

1 HOUSE BILL NO. 732

2 INTRODUCED BY D. BEDEY

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4 A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING THE PROMPT COST REPORT
5 REIMBURSEMENT ACT; GENERALLY REVISING THE RETROACTIVE ADJUSTMENT PROCESS BY THE
6 DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES FOR COST REPORTS SUBMITTED BY
7 CRITICAL ACCESS HOSPITALS; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A
8 RETROACTIVE APPLICABILITY DATE."

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10 WHEREAS, critical access hospitals in Montana participating in the Montana Medicaid program are
11 reimbursed for medical services provided to their communities based on the cost of delivering these services;
12 and

13 WHEREAS, to effectuate this reimbursement, the critical access hospital submits a cost report to the
14 applicable Medicare administrative contractor identifying the cost of services, which forms the basis for settling
15 interim payments to ensure the Medicare and Medicaid programs have paid the proper amount in
16 reimbursement; and

17 WHEREAS, the Medicare program performs an interim settlement upon the filing of a cost report with
18 the applicable Medicare administrative contractor; and

19 WHEREAS, a Medicare administrative contractor periodically performs a desk audit to review
20 previously filed cost reports, and Medicare will perform an additional adjustment as required based upon the
21 final desk audit; and

22 WHEREAS, the Montana Medicaid program does not perform initial settlements upon the filing of the
23 cost report and instead waits to settle cost reports until the Medicare administrative contractor has performed
24 the final desk audit; and

25 WHEREAS, Montana Medicaid's practice of waiting to settle cost reports until the final desk audit is
26 performed has resulted in multiple-year delays in settling reimbursement for participating critical access
27 hospitals whose cost reports are selected for a Medicare audit; and

28 WHEREAS, aligning Montana Medicaid's practice with Medicare's practice will ensure proper fiscal

management for the Montana Medicaid program and provide timely and accurate reimbursement to Montana critical access hospitals.

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

NEW SECTION. Section 1. Short title. [Sections 1 through 3] may be cited as the "Prompt Cost Report Reimbursement Act".

NEW SECTION. Section 2. Purpose. (1) The legislature finds that providers of service that participate in medicare and Montana medicaid are required to submit information to achieve the settlement of costs relating to health care social services rendered to beneficiaries. The submitted cost reports cover the providers' fiscal year of operations based on the providers' accounting year.

(2) The legislature finds that to balance prompt reimbursement to providers and maintain Montana medicaid's program integrity, the Montana medicaid program shall align cost-based reimbursement procedures with the procedures utilized by the medicare program. This includes prompt initial settlement upon submission of a provider's cost report and subsequent adjustment after a desk review or audit of the cost report is performed by the applicable medicare administrative contractor.

(3) [Sections 1 through 3] apply to annual cost reports when submitted by a critical access hospital, as defined 50-5-101.

NEW SECTION. Section 3. Retroactive adjustment and settlement of cost report. (1) (a) To reimburse a provider as quickly as possible, the department of public health and human services shall perform a tentative retroactive adjustment when a cost report is received by the applicable medicare administrative contractor.

(b) Costs must be accepted as reported except for obvious errors or inconsistencies, subject to adjustment by a later audit.

(c) The department shall make an interim settlement of the report and, if applicable, payment to the provider within 240 days after receipt of the cost report by the medicare administrative contractor or within

1 30 days after receipt of the interim medicaid cost settlement from the medicare administrative contractor,
2 whichever occurs sooner.

3 (d) In the event of an overpayment, the provider has 60 days from the date of the initial notification
4 indicated by the interim cost settlement to repay the amount of the overpayment, or to have an agreed upon
5 repayment schedule.

6 (2) (a) Upon receipt of the final desk review or audit of the cost report by the applicable medicare
7 administrative contractor, the department shall perform a final retroactive adjustment and, if applicable, a final
8 settlement of the cost report.

9 (b) In the event of an overpayment, the provider has 60 days from the date of the initial notification
10 to repay the amount of the overpayment or to have an agreed upon repayment schedule. In the event of an
11 underpayment, the department will reimburse the provider within 90 days from the date of the initial notification
12 to the provider.

13 (3) As used in this section, "medicare administrative contractor" has the same meaning as
14 provided in 42 CFR 421.401 and also includes an intermediary as defined in 42 CFR 421.3.

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16 NEW SECTION. Section 4. Transition. Notwithstanding the provisions of [section 6], the department
17 of public health and human services shall settle all cost reports submitted prior to [the effective date of this act]
18 within 240 days of [the effective date of this act].

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20 NEW SECTION. Section 5. Codification instruction. [Sections 1 through 3] are intended to be
21 codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [sections 1
22 through 3].

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24 NEW SECTION. Section 6. Effective date. [This act] is effective on passage and approval and
25 subject to the requirements of the centers for medicare and medicaid services.

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27 NEW SECTION. Section 7. Retroactive applicability. [This act] applies retroactively, within the
28 meaning of 1-2-109, to cost reports submitted prior to [the effective date of this act].

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