HOUSE BILL NO. 732

INTRODUCED BY D. BEDEY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **SECTION 5. APPROPRIATION.** (1) THERE IS APPROPRIATED $33,900 FROM THE GENERAL FUND AND $33,900 FROM THE FEDERAL SPECIAL REVENUE FUND TO THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES FOR THE FISCAL YEAR BEGINNING JULY 1, 2025, FOR THE SETTLEMENT OF COST REPORTS DESCRIBED IN [SECTIONS 3 AND 4].

(2) There is appropriated $7,500 from the general fund and $7,500 from the federal special revenue fund to the department of public health and human services for the fiscal year beginning July 1, 2026, for the settlement of cost reports described in [sections 3 and 4].

(3) The legislature intends that the appropriation of $15,000 from the general fund and $15,000 from the federal special revenue fund for the biennium be considered as part of the ongoing base for the next

legislative session.

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

NEW SECTION. **Section 7. Effective date.** [This act] is effective on passage and approval and subject to the requirements of the centers for medicare and medicaid services.

NEW SECTION. **Section 8. Retroactive applicability.** [This act] applies retroactively, within the meaning of 1-2-109, to cost reports submitted prior to [the effective date of this act].

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