SENATE BILL 267

Introduced by Yellowtail, et al.

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Senate BILL NO. 267

INTRODUCED BY Kennedy, Burnett, Jergeson, J.A. Weldon

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO UNIVERSAL HEALTH CARE PLANNING, ACCESS, AND COST CONTAINMENT; PROVIDING A STATE HEALTH CARE POLICY; CREATING THE MONTANA HEALTH CARE AUTHORITY AND BOARD; PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY AND BOARD; REQUIRING A STATE HEALTH RESOURCE MANAGEMENT PLAN, HEALTH CARE EXPENDITURE TARGET LEVELS, AND A UNIFIED HEALTH CARE BUDGET; REQUIRING HEALTH INSURER COST MANAGEMENT PLANS; REQUIRING THE DEVELOPMENT OF COMMON CLAIM FORMS AND PROCEDURES; AUTHORIZING THE CREATION OF HEALTH CARE BARGAINING GROUPS; REQUIRING THE ESTABLISHMENT OF A HEALTH CARE DATA BASE; REQUIRING THE HEALTH CARE AUTHORITY TO CONDUCT STUDIES CONCERNING PRESCRIPTION DRUGS AND THE CERTIFICATE OF NEED PROCESS; REQUIRING THE CREATION OF A HEALTH CARE PURCHASING POOL; REQUIRING THE DEVELOPMENT AND IMPLEMENTATION OF A SINGLE PAYOR HEALTH CARE SYSTEM; REQUIRING A REPORT ON LONG-TERM CARE; CREATING THE MONTANA HEALTH CARE FACILITIES PLANNING AND REVIEW PANEL AND PROVIDING THE POWERS AND DUTIES OF THE PANEL; REQUIRING REVIEW OF HOSPITAL BUDGETS; PROVIDING FOR ENFORCEMENT; PROVIDING FOR ANTITRUST EXEMPTIONS; CREATING HEALTH CARE PLANNING REGIONS AND REGIONAL PANELS; PROVIDING THE POWERS AND DUTIES OF THE

PANELS; TRANSFERRING CERTAIN FUNCTIONS FROM THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES TO THE MONTANA HEALTH CARE AUTHORITY; TRANSFERRING FUNCTIONS OF THE HEALTH FACILITY AUTHORITY TO THE MONTANA HEALTH CARE AUTHORITY; AMENDING SECTIONS 50-1-201, 50-5-101, 50-5-301, 50-5-304, 90-7-101, AND 90-7-102, MCA; REPEALING SECTION 2-15-1815, MCA; AND PROVIDING EFFECTIVE DATES."

STATEMENT OF INTENT

A statement of intent is required for this bill because:

(1) [section 5] authorizes the Montana health care authority board to adopt rules implementing [sections 1, 2, and 5 through 30]. In addition to those rulemaking matters addressed below, the authority may adopt rules governing such matters as its meetings, public hearings, and rules of procedure and the rules of ethical conduct governing its members.

(2) [section 7] requires the authority to adopt rules concerning the regional health resource plans. The regional plans must identify the current supply of a health care resource, changes recommended by regional health care planning panels, cost estimates, dates for proposed implementation of services, expenditure targets, and identification of any funding sources other than the authority's budget.

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(3) [section 8] requires the board to adopt by rule the various sectors of the unified health care budget. The sectors must include wages and salaries, cost of facilities and equipment, and fees. Economic indicators to be used to define rates of growth must primarily be population increases, joblessness, increases in wages or salaries, and inflation generally. The rates of growth allowed may differ from region to region.

(4) [section 10] requires the commissioner of insurance to adopt rules specifying uniform health insurance claim forms and procedures. The forms should be based upon existing formats, be as short and easily comprehensible as possible, and be compatible with electronic data transmission.

(5) [section 11] requires the board to adopt criteria for forming and approving health care provider bargaining groups, provisions for a nonbinding arbitration process, and the subject of negotiations generally. The approval of bargaining groups should be based upon rules governing certification of collective bargaining groups and should include a method by which an approved group may be challenged or decertified.

(6) [section 12] requires the board to adopt rules governing the information constituting the health care data base and the confidentiality of that information. The rules

must primarily address the submission of the data by specifying the data that is required, the providers required to submit it, and deadlines for submission. Confidentiality rules must consider the doctor/patient privilege and provide a method for patients to agree to the release of health care data.

(7) [section 15] requires that any uniform utilization review process be adopted by rule. If adopted, these rules must require as much uniformity in utilization review organization procedure and methods as possible.

(8) [section 22] requires the board to adopt rules governing the health care facilities planning and review panel.

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

NEW SECTION. **Section 1. State health care policy.** (1) It is the policy of the state of Montana to ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy, it is necessary to develop a health care system that is integrated and subject to the direction and oversight of a single state agency. Comprehensive health planning through the application of a statewide health resource management plan that is linked to a unified health care budget for Montana is essential.

(2) It is further the policy of the state of Montana that the health care system should:

(a) maintain and improve the quality of health care services offered to Montanans;

(b) contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Montanans' income or the money available for other services required to ensure the health, safety, and welfare of Montanans;

(c) avoid unnecessary duplication in the development and offering of health care facilities and services;

(d) encourage regional and local participation in decisions about health care delivery, financing, and provider supply;

(e) promote rational allocation of health care resources in the state; and

(f) facilitate universal access to preventive and medically necessary health care.

NEW SECTION. **Section 2.** Definitions. As used in [sections 1, 2, and 5 through 30], unless the context requires otherwise, the following definitions apply:

(1) "Authority" means the Montana health care authority created by [section 3].

(2) "Board" means the Montana health care authority board created by [section 4].

(3) "Facilities panel" means the health care facilities planning and review panel created by [section 21].

(4) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in 50-5-101(20), except health maintenance organizations as defined in 50-5-101(21). The term does not apply to a facility operated by a religious group relying solely on spiritual means, through prayer, for healing.

(5) "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession. The term does not include a person who provides health care solely through the sale or dispensing of drugs or medical devices.

(6) "Health insurer" means any health insurance company, nonprofit hospital, medical service corporation, health maintenance organization, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

(7) "Hospital" means a hospital as defined in 50-5-101.

(8) "Integrated system for health care delivery" means

an organized private or public, proprietary or nonprofit delivery system for a continuum of health care services. The system may include the following elements:

(a) care that is coordinated through a primary care manager chosen by the patient from a network of providers;

(b) continuous quality improvement processes to ensure quality of care, patient satisfaction, and efficiency; and

(c) financing methods that provide incentives for health care providers and patients and that encourage quality care, efficiency, successful outcomes, and appropriate use of health care services.

(9) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or other legal or commercial entity.

(10) "Professional review organization" means the professional review organization designated by the authority in [section 22].

(11) "Regional health resource plan" or "regional plan" means a plan developed by a regional panel pursuant to [section 30].

(12) "Regional panel" means one of the regional health care planning panels established by [section 28].

(13) "Resident" means a person who is domiciled in Montana as evidenced by an intent to:

(a) maintain a principal dwelling place in Montana indefinitely; and

(b) return to Montana if temporarily absent, coupled with an act or acts consistent with that intent.

(14) "State health resource management plan" or "state plan" means the plan for distribution of the health care resources in Montana required by [section 7].

(15) "Unified health care budget" means the budget established in accordance with [section 8].

NEW SECTION. **Section 3. Montana health care authority.** (1) There is a Montana health care authority.

(2) The authority is allocated to the department of health and environmental sciences for administrative purposes only, as provided in 2-15-121.

(3) The authority consists of the health care authority board, the executive director of the authority, and other persons employed by the board. The authority must be supervised and directed by the Montana health care authority board created in [section 4].

NEW SECTION. **Section 4. Health care authority board -- membership -- quasi-judicial.** (1) There is a Montana health care authority board.

(2) The board is allocated to the department of health and environmental sciences for administrative purposes only, as provided in 2-15-121.

(3) The board consists of five members. Each member must be knowledgeable in different aspects of health care. Three members must be health care consumers or represent consumer organizations.

(4) Board members are appointed by the governor and confirmed by the senate for terms of 6 years, except that of the initial members, one member must be appointed for a term of 2 years, two members must be appointed for a term of 4 years, and two members must be appointed for a term of 6 years.

(5) The governor shall designate one of the members to serve as presiding officer for a term of 2 years. The presiding officer is a voting member of the board.

(6) All the board members must be full-time state employees, exempt from Title 2, chapter 18, parts 1 and 2. The annual salary of the presiding officer is 85% of the annual salary of the presiding officer of the public service commission. The annual salary of each of the other members is 85% of the annual salary of public service commissioners other than the presiding officer.

(7) A member may not participate in a quasi-judicial proceeding in which the member has a personal or financial interest.

(8) The board is a quasi-judicial board for the purposes of 2-15-124.

NEW SECTION. **Section 5. Administration of authority.** (1) The board shall supervise and direct the execution of [sections 1, 2, and 5 through 30]; 50-1-201; Title 50, chapter 5, parts 3 and 4; Title 90, chapter 7; and [section 37] and shall formulate and carry out all policies relating to [sections 1, 2, and 5 through 30]; 50-1-201; Title 50, chapter 5, parts 3 and 4; Title 90, chapter 7; and [section 37].

(2) (a) The board shall employ an executive director, who is exempt from the application of 2-18-204, 2-18-205, 2-18-207, and 2-18-1011 through 2-18-1013 and serves at the pleasure of the board. The executive director is the chief administrative officer of the authority. The executive director has the power of a department head pursuant to 2-15-112, subject to the policies and procedures established by the board.

(b) The board may delegate its powers and assign the duties of the authority to the executive director as it may consider appropriate and necessary for the proper administration of the authority. The board may not delegate its quasi-judicial and rulemaking powers and may not delegate its authority to adopt the state health resource management plan, the unified health care budget, budgets for the authority and board, or budgets for the regional panels.

(3) The board may:

(a) employ professional and support staff necessary to carry out the functions of the authority; and

(b) employ consultants and contract with individuals and entities for the provision of services.

(4) The board may:

(a) apply for and accept gifts, grants, or contributions from any person for purposes consistent with [sections 1, 2, and 5 through 30]; 50-1-201; Title 50, chapter 5, parts 3 and 4; Title 90, chapter 7; and [section 37];

(b) adopt rules necessary to implement [sections 1, 2, and 5 through 30]; and

(c) enter into contracts and perform other acts necessary to accomplish the purposes of [sections 1, 2, and 5 through 30].

NEW SECTION. **Section 6.** **Eligibility for health care services.** A person may not receive health care services pursuant to [sections 1, 2, and 5 through 30] unless the person has been a resident of Montana for at least 3 months before making application for the services.

NEW SECTION. **Section 7.** **State health resource management plan.** (1) Beginning July 1, 1994, and every fourth year thereafter, the board shall adopt a state health resource management plan for the distribution of health resources in this state. The state plan must identify the

health care needs, including facility and human resource needs in Montana, the resources available to meet those needs, and priorities for addressing those needs on a statewide basis.

(2) The state plan must include:

(a) a statement of principles used in the allocation of resources and in establishing priorities for health services;

(b) identification of the current supply and distribution of:

(i) hospital, nursing home, and other inpatient services;

(ii) home health and mental health services;

(iii) treatment services for alcohol and drug abuse;

(iv) emergency care;

(v) ambulatory care services, including primary care resources;

(vi) nutrition benefits, prenatal benefits, and maternity care;

(vii) human resources;

(viii) major medical equipment; and

(ix) health screening and early intervention services;

(c) a determination of the appropriate supply and distribution of the resources and services identified in subsection (2)(b) and of the mechanisms that will encourage

the appropriate integration of these services on a local or regional basis. To arrive at a determination, the authority shall consider the following factors:

(i) the needs of the statewide population, with special consideration given to the development of health care services in underserved areas of the state;

(ii) the needs of particular geographic areas of the state;

(iii) the use of Montana facilities by out-of-state residents;

(iv) the use of out-of-state facilities by Montana residents;

(v) the needs of populations with special health care needs;

(vi) the desirability of providing high-quality services in an economical and efficient manner, including the appropriate use of midlevel practitioners; and

(vii) the cost impact of these resource requirements on health care expenditures.

(d) a component that addresses health promotion and disease prevention and that is prepared by the department of health and environmental sciences in a format established by the authority; and

(e) a component that addresses integration of the plan, to the extent allowed by state and federal law, with

services provided by the Indian health service and by the United States department of veterans affairs.

(3) The state plan must be based upon the regional health resource plans prepared by regional panels in accordance with [section 30]. The board shall adopt rules to ensure that regional health resource plans are developed in a consistent manner.

(4) The state plan must be revised annually in a manner determined by the board.

(5) Prior to adoption of the state plan, the board shall hold one or more public hearings for the purpose of receiving oral and written comment on a draft plan. After hearings have been concluded, the board shall adopt the state plan, taking comments into consideration.

NEW SECTION. **Section 8. Health care expenditure target -- unified health care budget.** (1) On or before January 1, 1995, the board shall adopt a health care expenditure target, consisting of the total amount of money to be spent in fiscal year 1996 for all services provided by health care facilities and providers in Montana and for all health care services provided to residents of this state. Except as applied to the certificate of need process under Title 50, chapter 5, part 3, the health care expenditure target is not binding.

(2) The health care expenditure target may include

sectors or subsectors for health care facilities, health care providers, or any other part of the health care system that the board determines is necessary. The board shall adopt processes and criteria for responding to exceptional and unforeseen circumstances that affect the health care system and the expenditure target. Prior to adopting the expenditure target, the board shall adopt:

(a) the methods and processes to be used to allocate resources among sectors; and

(b) the economic indicators to be used to define the parameters of the rate of growth in the cost of the system and the various sectors of the system.

(3) The expenditure target must be consistent with the state health resource management plan adopted pursuant to [section 7].

(4) Before adopting the expenditure target, the board shall:

(a) develop a proposed expenditure target and discuss the proposed target with health care providers, health care facilities, health insurers, and any health care provider bargaining groups approved by the board in accordance with [section 11]; and

(b) hold one or more public hearings for the purpose of receiving public comments.

(5) Beginning July 1, 1996, the board shall adopt an

annual unified health care budget to accomplish the policy set forth in [section 1]. The unified health care budget must:

(a) serve as the basic framework within which health care costs are controlled, resources are directed, and quality and access are assured;

(b) establish the total amount of money to be expended annually for all health care services provided by health care facilities and health care providers in Montana and for all health care services provided to residents of this state;

(c) be consistent with the state health resource management plan;

(d) establish the total amounts to be paid for services provided by various sectors of the health care system; and

(e) apply to the hospital budget review and the certificate of need processes and to any other regulatory mechanism in which the application of the uniform health care budget is authorized by statute.

(6) When preparing the uniform health care budget, the board shall consider health care costs and the impact of the budget on those who receive, provide, and pay for health care services.

(7) The board shall adopt by rule:

(a) the various sectors of the health care system to be

separately identified in the budget;

(b) the methods and processes to be used to allocate resources among the sectors;

(c) the economic indicators to be used to define the parameters of the rate of growth in the cost of the system and various sectors of the system; and

(d) processes and criteria for responding to exceptional and unforeseen circumstances that affect the system and the budget.

(8) The board shall enter into discussions or nonbinding negotiations with health care facilities and any health care provider bargaining groups created under [section 11] concerning matters related to the sectors of the unified health care budget.

NEW SECTION. **Section 9. Health insurer cost management plans.** (1) (a) Except as provided in subsection (3), each health insurer shall:

(i) prepare a cost management plan that includes integrated systems for health care delivery; and

(ii) file the plan with the board no later than January 1, 1994.

(b) The board may use plans filed under this section in the development of the unified health care budget.

(2) The plans required by this section must be developed in accordance with standards and procedures

established by the board.

(3) The provisions of this section do not apply to dental insurance.

NEW SECTION. **Section 10. Common claim forms and procedures.** By January 1, 1994, the commissioner of insurance, after consultation with the board, shall adopt by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims, including the submission of electronic claim forms.

NEW SECTION. **Section 11. Health care provider bargaining groups.** (1) The board may approve the creation of one or more health care provider bargaining groups, consisting of health care providers who choose to participate. On behalf of all of its member providers, a bargaining group is authorized to negotiate:

(a) with the authority with respect to any matter authorized by [section 8] related to sectors of the unified health care budget and with respect to any matter related to reimbursement of health care providers; and

(b) with the Montana health care purchasing pool, with respect to any matter authorized by [section 8] and to any matter related to reimbursement of health care providers.

(2) The board shall adopt by rule:

(a) criteria for forming and approving bargaining

groups; and

(b) criteria and procedures for negotiations authorized by this section.

(3) The rules relating to negotiations pertaining to sectors of the unified health care budget must include provisions for a nonbinding arbitration process to assist in the resolution of disputes. This section or rules adopted under this section may not be construed to limit the board's authority to reject the recommendation or decision of the arbiter or limit the board's authority under [section 8] to establish the unified budget.

(4) Contracts for reimbursement of health care providers negotiated under this section must be consistent with the unified health care budget and the state health resource management plan and may not take effect unless approved by the board.

(5) One or more health care providers may jointly comment on rules proposed by the board and discuss any other matters related to negotiations between the authority and health care providers.

(6) The negotiations authorized by this section are limited to the right to discuss the matters identified in subsection (1) and may not be construed to authorize a bargaining group to engage in any other type of activity. The board shall adopt rules to implement this subsection.

NEW SECTION. **Section 12. Health care data base -- rules -- penalty.** (1) The authority shall establish and maintain a health care data base to enable the authority to:

(a) determine the capacity and distribution of existing resources;

(b) identify health care needs and direct health care policy;

(c) evaluate effectiveness of intervention programs on improving patient outcomes;

(d) compare costs between various treatment settings and approaches;

(e) determine what techniques are required in the state for the prevention of acute and chronic health conditions; and

(f) provide information to consumers and purchasers of health care.

(2) The data base must:

(a) contain unique patient and provider identifiers and a uniform coding system;

(b) reflect all health care utilization, costs, and resources in this state; and

(c) reflect health care utilization and costs for services provided to Montana residents in another state.

(3) Health insurers, health care providers, health care facilities, and governmental agencies shall file reports,

data, schedules, statistics, or other information determined by the board to be necessary to carry out the purposes of this section. The information may include:

(a) health insurance claims and enrollment information used by health insurers;

(b) information relating to hospitals filed under [section 21]; and

(c) any other information relating to health care costs, utilization, or resources required to be filed with the board.

(4) The board, after consultation with the commissioner of insurance, shall by rule establish the types of information to be filed under this section and the time, place, and manner in which the information must be filed.

(5) Records or information protected by the provisions of the physician/patient privilege or otherwise required by law to be held confidential must be filed in a manner that does not disclose the identity of the protected person.

(6) The board shall adopt by rule a confidentiality code consistent with the requirements of state law to ensure that information obtained under this section is handled in an ethical manner.

(7) A person who fails to comply with the filing requirements of this section or rules or orders pursuant to this section is subject to a civil penalty of not more than

$1,000 for each act of noncompliance. The penalty may be collected by the board in a legal action or after a hearing pursuant to the contested case provisions of Title 2, chapter 4, part 6.

NEW SECTION. **Section 13. Study of prescription drug cost and distribution.** The authority shall conduct a study of the cost and distribution of prescription drugs in this state. The study must consider the feasibility of various methods of reducing the cost of purchasing and distributing prescription drugs to Montana residents. The study must include the feasibility of establishing a prescription drug purchasing pool for distribution of drugs through pharmacists in this state. The results of the study, including the board's recommendations for any necessary legislation, must be reported to the legislature by December 1, 1994. If the board determines that feasible methods are available without need for legislation or further appropriations, the board shall implement that part or those parts of its recommendations.

NEW SECTION. **Section 14. Study of certificate of need process.** (1) The board shall conduct a study of the certificate of need process established under Title 50, chapter 5, part 3. The study must determine whether changes in the certificate of need process are necessary or desirable in light of the board's recommendation for a

single payor health care system required by [section 17]. The study must include consideration of the role, effect, and desirability of:

(a) maintaining the exemptions from the certificate of need process for offices of private physicians, dentists, and other physical and mental health care professionals; and

(b) maintaining the dollar thresholds for health care services, equipment, and buildings and for construction of health care facilities.

(2) The results of the study, including any recommendations for legislation and changes in an agency's policies or rules, must be reported to the legislature no later than December 1, 1994.

NEW SECTION. **Section 15. Other powers and duties of board.** In addition to any other power or duty authorized or required by law, the board may:

(1) in conjunction with the department of health and environmental sciences and other entities, provide assistance to local communities, institutions, and provider groups in the development of organized primary health care systems throughout the state;

(2) develop processes or organizations to encourage regional and local decisionmaking about health care delivery, financing, and provider supply;

(3) establish advisory councils under 2-15-122 as

necessary to assist the authority in carrying out its duties;

(4) provide technical assistance or make grants to individuals and to public and nonprofit private entities, consistent with state and federal law, for the development of projects and programs that the board determines are necessary to achieve its objectives;

(5) apply for waivers that are authorized by federal law or regulations and that are necessary to accomplish the purposes of [sections 1, 2 and 5 through 30];

(6) designate one or more organizations to assist the authority in analyzing health care utilization in Montana and in developing uniform utilization review procedures, to carry out specific studies concerning the use of health care services, and to make recommendations for the development of standards of care and practice guidelines. Any uniform utilization review procedures must be adopted by the board by rule prior to implementation and enforcement.

(7) advise and consult with the directors of the departments of health and environmental sciences and social and rehabilitation services concerning the planning, funding and delivery of health care services for Montanans.

NEW SECTION. **Section 16. Montana health care purchasing pool.** (1) The board shall establish a Montana health care purchasing pool for the purpose of coordinating

and enhancing the purchasing power of health care benefit plans of the groups identified in subsection (2). It is not the intent of the legislature to exacerbate cost shifting or adverse selection in the Montana health care system through the creation of the health care purchasing pool. In offering and administering the purchasing pool, the board may not discriminate against individuals or groups based on age, gender, geographic area, industry, or medical history. The board may not administer the purchasing pool in a manner that pools the risks of participants. This section may not affect the rights of any party to a collective bargaining agreement.

(2) The board may include in the purchasing pool all employees, retirees, and dependents covered by the group health insurance plans of the following entities:

(a) the state of Montana;

(b) the Montana university system;

(c) any local government, including any municipality, county, consolidated city-county government, or school district, that chooses to participate in the pool; and

(d) those portions of the medicaid caseload as the board considers proper. Access to medical care or benefit levels for medicaid recipients may not diminish as a result of participation or nonparticipation in the pool.

(3) On and after July 1, 1994, the board may make the

purchasing pool available to any employer group, association, or trust that chooses to participate in the pool on behalf of the employees or members of the group, association, or trust.

(4) In administering the purchasing pool, the board may:

(a) contract on behalf of participants in the pool with health care providers, health care facilities, and health insurers for the delivery of health care services, including agreements securing discounts for regular, bulk payments to providers and agreements establishing uniform provider reimbursement;

(b) consolidate administrative functions on behalf of participants in the pool, including claims processing, utilization review, management reporting, benefit management, and bulk purchasing;

(c) create a health care cost and utilization data base for participants in the pool and evaluate potential cost savings; and

(d) establish incentive programs to encourage pool participants to use health care services judiciously and to improve their health status.

(5) On or before December 15, 1994, and December 15, 1996, the board shall report to the legislature on the operation of the purchasing pool, including the number and

types of groups and group members participating in the pool, the costs of administering the pool, the savings attributable to participating groups from the operation of the pool, and any changes in legislation considered necessary by the board.

(6) On or before December 15, 1996, the board shall report to the legislature with its recommendations concerning the feasibility and merits of authorizing the board to act as an insurer in pooling risks and providing benefits, including a common benefits plan, to participants of the purchasing pool.

NEW SECTION. **Section 17. Universal access plan -- single payor health care system proposal.** (1) On or before November 1, 1994, the board shall submit a report to the legislature containing the board's recommendations, including any necessary legislation, for a universal access plan based on the concept of a single payor. The plan must contain recommendations that if implemented, would provide universally accessible, medically necessary, and preventive health care by October 1, 1995.

(2) For the purposes of this section, "single payor system" means a method of financing health services predominantly through public funds so that all residents of Montana would have available to them a uniform set of benefits established by statute or administrative rule.

Policies governing all aspects of the management of the single payor system reside with state government, and benefits would be administered by a single entity. The single payor system must include:

(a) universal coverage for all Montana residents;

(b) a single governmental or nongovernmental administrative entity that makes payments through contracts with health care providers;

(c) portability of coverage regardless of job status;

(d) uniform benefits from a single source for all Montana residents;

(e) a broad-based public financing mechanism, including revenues from employers, employees, public sources, or any combination of the listed sources;

(f) a system capped for provider expenditures;

(g) global budgeting for hospitals;

(h) controlled capital expenditures;

(i) a binding cap on overall expenditures; and

(j) policymaking for the system as a whole and accountability within state government.

(3) The single payor system must provide for the use of the state health resource management plan, the unified health care budget, binding hospital budget reviews, the certificate of need process, and other health care cost containment mechanisms. The single payor system must include

the following features:

(a) an integrated system or systems of health care delivery;

(b) incentives to be used to contain costs and direct resources;

(c) uniform benefits to be made available, including nutrition benefits, prenatal benefits, and maternity care;

(d) reimbursement mechanisms for health care providers;

(e) administrative efficiencies;

(f) the appropriate use of midlevel practitioners, such as physicians' assistants and nurse practitioners;

(g) mechanisms for applying and implementing the unified health care budget on a statewide basis to all sectors of the health care system;

(h) mechanisms for reducing the cost of prescription drugs, both as part of and as separate from the uniform benefit plan;

(i) appropriate reallocation of existing health care resources;

(j) equitable financing of the proposal;

(k) requirements for the payment of premiums or copayments by health care consumers, based upon family size and ability to pay;

(l) a waiting period of a total of 3 months prior to receipt of benefits for a person who has been a resident of

Montana for less than that period of time; and

(m) integration, to the extent possible under federal and state law, of benefits provided under the single payor system with the benefits provided by the United States department of veterans affairs and benefits provided by the Indian health service.

(4) The single payor system must also include a mechanism for the authority to provide health care in those areas of Montana near the borders where it would be more practicable for health care consumers to seek care from metropolitan areas in neighboring states. If the authority determines that contracts with out-of-state providers are required to provide this mechanism and that it lacks sufficient authority to contract with those providers, the authority shall in its report propose legislation necessary for the exercise of those powers.

(5) In its report, the authority shall present, at a minimum, the range of services that would be available under the universal access plan if there were no increase, beyond inflation, in the total gross health care expenditures in Montana, as determined by the authority from the health care data base established under [section 12] for the first year that an expenditure figure is available.

(6) In developing the universal access plan, the authority shall examine the effect of government regulation

and economic incentives on the overall operation of the health care system and, specifically, on how those parts of the universal access plan recommended pursuant to subsections (2) through (5) may most appropriately be used in furthering the policies and goals of [sections 1, 2, and 5 through 30]; 50-1-201; Title 50, chapter 5, parts 3 and 4; Title 90, chapter 7; and [section 37].

NEW SECTION. **Section 18. Hearings on universal access plan.** The board shall seek public comment on the development of the universal access plan. In seeking public comment on the development of the board's recommendations for the universal access plan, the board shall provide extensive, multimedia notice to the public and hold at least one public hearing in each of the health care planning regions established by [section 27]. To the extent possible, the board shall arrange for hearings to be broadcast on interactive television. The hearings must take place before the board's report is submitted to the legislature. The board shall consult with health care providers in the development of the board's recommendations for the universal access plan.

NEW SECTION. **Section 19. Public education on universal access plan.** After submission of its report to the legislature under [section 17], the Montana health care authority board shall develop and conduct extensive public

education in different geographic regions of the state on the intent, content, and impact of the universal access plan that has been recommended to the legislature. All efforts must be made to communicate fully with the Montana public to enable all sectors to be informed of the board's recommendations for a universal access plan based on the single payor concept.

NEW SECTION. **Section 20. Long-term care report.** (1) The board shall, on or before December 1, 1996, report to the legislature the board's recommendations for long-term care services. Long-term care services include those long-term care services presently covered in Montana under Title XIX of the Social Security Act (medicaid), including Montana's home- and community-based waiver program.

(2) This section does not preclude the authority from recommending cost-sharing arrangements for long-term care services or from recommending that the services be phased in over time. The board's recommendations must support and may not supplant informal care giving by family and friends and must include cost containment recommendations for any long-term care service suggested for inclusion.

(3) The board's report must estimate costs associated with each of the long-term care services recommended and may suggest independent financing mechanisms for those services. The report must also set forth the projected cost to Montana

and its citizens over the next 20 years if there were no change in the present accessibility, affordability, or financing of long-term care services in this state.

(4) The board shall consult with the department of social and rehabilitation services in developing its recommendations under this section.

NEW SECTION. **Section 21. Health care facilities planning and review panel.** (1) There is a health care facilities planning and review panel. The facilities panel is created as part of the Montana health care authority and shall review all hospital budgets and collect and evaluate hospital costs in Montana on the basis of uniform data, utilization review information, the state health resource management plan, the health care expenditure target, and the unified health care budget.

(2) The facilities panel consists of the executive director of the authority and other employees as determined necessary by the board in consultation with the executive director.

NEW SECTION. **Section 22. Powers and duties of board and facilities panel -- penalty for noncompliance.** (1) On behalf of the facilities panel, the board shall:

(a) require hospitals to report financial, scope of services, and utilization data as the panel determines is necessary to accomplish its purposes and enforce the board's

requirements for information through appropriate judicial and administrative proceedings and orders;

(b) adopt uniform formats that hospitals shall use to report financial, scope of services, and utilization data and information;

(c) designate a data organization with which hospitals shall file financial, scope of services, and utilization data and information;

(d) designate a data organization or organizations to process, analyze, store, or retrieve data or information;

(e) designate a professional review organization for purposes of utilization review; and

(f) adopt rules to implement [sections 21 through 24].

(2) The facilities panel must be a party in any hearing before the board under [sections 1, 2, and 5 through 30]; 50-1-201; Title 50, chapter 5, parts 3 and 4; Title 90, chapter 7; and [section 37].

(3) Any person who fails to comply with the reporting requirements of this section or rules or orders of the board pursuant to this section or the requirements of the Montana Administrative Procedure Act is subject to a civil penalty of not more than $1,000 for each act of noncompliance. The penalty may be collected by the board in a legal action or after a hearing pursuant to the contested case provisions of Title 2, chapter 4, part 6.

NEW SECTION. **Section 23.** Public hearing process. As part of the budget review process, the facilities panel shall conduct at least five public hearings to solicit public comments on all aspects of hospital costs and use. At least one hearing must be held in each of the health care planning regions of the state.

NEW SECTION. **Section 24.** Hospital budget review. (1) Prior to October 1, 1995, and each year thereafter, the facilities panel shall conduct reviews of each hospital's proposed budget based on the information provided pursuant to [section 12] and [section 22], in accordance with a schedule established by the facilities panel.

(2) In conjunction with budget reviews, the facilities panel shall:

(a) review utilization information;

(b) consider the goals and recommendations of the state health resource management plan;

(c) for the limited purposes of the health care expenditure target to be adopted by the board under [section 8], consider the portion of the health care expenditure target applicable to hospitals;

(d) for the purposes of the adoption of the uniform health care budget adopted by the board under [section 8] in 1996 and thereafter, consider the portion of the uniform health care budget applicable to hospitals; and

(e) consider any reports from professional review organizations.

(3) After budget reviews under this section are completed, but no later than January 1, 1996, the facilities panel shall recommend a budget to the board and the board shall recommend a budget to each hospital. Each hospital shall consider the recommendations of the facilities panel and the board and shall adopt a budget.

(4) Beginning in 1996, the total of all budgets recommended by the facilities panel must be within the portion of the health care expenditure target or the unified health care budget, as appropriate, applicable to hospitals and must reflect the relative needs of all institutions.

(5) Individual hospital budgets recommended or established under this section must:

(a) be consistent with the provisions of subsection (4);

(b) be consistent with the state health resource management plan;

(c) reflect national, regional, or in-state peer group norms, according to indicators, ratios, and statistics established by the board by rule;

(d) promote efficient and economic operation of the hospital; and

(e) reflect prior year budget performance.

(6) In 1996 and 1997, the board shall recommend a budget for each hospital. Each hospital shall consider the recommendation of the board and adopt a budget.

(7) Beginning in 1998 and thereafter, the board shall, after notice and an opportunity for hearing pursuant to Title 2, chapter 4, establish a budget for each hospital and each hospital shall operate within the budget established under this subsection.

(8) The board may, upon application, adjust a budget established under subsection (7) upon a showing of need based upon exceptional or unforeseen circumstances in accordance with the criteria and processes established under [section 7].

(9) The facilities panel may request and a hospital shall provide information determined by the facilities panel to be necessary for the authority to determine whether the hospital is operating within a budget established under this section.

NEW SECTION. **Section 25. Enforcement.** (1) In order to carry out its duties, the duties of the authority, or the duties of the facilities panel under [sections 1, 2, and 5 through 30]; 50-1-201; Title 50, chapter 5, parts 3 and 4; Title 90, chapter 7; and [section 37], the board may examine the books, accounts, and papers of health insurers, health care providers, and health care facilities. The board may

administer oaths and may issue subpoenas in the course of any investigation or contested case to a person to appear and testify or to produce documents or things.

(2) The board may bring legal actions in its name in the district court of the first judicial district or in the district court in which a defendant resides to:

(a) enforce any requirement of [sections 1, 2, and 5 through 30]; 50-1-201; Title 50, chapter 5, parts 3 and 4; Title 90, chapter 7; and [section 37] or rules or orders adopted pursuant to those provisions;

(b) prevent the violations of those requirements, rules, or orders; or

(c) collect the penalties provided in [section 12] and [section 22].

(3) In addition to or in place of a legal action under subsection (2), the board may bring administrative proceedings under the contested case provisions of Title 2, chapter 4, part 6, for the same purposes as a legal action under subsection (2).

NEW SECTION. **Section 26. Antitrust exceptions.** (1) The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care services will be significantly enhanced by some cooperative arrangements involving health care providers or purchasers that would be prohibited by state and federal antitrust laws

if undertaken without governmental involvement. The purpose of this section is to create an opportunity for the state to review proposed arrangements and to substitute regulation for competition when an arrangement is likely to result either in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace. The legislature intends that approval of relationships be accompanied by appropriate conditions, supervision, and regulation to protect against private abuses of economic power.

(2) The authority shall establish criteria and procedures to review and authorize contracts, business or financial arrangements, or other activities, practices, or arrangements involving providers or purchasers that might be construed to be violations of state or federal antitrust laws but that are in the best interests of the state and further the policies and goals of [sections 1, 2, and 5 through 30]. The authority may not approve any application unless the authority finds that the proposed arrangement is likely to result in lower health care costs or in greater access to or quality of health care than would occur in the competitive marketplace. The authority may condition approval of a proposed arrangement on a modification of all or part of the arrangement to eliminate any restriction on competition that is not reasonably related to the goals of

controlling costs or improving access or quality. The authority may also establish conditions for approval that are reasonably necessary to protect against any abuses of private economic power and to ensure that the arrangement is appropriately supervised and regulated by the state. The authority shall actively monitor and regulate arrangements approved under this section to ensure that the arrangements remain in compliance with the conditions of approval. The authority may revoke an approval upon a finding that the arrangement is not in substantial compliance with the terms of the application or the conditions of approval.

(3) (a) Applications for approval under this section must be filed with the authority. An application for approval must describe the proposed arrangement in detail. The application must include:

(i) the identities of all parties;

(ii) the intent of the arrangement;

(iii) the expected effects of the arrangement;

(iv) an explanation of how the arrangement will control costs or improve access or quality; and

(v) financial statements showing how the efficiencies of operation will be passed along to patients and purchasers of health care.

(b) The authority may ask the attorney general to comment on an application, but the application and any

information obtained by the authority under this section are not admissible in any proceeding brought by the attorney general based on antitrust.

(4) Notwithstanding the state statutes concerning unfair trade practices, any contracts, business or financial arrangements, or other activities, practices, or arrangements involving providers or purchasers that are approved by the authority under this section do not constitute an unlawful contract, combination, or conspiracy in unreasonable restraint of trade or commerce or unfair trade practices under Title 30, chapter 14. Approval by the authority is an absolute defense against any action under state antitrust or unfair trade practices laws.

(5) The authority shall adopt rules to implement this section.

NEW SECTION. **Section 27.** **Health care planning regions.** (1) There are five health care planning regions. Subject to subsection 2, the regions consist of the following counties:

(a) region I: Phillips, Valley, Daniels, Sheridan, Roosevelt, Garfield, McCone, Richland, Dawson, Prairie, Wibaux, Treasure, Rosebud, Custer, Fallon, Powder River, and Carter;

(b) region II: Glacier, Toole, Liberty, Hill, Blaine, Pondera, Chouteau, Teton, and Cascade;

(c) region III: Judith Basin, Fergus, Petroleum,

Wheatland, Golden Valley, Musselshell, Sweet Grass, Stillwater, Yellowstone, Carbon, and Big Horn;

(d) region IV: Granite, Powell, Lewis and Clark, Deer Lodge, Silver Bow, Jefferson, Broadwater, Meagher, Beaverhead, Madison, Gallatin, and Park;

(e) region V: Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, and Ravalli.

(2) (a) A county may, by written request of the board of county commissioners, petition the authority at any time to be removed from a health care planning region and added to another region.

(b) The authority shall grant or deny the petition after a public hearing upon notice as the authority determines. The authority shall grant the petition if it appears by a preponderance of the evidence that the petitioning county's health care interests are more strongly associated with the region that the county seeks to join than with the region in which the county is then located. If the authority grants the petition, the county is considered for all purposes to be part of the health care planning region as approved by the board.

NEW SECTION. **Section 28.** **Regional health care planning panels.** (1) Within each health care planning region created by [section 27] is a regional health care planning panel.

(2) Each regional panel consists of 11 members as

provided in this section. Regional panel members must be appointed for 6-year terms, except that of the first panels appointed, three members must be appointed for a term of 2 years, three members must be appointed for a term of 4 years, and five members must be appointed for a term of 6 years.

(3) The county commission of each county within a region shall nominate five persons for membership on the regional panel. The list of nominees must be sent to the authority, which shall select from the list of nominees the members on each regional panel.

(4) Each regional panel must include:

(a) at least five members who represent health care consumers and who are not affiliated with a health care profession or health care facility;

(b) at least two representatives of health care providers;

(c) at least one representative of hospitals;

(d) at least one representative of health care facilities; and

(e) at least two representatives of private business.

(5) Each regional panel must include experts in law, economics, and other fields and must include members of the health care professions, sufficient for the panel to carry out its duties under [section 30].

(6) Each regional panel should achieve gender balance.

NEW SECTION. **Section 29. Administration and financing of regional panel.** (1) Each regional panel shall annually prepare an operating budget and submit the budget and a block grant application to the authority at the time and in the manner specified by the authority.

(2) Money provided by grant by the authority for the operation of a regional panel must be used by the regional panel in the manner provided in the regional panel's grant application and block grant.

NEW SECTION. **Section 30. Duties of regional panels.** (1) Regional panels shall:

(a) develop regional health resource plans that must address the health care needs of the region, address the development of health care services in underserved areas of the region and other matters, and be in the format determined by the authority;

(b) revise the regional plan annually;

(c) hold at least one public hearing on the regional plan within the region at the time and in the manner determined by the regional panel;

(d) transmit the regional plan to the authority at the time determined by the authority;

(e) apply to the authority for grant funds for operation of the regional panel and account, in the manner

specified by the authority, for grant funds provided by the authority; and

(f) seek from local sources money to supplement grant funds provided by the authority.

(2) Regional panels may:

(a) recommend that the authority sanction voluntary agreements between health care providers and between health care consumers in the region that will improve the quality of, access to, or affordability of health care but that might constitute a violation of antitrust laws if undertaken without government direction;

(b) make recommendations to the authority regarding major capital expenditures or the introduction of expensive new technologies and medical practices that are being proposed or considered by health care providers;

(c) undertake voluntary activities to educate consumers, providers, and purchasers and promote voluntary, cooperative community cost containment, access, or quality of care projects; and

(d) make recommendations to the department of health and environmental sciences or to the authority, or both, regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state.

(3) Each regional panel may review and advise the

authority on regional technical matters relating to the universal access plan required by [section 17], the common benefits package, procedures for developing and applying practice guidelines for use in the universal access plan, provider and facility contracts with the state, utilization review recommendations, expenditure targets, and uniform health care benefits and their impact upon the provision of quality health care within the region.

Section 31. Section 50-1-201, MCA, is amended to read:

"50-1-201. Administration of state health plan. The department Montana health care authority created in [section 3] is ~~hereby-established-as~~ the ~~sole--and--official~~ state agency to administer the state program for comprehensive health planning and ~~is-hereby-authorized-to~~ shall prepare a plan for comprehensive state health planning. The department authority ~~is-authorized-to~~ may confer and cooperate with ~~any and---all~~ other persons, organizations, or governmental agencies that have an interest in public health problems and needs. The department authority, while acting in this capacity as the ~~sole-and-official~~ state agency to administer and supervise the administration of the official comprehensive state health plan, is designated and authorized as the ~~sole-and-official~~ state agency to accept, receive, expend, and administer ~~any-and-all~~ funds ~~which--are now--available-or-which-may-be~~ donated, granted, bequeathed,

or appropriated to it for the preparation, and administration, and the supervision of the preparation and administration of the comprehensive state health plan."

Section 32. Section 50-5-101, MCA, is amended to read:

"50-5-101. Definitions. As used in parts 1 through 4 of this chapter, unless the context clearly indicates otherwise, the following definitions apply:

(1) "Accreditation" means a designation of approval.

(2) "Adult day-care center" means a facility, freestanding or connected to another health care facility, which provides adults, on an intermittent basis, with the care necessary to meet the needs of daily living.

(3) "Affected person" means an applicant for certificate of need, a member of the public who will be served by the proposal, a health care facility located in the geographic area affected by the application, an agency which establishes rates for health care facilities, a third-party payer payor who reimburses health care facilities in the area affected by the proposal, or an agency which plans or assists in planning for such affected facilities.

(4) "Ambulatory surgical facility" means a facility, not part of a hospital, which provides surgical treatment to patients not requiring hospitalization. This type of facility may include observation beds for patient recovery

from surgery or other treatment.

(5) "Authority" means the Montana health care authority created by [section 3].

~~(5)~~(6) "Batch" means those letters of intent to seek approval for new beds or major medical equipment that are accumulated during a single batching period.

~~(6)~~(7) "Batching period" means a period, not exceeding 1 month, established by department authority rule during which letters of intent to seek approval for new beds or major medical equipment are accumulated pending further processing of all letters of intent within the batch.

~~(7)~~(8) "Board" means the board of health and environmental sciences, provided for in 2-15-2104.

~~(8)~~(9) "Capital expenditure" means:

(a) an expenditure made by or on behalf of a health care facility that, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance; or

(b) a lease, donation, or comparable arrangement that would be a capital expenditure if money or any other property of value had changed hands.

~~(9)~~(10) "Certificate of need" means a written authorization by the department authority for a person to proceed with a proposal subject to 50-5-301.

~~(10)~~(11) "Challenge period" means a period, not

exceeding 1 month, established by department authority rule during which any person may apply for comparative review with an applicant whose letter of intent has been received during the preceding batching period.

~~(11)~~(12) "Chemical dependency facility" means a facility whose function is the treatment, rehabilitation, and prevention of the use of any chemical substance, including alcohol, ~~which~~ that creates behavioral or health problems and endangers the health, interpersonal relationships, or economic function of an individual or the public health, welfare, or safety.

~~(12)~~(13) "Clinical laboratory" means a facility for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

~~(13)~~(14) "College of American pathologists" means the organization nationally recognized by that name with headquarters in Traverse City, Michigan, that surveys clinical laboratories upon their requests and accredits clinical laboratories that it finds meet its standards and requirements.

~~(14)~~(15) "Comparative review" means a joint review of

two or more certificate of need applications ~~which~~ that are determined by the department authority to be competitive in that the granting of a certificate of need to one of the applicants would substantially prejudice the department's authority's review of the other applications.

~~(15)~~(16) "Construction" means the physical erection of a health care facility and any stage ~~thereof~~ of erection, including ground breaking, or remodeling, replacement, or renovation of an existing health care facility.

~~(16)~~(17) "Department" means the department of health and environmental sciences provided for in Title 2, chapter 15, part 21.

~~(17)~~(18) "Federal acts" means federal statutes for the construction of health care facilities.

~~(18)~~(19) "Governmental unit" means the state, a state agency, a county, municipality, or political subdivision of the state, or an agency of a political subdivision.

~~(19)~~(20) "Health care facility" or "facility" means any institution, building, or agency or portion ~~thereof~~ of any agency, private or public, excluding federal facilities, whether organized for profit or not, used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons. The term does not include offices of private physicians or dentists. The term includes but is not limited

to ambulatory surgical facilities, surgical centers, health maintenance organizations, home health agencies, hospices, hospitals, infirmaries, kidney treatment centers, long-term care facilities, medical assistance facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, residential treatment facilities, and adult day-care centers.

~~(20)~~(21) "Health maintenance organization" means a public or private organization ~~which~~ that provides or arranges for health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or group of providers.

~~(21)~~(22) "Home health agency" means a public agency or private organization or subdivision ~~thereof--which~~ of an agency or organization that is engaged in providing home health services to individuals in the places where they live. Home health services must include the services of a licensed registered nurse and at least one other therapeutic service and may include additional support services.

~~(22)~~(23) "Hospice" means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and ~~his~~ the patient's family arising out of physical, psychological, spiritual, social, and

economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component.

~~(23)~~(24) "Hospital" means a facility providing, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick persons. Services provided may or may not include obstetrical care, emergency care, or any other service as allowed by state licensing authority. A hospital has an organized medical staff ~~which~~ that is on call and available within 20 minutes, 24 hours per day, 7 days per week, and provides 24-hour nursing care by licensed registered nurses. This term includes hospitals specializing in providing health services for psychiatric, mentally retarded, and tubercular patients.

~~(24)~~(25) "Infirmary" means a facility located in a university, college, government institution, or industry for the treatment of the sick or injured, with the following subdefinitions:

(a) an "infirmary--A" provides outpatient and inpatient care;

(b) an "infirmary--B" provides outpatient care only.

~~(25)~~(26) "Joint commission on accreditation of hospitals" means the organization nationally recognized by that name with headquarters in Chicago, Illinois, that

surveys health care facilities upon their requests and grants accreditation status to any health care facility that it finds meets its standards and requirements.

~~(26)~~(27) "Kidney treatment center" means a facility ~~which~~ that specializes in treatment of kidney diseases, including freestanding hemodialysis units.

~~(27)~~(28) (a) "Long-term care facility" means a facility or part ~~thereof--which~~ of a facility that provides skilled nursing care, intermediate nursing care, or intermediate developmental disability care to a total of two or more persons or personal care to more than four persons who are not related to the owner or administrator by blood or marriage. The term does not include adult foster care licensed under 52-3-303, community homes for the developmentally disabled licensed under 53-20-305, community homes for persons with severe disabilities licensed under 52-4-203, youth care facilities licensed under 41-3-1142, hotels, motels, boardinghouses, roominghouses, or similar accommodations providing for transients, students, or persons not requiring institutional health care, or juvenile and adult correctional facilities operating under the authority of the department of corrections and human services.

(b) "Skilled nursing care" means the provision of nursing care services, health-related services, and social

services under the supervision of a licensed registered nurse on a 24-hour basis.

(c) "Intermediate nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed nurse to patients not requiring 24-hour nursing care.

(d) "Intermediate developmental disability care" means the provision of nursing care services, health-related services, and social services for the developmentally disabled, as defined in 53-20-102(4), or persons with related problems.

(e) "Personal care" means the provision of services and care ~~which~~ that do not require nursing skills to residents needing some assistance in performing the activities of daily living.

~~(28)~~(29) "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions ~~which~~ that is used to provide medical or other health services and costs a substantial sum of money.

~~(29)~~(30) "Medical assistance facility" means a facility that:

(a) provides inpatient care to ill or injured persons prior to their transportation to a hospital or provides inpatient medical care to persons needing that care for a period of no longer than 96 hours; and

(b) either is located in a county with fewer than six residents per square mile or is located more than 35 road miles from the nearest hospital.

~~(30)~~(31) "Mental health center" means a facility providing services for the prevention or diagnosis of mental illness, the care and treatment of mentally ill patients or the rehabilitation of ~~such~~ mentally ill persons, or any combination of these services.

~~(31)~~(32) "Nonprofit health care facility" means a health care facility owned or operated by one or more nonprofit corporations or associations.

~~(32)~~(33) "Observation bed" means a bed occupied for not more than 6 hours by a patient recovering from surgery or other treatment.

~~(33)~~(34) "Offer" means the holding out by a health care facility that it can provide specific health services.

~~(34)~~(35) "Outpatient facility" means a facility, located in or apart from a hospital, providing, under the direction of a licensed physician, either diagnosis or treatment, or both, to ambulatory patients in need of medical, surgical, or mental care. An outpatient facility may have observation beds.

~~(35)~~(36) "Patient" means an individual obtaining services, including skilled nursing care, from a health care facility.

~~(36)~~(37) "Person" means any individual, firm, partnership, association, organization, agency, institution, corporation, trust, estate, or governmental unit, whether organized for profit or not.

~~(37)~~(38) "Public health center" means a publicly owned facility providing health services, including laboratories, clinics, and administrative offices.

~~(38)~~(39) "Rehabilitation facility" means a facility ~~which~~ that is operated for the primary purpose of assisting in the rehabilitation of disabled persons by providing comprehensive medical evaluations and services, psychological and social services, or vocational evaluation and training or any combination of these services and in which the major portion of the services is furnished within the facility.

~~(39)~~(40) "Resident" means a person who is in a long-term care facility for intermediate or personal care.

~~(40)~~(41) "Residential psychiatric care" means active psychiatric treatment provided in a residential treatment facility to psychiatrically impaired individuals with persistent patterns of emotional, psychological, or behavioral dysfunction of such severity as to require 24-hour supervised care to adequately treat or remedy the individual's condition. Residential psychiatric care must be individualized and designed to achieve the patient's

discharge to less restrictive levels of care at the earliest possible time.

~~(41)~~(42) "Residential treatment facility" means a facility operated for the primary purpose of providing residential psychiatric care to persons under 21 years of age.

~~(42)~~(43) "State health plan" means the plan prepared by the department authority to project the need for health care facilities within Montana ~~and--approved--by--the--statewide health-coordinating-council-and-the-governor.~~"

Section 33. Section 50-5-301, MCA, is amended to read:

"50-5-301. When certificate of need is required -- definitions. (1) Unless a person has submitted an application for and is the holder of a certificate of need granted by the department authority, he the person may not initiate any of the following:

(a) the incurring of an obligation by or on behalf of a health care facility for any capital expenditure, other than to acquire an existing health care facility or to replace major medical equipment with equipment performing substantially the same function and in the same manner, that exceeds the expenditure thresholds established in subsection (4). The costs of any studies, surveys, designs, plans, working drawings, specifications, and other activities (including staff effort, consulting, and other services)

essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made must be included in determining if the expenditure exceeds the expenditure thresholds.

(b) a change in the bed capacity of a health care facility through an increase in the number of beds or a relocation of beds from one health care facility or site to another, unless:

(i) the number of beds involved is 10 or less or 10% or less of the licensed beds (if fractional, rounded down to the nearest whole number), whichever figure is smaller, in any 2-year period;

(ii) a letter of intent is submitted to the department authority; and

(iii) the department authority determines the proposal will not significantly increase the cost of care provided or exceed the bed need projected in the state health plan;

(c) the addition of a health service that is offered by or on behalf of a health care facility which that was not offered by or on behalf of the facility within the 12-month period before the month in which the service would be offered and which that will result in additional annual operating and amortization expenses of $150,000 or more;

(d) the acquisition by any person of major medical equipment, provided such the acquisition would have required

a certificate of need pursuant to subsection (1)(a) or (1)(c) if it had been made by or on behalf of a health care facility;

(e) the incurring of an obligation for a capital expenditure by any person or persons to acquire 50% or more of an existing health care facility unless:

(i) the person submits the letter of intent required by 50-5-302(2); and

(ii) the ~~department~~ authority finds that the acquisition will not significantly increase the cost of care provided or increase bed capacity;

(f) the construction, development, or other establishment of a health care facility ~~which~~ that is being replaced or ~~which~~ that did not previously exist, by any person, including another type of health care facility;

(g) the expansion of the geographical service area of a home health agency;

(h) the use of hospital beds to provide services to patients or residents needing only skilled nursing care, intermediate nursing care, or intermediate developmental disability care, as those levels of care are defined in 50-5-101; or

(i) the provision by a hospital of services for ambulatory surgical care, home health care, long-term care, inpatient mental health care, inpatient chemical dependency

treatment, inpatient rehabilitation, or personal care.

(2) For purposes of subsection (1)(b), a change in bed capacity occurs on the date new or relocated beds are licensed pursuant to part 2 of this chapter and the date a final decision is made to grant a certificate of need for new or relocated beds, unless the certificate of need expires pursuant to 50-5-305.

(3) For purposes of this part, the following definitions apply:

(a) "Authority" means the Montana health care authority created by [section 3].

~~(a)~~(b) (i) "Health care facility" or "facility" means a nonfederal ambulatory surgical facility, home health agency, long-term care facility, medical assistance facility, mental health center with inpatient services, inpatient chemical dependency facility, rehabilitation facility with inpatient services, residential treatment facility, or personal care facility.

(ii) The term does not include:

~~(i)--a-hospital,-except-to-the-extent-that-a-hospital-is subject-to-certificate--of--need--requirements--pursuant--to subsection-(1)(i);-or~~

~~(ii)~~ an office of a private physician, dentist, or other physical or mental health care professionals, including chemical dependency counselors.

~~(b)~~(c) (i) "Long-term care facility" means an entity ~~which~~ that provides skilled nursing care, intermediate nursing care, or intermediate developmental disability care, as defined in 50-5-101, to a total of two or more persons.

(ii) The term does not include adult foster care, licensed under 52-3-303; community homes for the developmentally disabled, licensed under 53-20-305; community homes for persons with severe disabilities, licensed under 52-4-203; boarding or foster homes for children, licensed under 41-3-1142; hotels, motels, boardinghouses, roominghouses, or similar accommodations providing for transients, students, or persons not requiring institutional health care; or juvenile and adult correctional facilities operating under the authority of the department of corrections and human services.

~~(c)~~(d) "Obligation for capital expenditure" does not include the authorization of bond sales or the offering or sale of bonds pursuant to the state long-range building program under Title 17, chapter 5, part 4, and Title 18, chapter 2, part 1.

~~(d)~~(e) "Personal care facility" means an entity ~~which~~ that provides services and care ~~which~~ that do not require nursing skills to more than four persons who are not related to the owner or administrator by blood or marriage and who need some assistance in performing the activities of

everyday living. The term does not include those entities excluded from the definition of "long-term care facility" in subsection ~~(3)~~(b) (3)(c).

(4) Expenditure thresholds for certificate of need review are established as follows:

(a) For acquisition of equipment and the construction of any building necessary to house the equipment, the expenditure threshold is $750,000.

(b) For construction of health care facilities, the expenditure threshold is $1,500,000."

Section 34. Section 50-5-304, MCA, is amended to read:

"**50-5-304. Review criteria, required findings, and standards.** The department authority shall by rule promulgate and utilize, as appropriate, specific criteria for reviewing certificate of need applications under this chapter, including but not limited to the following considerations and required findings:

(1) the degree to which the proposal being reviewed is consistent with the current state health resource management plan, the health care expenditure target, the unified health care budget, and the goal of universal access;

(2) the need that the population served or to be served by the proposal has for the services;

(3) the availability of less costly quality-equivalent or more effective alternative methods of providing such the

services;

(4) the immediate and long-term financial feasibility of the proposal as well as the probable impact of the proposal on the costs of and charges for providing health services by the person proposing the health service;

(5) the relationship and financial impact of the services proposed to be provided to the existing health care system of the area in which such the services are proposed to be provided;

(6) the consistency of the proposal with joint planning efforts by health care providers in the area;

(7) the availability of resources, including health manpower, management personnel, and funds for capital and operating needs, for the provision of services proposed to be provided and the availability of alternative uses of such resources for the provision of other health services;

(8) the relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services;

(9) in the case of a construction project, the costs and methods of the proposed construction, including the costs and methods of energy provision, and the probable impact of the construction project reviewed on the costs of providing health services by the person proposing the construction project; and

(10) the distance, convenience, cost of transportation, and accessibility of health services for persons who live outside urban areas in relation to the proposal."

Section 35. Section 90-7-101, MCA, is amended to read:

"90-7-101. Short title. This chapter may be cited as the "Montana Health Facility ~~Authority~~ Development Act"."

Section 36. Section 90-7-102, MCA, is amended to read:

"90-7-102. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Authority" means the Montana health ~~facility~~ care authority created in ~~2-15-1815~~ [section 3].

(2) "Capital reserve account" means the account established in 90-7-317.

(3) "Costs" means costs allowed under 90-7-103.

(4) "Health facility" means any facility provided for in 90-7-104.

(5) "Health institution" means any public or private nonprofit hospital, corporation, or other organization authorized to provide or operate a health facility in this state.

(6) "Participating health institution" means a health institution that undertakes the financing, refunding, or refinancing of obligations on the construction or acquisition of a health facility pursuant to the provisions

of this chapter.

(7) "Revenues" means, with respect to facilities, the rents, fees, charges, interest, principal repayments, and other income received or to be received by the authority from any source on account of such facilities."

NEW SECTION. **Section 37.** Functions transferred to authority -- short form amendment. (1) The functions of the department of health and environmental sciences relating to certificates of need under Title 50, chapter 5, part 3, and relating to the state medical facility plan under Title 50, chapter 5, part 4, are transferred to the Montana health care authority created in [section 3].

(2) The functions of the Montana health facility authority relating to health facilities under Title 90, chapter 7, are transferred to the Montana health care authority created in [section 3].

(3) All references to the "department" in Title 50, chapter 5, parts 3 and 4, and all references to the "authority" in Title 90, chapter 7, are changed to the "Montana health care authority" or "authority", as appropriate. The code commissioner shall conform internal references and grammar to these changes.

NEW SECTION. **Section 38.** Repealer. Section 2-15-1815, MCA, is repealed.

NEW SECTION. **Section 39.** Codification instruction. (1)

[Sections 3 and 4] are intended to be codified as an integral part of Title 2, chapter 15, and the provisions of Title 2, chapter 15, apply to [sections 3 and 4].

(2) [Sections 1, 2, and 5 through 30] are intended to be codified as an integral part of Title 50, and the provisions of Title 50 apply to [sections 1, 2, and 5 through 30].

NEW SECTION. **Section 40.** Effective dates. (1) [Sections 1 through 30, 39, and this section] are effective on passage and approval.

(2) [Sections 31 through 38] are effective July 1, 1996.

-End-

STATE OF MONTANA - FISCAL NOTE
Form BD-15
In compliance with a written request, there is hereby submitted a Fiscal Note for SB0267, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION: An act relating to universal health care planning, access, and cost containment; providing a state health care policy; creating the Montana Health Care Authority and Board; requiring a state health resource management plan, health care expenditure target levels, and a unified health care budget; requiring health insurer cost management plans; requiring the development of common claim forms and procedures; authorizing the creation of health care bargaining groups; requiring the establishment of a health care data base; requiring the health care authority to conduct studies concerning prescription drugs and the certificate of need process; requiring the creation of a health care purchasing pool; requiring the development and implementation of a single payor health care system; requiring a report on long-term care; creating the Montana health care facilities planning and review panel and providing the powers and duties of the panel; requiring review of hospital budgets; providing for enforcement; providing for antitrust exemptions; creating health care planning regions and regional panels; providing the powers and duties of the panels; transferring certain functions from the Department of Health and Environmental Sciences and the Department of Commerce Montana Health Facility Authority to the Montana Health Care Authority.

ASSUMPTIONS:
State Auditor:
1. The Insurance Commissioner will develop and write specifications and rules for the claim form beginning in FY93 and continuing into FY94.
2. Testing of the claim form will begin on Jan. 1, 1994.
3. The initial planning will require one coordinator position for six months and the associated mailing costs for 6,000 contracts.

Department of Commerce:
4. The Montana Health Facilities Authority (MHFA) will be physically relocated and become a distinct division within the Montana Health Care Authority.
5. The MHFA will continue to be self supporting through its initial and annual loan fee assessments.
6. The MHFA will continue to operate from a proprietary fund.
7. The MHFA annual budget of $177,116 will be transferred with the program.
8. The present MHFA contract with the Board of Investments (BOI) which provides for administrative support services(word processing, filing, mail distribution, accounting, photocopying, faxing, other) would be provided by personnel at the DHES through a similar contract.
9. The BOI bond program personnel will not be available at the DHES. MHFA would be required to employ a bond program specialist to continue its services. This assumption would be paid from a concurrent decrease in the BOI service contract and not create an additional expense.
10. There is no fiscal impact until FY97.

(Continued)

Dave Lewis 2-4-93
DAVID LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

2/9/93
WILLIAM YELLOWTAIL, PRIMARY SPONSOR DATE

Fiscal Note For SB0267, as introduced SB267

Department of Health & Environmental Sciences:

11. Due to the magnitude of the bill, DHES is unable to project fiscal impact at this time.

Commissioner Of Higher Education:

12. The administrative costs of the Health Care Authority and Board would be covered by administrative fees charged to the users of the system.
13. The new system would not decrease the costs of managing the existing health services and insurance.
14. The total cost of managing health care systems would increase; however, the extent of the increase cannot be determined from the information available.

Department of Administration:

15. The State Employee Health Plan would be incorporated into the purchasing pool.
16. There would be costs for administering the pool which would be born directly or indirectly by members of the pool.
17. There would be few if any significant short term (FY94 and FY95) savings in claims costs to any of the groups because group purchasing for such diverse groups with diverse needs, benefit structures, and insurers or self-insurance arrangements within the constraints of state purchasing laws will take two years to plan and implement. Also, the discounts available through bulk purchasing are constrained by 33-22-1740 (2) MCA (the any willing provider clause.)
18. The potential for claims savings for large groups in the pool, including the State Employee Plan, would be even smaller to the extent that these groups have bulk purchasing arrangements in place, or are in the process of instituting them either individually or in cooperation with other groups.
19. Groups are currently able to band together to group purchase and achieve any savings possible from this approach.
20. It is uncertain that any administrative consolidation and savings would be possible given the diversity of benefit structures, insurance arrangements, funding arrangements, computer/administrative systems already in place, etc.
21. Development of new consolidated systems would increase administrative costs for all groups in the short run (FY94 and FY95) and would likely require additional staff or displace existing programs.
22. Short term (FY94 and FY95) administrative costs are most likely to increase for large groups, including the State Employee Plan, to the extent they have already achieved administrative efficiencies which are possible for large organizations with uniform central computer/administrative systems. (The State Employee Plan costs for administration including plan administration and claims administration are 3.2% of total costs; of the remaining costs, 96.5% is claims costs and .3% is cost containment program costs.)

FISCAL IMPACT:

STATE AUDITOR:

	FY '94			FY '95		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
Expenditures:	0	$14,500	$14,500	0	0	0
Funding:						
General Fund(01)	0	$14,500	$14,500	0	0	0

(Continued)

SB 267

Commissioner of Higher Education:
The total cost of managing health care systems would increase; however, CHE cannot determine the extent of the increase from the information available.

Department of Administration:
Increased costs are projected but cannot be calculated.

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION: Administration - Long term claims savings may be possible from group purchasing, but other long term provisions of this act should provide more significant savings, making group purchasing obsolete when they take effect. Section 16 of the act appears to require FY94 and FY95 investment in a cost control mechanism that would begin to produce results at the same time it is replaced by more effective mechanisms -- next biennium.

TECHNICAL NOTES: Commerce - The bond issuance of the authority must be distinctly separate from the other activities to maintain that all present and future debt issued by the authority is not an obligation of the State of Montana.