_____ BILL NO. _____

INTRODUCED BY _____
(Primary Sponsor)

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING THE LAWS CONCERNING PRESCRIPTION DRUGS AND PRESCRIPTION DRUG COVERAGE; REQUIRING THE USE OF GENERIC DRUGS IN THE MEDICAID PROGRAM WHENEVER POSSIBLE; PROVIDING FOR ELECTRONICALLY TRANSMITTED PRESCRIPTIONS; ESTABLISHING A PRACTITIONER-MANAGED PRESCRIPTION DRUG PLAN; ESTABLISHING A PATIENT PRESCRIPTION DRUG ASSISTANCE PROGRAM TO MATCH LOW-INCOME MONTANANS WHO LACK PRESCRIPTION DRUG BENEFIT COVERAGE WITH PRESCRIPTION DRUG ASSISTANCE PROGRAMS OFFERED BY PHARMACEUTICAL COMPANIES; ESTABLISHING A SENIOR PRESCRIPTION DRUG ASSISTANCE PROGRAM; ESTABLISHING A SENIOR PRESCRIPTION DRUG ASSISTANCE ACCOUNT; PROVIDING A STATUTORY APPROPRIATION OF THE SENIOR PRESCRIPTION DRUG ASSISTANCE ACCOUNT; CREATING A DRUG USE REVIEW BOARD RESPONSIBLE FOR ADVISING THE DEPARTMENT ON THE IMPLEMENTATION OF THE RETROSPECTIVE AND PROSPECTIVE DRUG USE REVIEW PROGRAMS; AMENDING SECTIONS 17-7-502, 53-6-104, 53-6-113, AND 53-6-116, MCA; AND PROVIDING AN EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Prescription drugs -- use of legend or generic drugs -- prior authorization.** (1) A medical practitioner may prescribe drugs under this part that the practitioner in the exercise of professional judgment considers appropriate for the diagnosis or treatment of the patient in the practitioner's care and within the scope of practice. Prescriptions must be dispensed in the generic form pursuant to this section and pursuant to rules of the department of public health and human services unless the practitioner prescribes otherwise and an exception is granted by the department.

(2) Unless an exception has been granted by the department, if the federal food and drug administration has approved a generic version of a particular brand name drug that is chemically identical to the brand name drug according to federal food and drug administration rating standards, the department shall pay for drugs only in the generic form.

(3) An exception must be applied for and granted before the department is required to pay for minor

tranquilizers and amphetamines and amphetamine derivatives, as defined by rule of the department.

(4) Notwithstanding subsections (1) through (3), the department is authorized to:

(a) withhold payment for a legend drug when federal financial participation is not available; and

(b) require prior authorization of payment for drugs that the department has determined should be limited to those conditions generally recognized as appropriate by the medical profession.

(5) The department may not require prior authorization for therapeutic classes of nonsedating antihistamines and nasal inhalers, as defined by rule by the department, when prescribed by an allergist for treatment of any of the following conditions included on the funded portion of the department's prioritized list of services:

(a) asthma;

(b) sinusitis;

(c) rhinitis; or

(d) allergies.

(6) As used in this section, "legend drug" means any drug requiring a prescription by a medical practitioner, as defined in 37-2-101.

NEW SECTION. **Section 2. Electronically transmitted prescriptions -- federal waiver -- rules.** (1) The department shall seek a waiver from the federal centers for medicare and medicaid services to allow the department of public health and human services to communicate prescription drug orders by electronic means from a practitioner authorized to prescribe drugs directly to the dispensing pharmacist.

(2) The department shall adopt rules permitting the department to communicate prescription drug orders by electronic means from a practitioner authorized to prescribe drugs directly to the dispensing pharmacist. In adopting rules, the department shall consider the rules adopted in Oregon to implement a similar statute.

NEW SECTION. **Section 3. Legislative findings on prescription drugs.** The legislature finds that:

(1) the cost of prescription drugs in Montana is growing and will soon be unsustainable;

(2) the benefit of prescription drugs when appropriately used decreases the need for other expensive treatments and improves the health of Montanans; and

(3) providing the most effective drugs in the most cost-effective manner will benefit both patients and taxpayers.

NEW SECTION. **Section 4. Policy for practitioner-managed prescription drug plan.** It is the policy of the state of Montana that a practitioner-managed prescription drug plan will ensure that:

(1) Montanans have access to the most effective prescription drugs appropriate for their clinical conditions;

(2) decisions concerning the clinical effectiveness of prescription drugs are made by licensed health care practitioners, based on the latest peer-reviewed research, and consider the health condition of a patient or characteristics of a patient, including the patient's gender, race, or ethnicity; and

(3) the cost of prescription drugs in Montana is managed through market competition among pharmaceutical manufacturers by publicly considering the effectiveness of a given drug first and then considering its relative cost.

NEW SECTION. **Section 5. Practitioner-managed prescription drug plan.** (1) The department of public health and human services shall adopt a practitioner-managed prescription drug plan for Montana. The purpose of the plan is to ensure that enrollees of the Montana medicaid program receive the most effective prescription drug available at the best possible price.

(2) Before adopting the plan, the department shall conduct public meetings.

(3) The department shall consult with representatives of the regulatory boards and associations representing medical practitioners who are authorized to prescribe prescription drugs and shall ensure that practitioners receive educational materials and have access to training on the practitioner-managed prescription drug plan.

(4) Notwithstanding the practitioner-managed prescription drug plan adopted by the department, a medical practitioner may prescribe any drug that the practitioner indicates is medically necessary for an enrollee as being the most effective drug available.

(5) An enrollee may appeal to the department a decision of a medical practitioner or the department to not provide a prescription drug requested by the enrollee.

(6) This section does not limit the decision of a medical practitioner as to the scope and duration of treatment of chronic conditions, including but not limited to arthritis, diabetes, and asthma.

NEW SECTION. **Section 6. Reports to committee.** The children, families, health, and human services

interim committee shall:

(1) receive regular reports on the development and implementation of the practitioner-managed prescription drug plan;

(2) review the impact of the implementation of the practitioner-managed prescription drug plan, including but not limited to a review of whether the program realizes any savings, whether there is an increase in physician and hospital costs for individuals receiving medical assistance, and whether there is an impact on the ability of an individual receiving medical assistance to obtain prescribed drugs; and

(3) report its findings and recommendations periodically to the legislature.

NEW SECTION. **Section 7. Patient prescription drug assistance program -- pharmacy school to operate program.** (1) There is a patient prescription drug assistance program. The purpose of the program is to match low-income Montanans who lack prescription drug benefit coverage with prescription drug assistance programs offered by pharmaceutical companies.

(2) The program must:

(a) provide information on:

(i) eligibility requirements and coverage provided by publicly funded prescription drug benefit programs administered by the department of public health and human services; and

(ii) the process for applying to receive publicly funded prescription drug benefits;

(b) assist a patient in applying to pharmaceutical companies for free or discounted prescription drug medications if the patient is not eligible for any publicly funded prescription drug benefit program;

(c) provide information, in an organized and easily understood manner, to patients, physicians, pharmacists, and pharmacies regarding patient qualifications for prescription drug assistance programs;

(d) increase awareness of the various prescription drug assistance programs offered by pharmaceutical companies; and

(e) establish a toll-free hotline and internet website to increase public awareness of the patient prescription drug assistance program and to provide public access to the information and services provided through the program.

(3) The department may enter into a contract with the school of pharmacy at the university of Montana-Missoula to operate the patient prescription drug assistance program. In lieu of contracting with the school of pharmacy, the department may contract with any pharmacy provider to operate the patient prescription

drug assistance program.

NEW SECTION. **Section 8. Definitions.** As used in [sections 8 through 11], unless the context requires otherwise, the following definitions apply:

(1) "Department" means the department of public health and human services provided for in Title 2, chapter 15, part 22.

(2) "Eligible person" means a resident of this state who:

(a) is 65 years of age or older;

(b) has a gross annual income that does not exceed the lesser of the maximum amount established by the department by rule or 185% of the federal poverty guidelines;

(c) has not been covered under any public or private prescription drug benefit program for the previous 6 months; and

(d) has less than $2,000 in resources.

(3) "Enrollee" means a person who has been found to be eligible for the senior prescription drug assistance program, who has paid an enrollment fee of up to $50, and who has a senior prescription drug assistance program enrollment card issued by the department.

(4) "Federal poverty guidelines" means the most recent poverty guidelines as published annually in the Federal Register by the United States department of health and human services.

(5) "Income" means net income in cash or in kind available to the applicant or recipient the receipt of which is regular and predictable enough to afford security in the sense that the applicant or recipient may rely upon it to contribute toward meeting the needs of the applicant or recipient.

(6) (a) "Resources" includes but is not limited to cash, checking and savings accounts, certificates of deposit, money market funds, stocks, and bonds.

(b) The term does not include the primary residence or motor vehicle of an eligible person.

(7) "Senior prescription drug assistance program price" means the price of a prescription drug paid by an enrollee that is equal to or less than the medicaid price.

NEW SECTION. **Section 9. Senior prescription drug assistance program -- application and enrollment -- critical access pharmacies -- rules.** (1) There is a senior prescription drug assistance program in the department. The purpose of the program is to provide financial assistance to eligible persons for the

purchase of prescription drugs.

(2) A pharmacy shall charge an enrollee the senior prescription drug assistance program price for a prescription drug upon presentation of a senior prescription drug assistance program enrollment card.

(3) A pharmacy may charge the enrollee an amount established by the department to cover the professional dispensing fee, which may not exceed the fee paid by the state medicaid program.

(4) This section does not apply to over-the-counter medications.

(5) The department shall provide a mechanism to calculate and transmit the senior prescription drug assistance program price to the pharmacy.

(6) A person seeking to participate in the senior prescription drug assistance program shall apply annually by completing and mailing a one-page application and including payment of an enrollment fee established by the department, not to exceed $50. The department shall issue an enrollment card annually to enrollees of the program. Each individual's application must be considered separately, regardless of the number of persons in the individual's household.

(7) The maximum prescription drug assistance available annually to an enrollee is $2,000.

(8) Subject to available funds, the department may adjust the senior prescription drug assistance program price to subsidize up to 50% of the medicaid price of the prescription drug, using a sliding scale based on the income and resources of an enrollee.

(9) (a) The department shall adopt rules that:

(i) identify critical access pharmacies; and

(ii) provide for additional reimbursement to critical access pharmacies that participate in the senior prescription drug assistance program.

(b) The department may adopt other rules determined necessary to implement the senior prescription drug assistance program.

(10) A critical access pharmacy may charge an enrollee a fee of not more than $2 for each prescription. The department shall annually adjust the $2 charge for inflation using the consumer price index, U.S. city average, all urban consumers, as published by the bureau of labor statistics of the United States department of labor.

NEW SECTION. **Section 10. Contracts to provide services.** The department may contract with a pharmacy provider or a pharmacy benefits manager to provide services under the senior prescription drug

assistance program.

NEW SECTION. **Section 11. Senior prescription drug assistance account -- statutory appropriation.** There is a senior prescription drug assistance account in the state special revenue fund. The senior prescription drug assistance account may receive allocations of state funds, federal money, and gifts designated for the senior prescription drug assistance program. The senior prescription drug assistance account is statutorily appropriated, as provided in 17-7-502, to the department and must be used to reimburse retail pharmacies for subsidized prices provided to enrollees and to reimburse the department for the costs of administering the program, including contracted services costs, computer costs, professional fees paid to retained pharmacies, and other reasonable program costs. Interest earned on the account accrues to the account.

NEW SECTION. **Section 12. Definitions.** As used in [sections 12 through 22], unless the context requires otherwise, the following definitions apply:

(1) "Appropriate and medically necessary use" means the prescription of drugs, drug dispensing, and patient medication usage in conformity with the criteria and standards developed under [sections 12 through 22].

(2) "Board" means the drug use review board created under [section 13].

(3) "Compendia" means those resources widely accepted by the medical profession in the efficacious use of drugs, including the following sources:

(a) American hospital formulary services drug information;

(b) United States pharmacopoeia drug information;

(c) American medical association drug evaluations;

(d) peer-reviewed medical literature; and

(e) drug therapy information provided by manufacturers of drug products consistent with the federal food and drug administration requirements.

(4) "Criteria" means the predetermined and explicitly accepted elements based on the compendia that are used to measure drug use on an ongoing basis to determine if the use is an appropriate and medically necessary use and not likely to result in adverse medical outcomes.

(5) "Department" means the department of public health and human services provided for in Title 2, chapter 15, part 22.

(6) "Drug-disease contraindication" means the potential for or the occurrence of an undesirable alteration of the therapeutic effect of a given prescription because of the presence, in the patient for whom it is prescribed, of a disease condition or the potential for or the occurrence of a clinically significant adverse effect of the drug on the patient's disease condition.

(7) "Drug-drug interaction" means the pharmacological or clinical response to the administration of at least two drugs different from that response anticipated from the known effects of the two drugs when given alone, which may manifest clinically as antagonism, synergism, or idiosyncrasy. Drug-drug interactions have the potential to have an adverse effect on the individual or lead to a clinically significant adverse reaction, or both, that:

(a) is characteristic of one or any of the drugs present; or

(b) leads to interference with the absorption, distribution, metabolizing, excretion, or therapeutic efficacy of one or any of the drugs.

(8) "Drug use review programs" means the programs designed to measure and assess on a retrospective and a prospective basis, through an evaluation of claims data, the proper utilization, quantity, appropriateness as therapy, and medical necessity of prescribed medication in the medical assistance program.

(9) "Intervention" means an action taken by the department with a prescriber or pharmacist to give information about or to influence prescription or dispensing practices or utilization of drugs.

(10) "Medical assistance program" means the practitioner-managed prescription drug plan provided for in [sections 4 and 5], the patient prescription drug assistance program provided for in [section 7], and the senior prescription drug assistance program provided for in [sections 8 through 11].

(11) "Overutilization" means the use of a drug in quantities or for durations that put the recipient at risk of an adverse medical outcome.

(12) "Pharmacist" means an individual who is licensed as a pharmacist under Title 37, chapter 7.

(13) "Prescriber" means any person authorized by law to prescribe drugs.

(14) "Prospective program" means the prospective drug use review program described in [section 17].

(15) "Retrospective program" means the retrospective drug use review program described in [section 18].

(16) "Standards" means the acceptable prescription and dispensing methods determined by the compendia, in accordance with local standards of medical practice for health care providers.

(17) "Therapeutic appropriateness" means prescription of a drug based on scientifically based and

clinically relevant drug therapy that is consistent with the criteria and standards developed under [sections 12 through 22].

(18) "Therapeutic duplication" means the prescription and dispensing of two or more drugs from the same therapeutic class when the combined daily dose puts the recipient at risk of an adverse medical result or incurs additional program costs without additional therapeutic benefits.

(19) "Underutilization" means that a drug is used by a recipient in quantity that is insufficient to achieve a desired therapeutic goal.

NEW SECTION. **Section 13. Drug use review board -- membership -- terms -- qualifications.** (1) There is a 12-member drug use review board responsible for advising the department on the implementation of the retrospective and prospective programs.

(2) The members of the board must be appointed by the director of the department and shall serve terms of 2 years. An individual appointed to the board may be reappointed upon completion of the individual's term. The membership of the board must be composed of the following:

(a) four persons licensed as physicians and actively engaged in the practice of medicine or osteopathy in Montana who may be from among persons recommended by the Montana medical association or another organization representing physicians;

(b) one person licensed as a physician in Montana who is actively engaged in academic medicine;

(c) three persons licensed and actively practicing pharmacy in Montana who may be from among persons recommended by the board of pharmacy or other organizations representing pharmacists whether affiliated or unaffiliated with any association;

(d) one person licensed as a pharmacist in Montana who is actively engaged in academic pharmacy;

(e) two persons who represent persons receiving medical assistance; and

(f) one person licensed and actively practicing dentistry in Montana who may be from among persons recommended by the board of dentistry or other organizations representing dentists.

(3) Board members must have expertise in one or more of the following:

(a) clinically appropriate prescription of outpatient drugs covered by the medical assistance program;

(b) clinically appropriate dispensing and monitoring of outpatient drugs covered by the medical assistance program;

(c) drug use review, evaluation, and intervention; and

(d) medical quality assurance.

(4) The director shall fill a vacancy on the board by appointing a new member to serve the remainder of the unexpired term based upon qualifications described in subsections (2) and (3).

(5) A board member may be removed by a vote of eight members of the board, and the removal must be approved by the director. The director may remove a member, without board action, if a member fails to attend two consecutive meetings unless that member is prevented from attending by serious illness of the member or in the member's family.

NEW SECTION. **Section 14. Duties of drug use review board.** The board shall advise the department on:

(1) adoption of rules to implement [sections 12 through 22];

(2) implementation of the retrospective and prospective programs as described in [sections 17 and 18], including the type of software programs to be used by the pharmacist for prospective drug use review and the provisions of the contractual agreement between the state and any entity involved in the retrospective program;

(3) development of and application of the criteria and standards to be used in retrospective and prospective drug use review in a manner that ensures that the criteria and standards are based on the compendia, relevant guidelines obtained from professional groups through consensus-driven processes, the experience of practitioners with expertise in drug therapy, other data, and experience obtained from drug use review program operations. The board shall develop an open professional consensus process for establishing and revising criteria and standards. Criteria and standards must be available to the public. In developing recommendations for criteria and standards, the board shall establish an explicit ongoing process for soliciting and considering input from interested parties. The board shall make timely revisions to the criteria and standards based upon this input in addition to revisions based upon scheduled review of the criteria and standards. The drug use review standards must reflect the local practices of prescribers in order to monitor:

(a) therapeutic appropriateness;

(b) overutilization or underutilization;

(c) therapeutic duplication;

(d) drug-disease contraindications;

(e) drug-drug interactions;

(f) incorrect drug dosage or drug treatment duration;

(g) clinical abuse or misuse; and

(h) drug allergies.

(4) development, selection, and application of and assessment for interventions for medical assistance program prescribers, dispensers, and patients that are educational and not punitive in nature.

NEW SECTION. **Section 15. Educational and informational duties of board -- procedure to ensure confidentiality.** In addition to advising the department, the board, subject to the approval of the director of the department, shall do the following:

(1) publish an annual report, as described in [section 22];

(2) publish and disseminate educational information to prescribers and pharmacists regarding the board and the drug use review programs, including information on the following:

(a) identifying and reducing the frequency of patterns of fraud, abuse, or inappropriate or medically unnecessary care among prescribers, pharmacists, and recipients;

(b) potential or actual severe or adverse reactions to drugs;

(c) therapeutic appropriateness;

(d) overutilization or underutilization;

(e) appropriate use of generic products;

(f) therapeutic duplication;

(g) drug-disease contraindications;

(h) drug-drug interactions;

(i) drug allergy interactions; and

(j) clinical abuse and misuse; and

(3) adopt and implement procedures designed to ensure the confidentiality of any information that is collected, stored, retrieved, assessed, or analyzed by the board, staff of the board, or contractors to the drug use review programs and that identifies individual prescribers, pharmacists, or recipients.

NEW SECTION. **Section 16. Authorized intervention procedures.** In appropriate instances, interventions developed under [section 14(4)] may include the following:

(1) information disseminated to prescribers and pharmacists to ensure that they are aware of the duties and powers of the board;

(2) written, oral, or electronic reminders of recipient-specific or drug-specific information that are designed to ensure recipient, prescriber, and pharmacist confidentiality and suggested changes in prescription or dispensing practices designed to improve the quality of care;

(3) face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been targeted for educational intervention;

(4) intensified reviews or monitoring of selected prescribers or pharmacists;

(5) educational outreach through the retrospective program focusing on improvement of prescription and dispensing practices;

(6) the timely evaluation of interventions to determine if the interventions have improved the quality of care; and

(7) the review of case profiles before conducting an intervention.

NEW SECTION. **Section 17. Standards for prospective drug use review program.** The prospective program must be based on the guidelines established by the department in consultation with the board. The program must provide that prior to the prescription being filled or delivered, a review will be conducted by the pharmacist at the point of sale to screen for potential drug therapy problems resulting from the following:

(1) therapeutic duplication;

(2) drug-drug interactions, including serious interactions with nonprescription or over-the-counter drugs;

(3) incorrect dosage and duration of treatment;

(4) drug-allergy interactions;

(5) clinical abuse and misuse; and

(6) drug-disease contraindications.

NEW SECTION. **Section 18. Standards for retrospective drug use review program.** The retrospective program must:

(1) be based on the guidelines established by the department in consultation with the board; and

(2) use a mechanized drug claims processing and information retrieval system to analyze claims data on drug use against explicit predetermined standards that are based on the compendia and other sources to monitor the following:

(a) therapeutic appropriateness;

(b) overutilization or underutilization;

(c) fraud and abuse;

(d) therapeutic duplication;

(e) drug-disease contraindications;

(f) drug-drug interactions;

(g) incorrect drug dosage or duration of drug treatment; and

(h) clinical abuse and misuse.

NEW SECTION. **Section 19. Unauthorized disclosure of information prohibited -- staff access to information.** (1) Information collected under [sections 12 through 22] that identifies an individual is confidential and may not be disclosed by the board, the retrospective program, or the department to any person other than a health care provider appearing on a recipient's medication profile.

(2) The staff of the board may have access to identifying information for purposes of carrying out intervention activities. The identifying information may not be released to anyone other than to a staff member of the board, retrospective program, or department, to any health care provider appearing on a recipient's medication profile, or for purposes of investigating potential fraud in programs administered by the department, to the department of justice.

(3) The board may release cumulative, nonidentifying information for the purposes of legitimate research and for educational purposes.

NEW SECTION. **Section 20. Closed meetings -- public testimony.** (1) Because of the privacy interest involved, the board may close a meeting for purposes of reviewing the prescription or dispensing practices of individual prescribers or pharmacists, to discuss drug use review data pertaining to individual prescribers or pharmacists, or to review profiles of individual clients.

(2) The board shall provide appropriate opportunity for public testimony at the regularly scheduled board meetings.

NEW SECTION. **Section 21. Board subject to certain laws -- staff.** (1) The board shall operate in accordance with Title 2, chapter 6. The board shall annually elect a presiding officer from the members of the board.

(2) Each board member is entitled to reimbursement for travel, meals, and lodging expenses incurred in connection with the member's duties, pursuant to Title 2, chapter 18, part 5.

(3) A quorum consists of eight members of the board.

(4) With approval of the director, the board may establish advisory committees to assist in carrying out the board's duties under [sections 12 through 22]. The board is attached to the department for administrative purposes only as provided in 2-15-121.

NEW SECTION. **Section 22. Annual report -- public comment.** (1) The annual report under [section 15(1)] must be subject to public comment prior to its submission to the director of the department. Copies of the annual report must also be submitted to the legislature, as provided in 5-11-210, and other persons who request copies of the report.

(2) The annual report must include information on the following:

(a) an overview of the activities of the board and the retrospective and prospective programs;

(b) a summary of interventions made, including the number of cases brought before the board, and the number of interventions made;

(c) an assessment of the impact of the interventions, criteria, and standards used, including an overall assessment of the impact of the educational programs and interventions on prescription and dispensing patterns;

(d) an assessment of the impact of these criteria, standards, and educational interventions on quality of care; and

(e) an estimate of the cost savings generated as a result of the retrospective and prospective programs, including an overview of the fiscal impact of the programs to other areas of the medical assistance program such as hospitalization or long-term care costs. This analysis should include a cost-benefit analysis of both the retrospective and prospective programs and should take into account the administrative costs of the drug use review programs.

Section 23. Section 17-7-502, MCA, is amended to read:

"17-7-502. Statutory appropriations -- definition -- requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both

of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations: 2-15-151; 2-17-105; 5-13-403; 10-3-203; 10-3-310; 10-3-312; 10-3-314; 10-4-301; 15-1-111; 15-1-113; 15-1-121; 15-23-706; 15-35-108; 15-36-324; 15-37-117; 15-38-202; 15-65-121; 15-70-101; 17-3-106; 17-3-212; 17-3-222; 17-3-241; 17-6-101; 17-7-304; 18-11-112; 19-3-319; 19-9-702; 19-13-604; 19-17-301; 19-18-512; 19-19-305; 19-19-506; 19-20-604; 20-8-107; 20-9-534; 20-9-622; 20-26-1503; 22-3-1004; 23-5-306; 23-5-409; 23-5-612; 23-5-631; 23-7-301; 23-7-402; 37-43-204; 37-51-501; 39-71-503; 42-2-105; 44-12-206; 44-13-102; 50-4-623; 53-6-703; [section 11]; 53-24-206; 75-1-1101; 75-5-1108; 75-6-214; 75-11-313; 80-2-222; 80-4-416; 80-5-510; 80-11-518; 82-11-161; 87-1-513; 90-3-1003; 90-6-710; and 90-9-306.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for the payments. (In subsection (3): pursuant to Ch. 422, L. 1997, the inclusion of 15-1-111 terminates on July 1, 2008, which is the date that section is repealed; pursuant to sec. 10, Ch. 360, L. 1999, the inclusion of 19-20-604 terminates when the amortization period for the teachers' retirement system's unfunded liability is 10 years or less; pursuant to sec. 4, Ch. 497, L. 1999, the inclusion of 15-38-202 terminates July 1, 2014; pursuant to sec. 10(2), Ch. 10, Sp. L. May 2000, the inclusion of 15-35-108 and 90-6-710 terminates June 30, 2005; pursuant to sec. 17, Ch. 414, L. 2001, the inclusion of 2-15-151 terminates December 31, 2006; and pursuant to sec. 2, Ch. 594, L. 2001, the inclusion of 17-3-241 becomes effective July 1, 2003.)"

Section 24. Section 53-6-104, MCA, is amended to read:

"53-6-104. Freedom of doctors to treat recipients of medical assistance -- freedom to select doctor. (1) The department of public health and human services shall provide for professional freedom of those licensed practitioners who provide medical assistance under this part and provide reasonable freedom of choice to recipients of medical aid to select the vendor or provider of medical care, services, or subject to [sections 1

and 2], prescribed drugs.

(2) This section may not be construed to prohibit the department from imposing conditions on the payment of provider services and the receipt of medical assistance, as provided for under 53-6-111 and 53-6-113 through 53-6-116."

Section 25. Section 53-6-113, MCA, is amended to read:

"53-6-113. Department to adopt rules. (1) The department of public health and human services 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. 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.

(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) 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 to implement [sections 1 and 2]. In adopting rules, the department shall consider rules adopted in Oregon to implement the statutes upon which [sections 1 and 2] are based."

Section 26. 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 recipients.

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

(3) A managed care system is a program organized to serve the medical needs of medicaid recipients

in an efficient and cost-effective manner by managing the receipt of medical services for a geographical or otherwise defined population of recipients through appropriate health care professionals.

(4) The provision of medicaid services through managed care and capitated health care systems is not subject to the limitations provided in 53-6-104. The managed care or capitated health care system that is provided to a defined population of recipients may be based on one or more of the medical assistance services provided for in 53-6-101. If prescription drugs are included as a medical assistance service, the delivery of the drugs through the managed care system must conform to the requirements of [sections 1 and 2].

(5) The proposed systems, referred to in subsection (1), must be submitted to the legislative finance committee. The legislative finance committee shall review the proposed systems at its next regularly scheduled meeting and shall provide any comments concerning the proposed systems to the department."

NEW SECTION. **Section 27. Codification instruction.** (1) [Sections 1 through 6] are intended to be codified as an integral part of Title 53, chapter 6, part 1, and the provisions of Title 53, chapter 6, part 1, apply to [sections 1 through 6].

(2) [Sections 7 through 22] 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 7 through 22].

NEW SECTION. **Section 28. Effective date.** [This act] is effective July 1, 2003.

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