_____ BILL NO. _____

INTRODUCED BY _____
(Primary Sponsor)

A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING A STANDARDIZED COST REPORTING PROCESS FOR CERTAIN MEDICAID SERVICE PROVIDERS; PROVIDING AN APPROPRIATION; ESTABLISHING REPORTING REQUIREMENTS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTION 53-6-402, MCA; REPEALING SECTION 53-6-406, MCA; AND PROVIDING AN EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Purpose.** The department of public health and human services shall establish a standardized cost reporting process for certain medicaid service providers. The cost report information will be used to inform the department and the legislature about the adequacy of medicaid rates.

NEW SECTION. **Section 2. Reporting services.** (1) The department of public health and human services shall include the following services in its cost reporting process:

(a) adult mental health;

(b) children's mental health;

(c) substance use disorder;

(d) developmental disabilities; and

(e) senior and long-term care.

(2) Services included in the cost report must be funded in one of the following ways:

(a) as a medicaid state plan service;

(b) through a medicaid state plan option available to the state under 42 U.S.C. 1396n(k);

(c) under any type of medicaid waiver program;

(d) state-funded services; or

(e) other identified funding sources that support services in subsection (1).

NEW SECTION. **Section 3. Process to establish cost reporting.** (1) The department of public health and human services shall establish a cost reporting process that:

(a) implements a standardized cost reporting format that includes recognized revenues and expenditures incurred by medicaid service providers;

(b) identifies medicaid service providers and other providers that are required to submit cost reporting information;

(c) identifies providers that are exempt from cost reporting requirements;

(d) determines a base year for data collection and identifies the types of expenditures and revenues for which providers are required to report data in order for the department to analyze the data and make determinations about rate adequacy;

(e) collects data to update the base-year expenditures at least once every 4 years but not more than once in any 2-year period;

(f) consults medicaid service providers in the development of the cost report format; and

(g) establishes protocols to protect provider cost reporting data.

(2) Identified medicaid service providers shall:

(a) provide actual expenditures and revenue data to the department in the standardized reporting format established under this section;

(b) submit cost information reflecting costs incurred during the provider's most recent fiscal year; and

(c) provide audits or cooperate in audits of the submitted data if requested by the department.

NEW SECTION. **Section 4. Reporting.** (1) Contingent upon legislative appropriation, the department of public health and human services shall develop a report to document the adequacy of current medicaid rates compared to reported medicaid service provider costs at least once every 4 years.

(2) The report must consider the following data sources in the development of rate adequacy:

(a) medicaid service provider cost report information submitted as required in [section 3];

(b) claims data;

(c) United States bureau of labor statistics data;

(d) internal revenue service data;

(e) United States department of agriculture data;

(f) United States census bureau data

(g) peer state comparisons; and

(h) any other relevant regional and national data considered appropriate by the department.

(3) The report must provide information to support a biennial or supplemental budget request as necessary to adjust medicaid service provider reimbursement rates to ensure rate adequacy.

(4) The department shall provide the report at least once every 4 years to the office of budget and program planning, the children, families, health, and human services interim committee, and the interim budget committee in accordance with 5-11-210. The first report is due by September 1, 2026.

(5) In accordance with the Montana Procurement Act, the department may contract with a cost-based reporting expert to assist in completing subsections (1) through (4).

NEW SECTION. **Section 5. Rulemaking.** The department of public health and human services may adopt rules to carry out the cost reporting provisions of [sections 2 through 4], including rules on:

(1) the costs a medicaid service provider must report to the department;

(2) the report format; and

(3) the deadline for the department to file the report.

Section 6. 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) (a) 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.

(b) 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:

(i) copayments~~,~~;

(ii) payment of monthly or yearly enrollment fees~~,~~; or

(iii) deductibles.

(c) The financial participation requirements adopted by the department may vary among the various home and community-based services programs.

(d) 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) services provided by a licensed pediatric complex care assistant as authorized under Title 37, chapter 2, part 6;

(e) personal care services;

(f) adult day health services;

(g) habilitation services;

(h) respite care services; and

(i) 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) Reimbursement rates for pediatric complex care assistants licensed pursuant to 37-2-603 must reflect the special skills needed to meet the health care needs of the individuals receiving the services and must be comparable to the reimbursement rate for home health aide services.

(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.~~ (Subsections (9)(d) and (13)(c) terminate June 30, 2031--sec. 10, Ch. 628, L. 2023.)"

NEW SECTION. **Section 7. Repealer.** The following section of the Montana Code Annotated is repealed:

53-6-406. Fiscal accountability for home and community-based services -- report to legislature.

NEW SECTION. **Section 8. Appropriations.** (1) There is appropriated $600,000 from the general fund to the department of public health and human services for the biennium beginning July 1, 2025, for costs of the development of the report mandated by [section 4].

(2) There is appropriated $600,000 in federal special revenue to the department of public health and human services for the biennium beginning July 1, 2025, to provide matching funds to the department.

NEW SECTION. **Section 9. Codification instruction.** [Sections 1 through 5] are intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [sections 1 through 5].

NEW SECTION. **Section 10. Effective date.** [This act] is effective July 1, 2025.

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