HOUSE BILL NO. 410

INTRODUCED BY B. BECK

A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING PRINCIPLES FOR PAYMENTS TO PROVIDERS WHO CONTRACT WITH THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO OFFER CERTAIN SERVICES; ESTABLISHING A METHODOLOGY FOR REVIEWING AND RECOMMENDING PROVIDER RATES; REQUIRING THE DEPARTMENT TO COLLECT AND ANALYZE CERTAIN INFORMATION; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 53-10-201, 53-10-202, 53-10-204, 53-10-211, AND 53-10-212, MCA; AND PROVIDING AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. 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 analysis of both existing

provider reimbursement rates and the factors relevant to provider reimbursement rates pursuant to 53-10-211. The analysis must be conducted using existing department resources.

~~(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, in accordance with [section 5], 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."

Section 2. Section 53-10-202, MCA, is amended to read:

"53-10-202. Definitions. As used in this part, the following definitions apply:

(1) "Commission" means the commission on provider rates and services established in 53-10-203.

(2) "Department" means the department of public health and human services established in 2-15-2201.

(3) "Director" means the director of the department.

(4) "Provider" means an entity that contracts with the department to offer services to others.

(5) "Relevant market rate" means a rate that is based on a comparison of rates for similar services in states with similar economies.

~~(5)~~(6) "Services" means those services paid for by the department for:

(a) a child pursuant to Title 41, Title 42, chapter 3, or Title 52, chapter 2; or

(b) a child or an adult in a community or long-term care setting and not in a state institution, pursuant to Title 53."

Section 3. 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 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) In conducting its review and making recommendations, 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.~~"

NEW SECTION. **Section 4. Principles for provider rates.** The commission, in its role of reviewing and recommending provider reimbursement rates, and the department, in its role of setting provider reimbursement rates, shall use the following principles:

(1) The department shall consider the reasonable costs of meeting applicable federal and state regulations.

(2) Rates must be driven by standards established for the desired outcomes of the services provided.

The department shall establish the applicable standards for desired outcomes.

NEW SECTION. **Section 5. Methodology for reviewing provider reimbursement rates -- rulemaking authority for exclusions.** (1) (a) Over a 5-biennium period beginning July 1, 2011, the department shall initiate in each biennium a review of the costs and reimbursement rates for providers of direct care and supportive services in one of the following service areas:

(i) children's mental health services;

(ii) adult mental health services;

(iii) developmental disabilities;

(iv) services provided to a child in the legal custody of the state pursuant to Title 41, chapter 3; and

(v) senior and long-term care services.

(b) After the initial 5-biennium period, the department shall continue to review the five service areas on an ongoing basis as provided in 53-10-211 in the order in which the service areas were reviewed during the initial period.

(c) The department may establish by rule the services that it may exclude from its methodologies because the services are:

(i) delivered on an individual basis by licensed health care providers;

(ii) used infrequently; or

(iii) not typically included in the rate-setting system for services covered under this part.

(2) The methodologies established under this section must be objective, predictable, and balanced and equitable, as evidenced by consideration of the following factors:

(a) whether the provider has created reasonable access to services for the clients being served;

(b) the quality of services provided;

(c) provider networks;

(d) equitable reimbursement among provider types;

(e) provider occupancy rates;

(f) other revenue received by the provider; and

(g) good stewardship of taxpayer resources.

(3) The department shall establish appropriate methodologies for setting provider reimbursement rates by considering the reasonable and allowable costs of providing quality care and services. These costs include

but are not limited to:

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

(b) the relevant market rate for reasonable and allowable direct costs;

(c) the relevant market rate for any applicable indirect costs, which may include but are not limited to the reasonable and allowable costs of:

(i) providing case management;

(ii) owning and operating property and facilities, including administrative overhead in the provider's business;

(iii) obtaining required licenses;

(iv) complying with administrative rules;

(v) complying with contract requirements; and

(vi) meeting personnel needs, 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 provider's services.

(4) The commission shall use the methodology principles established in this section when reviewing existing provider reimbursement rates and recommending new or altered provider reimbursement rates.

Section 6. Section 53-10-211, MCA, is amended to read:

"53-10-211. Department to assist and cooperate with commission on provider rates and services -- records privacy -- data collection and analysis required. (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. 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.

(2) (a) As part of the methodology for reviewing and setting provider reimbursement rates pursuant to [section 5], the department shall periodically collect and analyze data about providers and populations in the

service areas listed in [section 5(1)]. The department shall use existing department resources to collect and analyze the data.

(b) The department shall update the data for each area listed in [section 5(1)] every 8 years after completion of the initial data collection and analysis.

(3) The department shall analyze and compare all data available on the actual cost, trends, and changes in reimbursing and providing quality, evidence-based services.

(4) The department shall annually report the information and analysis required in this section to the commission.

(5) The duties outlined in this section must be carried out by the department if the department contracts any or all of the administration of medicaid services to a managed care company or private vendor."

Section 7. 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 each interim to the children, families, health, and human services interim committee and the legislative finance committee."

NEW SECTION. **Section 8. Codification instruction.** [Sections 4 and 5] are intended to be codified as an integral part of Title 53, chapter 10, part 2, and the provisions of Title 53, chapter 10, part 2, apply to [sections 4 and 5].

NEW SECTION. **Section 9. Effective date.** [This act] is effective July 1, 2011.

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