

Amendments to Senate Bill No. 395
3rd Reading Copy

Requested by Senator David Wanzenried

For the House Human Services Committee

Prepared by Sue O'Connell
April 15, 2013 (2:23pm)

1. Title, page 1, line 5.

Strike: "EXPAND"

Insert: "ALLOW USE OF"

Following: "MEDICAID"

Strike: "TO"

Insert: "FUNDS TO PURCHASE INSURANCE FOR"

2. Title, page 1, line 7.

Strike: "MEDICAID"

Following: "CRITERIA"

Insert: "FOR INDIVIDUALS PURCHASING HEALTH INSURANCE WITH
MEDICAID FUNDS;"

3. Title, page 1, line 15.

Following: "DEFINITIONS;"

Insert: "PROVIDING RULEMAKING AUTHORITY;"

4. Title, page 1, line 16.

Following: "~~37-8-204,~~"

Insert: "15-66-101, 15-66-102, 15-66-103, 15-66-201, 15-66-202,
15-66-203, 15-66-204, 15-66-206, 15-66-207, 15-66-208, 15-
66-209,"

Strike: "53-6-131"

Strike: "53-6-155"

Insert: "53-6-149"

5. Page 3, line 13 through line 14.

Strike: "the way in which" on line 13

Following: "implementation of"

Strike: "the expansion" on line 13 through "out" on line 14

Insert: "any waiver granted to the department to authorize use of
medicaid funds to purchase insurance coverage for eligible
individuals as defined in [section 10];"

6. Page 4, line 1 through line 3.

Strike: "pursue contracting" on line 1 through "111-152" on line
3

Insert: "obtain and implement a waiver pursuant to [sections 9
through 14]"

7. Page 4, line 12.

Following: "medicaid"

Insert: "services"

8. Page 6, line 17 through page 7, line 13.

Strike: section 9 in its entirety

Following: line 13

Insert: "NEW SECTION. **Section 9. Health coverage options for low-income individuals -- legislative findings and intent.** (1)

The legislature finds that providing expanded health care coverage to low-income Montanans through an integrated market-based medicaid benefits program has the potential to:

(a) provide new coverage opportunities for additional Montanans;

(b) stimulate market competition; and

(c) offer alternatives to existing medicaid coverage.

(2) The legislature further finds that a market-based medicaid benefits program may offer fiscally sustainable and cost-effective health care, as well as allow for greater personal responsibility in the use of health care services.

(3) The legislature further finds that a program offered under a waiver:

(a) is not a perpetual federal or state right or a guaranteed entitlement; and

(b) is subject to cancellation upon appropriate notice.

(4) It is the intent of the legislature that the department shall apply to the secretary of the U.S. department of health and human services for authority under 42 U.S.C. 1315 to provide health care services through a program operated in accordance with the provisions of [sections 9 through 14] for eligible individuals.

(5) The intent of the proposed program is to increase participation and competition in the health insurance market, intensify price pressures, and reduce costs for both publicly and privately funded health care."

Insert: "NEW SECTION. **Section 10. Definitions.** As used in [sections 9 through 14], the following definitions apply:

(1) "Carrier" means a private entity offering qualified health plans through the health insurance exchange.

(2) "Cost sharing" means the portion of the cost of a covered medical service that must be paid by or on behalf of eligible individuals.

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

(4) "Eligible individual" means an individual who meets the requirements of 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).

(5) "Health insurance exchange" or "exchange" means an American health benefit exchange established pursuant to 42 U.S.C. 18031.

(6) "Premium" means the charge established as a condition of enrolling in a qualified health plan.

(7) "Program" means the waiver program established under [sections 9 through 14];

(8) "Qualified health plan" means a qualified health plan as defined in 42 U.S.C. 18021(a).

(9) "Secretary" means the secretary of the U.S. department of health and human services.

(10) "Waiver" means a waiver of medicaid state plan requirements, subject to approval by the secretary of the U.S. department of health and human services, authorized by:

(a) 42 U.S.C. 1315;

(b) 42 U.S.C. 1315 in combination with 42 U.S.C. 1396n; or

(c) any other federal statutes the secretary considers necessary for implementation of [sections 9 through 14] 42 U.S.C. 1315."

Insert: "NEW SECTION. Section 11. Design of waiver program -- rulemaking authority.

(1) The department shall submit, as may be necessary in seeking approval, one or more requests to the secretary of the U.S. department of health and human services for a waiver that provides health insurance coverage to eligible individuals who have a low risk of needing extensive medical services by primarily using a private insurance option.

(2) A waiver request must seek to:

(a) improve access to quality health care;

(b) attract insurance carriers and enhance competition in the insurance marketplace;

(c) promote individually owned health insurance;

(d) strengthen personal responsibility through cost-sharing;

(e) improve continuity of coverage;

(f) maximize available service options;

(g) reduce growth in the state-administered medicaid program;

(h) encourage appropriate care, including early intervention, prevention, and wellness;

(i) increase quality and delivery system efficiencies;

(j) facilitate Montana's continued payment innovation, delivery system reform, and market-driven improvements;

(k) discourage overutilization of health care services;

(l) reduce waste, fraud, and abuse;

(m) encourage and reward health outcomes and responsible choices; and

(n) promote efficiencies that will deliver value to the taxpayer.

(3) Any proposal to be submitted to the secretary shall:

(a) result in a federal medical assistance percentage that is commensurate with the percentage authorized for eligible individuals by Public Law 111-148 and Public Law 111-152 on [the effective date of this act];

(b) use the health insurance exchange to purchase qualified

health plans for eligible individuals;

(c) require that eligible individuals participate in cost sharing on a basis that is comparable to the cost sharing required of persons in the same income range in the private insurance market and that is structured to enhance the ability of eligible individuals to invest in their health care purchasing decisions; and

(d) allow the department to provide payment to carriers for the premiums and cost sharing of eligible individuals enrolled in plans offered by the carriers.

(4) The department shall propose that participation in the program be limited to adults who are:

(a) currently employed or actively seeking employment;

(b) the primary caregiver for a family member; or

(c) the spouse of an adult who is employed or actively seeking employment.

(5) The department may propose that the program exempt from purchase of a qualified health plan any eligible individuals for whom obtaining a qualified health plan is determined to be impractical, overly complex, or contrary to continuity or effectiveness of health care because the individuals:

(a) have exceptional health care needs, including but not limited to medical, mental health, or developmental conditions; or

(b) live in a geographical area, including an Indian reservation, that lacks health care providers who are participating in a qualified plan available to the individuals.

(6) To the greatest extent possible, the department shall negotiate with the U.S. department of health and human services to develop waiver provisions that limit the extent to which the waiver would apply to eligible individuals who are able-bodied and who are not actively seeking employment.

(7) In seeking authority from the secretary for implementation of [sections 9 through 14], the department may submit multiple proposals as necessary in order to gain approval of the secretary.

(8) The department shall implement the program as allowed under the waiver approved by the secretary. The department may adopt rules to carry out the program, including but not limited to rules establishing procedures for:

(a) determining eligibility; and

(b) payment of premiums and cost-sharing requirements.

(9) The implementation of a program authorized under this section and the authority of 42 U.S.C. 1315 is not subject to Title 53, chapter 6, part 7, or any other state law pertaining to managed care that would adversely affect:

(a) approval of the program by the secretary; or

(b) timely implementation of the program."

Renumber: subsequent sections

Strike: "expansion of the medicaid program"

Insert: "option of participating in the program provided for in [section 11]"

10. Page 7, line 25 through page 8, line 19.

Strike: section 11 in its entirety

Renumber: subsequent sections

11. Page 8, line 22.

Strike: "medicaid expansion"

Insert: "insurance assistance"

Strike: "13"

Insert: "14"

12. Page 8, line 25.

Strike: "Medicaid expansion"

Insert: "Insurance assistance"

13. Page 8, line 28.

Strike: "and"

14. Page 9, line 1 through line 3.

Strike: "the Montana" on line 1 through "111-152" on line 3

Insert: "of the use of medicaid funds to purchase health insurance and provide coverage for eligible individuals as allowed under [sections 9 through 14]"

15. Page 9, line 5.

Following: "program"

Insert: "; and

(c) the hospital utilization surcharge provided for in 15-66-102(3)"

16. Page 9, line 8 through line 9.

Following: "used"

Insert: "by the department"

Strike: "medical services" on line 8 through "111-152" on line 9

Insert: "eligible individuals as allowed under [sections 9 through 14]"

17. Page 9, line 12 through line 13.

Strike: "the medicaid program" on line 12 through "111-152" on line 13

Insert: "medicaid funds were used to cover eligible individuals as allowed under [sections 9 through 14]"

18. Page 9, line 20 through line 23.

Following: "other" on line 20

Insert: "eligible"

Strike: ":" on line 20 through "medicaid and" on line 23

Insert: "is"

19. Page 10.

Following: line 4

Insert: "NEW SECTION. **Section 15. Medicaid program reforms.**

(1) The department shall undertake efforts to redesign and reform the Montana medicaid program as outlined in this section. The department shall include parties interested in the operation of the programs in the process of developing and implementing the reforms.

(2) As part of its efforts under this section, the department shall:

(a) implement a patient-centered medical home model of care; and

(b) design and implement a plan to reduce use of hospital emergency departments for nonemergency care, using methods that include but are not limited to:

(i) allowing nurses to evaluate the level of care a patient may need;

(ii) providing targeted patient education;

(iii) increasing the monitoring of excessive emergency room use and behavior that may indicate that an individual is seeking prescription drugs from multiple sources; and

(iv) requiring providers participating in any primary care case management program to see a medicaid recipient assigned to their care within the timeframe established by the department by rule. The department shall establish by rule timeframes that may differ based on the urgency of a patient's medical condition.

(3) To the greatest extent possible, the department shall undertake the activities in subsection (2) no later than January 1, 2014."

Insert: "NEW SECTION. **Section 16. Value-based purchasing.** (1)

The department shall establish a value-based purchasing system for the medicaid program. The program shall allow for incentive payments to the following providers if the providers meet established performance standards:

(a) hospitals;

(b) physicians;

(c) advanced practice registered nurses;

(d) long-term care facilities; and

(e) home health care agencies.

(2) The department shall identify quality indicators and benchmarks using standards established by the medicare value-based purchasing program authorized pursuant to 42 U.S.C. 1395ww.

(3) The department shall require the providers listed in subsection (1) to begin reporting by July 1, 2014, the data required for quality indicators identified by the department.

(4) Medicaid payments to providers may be adjusted beginning in fiscal year 2016 to recognize a provider's compliance with quality indicators and benchmarks established

pursuant to this section."

Insert: "Section 17. Section 15-66-101, MCA, is amended to read:

"15-66-101. (Temporary) Definitions. For purposes of this chapter, the following definitions apply:

(1) (a) "Hospital" means a facility licensed as a hospital pursuant to Title 50, chapter 5, and includes a critical access hospital.

(b) The term does not include Montana state hospital.

(2) (a) "Inpatient bed day" means a day of inpatient care provided to a patient in a hospital. A day begins at midnight and ends 24 hours later. A part of a day, including the day of admission, counts as a full day. The day of discharge or death is not counted as a day. If admission and discharge or death occur on the same day, the day is considered a day of admission and is counted as one inpatient bed day. Inpatient bed days include all inpatient hospital benefit days as defined for medicare reporting purposes in section 20.1 of chapter 3 of the centers for medicare and medicaid services publication 100-02, the Medicare Benefit Policy Manual. Inpatient bed days also include all nursery days during which a newborn infant receives care in a nursery.

(b) The term does not include observation days or days of care in a swing bed, as defined in 50-5-101.

(3) "Patient" means an individual obtaining skilled medical and nursing services in a hospital. The term includes newborn infants.

(4) "Report" means the report of inpatient bed days required in 15-66-201.

(5) "Utilization fee assessment" or "fee assessment" means the utilization fee and utilization surcharge required to be paid for each inpatient bed day, as provided in 15-66-102.

(Void on occurrence of contingency--sec. 18, Ch. 390, L.

2003--see chapter compiler's comment.)"

{Internal References to 15-66-101: None.}"

Insert: "Section 18. Section 15-66-102, MCA, is amended to read:

"15-66-102. (Temporary) Utilization fee assessments for inpatient bed days. (1) Each hospital in the state shall pay to the department a utilization fee in the amount of \$50 for each inpatient bed day.

(2) All proceeds from the collection of utilization fees, including penalties and interest, must, in accordance with the provisions of 17-2-124, be deposited to the credit of the department of public health and human services in a state special revenue account as provided in 53-6-149.

(3) Each hospital in the state shall pay to the department a utilization surcharge in the amount of:

(a) \$2 for each bed day from July 1, 2013, through December 31, 2013;

(b) \$3 for each bed day from January 1, 2014, through December 31, 2015; and

(c) \$25 for each bed day on or after January 1, 2016.

(4) All proceeds from the collection of the utilization

surcharge established in subsection (3), including penalties and interest, must, in accordance with the provisions of 17-2-124, be deposited to the credit of the department of public health and human services in the insurance assistance mitigation special revenue account provided for in [section 14]. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

{Internal References to 15-66-102:

15-66-101a 15-66-103a 15-66-201a 53-6-149a }"

Insert: "Section 19. Section 15-66-103, MCA, is amended to read:

"15-66-103. (Temporary) Relation to other taxes and fees.

The utilization ~~fee~~ assessments imposed under 15-66-102 ~~is~~ are in addition to any other taxes and fees required to be paid by hospitals. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

{Internal References to 15-66-103: None.}"

Insert: "Section 20. Section 15-66-201, MCA, is amended to read:

"15-66-201. (Temporary) Reporting and collection of fee

assessment. (1) On or before January 31 of each year, a hospital shall file with the department an annual report of the number of inpatient bed days during the preceding year beginning January 1 and ending December 31. The report must be in the form prescribed by the department. The report must be accompanied by a payment in an amount equal to the ~~fee~~ assessments required to be paid under 15-66-102.

(2) On or before January 31 of each year, the department of public health and human services shall provide the department with a list of hospitals licensed and operating in the state during the preceding year beginning January 1 and ending December 31. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

{Internal References to 15-66-201:

15-66-101a 15-66-204a 15-66-206a }"

Insert: "Section 21. Section 15-66-202, MCA, is amended to read:

"15-66-202. (Temporary) Audit -- records. (1) The department may audit the records and other documents of any hospital to ensure that the proper utilization ~~fee has~~ assessments have been collected.

(2) The department may require the hospital to provide records and other documentation, including books, ledgers, and registers, necessary for the department to verify the proper amount of the ~~utilization fee~~ assessment paid.

(3) A hospital shall maintain and make available for inspection by the department sufficient records and other documentation to demonstrate the number of inpatient bed days in the facility subject to the utilization ~~fee~~ assessments. The facility shall maintain these records for a period of at least 5 years from the date the report is due. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

{Internal References to 15-66-202: None.}"

Insert: "Section 22. Section 15-66-203, MCA, is amended to read:

"15-66-203. (Temporary) Periods of limitation. (1) Except as otherwise provided in this section, a deficiency may not be assessed or collected with respect to the year for which a report is filed unless the notice of additional fees amount proposed to be assessed is mailed within 5 years from the date the report was filed. For the purposes of this section, a report filed before the last day prescribed for filing is considered filed on the last day. If, before the expiration of the period prescribed for assessment of the fee additional amount, the hospital consents in writing to an assessment after the 5-year period, the fee additional amount may be assessed at any time prior to the expiration of the period agreed upon.

(2) A refund or credit may not be paid or allowed with respect to the year for which a report is filed after 5 years from the last day prescribed for filing the report or after 1 year from the date of the overpayment, whichever period expires later, unless before the expiration of the period, the hospital files a claim or the department has determined the existence of the overpayment and has approved the refund or credit. If the hospital has agreed in writing under the provisions of subsection (1) to extend the time within which the department may propose an additional assessment, the period within which a claim for refund or credit is filed or a credit or refund is allowed if a claim is not filed is automatically extended. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

{Internal References to 15-66-203: None.}"

Insert: "Section 23. Section 15-66-204, MCA, is amended to read:

"15-66-204. (Temporary) Penalty and interest for delinquent fees assessments -- waiver. If the fee assessment for any hospital is not paid on or before the due date of the report as provided in 15-66-201, penalty and interest, as provided in 15-1-216, must be added to the fee assessment. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

{Internal References to 15-66-204: None.}"

Insert: "Section 24. Section 15-66-206, MCA, is amended to read:

"15-66-206. (Temporary) Deficiency assessment -- penalty and interest -- hearing. (1) If the department determines that the amount of fees assessments due is greater than the amount disclosed by the report, it shall mail to the hospital a notice of the additional fees amount proposed to be assessed. Within 30 days after the mailing of the notice, the hospital may file with the department a written protest against the proposed additional fees assessments, setting forth the grounds upon which the protest is based, and may request in its protest an oral hearing or an opportunity to present additional evidence relating to its fees assessment liability. If a protest is not filed, the amount

~~of the additional fees~~ proposed to be assessed becomes final upon the expiration of the 30-day period. If a protest is filed, the department shall reconsider the proposed assessment and, if the hospital has requested, shall grant the hospital an oral hearing. After consideration of the protest and the evidence presented at an oral hearing, the department's action upon the protest is final when it mails notice of its action to the hospital.

(2) When a deficiency is determined and the ~~fees~~ assessments become final, the department shall mail notice and demand for payment to the hospital. Penalty and interest must be added to any deficiency assessment as provided in 15-1-216 from the date specified in 15-66-201 for payment of the ~~fees~~ assessments. A certificate by the department of the mailing of the notices specified in this section is prima facie evidence of the computation and levy of the deficiency in the ~~fees~~ assessments and of the giving of the notice. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

{Internal References to 15-66-206: None.}"

Insert: "Section 25. Section 15-66-207, MCA, is amended to read:

"15-66-207. (Temporary) Closing agreements. (1) The director of the department or any person authorized in writing by the director may enter into an agreement with a hospital relating to the liability of the hospital with respect to the ~~fees~~ assessments imposed by this chapter for any period.

(2) An agreement under this section is final and conclusive and, except upon a showing of fraud or malfeasance or misrepresentation of a material fact:

(a) in a case involving the agreement, the agreement may not be reopened as to matters agreed upon or modified by any officer, employee, or agent of this state; and

(b) the agreement may not be annulled, modified, set aside, or disregarded in any suit, action, or proceeding concerning the agreement or concerning any determination, assessment, collection, payment, abatement, refund, or credit made in accordance with the agreement. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

{Internal References to 15-66-207: None.}"

Insert: "Section 26. Section 15-66-208, MCA, is amended to read:

"15-66-208. (Temporary) Credit for overpayment -- interest on overpayment. (1) If the department determines that the amount of ~~fees~~ assessments, penalty, or interest due for any period is less than the amount paid, the amount of the overpayment must be credited against any ~~fees~~ assessments, penalty, or interest due from the hospital at that time and the balance must be refunded to the hospital or its successor through reorganization, merger, or consolidation or to its shareholders upon dissolution.

(2) Except as provided in subsection (3), interest is allowed on overpayments at the same rate as is charged on unpaid taxes, as provided in 15-1-216, from the due date of the report

or from the date of overpayment, whichever date is later, to the date the department approves refunding or crediting of the overpayment. Interest does not accrue during any period during which the processing of a claim for refund is delayed more than 30 days by reason of failure of the hospital to furnish information requested by the department for the purpose of verifying the amount of the overpayment.

(3) Interest is not allowed:

(a) if the overpayment is refunded within 6 months from the date the report is due or from the date the return is filed, whichever is later; or

(b) if the amount of interest is less than \$1.

(4) A payment not made incident to a discharge of actual utilization ~~fee~~ assessment liability or a payment reasonably assumed to be imposed by this chapter is not considered an overpayment with respect to which interest is allowable. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

{Internal References to 15-66-208: None.}"

Insert: "Section 27. Section 15-66-209, MCA, is amended to read:

"15-66-209. (Temporary) Warrant for distraint. If the ~~utilization fee~~ an assessment is not paid when due, the department may issue a warrant for distraint as provided in Title 15, chapter 1, part 7. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

{Internal References to 15-66-209: None.}"

Renumber: subsequent sections

20. Page 12, line 9 through page 15, line 3.

Strike: section 16 in its entirety

Renumber: subsequent sections

21. Page 15.

Following: line 28

Insert: "Section 32. Section 53-6-149, MCA, is amended to read:

"53-6-149. State special revenue fund account --
administration. (1) There is a hospital medicaid reimbursement account in the state special revenue fund provided for in 17-2-102.

(2) All money collected under 15-66-102(2) must be deposited in the account.

(3) Money in the account must be used by the department of public health and human services to provide funding for increases in medicaid payments to hospitals and for the costs of collection of the fee and other administrative activities associated with the implementation of increases in the medicaid payments to hospitals."

{Internal References to 53-6-149:

15-66-102a 53-6-707a }"

22. Page 15, line 30 through page 18, line 3.

Strike: section 19 in its entirety

Renumber: subsequent sections

23. Page 18, line 10.

Strike: "13"

Insert: "14"

Strike: "part 1,"

24. Page 18, line 11.

Strike: "part 1,"

Strike: "13"

Insert: "14"

25. Page 18.

Following: line 11

Insert: "(4) [Sections 15 and 16] are intended to be codified as an integral part of Title 53, chapter 6, part 1, and the provisions of Title 53, chapter 6, part 1, apply to [sections 15 and 16]."

26. Page 18, line 13 through page 16.

Strike: section 21 in its entirety

Renumber: subsequent sections

27. Page 18.

Following: line 20

Insert: "NEW SECTION. **Section 35. Contingent voidness.** (1) If the secretary of the U.S. department of health and human services gives notice to the state that the U.S. department of health and human services will not consider for approval or would not approve the purchase of health insurance with medicaid funds for eligible individuals pursuant to [sections 9 through 11], the [sections 9 through 14] are void and the state may not obtain or use medicaid funds for individuals who would be eligible for medicaid under 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).

(2) The director of the department of public health and human services shall notify the code commissioner of the occurrence of the contingency within 10 days of its occurrence."

Renumber: subsequent sections

28. Page 18, line 22.

Strike: "subsection (2)"

Insert: "subsections (2) and (3)"

29. Page 18, line 24.

Strike: "[Sections 1" through "and this section"

Insert: "[Sections 1 through 8, 17 through 27, and 32]"

Strike: "and this section"

Following: line 24

Insert: "(3) [Sections 9 through 14 and 33 through 38] are effective on passage and approval."

30. Page 18, line 26.

Strike: "(Sections 9" through "16(1)(h))"

Insert: "[Sections 9 through 13, 17 through 27, and 32]"

31. Page 18, line 28.

Strike: "53-6-131(1)(h)"

Insert: "42 U.S.C. 1396a(a)(10)(A)(i)(VIII)"

32. Page 18, line 30.

Strike: "13"

Insert: "14"

33. Page 19, line 5 through line 6.

Strike: "24" on line 5

Insert: "37"

Following: "sections" on line 5

Strike: "[section 1" through "19]"

Insert: "[sections 9 through 13, sections 17 through 27, and 32]"

34. Page 19.

Following: line 6

Insert: "(2) Except as provided in [section 32], [section 14] terminates 15 months after the contingency provided for in [section 32(1)]."

Renumber: subsequent subsections

- END -