findings and recommendations to the children, families, health, and human services interim committee each

interim."

{*Internal References to 53-10-212: None.*}

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{Name : Sue O'Connell
Title : Research Analyst
Agency: Legislative Services Division-111D
Phone : (406) 444-3597
E-Mail: soconnell@mt.gov}