AN ACT ESTABLISHING STANDARDS FOR PATIENT-CENTERED MEDICAL HOMES; PROVIDING THAT PATIENT-CENTERED MEDICAL HOMES HAVE A STATE PURPOSE THAT PROVIDES STATE ACTION IMMUNITY ON ANTICOMPETITION CONCERNS; ALLOWING THE USE OF PATIENT-CENTERED MEDICAL HOMES IN THE MEDICAID AND HEALTHY MONTANA KIDS PROGRAMS; ALLOWING THE VOLUNTARY PARTICIPATION OF ALL STATE, UNIVERSITY, AND LOCAL GOVERNMENT PLANS, INCLUDING STATE-REGULATED MULTIPLE-WELFARE ARRANGEMENTS, THIRD-PARTY ADMINISTRATORS, AND SELF-INSURED STUDENT HEALTH PLANS AS POTENTIAL HEALTH PLAN PARTICIPANTS IN A PATIENT-CENTERED MEDICAL HOME PROGRAM; PROVIDING RULEMAKING AUTHORITY FOR THE STATE AUDITOR'S OFFICE AND THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; AMENDING SECTIONS 20-25-1403, 33-1-102, 33-31-111, 33-35-306, AND 53-6-113, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A TERMINATION DATE.

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

Section 1. Short title -- legislative findings. (1) [Sections 1 through 5] may be cited as the "Patient-Centered Medical Homes Act".

(2) The legislature finds that the increasing cost of health care makes health plans more difficult for individuals, families, and businesses to afford. These increases in health care costs are attributable in part to inadequate coordination of care among providers, difficulties in accessing primary care, and a lack of engagement between patients and their primary care providers. The purpose of [sections 1 through 5] is to enhance care coordination and promote high-quality, cost-effective care through patient-centered medical homes by engaging patients and their primary care providers.

(3) The legislature also finds that chronic diseases are one of the biggest threats to the health of Montana residents. The purpose of [sections 1 through 5] includes promoting episodic evidence-based care in the community to reduce hospital admissions, enhance chronic disease management, and reduce costs for treating chronic diseases.

(4) The legislature finds that there is a shortage of primary care providers in areas of Montana and that inconsistent access to health care services and variable quality of care have been shown to result in poorer health outcomes and health care disparities but that patient-centered medical homes offer a model of primary care that may attract new providers to Montana because the model is effective, sustainable, and replicable in small communities and provides a process to achieve higher quality health care for Montana citizens and a way to help slow the continuing escalation of health care costs as well as improve health outcomes for Montana citizens.

(5) The legislature further finds that a single definition and common set of quality measures as well as a uniform payment methodology provide the best chance of success for the patient-centered medical homes model by increasing consistency in reporting across health plans and primary care practices.

(6) The legislature finds that best practices are most likely to be recognized and adopted by primary care practices if a state-structured patient-centered medical home program works with programs that may be developed for health plans and primary care practices and for any programs in Title 53 for medicaid and in Title 53, chapter 4, part 11, for the healthy Montana kids plan.

(7) The legislature also finds that an ongoing process is desirable to evaluate the effectiveness of patient-centered medical homes.

(8) Notwithstanding any state or federal law that prohibits the collaboration of insurers, other health plans, or providers regarding payment methods, the legislature finds that patient-centered medical homes are likely to result in the delivery of more efficient and effective health care services and are in the public interest.

Section 2. State action immunity doctrine. The state action immunity doctrine applies to the patient-centered medical home program in Montana, and federal or state antitrust laws that prohibit collusion do not apply to any standards used by the patient-centered medical home program regarding medical payments. The legislative findings, as provided in [section 1], and oversight by the insurance commissioner combine to determine that patient-centered medical homes are in the public interest and are likely to result in the delivery of more efficient and effective health care services sufficient to override concerns about collusion regarding medical payments among insurers, other health plans, or primary care practices.

Section 3. Definitions. As used in [sections 1 through 5], the following definitions apply:

(1) "Covered medical services" means the health care services that are included as benefits under a

health plan.

(2) "Department" means the department of public health and human services provided for in 2-15-2201.

(3) (a) "Health plan" means any public or private program that pays for medical care, including but not limited to a health benefit plan issued by or administered by an insurer, a health service corporation, a health maintenance organization, a multiple employer welfare arrangement, or a third-party administrator or a plan described under 33-1-102(7), (9), or (12).

(b) The term does not include the provision of services through the medicaid program or the healthy Montana kids program as authorized in Title 53.

(4) "Patient-centered medical home" means a model of health care that is:

(a) directed by a primary care provider offering family-centered, culturally effective care that is coordinated, comprehensive, continuous, and, whenever possible, located in the patient's community and integrated across systems;

(b) characterized by enhanced access, with an emphasis on prevention, improved health outcomes, and satisfaction;

(c) qualified by the commissioner under [section 4] as meeting the standards of a patient-centered medical home; and

(d) reimbursed under a payment system that recognizes the value of services that meet the standards of the patient-centered medical home program.

(5) "Prevention services" means health care services that include primary prevention services and clinical prevention services.

(6) "Primary care practice" means a solo health care provider or a health care practice that is organized by or includes licensees under Title 37 who provide primary medical care, including but not limited to pediatricians, internal medicine physicians, family medicine physicians, nurse practitioners, and physician assistants.

(7) "Qualified individual" means a policyholder, certificate holder, member, subscriber, enrollee, or other individual who is participating in a health plan and who is enrolled in a patient-centered medical home program.

Section 4. Powers and duties of commissioner -- rulemaking. (1) The commissioner shall:

(a) adopt rules necessary to implement the provisions of [sections 1 through 5];

(b) in consultation with interested parties, qualify patient-centered medical homes that have been accredited by a nationally recognized accrediting organization approved by the commissioner and that meet any other standards established by the commissioner;

(c) oversee, promote, coordinate, and provide guidance concerning the creation and activities of any patient-centered medical homes doing business in Montana in order to ensure that the requirements of [sections 1 through 5] are met;

(d) consult with all interested parties in association with carrying out the activities required under [sections 1 through 5]; and

(e) develop and implement standards as set forth in [section 5] in consultation with interested parties.

(2) For the purposes of this section, interested parties include but are not limited to the department, public health agencies, health plans, government health plans, primary health care providers, and health care consumers. Interested parties must be organized as a stakeholder council with regular meetings, the scheduling of which must be determined by the commissioner.

Section 5. Standards for patient-centered medical homes. (1) The commissioner shall, in consultation with the stakeholder council of interested parties, set standards from the list provided in subsection (2).

(2) Standards may be set for one or more of the following or for other topics determined by the commissioner in consultation with stakeholders:

(a) payment methods used by health plans to pay patient-centered medical homes for services associated with the coordination of covered health care services;

(b) bonuses, fee-based incentives, bundled fees, or other incentives that a health plan may use to pay a patient-centered medical home based on the savings from reduced health care expenditures associated with improved health outcomes and care coordination by qualified individuals attributed to the participation in the patient-centered medical homes;

(c) a uniform set of health care quality and performance measures that include prevention services; and

(d) a uniform set of measures related to cost and medical usage.

(3) A patient-centered medical home must meet the standards in this section in full or in part by providing proof to the commissioner that it has been accredited by a nationally recognized accrediting organization

approved by the commissioner.

(4) The commissioner may, in consultation with stakeholders, set standards that are specific to Montana and may be required in addition to nationally recognized accreditation standards.

(5) A patient-centered medical home shall report on its compliance with the uniform set of health care quality and performance measures adopted by the commissioner to:

(a) health plans and other payers with which the patient-centered medical home contracts;

(b) the commissioner; and

(c) the department, if the department is a participant.

(6) A health plan and other payers shall report to the patient-centered medical home regarding their compliance with the uniform set of cost and utilization measures adopted by the commissioner for patients covered under the health plan.

(7) In developing the standards described in subsection (2), the commissioner may consider:

(a) the use of health information technology, including electronic medical records;

(b) the relationship between the primary care practice, specialists, other health care providers, and hospitals;

(c) the access standards for individuals covered by a health plan to receive primary medical care in a timely manner;

(d) the ability of the primary care practice to foster a partnership with patients; and

(e) the use of comprehensive medication management to improve clinical outcomes.

(8) All health care providers and payers who participate in a patient-centered medical home shall, as a condition of participation, collectively commission one independent study on savings generated by the patient-centered medical home program and report to the children, families, health, and human services interim committee no later than September 30, 2016.

Section 6. Participation in patient-centered medical home optional. The participation of an insurance contract or plan issued under this part in a patient-centered medical home program is not required. If a plan chooses to participate in a patient-centered medical home program, the plan shall comply with the requirements of [sections 1 through 5].

Section 7. Section 20-25-1403, MCA, is amended to read:

"20-25-1403. Authorization to establish self-insured health plan for students -- requirements -- exemption. (1) The commissioner may establish a self-insured student health plan for enrolled students of the system and their dependents, including students of a community college district. In developing a self-insured student health plan, the commissioner shall:

(a) maintain the plan on an actuarially sound basis;

(b) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the plan; and

(c) deposit all reserve funds, contributions and payments, interest earnings, and premiums paid to the plan. The deposits must be expended for claims under the plan and for the costs of administering the plan, including but not limited to the costs of hiring staff, consultants, actuaries, and auditors, purchasing necessary reinsurance, and repaying debts.

(2) Prior to the implementation of a self-insured student health plan, the commissioner shall consult with affected parties, including but not limited to the board of regents and representatives of enrolled students of the system.

(3) A self-insured student health plan developed under this part is not responsible for and may not cover any services or pay any expenses for which payment has been made or is due under an automobile, premises, or other private or public medical payment coverage plan or provision or under a workers' compensation plan or program, except when the other payor is required by federal law to be a payor of last resort. The term "services" includes but is not limited to all medical services, procedures, supplies, medications, or other items or services provided to treat an injury or medical condition sustained by a member of the plan.

(4) ~~The~~ Except for the provisions of [sections 1 through 5], the provisions of Title 33 do not apply to the commissioner when exercising the duties provided for in this part."

Section 8. Section 33-1-102, MCA, is amended to read:

"33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance organizations -- governmental insurance programs -- service contracts. (1) A person may not transact a business of insurance in Montana or a business relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) The provisions of this code do not apply with respect to:

(a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;

(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

(c) fraternal benefit societies, except as stated in chapter 7.

(3) This code applies to health service corporations as prescribed in 33-30-102. The existence of the corporations is governed by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) ~~This~~ Except as provided in [sections 1 through 5], this code does not apply to health maintenance organizations to the extent that the existence and operations of those organizations are governed by chapter 31.

(5) This code does not apply to workers' compensation insurance programs provided for in Title 39, chapter 71, parts 21 and 23, and related sections.

(6) The department of public health and human services may limit the amount, scope, and duration of services for programs established under Title 53 that are provided under contract by entities subject to this title. The department of public health and human services may establish more restrictive eligibility requirements and fewer services than may be required by this title.

(7) ~~This~~ This code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8, or the Montana university system group benefits plans established in Title 20, chapter 25, part 13.

(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided for in 2-9-202.

(9) (a) Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state in which the political subdivisions undertake to separately or jointly indemnify one another by way of a pooling, joint retention, deductible, or self-insurance plan.

(b) Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state or any arrangement, plan, or program of a single political subdivision of this state in which the political subdivision provides to its officers, elected officials, or employees disability insurance or life insurance through a self-funded program.

(10) (a) This code does not apply to the marketing of, sale of, offering for sale of, issuance of, making of, proposal to make, and administration of a service contract.

(b) A "service contract" means a contract or agreement for a separately stated consideration for a specific duration to perform the repair, replacement, or maintenance of property or to indemnify for the repair, replacement, or maintenance of property if an operational or structural failure is due to a defect in materials or manufacturing or to normal wear and tear, with or without an additional provision for incidental payment or indemnity under limited circumstances, including but not limited to towing, rental, and emergency road service. A service contract may provide for the repair, replacement, or maintenance of property for damage resulting from power surges or accidental damage from handling. A service contract does not include motor club service as defined in 61-12-301.

(11) (a) Subject to 33-18-201 and 33-18-242, this code does not apply to insurance for ambulance services sold by a county, city, or town or to insurance sold by a third party if the county, city, or town is liable for the financial risk under the contract with the third party as provided in 7-34-103.

(b) If the financial risk for ambulance service insurance is with an entity other than the county, city, or town, the entity is subject to the provisions of this code.

(12) ~~This~~ Except as provided in [sections 1 through 5], this code does not apply to the self-insured student health plan established in Title 20, chapter 25, part 14.

(13) This code does not apply to private air ambulance services that are in compliance with 50-6-320 and that solicit membership subscriptions, accept membership applications, charge membership fees, and provide air ambulance services to subscription members and designated members of their households."

Section 9. Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is

exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Title 33, chapter 1, parts 12 and 13, [sections 1 through 5], Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-401, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-137, 33-22-141, 33-22-142, 33-22-152, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance organizations."

Section 10. Section 33-35-306, MCA, is amended to read:

"33-35-306. Application of insurance code to arrangements. (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions:

(a) 33-1-111;

(b) [sections 1 through 5];

~~(b)~~(c) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

~~(c)~~(d) Title 33, chapter 1, part 7;

~~(d)~~(e) 33-3-308;

~~(e)~~(f) Title 33, chapter 18, except 33-18-242;

~~(f)~~(g) Title 33, chapter 19;

~~(g)~~(h) 33-22-107, 33-22-131, 33-22-134, 33-22-135, 33-22-141, 33-22-142, and 33-22-152; and

~~(h)~~(i) 33-22-512, 33-22-515, 33-22-525, and 33-22-526.

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

Section 11. Section 53-6-113, MCA, is amended to read:

"53-6-113. Department to adopt rules. (1) The department shall adopt appropriate rules necessary for the administration of the Montana medicaid program as provided for in this part and that may be required by federal laws and regulations governing state participation in medicaid under Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as amended.

(2) The department shall adopt rules that are necessary to further define for the purposes of this part the services provided under 53-6-101 and to provide that services being used are medically necessary and that the services are the most efficient and cost-effective available. The rules may establish the amount, scope, and duration of services provided under the Montana medicaid program, including the items and components constituting the services.

(3) The department shall establish by rule the rates for reimbursement of services provided under this part. The department may in its discretion set rates of reimbursement that it determines necessary for the purposes of the program. In establishing rates of reimbursement, the department may consider but is not limited to considering:

(a) the availability of appropriated funds;

(b) the actual cost of services;

(c) the quality of services;

(d) the professional knowledge and skills necessary for the delivery of services; and

(e) the availability of services.

(4) The department shall specify by rule those professionals who may deliver or direct the delivery of particular services.

(5) The department may provide by rule for payment by a recipient of a portion of the reimbursements established by the department for services provided under this part.

(6) The department may adopt rules consistent with this part to govern eligibility for the Montana medicaid program, including the medicaid program provided for in 53-6-195. Rules may include but are not limited to financial standards and criteria for income and resources, treatment of resources, nonfinancial criteria, family responsibilities, residency, application, termination, definition of terms, confidentiality of applicant and recipient information, and cooperation with the state agency administering the child support enforcement program under Title IV-D of the Social Security Act, 42 U.S.C. 651, et seq. The department may not apply financial criteria below $15,000 for resources other than income in determining the eligibility of a child under 19 years of age for poverty level-related children's medicaid coverage groups, as provided in 42 U.S.C. 1396a(l)(1)(B) through (l)(1)(D).

(7) The department may adopt rules limiting eligibility based on criteria more restrictive than that provided in 53-6-131 if required by Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, or if funds appropriated are not sufficient to provide medical care for all eligible persons.

(8) The department may adopt rules necessary for the administration of medicaid managed care systems. Rules to be adopted may include but are not limited to rules concerning:

(a) participation in managed care;

(b) selection and qualifications for providers of managed care; and

(c) standards for the provision of managed care.

(9) Subject to subsection (6), the department shall establish by rule income limits for eligibility for extended medical assistance of persons receiving section 1931 medicaid benefits, as defined in 53-4-602, who lose eligibility because of increased income to the assistance unit, as that term is defined in the rules of the department, as provided in 53-6-134, and shall also establish by rule the length of time for which extended medical assistance will be provided. The department, in exercising its discretion to set income limits and duration of assistance, may consider the amount of funds appropriated by the legislature.

(10) The department may adopt rules for implementing and administering one or more patient-centered medical home programs. The rules may include but are not limited to provider qualifications, coverage groups, services coverage, measures to ensure the appropriateness and quality of services delivered, payment rates and fees, and utilization measures. In implementing and administering patient-centered medical home programs, the department shall use only health care providers that have been qualified by the commissioner and authorized to use the designation of a patient-centered medical home. The department shall use the standards adopted by the commissioner for patient-centered medical homes under [section 5], except for those standards relating to

settling payment rates and fees and any standards that may conflict with federal medicaid requirements."

Section 12. Codification instruction. (1) [Sections 1 through 5] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 1 through 5].

(2) [Section 6] is intended to be codified as an integral part of Title 2, chapter 18, part 7, and the provisions of Title 2, chapter 18, part 7, apply to [section 6].

Section 13. Effective date. [This act] is effective on passage and approval.

Section 14. Termination. [This act] terminates December 31, 2017.

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