SENATE BILL NO. 381

INTRODUCED BY

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO HEALTH CARE POLICY, ACCESS, PLANNING, AND COST CONTAINMENT; AMENDING LAWS CONCERNING A STATE HEALTH CARE POLICY STATEMENT, COST CONTAINMENT, THE HEALTH CARE RESOURCE MANAGEMENT PLAN, HEALTH CARE BILLING SIMPLIFICATION, HEALTH CARE PLANNING REGIONS, AND THE POWERS AND DUTIES OF REGIONAL HEALTH CARE PLANNING BOARDS; REPEALING LAWS RELATING TO STATEWIDE UNIVERSAL ACCESS PLANS; REPEALING REQUIREMENTS FOR REPORTS CONCERNING A STATE PURCHASING POOL, A STUDY OF PRESCRIPTION DRUG COSTS, A STUDY OF LONG-TERM CARE COSTS, AND A STUDY OF THE CERTIFICATE OF NEED PROCESS; REPEALING A REQUIREMENT FOR HEALTH INSURER COST MANAGEMENT PLANS; PROVIDING FOR A STUDY OF STATE REGULATION OF HEALTH CARE SERVICES AND FACILITIES; AMENDING SECTIONS 50-4-101, 50-4-102, 50-4-303, 50-4-304, 50-4-305, 50-4-401, AND 50-4-402, MCA; REPEALING SECTIONS 50-4-301, 50-4-302, 50-4-306, 50-4-307, 50-4-308, 50-4-309, 50-4-310, 50-4-311, AND 50-4-503, MCA."

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

Section 1. Section 50-4-101, MCA, is amended to read:

"**50-4-101. 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 care 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) facilitate universal access to health sciences information;~~

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

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

(a) Montanans should have access to health care services that they need without having to incur excessive out-of-pocket expenses;

(b) Montana's health care system should ensure that care is delivered in the most effective and efficient manner possible;

(c) health promotion and preventive health care services should play a central role in the health care system;

(d) the patient-provider relationship should be a fundamental component of Montana's health care system;

(e) individuals should be encouraged to play a significant role in determining their health and using the health care system appropriately;

(f) accurate and timely health care information should play a significant role in guiding health care resource allocation, health care use, and quality of care decisions, both by consumers and providers;

(g) whenever possible, market-based approaches should be relied on to contain the growth in health care spending while attempting to achieve expanded access, cost containment, and improved quality; and

(h) the process of health care reform in Montana should be carried out gradually and sequentially to ensure that any undesirable impacts of the state's reform policies on other aspects of the state's economy, particularly on small businesses, are minimized.

(3) It is further the policy of the state of Montana that regardless of whether or what form of a health care access plan is adopted by the legislature, the health care authority, health care providers, and other persons involved in the delivery of health care services need to increase their emphasis on the education of consumers of health care services. Consumers should be educated concerning the health care system, payment for services, ultimate costs of health care services, and the benefit to consumers generally of providing only services to the consumer that are reasonable and necessary.

(4) This part may not be interpreted to prevent Montana residents from seeking health care services

not otherwise recommended or provided for as a result of the provisions of this part."

Section 2. Section 50-4-102, MCA, is amended to read:

"**50-4-102. Definitions.** For the purposes of this chapter, the following definitions apply:

(1) "Authority" means the Montana health care authority created by 50-4-201.

(2) "Board" means one of the regional health care planning boards created pursuant to 50-4-401.

(3) "Certificate of public advantage" or "certificate" means a written certificate issued by the authority as evidence of the authority's intention that the implementation of a cooperative agreement, when actively supervised by the authority, receive state action immunity from prosecution as a violation of state or federal antitrust laws.

(4) "Cooperative agreement" or "agreement" means a written agreement between two or more health care facilities for:

(a) the sharing, allocation, or referral of patients;

(b) personnel;

(c) instructional programs;

(d) emergency medical services;

(e) support services and facilities;

(f) medical, diagnostic, or laboratory facilities or procedures; or

(g) other services customarily offered by health care facilities.

(5) "Data base" means the unified health care data base created pursuant to 50-4-502.

(6) "Health care" includes both physical health care and mental health care.

(7) (a) "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(19).

(b) The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing.

(8) "Health insurer" means any health insurance company, health service corporation, health maintenance organization, insurer providing disability insurance as described in 33-1-207, 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.

(9) "Health care provider" or "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.

(10) "Management plan" means the health care resource management plan required by 50-4-304.

(11) "Region" means one of the health care planning regions created pursuant to 50-4-401.

~~(12) "Statewide plan" means one of the statewide universal health care access plans for access to health care required by 50-4-301.~~"

Section 3. Section 50-4-303, MCA, is amended to read:

"**50-4-303. Cost containment.** (1) ~~The statewide plans must contain a cost containment component, including annual cost containment targets. Except as otherwise provided in this section, each statewide plan must establish~~ It is the goal of the state to promote voluntary targets for cost containment so that by 1999, the annual average percentage increase in statewide health care costs does not exceed the average annual percentage increase in the gross domestic product, as determined by the U.S. department of commerce, for the 5 preceding years. Whenever possible, market incentives should be relied on to achieve this goal.

~~(2) The authority shall adopt processes and criteria for responding to exceptional and unforeseen circumstances that affect the health care system and the targets required in subsection (1), including such factors as population increases or decreases, demographic changes, costs beyond the control of health care providers, and other factors that the authority considers significant.~~

~~(3) The authority shall, at a minimum, include the following features in the cost containment component:~~

~~(a) global budgeting for all health care spending;~~

~~(b) a system for limiting demand of health care services and controlling unnecessary and inappropriate health care. The system may include prioritization of services that allows for consideration of an individual patient's prognosis.~~

~~(c) a system for reimbursing health care providers for services and health care items. The reimbursement system must provide that all payors, public or private, pay the same rate for the same health care services and items and that reimbursement for services is based predominantly upon the health care service provided rather than upon the discipline of the health care provider.~~

~~(d) a method of monitoring compliance with the targets required in subsection (1);~~

~~(e) expenditure targets for health care providers and facilities;~~

~~(f) disincentives for exceeding the targets established pursuant to subsection (3)(e), including reduction of reimbursement levels in subsequent years;~~

~~(g) reimbursement of health care providers and health care facilities that is based upon negotiated annual budgets or fees for services; and~~

~~(h) a plan by the authority, health care providers, health insurers, and health care facilities to educate the public concerning the purpose and content of the statewide plans.~~

(2) The authority shall prepare a report containing a strategy that accomplishes the cost containment targets provided in subsection (1), including analysis of annual health care cost trends and health insurer cost management efforts. The report must be presented to the legislature no later than October 1, 1996."

Section 4. Section 50-4-304, MCA, is amended to read:

"**50-4-304. Health care resource management plan.** (1) ~~Each statewide plan must contain~~ The authority shall develop a health care resource management plan ~~that takes into account the provisions of 50-4-303~~. The management plan must ~~provide~~ make recommendations for the distribution of health care resources within the regions established pursuant to 50-4-401 and within the state as a whole, consistent with the principles provided in subsection (2). The authority shall apply the provisions of the management plan to develop the state health plan provided for in 50-1-201.

(2) The management 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~~:~~ health care services, health care providers, and health care facilities in the state;

~~(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) health sciences library resources and services;~~

~~(ix) major medical equipment; and~~

~~(x) health screening and early intervention services;~~

(c) a ~~determination~~ recommendation of the appropriate supply and distribution of the resources and services identified ~~in~~ under the provisions of 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;

(e) incentives to improve access to and use of preventive care; primary care services, including mental health services; and community-based care;

(f) incentives for healthy lifestyles; and

~~(g) incentives to improve access to health care in underserved areas, including:~~

~~(i) a system by which the authority may identify persons with an interest in becoming health care professionals and provide or assist in providing health care education for those persons; and~~

~~(ii) tax credits and other financial incentives to attract and retain health care professionals in underserved areas; and~~

~~(h)~~(g) a component that addresses ~~integration of the plan~~ coordination, 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 and by the medicare and medicaid programs.

(3) In adopting the management plan, the authority shall consider the ~~regional health resource plans recommended by~~ recommendations of the regional panels.

(4) The management plan must be revised ~~annually~~ biannually in a manner determined by the authority.

(5) Prior to adoption of the management plan, the authority 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 authority shall adopt the management plan, taking comments into consideration."

Section 5. Section 50-4-305, MCA, is amended to read:

"**50-4-305. Health care billing simplification.** (1) ~~Each statewide plan~~ The report required by 50-4-303 must contain a component providing for simplification and reduction of the costs associated with health care billing. In designing this component, the authority may consider:

(a) conversion from paper health care claims to standardized electronic billing; and

(b) creating a claims clearinghouse, consisting of a state agency or private entity, to receive claims from all health care providers for compiling, editing, and submitting the claims to payors.

(2) The health care billing component must include a method to educate and assist health care providers and payors who will use any health care billing simplification system recommended by the authority.

(3) The billing component must provide a schedule for a phasein of any health care billing simplification system recommended by the authority. The schedule must relieve health care providers, payors, and consumers of undue burdens in using the system."

Section 6. Section 50-4-401, MCA, is amended to read:

"**50-4-401. Health care planning regions and regional planning boards created -- selection -- membership.** (1) There are five health care planning regions. Subject to subsection (2), the regions must consist of the following counties:

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

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

(c) region III: Judith Basin, Fergus, Petroleum, Musselshell, Golden Valley, Wheatland, Sweet Grass, Stillwater, Yellowstone, Carbon, and Big Horn;

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

(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. The authority shall give notice as the authority determines appropriate. 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 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 authority.

(3) Within each region, the authority shall establish by rule a regional health care planning board. Each board must include one member from each county within the region. The members on each board shall represent a balance of individuals who are health care consumers and individuals who are recognized for their interest or expertise, or both, in health care. Each regional board should attempt to achieve gender balance.

(4) The authority shall, within 30 days of appointment of its members, propose by rule a procedure for selecting members of boards. The authority shall select the members for each board within 180 days of appointment of the authority, using the selection procedure adopted by rule under this subsection. Vacancies on a board must be filled by using the authority's selection process.

(5) Regional board members serve 4-year terms, except that of the board members initially selected, at least three members serve for 2 years, at least three members serve for 3 years, and at least three members serve for 4 years, to be determined by lot. A majority of each regional board shall select a presiding officer. The presiding officer initially selected must serve a 4-year term. Board members must be compensated and reimbursed in accordance with ~~2-15-124~~ 2-15-122."

Section 7. Section 50-4-402, MCA, is amended to read:

"**50-4-402. ~~Powers and duties~~ Duties of boards.** (1) A board shall:

~~(a)~~ meet quarterly at the time and place designated by the presiding officer~~, but not less than quarterly~~;

~~(b) submit an annual budget and grant application to the authority at the time and in the manner directed by the authority;~~

~~(c) adopt procedures governing its meetings and other aspects of its day-to-day operations as the board determines necessary;~~

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

~~(e) revise the regional plan annually;~~

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

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

~~(h) apply to the authority for grant funds for operation of the regional board and account, in the manner specified by the authority, for grant funds provided by the authority; and~~

~~(i) seek from public and private sources money to supplement grant funds provided by the authority.~~

(2) Regional boards ~~may~~ shall:

(a) ~~recommend that the authority sanction~~ review and comment on 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)~~ and on the health care resource management plan required by 50-4-304;

(b) 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 board may review and advise the authority on regional technical matters relating to the statewide plans required by 50-4-301, the common benefits package, procedures for developing and applying practice guidelines for use in the statewide plans, provider and facility contracts with the state, utilization review recommendations, expenditure targets, and uniform health care benefits and the impact of the benefits upon the provision of quality health care within the region~~

(c) periodically communicate with the authority regarding pertinent local and regional health care issues that require the attention of or a response from the authority."

NEW SECTION. **Section 8. Study of health care service and facility regulation.** (1) The authority shall conduct a study of the regulatory requirements and processes established by statute regarding health care services and facilities in the state. The study must include an examination of overlapping jurisdictions or requirements applicable to health care services and facilities.

(2) The results of the study, including any recommendations for legislation, must be reported to the legislature no later than October 1, 1996.

NEW SECTION. **Section 9. Repealer.** Sections 50-4-301, 50-4-302, 50-4-306, 50-4-307, 50-4-308, 50-4-309, 50-4-310, 50-4-311, and 50-4-503, MCA, are repealed.

NEW SECTION. **Section 10. Codification instruction.** [Section 8] is intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, apply to [section 8].

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0381, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:
A bill relating to health care policy, access, planning, and cost containment; amending laws concerning a state health care policy statement, cost containment, the health care resource management plan, health care billing simplification, health care planning regions, and the powers and duties of regional health care planning boards.

ASSUMPTIONS:
1. The Governor's Executive Budget present law base serves as the starting point from which to calculate any fiscal impact due to this bill.
2. The present law base recommendation for the Montana Health Care Authority (MHCA) contains 3.00 FTE and total funding of $418,291 in FY96 and $344,242 in FY97. The total for the 1997 biennium is $762,533.
3. The Executive Budget contains $250,000 of state special revenue during each year of the biennium to fund the ongoing activities of the MHCA. At the time the Executive Budget was prepared, the MHCA had applied for grant funds totaling $500,000. Subsequently, both grant requests were denied. Therefore, the special revenue is empty spending authority and would have to be replaced with general fund appropriations unless the MHCA can secure the funds through other grant activities. The funding situation is not a result of this bill nor is it impacted by this bill.
4. The bill will have no fiscal impact on the State Auditor's Office.

FISCAL IMPACT:
The bill has no material fiscal impact on the Montana Health Care Authority or other state agencies.

Dave Lewis 2-19-95

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Eve Franklin 2/20/95

EVE FRANKLIN, PRIMARY SPONSOR DATE