

SENATE BILL NO. 534

INTRODUCED BY B. KEENAN

BY REQUEST OF THE HOUSE JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN SERVICES AND AGING

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS REGARDING PUBLIC MENTAL HEALTH DELIVERY; REQUIRING THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO INCREMENTALLY IMPLEMENT A REGIONAL MENTAL HEALTH MANAGED CARE SYSTEM; REQUIRING A MENTAL HEALTH MANAGED CARE SYSTEM CONTRACTOR THAT ASSUMES RISK TO COMPLY WITH MEDICAID MANAGED CARE LAWS; PROVIDING FOR DEPARTMENT RESPONSIBILITIES; PROVIDING RULEMAKING AUTHORITY; CREATING THE OFFICE OF A MENTAL HEALTH MANAGED CARE OMBUDSMAN; AMENDING SECTIONS 53-6-116 AND 33-1-102, 33-31-115, 33-31-202, 53-1-413, 53-6-131, 53-6-703, 53-6-704, 53-6-706, AND 53-6-709, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A TERMINATION DATE."

WHEREAS, the Legislature is firmly committed to a managed care system for the delivery of public mental health services in an efficient and cost-effective manner AND TO ENSURING ACCESS TO SERVICES AND QUALITY OF CARE; and

WHEREAS, in order for mental health managed care to be successful, care management must be carefully monitored and any contract for services must be enforced; and

WHEREAS, the state, service providers, and service recipients and their families must work cooperatively to ensure that the public mental health delivery system is successful; and

WHEREAS, the Legislature is committed to a transition from the existing contract to a competitive procurement of mental health managed care services.

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

~~Section 1. Section 53-6-116, MCA, is amended to read:~~

~~"53-6-116. Medicaid managed care -- capitated health care. (1) The department of public health and human services, in its discretion, may develop managed-care and capitated health-care systems for medicaid~~



1 recipients.

2 ~~———(2) The department may contract with one or more persons for the management of comprehensive~~  
 3 ~~physical health services and the management of comprehensive mental health services for medicaid recipients.~~  
 4 ~~The department may contract for the provision of these services by means of a fixed monetary or capitated~~  
 5 ~~amount per recipient.~~

6 ~~———(3) A managed-care system is a program organized to serve the medical needs of medicaid recipients~~  
 7 ~~in an efficient and cost-effective manner by managing the receipt of medical services for a geographical or~~  
 8 ~~otherwise defined population of recipients through appropriate health care professionals.~~

9 ~~———(4) The provision of medicaid services through managed-care and capitated health care systems is not~~  
 10 ~~subject to the limitations provided in 53-6-101 and 53-6-104.~~

11 ~~———(5) The proposed systems, referred to in subsection (1), must be submitted to the legislative finance~~  
 12 ~~committee. The legislative finance committee shall review the proposed systems at its next regularly scheduled~~  
 13 ~~meeting and shall provide any comments concerning the proposed systems to the department of public health~~  
 14 ~~and human services."~~

15

16 **SECTION 1. SECTION 33-1-102, MCA, IS AMENDED TO READ:**

17 **"33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance**  
 18 **organizations -- governmental insurance programs. (1) A person may not transact a business of insurance**  
 19 **in Montana or a business relative to a subject resident, located, or to be performed in Montana without complying**  
 20 **with the applicable provisions of this code.**

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

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

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

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

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

27 (4) This code does not apply to health maintenance organizations or to managed care community  
 28 networks, as defined in 53-6-702, to the extent that the existence and operations of those organizations are  
 29 governed by chapter 31 or to the extent that the existence and operations of those networks are governed by Title  
 30 53, chapter 6, part 7. THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES IS RESPONSIBLE TO PROTECT THE

1 INTERESTS OF CONSUMERS BY PROVIDING COMPLAINT, APPEAL, AND GRIEVANCE PROCEDURES RELATING TO MANAGED  
 2 CARE COMMUNITY NETWORKS AND HEALTH MAINTENANCE ORGANIZATIONS UNDER CONTRACT TO PROVIDE SERVICES  
 3 UNDER TITLE 53, CHAPTER 6.

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

6 ~~(6) This code does not apply to the functions performed by a managed care contractor providing mental~~  
 7 ~~health services under the Montana medicaid program as established in Title 53, chapter 6.~~

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

12 (7) This code does not apply to the state employee group insurance program established in Title 2,  
 13 chapter 18, part 8.

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

16 (9) (a) This code does not apply to any arrangement, plan, or interlocal agreement between political  
 17 subdivisions of this state in which the political subdivisions undertake to separately or jointly indemnify one  
 18 another by way of a pooling, joint retention, deductible, or self-insurance plan.

19 (b) This code does not apply to any arrangement, plan, or interlocal agreement between political  
 20 subdivisions of this state or any arrangement, plan, or program of a single political subdivision of this state in  
 21 which the political subdivision provides to its officers, elected officials, or employees disability insurance or life  
 22 insurance through a self-funded program."

23

24 **SECTION 2.** SECTION 33-31-115, MCA, IS AMENDED TO READ:

25 **"33-31-115. Applicability to managed health care community networks entity.** (1) A managed health  
 26 care community network entity, as defined in 53-6-702, is governed by the ~~LICENSURE AND FINANCIAL SOLVENCY~~  
 27 provisions of Title 53, chapter 6, part 7, and by THE LICENSURE AND FINANCIAL SOLVENCY PROVISIONS OF this  
 28 chapter, but the commissioner may by rule reduce or eliminate a requirement of this chapter if the requirement  
 29 is demonstrated to be unnecessary for the operation of a managed health care community network entity.

30 (2) The department of public health and human services may limit the amount, scope, and duration of

1 services provided by a managed health care entity under contract for programs established under Title 53. These  
2 services may be less than services required by this title."

3

4 **SECTION 3. SECTION 33-31-202, MCA, IS AMENDED TO READ:**

5 **"33-31-202. Issuance of certificate of authority.** (1) The commissioner shall issue or deny a certificate  
6 of authority to any person filing an application pursuant to 33-31-201 within 180 days after receipt of the  
7 application. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed  
8 in 33-31-212 if the commissioner is satisfied that each of the following conditions is met:

9 (a) The persons responsible for the conduct of the applicant's affairs are competent and trustworthy.

10 (b) The health maintenance organization will effectively provide or arrange for the provision of basic  
11 health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable  
12 requirements for copayments. This requirement does not apply to the physical or mental health care services  
13 provided by a health maintenance organization to a person receiving medicaid services under the Montana  
14 medicaid program as established in Title 53, chapter 6.

15 (c) The health maintenance organization is financially responsible and can reasonably be expected to  
16 meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may  
17 consider:

18 (i) the financial soundness of the arrangements for health care services and the schedule of charges  
19 used in connection with the services;

20 (ii) the adequacy of working capital;

21 (iii) any agreement with an insurer, a health service corporation, a government, or any other organization  
22 for ensuring the payment of the cost of health care services or the provision for automatic applicability of an  
23 alternative coverage in the event of discontinuance of the health maintenance organization;

24 (iv) any agreement with providers for the provision of health care services;

25 (v) any deposit of cash or securities submitted in accordance with 33-31-216; and

26 (vi) any additional information that the commissioner may reasonably require.

27 (d) The enrollees must be afforded an opportunity to participate in matters of policy and operation  
28 pursuant to 33-31-222.

29 (e) Nothing in the proposed method of operation, as shown by the information submitted pursuant to  
30 33-31-201 or by independent investigation, violates any provision of this chapter or rules adopted by the

1 commissioner.

2 (2) The commissioner may deny a certificate of authority only if the requirements of 33-31-404 are  
3 complied with."

4

5 **SECTION 4. SECTION 53-1-413, MCA, IS AMENDED TO READ:**

6 **"53-1-413. Deposit of payments and collections.** (1) Except as provided in 90-7-220, 90-7-221, and  
7 this section, the department shall deposit payments and collections of charges for a resident's cost of care in the  
8 state treasury to the credit of the general fund.

9 (2) Payments and collections for services provided to residents of the Montana veterans' home must be  
10 deposited in the special revenue account for the benefit of the home. Payments and collections for services  
11 provided to residents of the Montana chemical dependency treatment center must be deposited in the state  
12 special revenue account for the facility.

13 (3) Subject to 90-7-221, payments from a managed care organization that is contracting with the  
14 department to administer a mental health managed care program for services provided by the Montana state  
15 hospital and the Montana mental health nursing care center must be deposited in the state special revenue  
16 account, subject to appropriation by the legislature for the benefit of those institutions.

17 (4) Medicaid payments for services provided by the Montana state hospital and the Montana mental  
18 health nursing care center must be deposited in the federal special revenue fund and are subject to appropriation  
19 for the benefit of the mental health managed care program."

20

21 **Section 5.** Section 53-6-131, MCA, is amended to read:

22 **"53-6-131. Eligibility requirements.** (1) Medical assistance under the Montana medicaid program may  
23 be granted to a person who is determined by the department of public health and human services, in its  
24 discretion, to be eligible as follows:

25 (a) The person receives or is considered to be receiving supplemental security income benefits under  
26 Title XVI of the Social Security Act, 42 U.S.C. 1381, et seq., and does not have income or resources in excess  
27 of the applicable medical assistance limits or receive from FAIM financial assistance, as defined in 53-4-702,  
28 benefits under Title IV of the federal Social Security Act, 42 U.S.C. 601, et seq.

29 (b) The person would be eligible for assistance under a program described in subsection (1)(a) if that  
30 person were to apply for that assistance.

1 (c) The person is in a medical facility that is a medicaid provider and, but for residence in the facility, the  
2 person would be receiving assistance under one of the programs in subsection (1)(a).

3 (d) The person is under 19 years of age and meets the conditions of eligibility in the state plan, as  
4 defined in 53-4-201, other than with respect to age and school attendance.

5 (e) The person is under 21 years of age and in foster care under the supervision of the state or was in  
6 foster care under the supervision of the state and has been adopted as a hard-to-place child.

7 (f) The person meets the nonfinancial criteria of the categories in subsections (1)(a) through (1)(e) and:

8 (i) the person's income does not exceed the income level specified for federally aided categories of  
9 assistance and the person's resources are within the resource standards of the federal supplemental security  
10 income program; or

11 (ii) the person, while having income greater than the medically needy income level specified for federally  
12 aided categories of assistance:

13 (A) has an adjusted income level, after incurring medical expenses, that does not exceed the medically  
14 needy income level specified for federally aided categories of assistance or, alternatively, has paid in cash to the  
15 department the amount by which the person's income exceeds the medically needy income level specified for  
16 federally aided categories of assistance; and

17 (B) has resources that are within the resource standards of the federal supplemental security income  
18 program.

19 (g) The person is a qualified pregnant woman or child as defined in 42 U.S.C. 1396d(n).

20 (2) The department may establish income and resource limitations. Limitations of income and resources  
21 must be within the amounts permitted by federal law for the medicaid program.

22 (3) The Montana medicaid program shall pay, as required by federal law, the premiums necessary for  
23 medicaid-eligible persons participating in the medicare program and may, within the discretion of the department,  
24 pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified medicare-eligible  
25 person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the federal Omnibus  
26 Budget Reconciliation Act of 1989, Public Law 101-239, who:

27 (a) has income that does not exceed income standards as may be required by the Social Security Act;  
28 and

29 (b) has resources that do not exceed standards that the department determines reasonable for purposes  
30 of the program.

1 (4) The department may pay a medicaid-eligible person's expenses for premiums, coinsurance, and  
2 similar costs for health insurance or other available health coverage, as provided in 42 U.S.C. 1396b(a)(1).

3 (5) In accordance with waivers of federal law that are granted by the secretary of the U.S. department  
4 of health and human services, the department of public health and human services may grant eligibility for basic  
5 medicaid benefits as described in 53-6-101 to an individual receiving FAIM financial assistance, as defined in  
6 53-4-702, as the specified caretaker relative of a dependent child under the FAIM project and to all adult  
7 recipients of medical assistance only who are covered under a group related to the program of FAIM financial  
8 assistance. A recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security  
9 Act, 42 U.S.C. 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage as provided in  
10 53-6-101.

11 (6) The department, under the Montana medicaid program, may provide, if a waiver is not available from  
12 the federal government, medicaid and other assistance mandated by Title XIX of the Social Security Act, 42  
13 U.S.C. 1396, et seq., as may be amended, and not specifically listed in this part to categories of persons that may  
14 be designated by the act for receipt of assistance.

15 (7) Notwithstanding any other provision of this chapter, medical assistance must be provided to infants  
16 and pregnant women whose family income does not exceed 133% of the federal poverty threshold, as provided  
17 in 42 U.S.C. 1396a(a)(10)(A)(ii)(IX) and 42 U.S.C. 1396a(l)(2)(A)(i), and whose family resources do not exceed  
18 standards that the department determines reasonable for purposes of the program.

19 (8) Subject to appropriations, the department may cooperate with and make grants to a nonprofit  
20 corporation that uses donated funds to provide basic preventive and primary health care medical benefits to  
21 children whose families are ineligible for the Montana medicaid program and who are ineligible for any other  
22 health care coverage, are under 19 years of age, and are enrolled in school if of school age.

23 (9) A person described in subsection (7) must be provided continuous eligibility for medical assistance,  
24 as authorized in 42 U.S.C. 1396a(e)(5) through a(e)(7).

25 (10) The department may establish resource and income standards of eligibility for mental health services  
26 that are more liberal than the resource and income standards of eligibility for physical health services. The  
27 standards for eligibility for mental health services may provide for eligibility for households NOT ELIGIBLE FOR  
28 MEDICAID with family income that does not exceed 200% of the federal poverty threshold or that does not exceed  
29 a lesser amount determined in the discretion of the department. The department may by rule specify under what  
30 circumstances deductions for medical expenses should be used to reduce countable family income in determining

1 eligibility. The department may also adopt rules establishing fees, PREMIUMS, or copayments to be charged  
 2 recipients for services. The fees, PREMIUMS, or copayments may vary according to family income."

3

4 NEW SECTION. Section 6. Mental health managed care -- CONTRACT -- ADVISORY COUNCIL. (1) The  
 5 department of public health and human services shall INCREMENTALLY develop managed care systems for  
 6 recipients of public mental health services. The department may contract with one or more persons for the  
 7 management of comprehensive mental health services for medicaid recipients and for persons as specified in  
 8 53-6-131(10). The department may contract for the provision of these services by means of a fixed monetary or  
 9 capitated amount per recipient. THE DEPARTMENT SHALL ENSURE THAT EACH CONTRACTOR THAT ASSUMES RISK IS  
 10 REQUIRED TO COMPLY WITH THE PROVISIONS OF TITLE 53, CHAPTER 6, PART 7, FOR THE MEDICAID PORTION OF THE  
 11 PROGRAM. THE DEPARTMENT MAY INCLUDE A PHARMACY BENEFIT AS PART OF THE MANAGED CARE CONTRACT FOR  
 12 PERSONS SERVED AS ALLOWED UNDER 53-6-131(10).

13 (2) A managed care system is a program organized to serve the mental health needs of recipients in an  
 14 efficient and cost-effective manner by managing the receipt of mental health care and services for a geographical  
 15 or otherwise defined population of recipients through appropriate health care professionals. The management  
 16 of mental health care services must provide for services in the most cost-effective manner through coordination  
 17 and management of the appropriate level of care AND APPROPRIATE LEVEL OF SERVICES. The managed care system  
 18 ~~must include case management that reviews and determines~~ SHALL REVIEW AND DETERMINE the appropriate level  
 19 of services on an individual basis in order to ensure that access to care, quality of care, and the cost of the  
 20 program are maintained.

21 (3) THE DEPARTMENT MAY ENTER INTO ONE OR MORE CONTRACTS WITH MANAGED CARE ENTITIES FOR THE  
 22 ADMINISTRATION OR DELIVERY OF MENTAL HEALTH SERVICES. THESE CONTRACTS MAY BE BASED UPON A FIXED MONETARY  
 23 AMOUNT OR A CAPITATED AMOUNT PER INDIVIDUAL, AND EACH A CONTRACTOR SHALL MAY ASSUME ALL OR A PART OF THE  
 24 FINANCIAL RISK OF PROVIDING SERVICES TO A SET POPULATION OF ELIGIBLE INDIVIDUALS. THE DEPARTMENT MAY REQUIRE  
 25 THE PARTICIPATION OF RECIPIENTS IN MANAGED CARE SYSTEMS BASED UPON GEOGRAPHICAL, FINANCIAL, MEDICAL, OR  
 26 OTHER FACTORS THAT THE DEPARTMENT MAY DETERMINE ARE RELEVANT TO THE DEVELOPMENT AND EFFICIENT  
 27 OPERATION OF THE MANAGED CARE SYSTEMS.

28 (4) THE DEPARTMENT MAY ESTABLISH ELIGIBILITY REQUIREMENTS, RESOURCE AND INCOME STANDARDS,  
 29 PREMIUMS, FEES, AND COPAYMENTS. ELIGIBLE INDIVIDUALS MAY NOT HAVE A FAMILY INCOME THAT EXCEEDS THE AMOUNT  
 30 ESTABLISHED PURSUANT TO 53-6-131(10).

1 (5) THE DEPARTMENT SHALL ESTABLISH THE AMOUNT, SCOPE, AND DURATION OF SERVICES TO BE PROVIDED  
 2 UNDER THE PROGRAM. THE SERVICES TO BE PROVIDED AND ELIGIBILITY REQUIREMENTS MAY BE MORE LIMITED THAN  
 3 THOSE IN THE MEDICAID PROGRAM UNDER CHAPTER 6.

4 ~~(3)(6)~~ (A) The department shall form ~~a consumer~~ AN advisory council, TO BE KNOWN AS THE MENTAL HEALTH  
 5 OVERSIGHT ADVISORY COUNCIL, as provided in THAT IS NOT SUBJECT TO 2-15-122 to provide consumer input to the  
 6 department in the development and management of any public mental health system. ~~Consumers must be~~  
 7 ~~included as a majority of any~~ THE advisory council and MEMBERSHIP must include:

8 (I) ONE-HALF OF THE MEMBERS AS CONSUMERS OF MENTAL HEALTH SERVICES, INCLUDING persons with serious  
 9 mental illnesses who are receiving public mental health services, other recipients of ~~public~~ mental health services,  
 10 former recipients of public mental health services, and immediate family members of recipients of ~~public~~ mental  
 11 health services. ~~Other members of an advisory council may be;~~ AND

12 (II) advocates for consumers or family members of consumers, MEMBERS OF THE PUBLIC AT LARGE,  
 13 providers of mental health services, legislators, ~~and department and contractor~~ representatives, AND A  
 14 REPRESENTATIVE OF THE COMMISSIONER OF INSURANCE.

15 (B) The advisory council under this section may be administered so as to fulfill any federal advisory  
 16 council requirements to obtain federal funds for this program.

17 (C) GEOGRAPHIC REPRESENTATION MUST BE CONSIDERED WHEN APPOINTING MEMBERS TO THE ADVISORY  
 18 COUNCIL IN ORDER TO PROVIDE AS WIDE A REPRESENTATION AS POSSIBLE.

19 (D) THE ADVISORY COUNCIL SHALL PROVIDE A SUMMARY OF EACH MEETING AND A COPY OF ANY  
 20 RECOMMENDATIONS MADE TO THE DEPARTMENT TO THE LEGISLATIVE FINANCE COMMITTEE AND ANY OTHER DESIGNATED  
 21 APPROPRIATE LEGISLATIVE INTERIM COMMITTEE. THE DEPARTMENT SHALL PROVIDE THE SAME COMMITTEES WITH THE  
 22 DEPARTMENT'S RATIONALE FOR NOT ACCEPTING OR IMPLEMENTING ANY RECOMMENDATION OF THE ADVISORY COUNCIL.

23 (7) THE DEPARTMENT SHALL FORMALLY EVALUATE CONTRACT PERFORMANCE WITH REGARD TO SPECIFIC  
 24 OUTCOME MEASURES. THE DEPARTMENT SHALL EXPLICITLY IDENTIFY PERFORMANCE AND OUTCOME MEASURES THAT  
 25 CONTRACTORS ARE REQUIRED TO ACHIEVE IN ORDER TO COMPLY WITH CONTRACT REQUIREMENTS AND TO CONTINUE THE  
 26 CONTRACT. THE CONTRACT MUST PROVIDE FOR PROGRESSIVE INTERMEDIATE SANCTIONS THAT MAY BE IMPOSED FOR  
 27 NONPERFORMANCE. THE EVALUATION MUST BE PERFORMED AT LEAST ANNUALLY.

28

29 **NEW SECTION. Section 7. Mental health managed care -- request for proposals CONTRACT SYSTEM**

30 **ELEMENTS. (1)** The department of public health and human services shall develop a ~~request for proposals for a~~

1 ~~regional~~ delivery system of mental health managed care from current providers or other entities that are able to  
 2 provide administration and OR delivery of mental health services ~~within a specified region. The request for~~  
 3 ~~proposals~~ A SYSTEM OF MENTAL HEALTH MANAGED CARE ~~may be based upon the existing mental health managed~~  
 4 ~~care contract, but~~ ANY CONTRACT FOR ADMINISTRATION OR CARE DELIVERY must include the following elements:

5 (1)(A) specific outcome and performance measures for the administration and OR delivery of a continuum  
 6 of mental health services IN ORDER to provide contract compliance monitoring;

7 (2)(B) a fully FIXED MONETARY OR capitated ~~system~~ PAYMENT MECHANISM ~~in which each regional contractor~~  
 8 ~~assumes ALL OR PART OF the financial risk;~~

9 (3)(C) a provision for ~~consumer~~ LOCAL advisory councils ~~within each region~~ THAT SHALL REPORT TO AND  
 10 MEET ON A REGULAR BASIS WITH THE ADVISORY COUNCIL PROVIDED FOR IN [SECTION 6(6)];

11 (4)(D) provisions for appeal at the ~~regional~~ LOCAL level;

12 (5)(E) ~~provisions for insurance, indemnification, performance bond, or a combination of insurance,~~  
 13 ~~indemnification, or performance bond that is sufficient to protect the state from damages upon default or~~  
 14 ~~nonperformance~~ A REQUIREMENT THAT EACH CONTRACTOR THAT ASSUMES ANY FINANCIAL RISK SHALL COMPLY WITH  
 15 THE PROVISIONS OF TITLE 53, CHAPTER 6, PART 7, FOR THE MEDICAID PORTION OF THE PROGRAM;

16 (6)(F) provisions that require documentation of evidence of the ability to provide services THROUGH AN  
 17 ADEQUATE PROVIDER NETWORK, AS PROVIDED FOR IN TITLE 33, CHAPTER 36, and to comply with rules, regulations,  
 18 and contract requirements ~~and evidence of financial stability or security;~~

19 ~~———— (7) a provision that the Montana state hospital will compete for services with prices charged to regional~~  
 20 ~~providers to be based on actual per diem charges, as provided for in 53-1-402 and 53-1-413, and for which a~~  
 21 ~~charge may not be assessed to any provider for nonuse;~~

22 (G) A PROVISION THAT, PRIOR TO FINAL AWARD OF THE A CONTRACT, THE A SUCCESSFUL BIDDER THAT SERVES  
 23 ADULTS SHALL ENTER INTO A CONTRACT WITH THE MONTANA STATE HOSPITAL AND THE MONTANA MENTAL HEALTH  
 24 NURSING CARE CENTER THAT IS CONSISTENT WITH 53-1-402, 53-1-413, AND 90-7-312 AND THAT INCLUDES FINANCIAL  
 25 INCENTIVES FOR THE DEVELOPMENT AND USE OF COMMUNITY-BASED SERVICES, RATHER THAN THE USE OF THE STATE  
 26 INSTITUTIONAL SERVICES;

27 (8)(H) the services that must be provided for the ~~the~~ medicaid-eligible individuals ~~and medically needy~~  
 28 ~~individuals and;~~

29 (I) a provision to allow a spenddown by medically needy individuals to become eligible for medicaid;

30 (9)(J) the services, WHICH MAY INCLUDE A PHARMACY BENEFIT, that must be provided to

1 nonmedicaid-eligible individuals whose income levels are below 200% of the federal poverty level as provided  
 2 for in 53-6-131(10); and

3 ~~(10)(k)~~ a provision that allows implementation of a specific sliding fee scale for PREMIUMS OR copayments  
 4 by nonmedicaid-eligible individuals ~~by copayment and specific~~ TAKING INTO ACCOUNT INCOME AND percentage of  
 5 poverty level;

6 (L) A PROVISION FOR CHILDREN WHO NEED MENTAL HEALTH SERVICES THAT ARE PROVIDED UNDER SUBSTANTIVE  
 7 INTERAGENCY AGREEMENTS BETWEEN STATE AGENCIES RESPONSIBLE FOR ADDICTIVE AND MENTAL DISORDERS, FOSTER  
 8 CARE, CHILDREN WITH DEVELOPMENTAL DISABILITIES, SPECIAL EDUCATION, AND JUVENILE CORRECTIONS; AND

9 (M) REQUIREMENTS TO ENSURE THAT THE MENTAL HEALTH MANAGED CARE SYSTEM WILL BE OPERATED IN A  
 10 COST-EFFECTIVE MANNER.

11 (2) SERVICES FOR NONMEDICAID-ELIGIBLE INDIVIDUALS MAY BE MORE LIMITED THAN THOSE SERVICES PROVIDED  
 12 TO MEDICAID-ELIGIBLE INDIVIDUALS.

13 ~~(3) IF THE DEPARTMENT DETERMINES THAT AN ACCEPTABLE PROPOSAL DOES NOT EXIST IN ORDER TO AWARD~~  
 14 ~~A CONTRACT, THEN THE DEPARTMENT MAY PROVIDE MENTAL HEALTH SERVICES AS OTHERWISE PERMITTED BY LAW.~~

15 ~~(4)~~(3) THE DEPARTMENT SHALL CONTRACT WITH AN INDEPENDENT PROFESSIONAL CONSULTING FIRM THAT IS  
 16 KNOWLEDGEABLE AND EXPERIENCED IN DEVELOPING STATEWIDE MANAGED MENTAL HEALTH CARE SYSTEMS. THE  
 17 DEPARTMENT SHALL REQUIRE, AS PART OF THE CONTRACT, THAT THE CONSULTING FIRM MAKE REGULAR REPORTS TO THE  
 18 LEGISLATIVE FINANCE COMMITTEE AND ANY OTHER APPROPRIATE LEGISLATIVE INTERIM COMMITTEE. REPORTS MUST BE  
 19 MADE AT LEAST EVERY 6 MONTHS AND MUST INCLUDE INFORMATION ABOUT THE DEVELOPMENT AND IMPLEMENTATION OF  
 20 THE NEW MENTAL HEALTH MANAGED CARE SYSTEM.

21 ~~(5)~~(4) THE TERM OF A MENTAL HEALTH MANAGED CARE CONTRACT MAY NOT BE MORE THAN 5 YEARS. THE  
 22 DEPARTMENT MAY REVERT TO A IMPLEMENT CARE-MANAGED FEE-FOR-SERVICE REIMBURSEMENT FOR SERVICES TO  
 23 PROVIDE MENTAL HEALTH SERVICES AS OTHERWISE PERMITTED BY LAW DURING THE TRANSITION FROM A SINGLE  
 24 STATEWIDE CONTRACT FOR MENTAL HEALTH MANAGED CARE TO ONE OR MORE CONTRACTS FOR MENTAL HEALTH  
 25 MANAGED CARE.

26

27 **NEW SECTION. SECTION 8. RULEMAKING AUTHORITY. (1) THE DEPARTMENT SHALL ADOPT APPROPRIATE**  
 28 **RULES NECESSARY FOR THE ADMINISTRATION OF A PROGRAM TO PROVIDE MENTAL HEALTH MANAGED CARE SERVICES.**  
 29 **THE RULES MUST ESTABLISH ELIGIBILITY CRITERIA AND MAY INCLUDE BUT ARE NOT LIMITED TO FINANCIAL STANDARDS AND**  
 30 **CRITERIA FOR INCOME AND RESOURCES, TREATMENT OF RESOURCES, NONFINANCIAL CRITERIA, RESIDENCY, APPLICATION,**

1 TERMINATION, DEFINITION OF TERMS, AND CONFIDENTIALITY OF APPLICANT AND RECIPIENT INFORMATION.

2 (2) THE DEPARTMENT SHALL ADOPT RULES ESTABLISHING THE AMOUNT, SCOPE, AND DURATION OF SERVICES.

3 THE RULES MAY ALSO INCLUDE BUT ARE NOT LIMITED TO ENSURING THAT SERVICES ARE MEDICALLY NECESSARY AND THAT

4 THE SERVICES ARE THE MOST EFFICIENT AND COST-EFFECTIVE AVAILABLE.

5 (3) THE DEPARTMENT MAY ADOPT RULES ESTABLISHING RATES OF REIMBURSEMENT OF SERVICES PROVIDED

6 UNDER THIS PART, SELECTION AND QUALIFICATION OF PROVIDERS, AND STANDARDS FOR MANAGED CARE.

7 (4) RULES ADOPTED BY THE DEPARTMENT MUST TAKE INTO ACCOUNT, WHEN APPROPRIATE, THE AVAILABILITY

8 OF APPROPRIATED FUNDS, THE ACTUAL COSTS OF SERVICES, THE QUALITY OF SERVICES, THE PROFESSIONAL KNOWLEDGE

9 AND SKILLS NECESSARY FOR THE DELIVERY OF SERVICES, AND THE AVAILABILITY OF SERVICES.

10

11 **SECTION 9. SECTION 53-6-703, MCA, IS AMENDED TO READ:**

12 **"53-6-703. Managed care community network.** (1) A managed care community network shall comply

13 with:

14 (a) the licensure and financial solvency requirements of Title 33, chapter 31, but the commissioner may

15 by rule reduce or eliminate a requirement of Title 33, chapter 31, if the requirement is demonstrated to be

16 unnecessary for the operation of the managed care community network; and

17 (b) the federal requirements for prepaid health plans as provided in 42 CFR, part 434.

18 (2) A managed care community network may contract with the department to provide any combination

19 of medicaid-covered health care services that is acceptable to the department.

20 (3) A managed care community network shall demonstrate its ability to bear the financial risk of servicing

21 enrollees under the program. The commissioner shall by rule adopt criteria for assessing the financial soundness

22 of a network. ~~The rules must consider the extent to which a network is composed of providers who directly render~~

23 ~~health care and are located within the community in which they seek to contract rather than solely arrange or~~

24 ~~finance the delivery of health care.~~ The rules must consider risk-bearing and management techniques, as

25 determined appropriate by the commissioner. The rules must also consider whether a network has sufficiently

26 demonstrated its financial solvency and net worth. The commissioner's criteria must be based on sound actuarial,

27 financial, and accounting principles. The commissioner is responsible for monitoring compliance with the rules.

28 (4) A managed care community network may not begin operation before the effective date of rules

29 adopted by the commissioner under this part, the approval of any necessary federal waivers, and the completion

30 of the review of an application submitted to the commissioner. The commissioner may charge the applicant an

1 application review fee for the commissioner's actual cost of review of the application. The fees must be adopted  
 2 by rule by the commissioner. Fees collected by the commissioner must be deposited in an account in the special  
 3 revenue fund and are statutorily appropriated, as provided in 17-7-502, to the commissioner to defray the cost  
 4 of application review.

5 (5) A health care delivery system that contracts with the department under the program may not be  
 6 required to provide or arrange for any health care or medical service, procedure, or product that violates religious  
 7 or moral teachings and beliefs if that health care delivery system is owned, controlled, or sponsored by or  
 8 affiliated with a religious institution or religious organization but must comply with the notice requirements of  
 9 53-6-705(4)(c).

10 (6) The commissioner shall adopt rules to protect managed care community networks against financial  
 11 insolvency. Managed care community networks are subject to health maintenance protections against financial  
 12 insolvency contained in 33-31-216 in the event that a managed care community network is declared insolvent  
 13 or bankrupt."

14

15 **SECTION 10. SECTION 53-6-704, MCA, IS AMENDED TO READ:**

16 **"53-6-704. Different benefit packages.** (1) The department may by rule provide for different benefit  
 17 packages for different categories of persons enrolled in the program. Alcohol and substance abuse services,  
 18 services for mental disorders, services related to children with chronic or acute conditions requiring longer-term  
 19 treatment and followup, and rehabilitation care provided by a freestanding rehabilitation hospital or a rehabilitation  
 20 unit may be excluded from a benefit package ~~if and~~ those services ~~are~~ may be made available through a separate  
 21 delivery system. If a service is excluded from the program but made available in a separate delivery system by  
 22 a managed care entity, that managed care entity is subject to this part. An exclusion does not prohibit the  
 23 department from developing and implementing demonstration projects for categories of persons or services.  
 24 Benefit packages for persons eligible for medical assistance under Title 53, chapter 6, parts 1 and 4, may be  
 25 based on the requirements of those parts and must be consistent with the Title XIX of the Social Security Act. This  
 26 part applies only to services purchased by the department.

27 (2) The program established by this part may be implemented by the department in various contracting  
 28 areas at various times. The health care delivery systems and providers available under the program may vary  
 29 throughout the state. ~~A~~ Except as otherwise provided in a contract for mental health services, a licensed managed  
 30 health care entity must be permitted to contract in any geographic area for which it has a sufficient provider

1 network and that otherwise meets the requirements of the state contract."

2

3 **SECTION 11. SECTION 53-6-706, MCA, IS AMENDED TO READ:**

4 **"53-6-706. Requirements relating to enrollees.** (1) All individuals enrolled in the program must be  
5 provided with a full written explanation of all fee-for-service and managed health care plan options as provided  
6 by rule. The department shall provide to enrollees, upon enrollment in the program and at least annually, notice  
7 of the process for requesting an appeal under the department's administrative appeal procedures. The  
8 department shall maintain a toll-free telephone number for program enrollees' use in reporting problems with  
9 managed health care entities.

10 (2) If an individual becomes eligible for participation in the program while the individual is hospitalized,  
11 ~~the department may not enroll~~ ~~is not prohibited from enrolling~~ MAY, BUT IS NOT REQUIRED TO, ENROLL the individual  
12 in the program ~~until after~~ prior to the individual ~~has been discharged~~ individual's discharge from the hospital. This  
13 subsection does not apply to a newborn infant whose mother is enrolled in the program.

14 (3) The department shall, by rule, establish rates for managed health care entities that:

15 (a) ~~are certified to be actuarially sound,~~ in accordance with federal requirements and with the  
16 department's current payment system;

17 (b) take into account any difference of cost to provide health care to different populations based on age  
18 and eligibility category. The rates for managed health care entities must be determined on a capitated basis.

19 (c) are based on treatment settings reasonably available to enrollees."  
20

21 **SECTION 12. SECTION 53-6-709, MCA, IS AMENDED TO READ:**

22 **"53-6-709. Legislative auditor -- oversight.** (1) In order to prevent, detect, and eliminate fraud, waste,  
23 abuse, mismanagement, and misconduct and to determine that the program is administered fairly and effectively,  
24 the legislative auditor shall oversee ~~all aspects of~~ the managed care covered by this part.

25 (2) A medical provider may not be compelled to provide individual medical records of patients unless the  
26 records are provided in accordance with the provisions of the Government Health Care Information Act. State  
27 and local governmental agencies shall provide the requested information, assistance, or cooperation.

28 (3) All activities conducted by the legislative auditor must be conducted in a manner that ensures the  
29 preservation of evidence for use in criminal prosecutions. The legislative auditor may present for prosecution the  
30 findings of any activity to the office of the attorney general or to United States attorneys in Montana.

1 (4) The legislative auditor shall report all convictions, terminations, and suspensions taken against  
 2 vendors, contractors, and health care providers to the department and to any agency responsible for licensing  
 3 or regulating those persons or entities.

4 (5) The legislative auditor shall make periodic reports, findings, and recommendations regarding its  
 5 oversight activities authorized by this section.

6 (6) This part does not limit investigations by the department that may otherwise be required by law or  
 7 that may be necessary in the department's capacity as the central administrative authority responsible for  
 8 administration of public aid programs in this state."  
 9

10 **NEW SECTION. SECTION 13. MENTAL HEALTH MANAGED CARE OMBUDSMAN.** THERE IS A MENTAL HEALTH  
 11 MANAGED CARE OMBUDSMAN. THE OMBUDSMAN MUST BE APPOINTED BY THE GOVERNOR FOR A TERM OF 4 YEARS. THE  
 12 OMBUDSMAN IS ATTACHED TO THE MENTAL DISABILITIES BOARD OF VISITORS FOR ADMINISTRATIVE PURPOSES. THE  
 13 OMBUDSMAN SHALL OVERSEE ALL ASPECTS OF MENTAL HEALTH MANAGED CARE UNDER THE PROVISIONS OF TITLE 53,  
 14 CHAPTERS 6 AND 21. THE OMBUDSMAN SHALL REPRESENT THE INTERESTS OF CONSUMERS OF SERVICES WITH THE  
 15 CONTRACTOR OR THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES UNDER THE MENTAL HEALTH PROVISIONS  
 16 OF TITLE 53, CHAPTERS 6 AND 21.  
 17

18 **NEW SECTION. SECTION 14. INPATIENT HOSPITAL YOUTH PSYCHIATRIC BENEFITS.** THE DEPARTMENT MAY  
 19 AUTHORIZE NOT EXCLUDE AUTHORIZE INPATIENT HOSPITAL YOUTH PSYCHIATRIC BENEFITS FOR MEDICAID-ELIGIBLE  
 20 CHILDREN IN A FREESTANDING YOUTH PSYCHIATRIC HOSPITAL IN ANY FEE-FOR-SERVICE MEDICAID SYSTEM FACILITIES  
 21 FROM PARTICIPATING TO PARTICIPATE IN THE MEDICAID PROGRAM FOR ACUTE CARE INPATIENT HOSPITAL SERVICES.  
 22 PAYMENTS MADE BY THE DEPARTMENT FOR THE PROVISION OF INPATIENT HOSPITAL PSYCHIATRIC SERVICES TO YOUTH  
 23 WHO ARE UNDER 21 YEARS OF AGE MUST COMPLY WITH ALL OF THE REQUIREMENTS OF CHAPTER 6, INCLUDING BUT NOT  
 24 LIMITED TO THE DETERMINATION OF MEDICAL NECESSITY, THE DIAGNOSTIC-RELATED GROUP RATES ESTABLISHED BY THE  
 25 DEPARTMENT FOR ACUTE CARE INPATIENT HOSPITAL SERVICES, ANY TRAVEL RESTRICTIONS, AND EXCLUSION OF SERVICES  
 26 NOT COVERED BY THE MEDICAID PROGRAM.  
 27

28 **NEW SECTION. SECTION 15. TRANSITION.** THE DEPARTMENT SHALL SEEK TO CONTINUE ITS MEDICAID MENTAL  
 29 HEALTH MANAGED CARE WAIVER AS LONG AS POSSIBLE DURING THE TRANSITION PERIOD TO THE NEW MENTAL HEALTH  
 30 MANAGED CARE PROGRAM AS PROVIDED IN [SECTION 6]. IF THE STATE LOSES ITS EXISTING MEDICAID WAIVER FOR MENTAL

1 ~~HEALTH MANAGED CARE, THEN IT SHALL IMMEDIATELY PURSUE A NEW WAIVER PURSUE APPROPRIATE WAIVERS FOR THE~~  
2 ~~TRANSITION TO A NEW MENTAL HEALTH MANAGED CARE SYSTEM AS PROVIDED IN [SECTION 6].~~

3

4 NEW SECTION. Section 16. Codification instruction. ~~[Section 3] is (1) [SECTIONS 6 THROUGH 8 AND~~  
5 ~~14 15] ARE~~ intended to be codified as an integral part of Title 53, chapter 6 21, and the provisions of Title 53,  
6 chapter 6 21, apply to ~~[section 3] [SECTIONS 6 THROUGH 8 AND 14 15].~~

7 (2) [SECTION 42 13] IS INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 2, CHAPTER 15, PART 2, AND  
8 THE PROVISIONS OF TITLE 2, CHAPTER 15, PART 2, APPLY TO [SECTION 42 13].

9 (3) [SECTION 43 14] IS INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 53, CHAPTER 6, PART 1, AND  
10 THE PROVISIONS OF TITLE 53, CHAPTER 6, PART 1 APPLY TO [SECTION 43 14].

11

12 NEW SECTION. Section 17. Effective date. [This act] is effective on passage and approval.

13

14 NEW SECTION. SECTION 18. TERMINATION. [SECTION 14] TERMINATES JUNE 30, 2001.

15

- END -