

1 HOUSE BILL NO. 419

2 INTRODUCED BY D. BEDEY, J. ESP

3
4 A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING A STANDARDIZED COST REPORTING
5 PROCESS FOR CERTAIN MEDICAID SERVICE PROVIDERS; PROVIDING AN APPROPRIATION;
6 ESTABLISHING REPORTING REQUIREMENTS; PROVIDING RULEMAKING AUTHORITY; AMENDING
7 SECTION 53-6-402, MCA; REPEALING SECTION 53-6-406, MCA; AND PROVIDING AN EFFECTIVE DATE."

8
9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
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11 NEW SECTION. Section 1. Purpose. The department of public health and human services shall
12 establish a standardized cost reporting process for certain medicaid service providers. The cost report
13 information will be used to inform the department and the legislature about the adequacy of medicaid rates.
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15 NEW SECTION. Section 2. Reporting services. (1) The department of public health and human
16 services shall include the following services in its cost reporting process:

- 17 (a) adult mental health;
18 (b) children's mental health;
19 (c) substance use disorder;
20 (d) developmental disabilities; and
21 (e) senior and long-term care.
22 (2) Services included in the cost report must be funded in one of the following ways:
23 (a) as a medicaid state plan service;
24 (b) through a medicaid state plan option available to the state under 42 U.S.C. 1396n(k);
25 (c) under any type of medicaid waiver program;
26 (d) state-funded services; or
27 (e) other identified funding sources that support services in subsection (1).
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1 **NEW SECTION. Section 3. Process to establish cost reporting.** (1) The department of public

2 health and human services shall establish a cost reporting process that:

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

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

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

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

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

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

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

15 (2) Identified medicaid service providers shall:

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

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

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

21
22 **NEW SECTION. Section 4. Reporting.** (1) Contingent upon legislative appropriation, the department
23 of public health and human services shall develop a report to document the adequacy of current medicaid rates
24 compared to reported medicaid service provider costs at least once every 4 years.

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

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

27 (b) claims data;

28 (c) United States bureau of labor statistics data;

- 1 (d) internal revenue service data;
- 2 (e) United States department of agriculture data;
- 3 (f) United States census bureau data
- 4 (g) peer state comparisons; and
- 5 (h) any other relevant regional and national data considered appropriate by the department.
- 6 (3) The report must provide information to support a biennial or supplemental budget request as
- 7 necessary to adjust medicaid service provider reimbursement rates to ensure rate adequacy.
- 8 (4) The department shall provide the report at least once every 4 years to the office of budget and
- 9 program planning, the children, families, health, and human services interim committee, and the interim budget
- 10 committee in accordance with 5-11-210. The first report is due by September 1, 2026.
- 11 (5) In accordance with the Montana Procurement Act, the department may contract with a cost-
- 12 based reporting expert to assist in completing subsections (1) through (4).

13

14 NEW SECTION. Section 5. Rulemaking. The department of public health and human services may

15 adopt rules to carry out the cost reporting provisions of [sections 2 through 4], including rules on:

- 16 (1) the costs a medicaid service provider must report to the department;
- 17 (2) the report format; and
- 18 (3) the deadline for the department to file the report.

19

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

21 **"53-6-402. Medicaid-funded home and community-based services -- waivers -- funding**

22 **limitations -- populations -- services -- providers -- long-term care preadmission screening -- powers**

23 **and duties of department -- rulemaking authority.** (1) The department may obtain waivers of federal

24 medicaid law in accordance with section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n, and

25 administer programs of home and community-based services funded with medicaid money for categories of

26 persons with disabilities or persons who are elderly.

- 27 (2) The department may seek and obtain any necessary authorization provided under federal law
- 28 to implement home and community-based services for seriously emotionally disturbed children pursuant to a

1 waiver of federal law as permitted by section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n(c).

2 The home and community-based services system shall strive to incorporate the following components:

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

4 (b) local involvement in development and administration;

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

6 (d) accountability of recipients and providers; and

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

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

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

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

23 (6) (a) The department, in establishing programs of home and community-based services, shall
24 administer the expenditures for each program within the available state spending authority that may be applied
25 to that program. In establishing covered services for a home and community-based services program, the
26 department shall establish those services in a manner to ensure that the resulting expenditures remain within
27 the available funding for that program.

28 (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

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

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

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

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

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

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

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

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

27 (a) case management services;

28 (b) homemaker services;

1 (c) home health aide services;

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

3 chapter 2, part 6;

4 (e) personal care services;

5 (f) adult day health services;

6 (g) habilitation services;

7 (h) respite care services; and

8 (i) other cost-effective services appropriate for maintaining the health and well-being of persons

9 and to avoid institutionalization of persons.

10 (10) Subject to the approval of the U.S. department of health and human services, the department

11 may establish appropriate programs of home and community-based services under this section in conjunction

12 with programs that have limited pools of providers or with managed care arrangements, as implemented

13 through 53-6-116 and as authorized under section 1915 of Title XIX of the Social Security Act, 42 U.S.C.

14 1396n, or in conjunction with a health insurance flexibility and accountability demonstration initiative or other

15 demonstration project as authorized under section 1115 of Title XI of the Social Security Act, 42 U.S.C. 1315.

16 (11) (a) The department may conduct long-term care preadmission screenings in accordance with

17 section 1919 of Title XIX of the Social Security Act, 42 U.S.C. 1396r.

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

19 long-term care facility.

20 (c) A person determined through a long-term care preadmission screening to have an intellectual

21 disability or a mental illness may not reside in a long-term care facility unless the person meets the long-term

22 care level-of-care determination applicable to the type of facility and is determined to have a primary need for

23 the care provided through the facility.

24 (d) The long-term care preadmission screenings must include a determination of whether the

25 person needs specialized intellectual disability or mental health treatment while residing in the facility.

26 (12) The department may adopt rules necessary to implement the long-term care preadmission

27 screening process as required by section 1919 of Title XIX of the Social Security Act, 42 U.S.C. 1396r. The

28 rules must provide criteria, procedures, schedules, delegations of responsibilities, and other requirements

1 necessary to implement long-term care preadmission screenings.

2 (13) (a) The department shall adopt rules necessary for the implementation of each program of
3 home and community-based services, including rules for substantive changes to approved waiver provisions as
4 required under 53-6-413. The rules may include but are not limited to the following:

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

7 (ii) limits on enrollment;

8 (iii) limits on per capita expenditures;

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

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

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

13 (vii) provider requirements and reimbursement;

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

15 (ix) utilization measures;

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

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

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

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

27 (14) The department shall establish by rule the procedures for moving a person from a waiting list
28 for services provided through a medicaid home and community-based services waiver into the waiver services,

1 including the process and priorities to be used in making determinations related to the waiting list. The
2 department may not modify the policies established in rule by adopting supplemental policies or procedures not
3 subject to the administrative rulemaking process.

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

7 ~~(16) The department shall adopt rules to carry out the cost reporting provisions of 53-6-406,~~
8 ~~including but not limited to the costs that a provider is required to report to the department, the format of the~~
9 ~~report, and the deadline for filing the report. (Subsections (9)(d) and (13)(c) terminate June 30, 2031--sec. 10,~~
10 ~~Ch. 628, L. 2023.)"~~

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

14 53-6-406. Fiscal accountability for home and community-based services -- report to legislature.

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

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

21
22 NEW SECTION. Section 9. Codification instruction. [Sections 1 through 5] are intended to be
23 codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [sections 1
24 through 5].

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

27 - END -