HOUSE BILL NO. 649

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A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING REIMBURSEMENT RATES FOR PROVIDERS COVERED BY THE RATE STUDY AUTHORIZED UNDER CHAPTER 401, LAWS OF 2021; REQUIRING IMPLEMENTATION OF RECOMMENDED RATE INCREASES; ~~PROVIDING FOR INFLATIONARY INCREASES;~~ PROVIDING REPORTING REQUIREMENTS; AMENDING SECTIONS 53-6-113 AND 53-6-402, MCA; AND PROVIDING AN EFFECTIVE DATE."

WHEREAS, the 2021 Legislature appropriated $2.75 million in House Bill 632 for a study of the reimbursement rates paid by the Department of Public Health and Human Services to providers of health care, behavioral health care, developmental disabilities, and senior and long-term care services, including nursing homes; and

WHEREAS, the Governor and the Department of Public Health and Human Services used the appropriation to contract with the consulting firm of Guidehouse; and

WHEREAS, Guidehouse produced two reports in 2022 identifying the rates necessary to cover the costs of providing services and detailing the extent to which the state's rates fall short of the benchmarks; and

WHEREAS, the rate levels identified in the rate study reports specify how the state can improve its provider rates to account for the true costs of operating as a health care provider in this state; and

WHEREAS, the insufficiency of reimbursement rates has resulted in the closure of 11 nursing homes and the loss of 857 skilled nursing facility beds in the state, with more nursing homes on the brink of closure; and

WHEREAS, the insufficiency of reimbursement rates has contributed, and continues to contribute, to extensive and serious shortages of health care and behavioral health care providers; and

WHEREAS, the rate shortfalls and workforce shortages have forced the closure of many providers of services to Montanans with physical and developmental disabilities, including the closure of group homes; and

WHEREAS, the Legislature recognizes the urgent need to fully reimburse providers at the rates identified in the provider rate studies.

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

NEW SECTION. **Section 1. Establishment of certain provider reimbursement rates ~~-- inflationary increase~~ -- outcome measurement.** (1) The department shall reimburse providers of services reviewed as part of the 2021-2022 provider rate studies authorized under Chapter 401, Laws of 2021, and completed in 2022 in accordance with this section in order to~~:~~

~~(a)~~ implement the rate increase recommendations resulting from the studies~~; and~~

~~(b) provide inflationary adjustments in subsequent years~~.

(2) For the fiscal year beginning July 1, 2023, the department shall:

(a) set the base daily rate for nursing homes at the ~~base daily~~ gross single rate ~~determined~~ recommended by the nursing facility rate study prior to applying ~~the occupancy adjustment~~ quality and acuity add-ons; and

(b) ~~except as provided in subsection (2)(c) and~~ except for physician services reimbursed as provided in 53-6-125, set reimbursement rates for other provider types that were included in the rate studies at the benchmark rate identified for each service or provider type ~~plus an inflationary factor equal to the increase in the consumer price index, U.S. city average, all urban consumers, for all items, as published by the bureau of labor statistics of the U.S. department of labor; and~~

~~(c) for any service or provider type for which the study identified a rate decrease, provide the increase appropriated for provider types not covered by the provider rate studies~~.

(3) ~~In subsequent fiscal years, the~~ The department ~~shall increase~~ may not decrease the rates for the providers and services covered under this section ~~by an inflationary factor equal to the greater of 3% or the increase in the consumer price index, U.S. city average, all urban consumers, for all items, as published by the bureau of labor statistics of the U.S. department of labor~~ in subsequent fiscal years.

(4) The department shall continue to supplement the base daily rate for nursing facility services with add-on payments based on the quality of services provided and acuity of resident needs.

(5) The department shall, in accordance with 5-11-210, report the following information, as measured on July 1 each year, to the children, families, health, and human services interim committee, the health and human services interim budget committee, and the legislative finance committee no later than September 15 of each even-numbered year:

(a) the number of providers participating in the medicaid program;

(b) the number of individuals on waiting lists for medicaid waiver services;

(c) the number of children receiving treatment in out-of-state psychiatric residential facilities and therapeutic group homes; and

(d) the number of vacant direct-care worker staff positions and the rate of direct-care staff turnover, as reported to the department by providers included in the rate studies.

Section 2. Section 53-6-113, MCA, is amended to read:

"**53-6-113. Department to adopt rules.** (1) The department shall adopt appropriate rules necessary for the administration of the Montana medicaid program as provided for in this part and that may be required by federal laws and regulations governing state participation in medicaid under Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as amended.

(2) The department shall adopt rules that are necessary to further define for the purposes of this part the services provided under 53-6-101 and to provide that services being used are medically necessary and that the services are the most efficient and cost-effective available. The rules may establish the amount, scope, and duration of services provided under the Montana medicaid program, including the items and components constituting the services.

(3) (a) The department shall establish by rule the rates for reimbursement of services provided under this part. ~~The~~ Except as provided in subsection (3)(b), the department may in its discretion set rates of reimbursement that it determines necessary for the purposes of the program. In establishing rates of reimbursement, the department may consider but is not limited to considering:

~~(a)~~(i) the availability of appropriated funds;

~~(b)~~(ii) the actual cost of services;

~~(c)~~(iii) the quality of services;

~~(d)~~(iv) the professional knowledge and skills necessary for the delivery of services; and

~~(e)~~(v) the availability of services.

(b) The department shall set rates subject to the rate study authorized by Chapter 401, Laws of 2021, in accordance with the provisions of [section 1].

(4) The department shall specify by rule those professionals who may:

(a) deliver or direct the delivery of particular services; and

(b) deliver services by means of telehealth in accordance with 53-6-122.

(5) The department may provide by rule for payment by a recipient of a portion of the reimbursements established by the department for services provided under this part.

(6) (a) The department may adopt rules consistent with this part to govern eligibility for the Montana medicaid program, including the medicaid program provided for in 53-6-195. Rules may include but are not limited to financial standards and criteria for income and resources, treatment of resources, nonfinancial criteria, family responsibilities, residency, application, termination, definition of terms, confidentiality of applicant and recipient information, and cooperation with the state agency administering the child support enforcement program under Title IV-D of the Social Security Act, 42 U.S.C. 651, et seq.

(b) The department may not apply financial criteria below $15,000 for resources other than income in determining the eligibility of a child under 19 years of age for poverty level-related children's medicaid coverage groups, as provided in 42 U.S.C. 1396a(l)(1)(B) through (l)(1)(D).

(c) The department may not apply financial criteria below $15,000 for an individual and $30,000 for a couple for resources other than income in determining the eligibility of individuals for the medicaid program for workers with disabilities provided for in 53-6-195.

(d) (i) The department may not adopt rules or policies requiring a person who is eligible for medicaid pursuant to 53-6-131(1)(e)(ii)(A) to:

(A) make only a cash payment to qualify for medicaid under that subsection; or

(B) only incur medical expenses as a means of qualifying for medicaid under that subsection.

(ii) If a person eligible for medicaid under 53-6-131(1)(e)(ii)(A) is participating in a home and

community-based services waiver, the department shall count as an eligible medical expense any medical service or item that a nonwaiver medicaid member is allowed to count as a medical expense to qualify for medicaid under 53-6-131(1)(e)(ii)(A).

(iii) Nothing in this subsection (6)(d) may be construed as preventing a person from making only a cash payment to qualify for medicaid pursuant to 53-6-131(1)(e)(ii)(A).

(7) The department may adopt rules limiting eligibility based on criteria more restrictive than that provided in 53-6-131 if required by Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, or if funds appropriated are not sufficient to provide medical care for all eligible persons.

(8) The department may adopt rules necessary for the administration of medicaid managed care systems. Rules to be adopted may include but are not limited to rules concerning:

(a) participation in managed care;

(b) selection and qualifications for providers of managed care; and

(c) standards for the provision of managed care.

(9) Subject to subsection (6), the department shall establish by rule income limits for eligibility for extended medical assistance of persons receiving section 1931 medicaid benefits, as defined in 53-4-602, who lose eligibility because of increased income to the assistance unit, as that term is defined in the rules of the department, as provided in 53-6-134, and shall also establish by rule the length of time for which extended medical assistance will be provided. The department, in exercising its discretion to set income limits and duration of assistance, may consider the amount of funds appropriated by the legislature.

(10) Unless required by federal law or regulation, the department may not adopt rules that exclude a child from medicaid services or require prior authorization for a child to access medicaid services if the child would be eligible for or able to access the services without prior authorization if the child was not in foster care."

Section 3. Section 53-6-402, MCA, is amended to read:

"**53-6-402. Medicaid-funded home and community-based services -- waivers -- funding limitations -- populations -- services -- providers -- long-term care preadmission screening -- powers and duties of department -- rulemaking authority.** (1) The department may obtain waivers of federal medicaid law in accordance with section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n, and

administer programs of home and community-based services funded with medicaid money for categories of persons with disabilities or persons who are elderly.

(2) The department may seek and obtain any necessary authorization provided under federal law to implement home and community-based services for seriously emotionally disturbed children pursuant to a waiver of federal law as permitted by section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n(c). The home and community-based services system shall strive to incorporate the following components:

(a) flexibility in design of the system to attempt to meet individual needs;

(b) local involvement in development and administration;

(c) encouragement of culturally sensitive and appropriately trained mental health providers;

(d) accountability of recipients and providers; and

(e) development of a system consistent with the state policy as provided in 52-2-301.

(3) The department may, subject to the terms and conditions of a federal waiver of law, administer programs of home and community-based services to serve persons with disabilities or persons who are elderly who meet the level of care requirements for one of the categories of long-term care services that may be funded with medicaid money. Persons with disabilities include persons with physical disabilities, chronic mental illness, developmental disabilities, brain injury, or other characteristics and needs recognized as appropriate populations by the U.S. department of health and human services. Programs may serve combinations of populations and subsets of populations that are appropriate subjects for a particular program of services.

(4) The provision of services to a specific population through a home and community-based services program must be less costly in total medicaid funding than serving that population through the categories of long-term care facility services that the specific population would be eligible to receive otherwise.

(5) The department may initiate and operate a home and community-based services program to more efficiently apply available state general fund money, other available state and local public and private money, and federal money to the development and maintenance of medicaid-funded programs of health care and related services and to structure those programs for more efficient and effective delivery to specific populations.

(6) The department, in establishing programs of home and community-based services, shall administer the expenditures for each program within the available state spending authority that may be applied

to that program. In establishing covered services for a home and community-based services program, the department shall establish those services in a manner to ensure that the resulting expenditures remain within the available funding for that program. To the extent permitted under federal law, the department may adopt financial participation requirements for enrollees in a home and community-based services program to foster appropriate utilization of services among enrollees and to maintain fiscal accountability of the program. The department may adopt financial participation requirements that may include but are not limited to copayments, payment of monthly or yearly enrollment fees, or deductibles. The financial participation requirements adopted by the department may vary among the various home and community-based services programs. The department, as necessary, may further limit enrollment in programs, reduce the per capita expenditures available to enrollees, and modify and reduce the types and amounts of services available through a home and community-based services program when the department determines that expenditures for a program are reasonably expected to exceed the available spending authority.

(7) The department may consider the following populations or subsets of populations for home and community-based services programs:

(a) persons with developmental disabilities who need, on an ongoing or frequent basis, habilitative and other specialized and supportive developmental disabilities services to meet their needs of daily living and to maintain the persons in community-integrated residential and day or work situations;

(b) persons with developmental disabilities who are 18 years of age and older and who are in need of habilitative and other specialized and supportive developmental disabilities services necessary to maintain the persons in personal residential situations and in integrated work opportunities;

(c) persons 18 years of age and older with developmental disabilities and chronic mental illness who are in need of mental health services in addition to habilitative and other developmental disabilities services necessary to meet their needs of daily living, to treat their mental illness, and to maintain the persons in community-integrated residential and day or work situations;

(d) children under 21 years of age who are seriously emotionally disturbed and in need of mental health and other specialized and supportive services to treat their mental illness and to maintain the children with their families or in other community-integrated residential situations;

(e) persons 18 years of age and older with brain injuries who are in need, on an ongoing or

frequent basis, of habilitative and other specialized and supportive services to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations;

(f) persons 18 years of age and older with physical disabilities who are in need, on an ongoing or frequent basis, of specialized health services and personal assistance and other supportive services necessary to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations;

(g) persons with human immunodeficiency virus (HIV) infection who are in need of specialized health services and intensive pharmaceutical therapeutic regimens for abatement and control of the HIV infection and related symptoms in order to maintain the persons in personal residential situations;

(h) persons with chronic mental illness who suffer from serious chemical dependency and who are in need of intensive mental health and chemical dependency services to maintain the persons in personal or other community-integrated residential situations;

(i) persons 65 years of age and older who are in need, on an ongoing or frequent basis, of health services, personal assistance, and other supportive services necessary to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations; or

(j) persons 18 years of age and older with chronic mental illness who are in need, on an ongoing or frequent basis, of specialized health services and other supportive services necessary to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations.

(8) For each authorized program of home and community-based services, the department shall set limits on overall expenditures and enrollment and limit expenditures as necessary to conform with the requirements of section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n, and the conditions placed upon approval of a program authorized through a waiver of federal law by the U.S. department of health and human services.

(9) A home and community-based services program may include any of the following categories of services as determined by the department to be appropriate for the population or populations to be served and as approved by the U.S. department of health and human services:

(a) case management services;

(b) homemaker services;

(c) home health aide services;

(d) personal care services;

(e) adult day health services;

(f) habilitation services;

(g) respite care services; and

(h) other cost-effective services appropriate for maintaining the health and well-being of persons and to avoid institutionalization of persons.

(10) Subject to the approval of the U.S. department of health and human services, the department may establish appropriate programs of home and community-based services under this section in conjunction with programs that have limited pools of providers or with managed care arrangements, as implemented through 53-6-116 and as authorized under section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n, or in conjunction with a health insurance flexibility and accountability demonstration initiative or other demonstration project as authorized under section 1115 of Title XI of the Social Security Act, 42 U.S.C. 1315.

(11) (a) The department may conduct long-term care preadmission screenings in accordance with section 1919 of Title XIX of the Social Security Act, 42 U.S.C. 1396r.

(b) Long-term care preadmission screenings are required for all persons seeking admission to a long-term care facility.

(c) A person determined through a long-term care preadmission screening to have an intellectual disability or a mental illness may not reside in a long-term care facility unless the person meets the long-term care level-of-care determination applicable to the type of facility and is determined to have a primary need for the care provided through the facility.

(d) The long-term care preadmission screenings must include a determination of whether the person needs specialized intellectual disability or mental health treatment while residing in the facility.

(12) The department may adopt rules necessary to implement the long-term care preadmission screening process as required by section 1919 of Title XIX of the Social Security Act, 42 U.S.C. 1396r. The rules must provide criteria, procedures, schedules, delegations of responsibilities, and other requirements necessary to implement long-term care preadmission screenings.

(13) (a) The department shall adopt rules necessary for the implementation of each program of

home and community-based services, including rules for substantive changes to approved waiver provisions as required under 53-6-413. The rules may include but are not limited to the following:

(i) the populations or subsets of populations, as provided in subsection (7), to be served in each program;

(ii) limits on enrollment;

(iii) limits on per capita expenditures;

(iv) requirements and limitations for service costs and expenditures;

(v) eligibility categories criteria, requirements, and related measures;

(vi) designation and description of the types and features of the particular services provided for under subsection (9);

(vii) provider requirements and reimbursement;

(viii) financial participation requirements for enrollees as provided in subsection (6);

(ix) utilization measures;

(x) measures to ensure the appropriateness and quality of services to be delivered; and

(xi) other appropriate provisions necessary to the administration of the program and the delivery of services in accordance with 42 U.S.C. 1396n and any conditions placed upon approval of a program by the U.S. department of health and human services.

(b) Unless required by federal law or regulation, the department may not adopt rules that exclude a child from home and community-based services or require prior authorization for a child to access home and community-based services if the child would be eligible for or able to access the home and community-based services without prior authorization if the child was not in foster care.

(c) The department shall adopt reimbursement rates for providers covered by the rate study authorized by Chapter 401, Laws of 2021, in accordance with the provisions of [section 1].

(14) The department shall establish by rule the procedures for moving a person from a waiting list for services provided through a medicaid home and community-based services waiver into the waiver services, including the process and priorities to be used in making determinations related to the waiting list. The department may not modify the policies established in rule by adopting supplemental policies or procedures not subject to the administrative rulemaking process.

(15) The department shall adopt rules for the provision of the fraud prevention training required under 53-6-405, including but not limited to establishing the elements that must be contained in fraud prevention education materials and the models that may be used for the training.

(16) The department shall adopt rules to carry out the cost reporting provisions of 53-6-406, including but not limited to the costs that a provider is required to report to the department, the format of the report, and the deadline for filing the report."

NEW SECTION. **SECTION 4. LEGISLATIVE INTENT AND DIRECTION TO DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES.** THE LEGISLATURE INTENDS THAT:

(1) NOTHING IN [THIS ACT] MAY BE CONSTRUED AS REQUIRING REIMBURSEMENT RATES FOR MEDICAID AND NONMEDICAID SERVICES TO BE HIGHER THAN THE LEVELS PROVIDED FOR IN [THIS ACT]; AND

(2) THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES APPLIES TOWARD THE COST OF IMPLEMENTING [THIS ACT] ANY GENERAL FUND, STATE SPECIAL REVENUE, AND FEDERAL SPECIAL REVENUE APPROPRIATED IN HOUSE BILL NO. 2 FOR THE PURPOSES OF INCREASING REIMBURSEMENT RATES FOR MEDICAID AND NONMEDICAID SERVICES REVIEWED BY THE PROVIDER RATE STUDIES AUTHORIZED UNDER CHAPTER 401, LAWS OF 2021, SO THAT THE TOTAL COSTS OF THE PROVIDER RATE INCREASES DO NOT EXCEED THE COSTS REFLECTED IN [THIS ACT].

NEW SECTION. **Section 5. Codification instruction.** [Section 1] is 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 [section 1].

COORDINATION SECTION. **Section 6. Coordination instruction**. (1) If both House Bill No. 2 and [this act] are passed and approved and House Bill No. 2 contains appropriations that fully fund or exceed the benchmark rates for services and providers included in the Montana Rate Studies report published July 22, 2022, and funds the daily base rate for nursing facilities at or above the gross single rate recommended in the Montana Nursing Facility Rate Study report published November 30, 2022, then [this act] is void.

(2) If both House Bill No. 2 and [this act] are passed and approved and House Bill No. 2 contains appropriations that fully fund or exceed the benchmark rates for services and providers included in the Montana

Rate Studies report but funds the daily base rate for nursing facilities at less than the gross single rate recommended in the Montana Nursing Facility Rate Study, then [section 1(2)(b) of this act] is void.

(3) If both House Bill No. 2 and [this act] are passed and approved and House Bill No. 2 contains appropriations that fully fund the daily base rate for nursing facilities at or above the gross single rate recommended in the Montana Nursing Facility Rate Study but funds the rates for services and providers included in the Montana Rate Studies report at less than the benchmark rate recommended for those providers and services, then [section 1(2)(a) of this act] is void.

NEW SECTION. **Section 7. Effective date.** [This act] is effective July 1, 2023.

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