

1 SENATE BILL NO. 351

2 INTRODUCED BY R. RIPLEY

3

4 A BILL FOR AN ACT ENTITLED: "AN ACT REVISING LAWS RELATED TO MEDICAID MANAGED CARE
5 CONTRACTS; ESTABLISHING AN ADVISORY COUNCIL; REQUIRING REVIEW OF REQUESTS FOR
6 PROPOSALS AND PROPOSED CONTRACTS; AMENDING SECTIONS 33-1-102, 33-31-115, 53-6-116,
7 53-6-702, 53-6-704, 53-6-705, 53-6-707, AND 53-21-701, MCA; REPEALING SECTION 53-6-703, MCA; AND
8 PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

9

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

11

12 NEW SECTION. **Section 1. Advisory council -- duties.** (1) There is an advisory council to review
13 requests for proposals issued and contracts proposed to be awarded under this part.

14 (2) The advisory council consists of seven members appointed as follows:

15 (a) two members appointed by the speaker of the house of representatives, at least one of whom must
16 be a health care provider;17 (b) two members appointed by the president of the senate, at least one of whom must be a health care
18 provider; and

19 (c) three members appointed by the governor, at least one of whom must be a health care provider.

20 (3) Members shall serve staggered, 3-year terms.

21 (4) When the department proposes to seek a medicaid waiver for managed care, the council shall
22 conduct the following activities before the department issues a request for proposal and after it has selected a
23 vendor but before a contract is awarded:

24 (a) hold a public hearing in the geographic area that would be affected by the program or contract in
25 order to:26 (i) educate medicaid recipients, health care providers, and the public residing in the area about the
27 provisions of the proposed program or contract and the consumer's options; and

28 (ii) accept public comment about the proposed program or contract;

29 (b) submit a report of its findings related to the public comment process to the appropriate interim or
30 legislative committee, the legislative auditor's office, and the department.

1 (5) The council shall meet according to a schedule adopted by a majority vote of the council.

2 (6) The council is attached to the department for administrative purposes only, and members are entitled
3 to reimbursement for travel expenses as provided in 2-18-501 through 2-18-503.

4
5 **NEW SECTION. Section 2. Requests for proposals and contracts -- review requirements -- public**

6 **notice and comment.** (1) Before the department issues a request for proposals or awards a contract for a
7 managed care program:

8 (a) the department shall meet the public notice, legislative presentation, and public comment
9 requirements of 53-2-215;

10 (b) the legislative auditor's office and the state auditor's office, in consultation with the department, shall
11 analyze the request for proposal and the proposed contract for:

- 12 (i) actuarial soundness;
- 13 (ii) network adequacy as provided for in Title 33, chapter 36, part 2; and
- 14 (iii) consumer choice; and

15 (c) the legislative auditor's office and state auditor's office shall publish the findings of their analyses.

16 (2) (a) Before the department may award a contract, it shall seek an independent analysis to verify that
17 the potential vendor is able to comply with the goals of the proposed managed care program.

18 (b) The vendor shall pay the costs of the analysis.

19
20 **Section 3.** Section 33-1-102, MCA, is amended to read:

21 **"33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance**
22 **organizations -- governmental insurance programs -- service contracts.** (1) A person may not transact a
23 business of insurance in Montana or a business relative to a subject resident, located, or to be performed in
24 Montana without complying with the applicable provisions of this code.

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

- 26 (a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;
- 27 (b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and
- 28 (c) fraternal benefit societies, except as stated in chapter 7.

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

1 (4) This code does not apply to health maintenance organizations ~~or to managed care community~~
2 ~~networks, as defined in 53-6-702;~~ to the extent that the existence and operations of those organizations are
3 governed by chapter 31 ~~or to the extent that the existence and operations of those networks are governed by Title~~
4 ~~53, chapter 6, part 7. The department of public health and human services is responsible to protect the interests~~
5 ~~of consumers by providing complaint, appeal, and grievance procedures relating to managed care community~~
6 ~~networks and health maintenance organizations under contract to provide services under Title 53, chapter 6.~~

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

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

13 (7) Except as otherwise provided in Title 33, chapter 22, this code does not apply to the state employee
14 group insurance program established in Title 2, chapter 18, part 8.

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

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

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

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

27 (b) A "service contract" means a contract or agreement for a separately stated consideration for a
28 specific duration to perform the repair, replacement, or maintenance of property or to indemnify for the repair,
29 replacement, or maintenance of property if an operational or structural failure is due to a defect in materials or
30 manufacturing or to normal wear and tear, with or without an additional provision for incidental payment or

1 indemnity under limited circumstances, including but not limited to towing, rental, and emergency road service.
 2 A service contract may provide for the repair, replacement, or maintenance of property for damage resulting from
 3 power surges or accidental damage from handling. A service contract does not include motor club service as
 4 defined in 61-12-301.

5 (11) (a) Subject to 33-18-201 and 33-18-242, this code does not apply to insurance for ambulance
 6 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
 7 the financial risk under the contract with the third party as provided in 7-34-103.

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

10

11 **Section 4.** Section 33-31-115, MCA, is amended to read:

12 **"33-31-115. Applicability to managed health care entity.** ~~(1) A managed health care entity, as defined~~
 13 ~~in 53-6-702, is governed by the provisions of Title 53, chapter 6, part 7.~~

14 ~~(2)(1)~~ The department of public health and human services may limit the amount, scope, and duration
 15 of services provided by a managed health care entity under contract for programs established under Title 53.
 16 These services may be less than services required by this title.

17 (2) A managed health care entity under contract with the department of public health and human services
 18 is exempt from the provisions of 33-31-301 and 33-31-321."

19

20 **Section 5.** Section 53-6-116, MCA, is amended to read:

21 **"53-6-116. Medicaid managed care -- capitated health care.** (1) The department of public health and
 22 human services, in its discretion, may develop managed care and capitated health care systems for medicaid
 23 recipients.

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

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

1 (4) The provision of medicaid services through managed care and capitated health care systems is not
 2 subject to the limitations provided in 53-6-104. The managed care or capitated health care system that is provided
 3 to a defined population of recipients may be based on one or more of the medical assistance services provided
 4 for in 53-6-101.

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

8 (6) A managed care or capitated health care system that requires a waiver from the centers for medicare
 9 and medicaid is subject to the provisions of Title 53, chapter 6, part 7."

10

11 **Section 6.** Section 53-6-702, MCA, is amended to read:

12 **"53-6-702. Definitions.** As used in this part, the following definitions apply:

13 (1) "Department" means the department of public health and human services.

14 (2) "Health maintenance organization" means a health maintenance organization as defined in
 15 33-31-102.

16 ~~———— (3) (a) "Managed care community network" or "network" means an entity, other than a health~~
 17 ~~maintenance organization, that provides or arranges for comprehensive physical or mental health care services~~
 18 ~~under a contract with the department, that is reimbursed by a capitated rate or a fixed monetary amount for a~~
 19 ~~specified time period with a risk of financial loss or a financial incentive to the entity, and that:~~

20 ~~———— (i) contracts for an estimated annual value of \$1 million or more of state and federal medicaid funds; or~~

21 ~~———— (ii) operates statewide or covers 20% or more of the medicaid population.~~

22 ~~———— (b) The term does not include a provider of health care services under a contract with the department~~
 23 ~~on a fee-for-service basis or a PACE organization, as defined in 42 CFR 460.6, that has received a waiver under~~
 24 ~~33-31-201.~~

25 (4)(3) (a) "Managed health care entity" or "entity" means a health maintenance organization or a
 26 managed care community network an insurer regulated under Title 33 that:

27 (i) contracts for an estimated annual value of \$1 million or more of state and federal medicaid funds; or

28 (ii) operates statewide or covers 20% or more of the medicaid population.

29 (b) The term does not include a provider of health care services under a contract with the department
 30 on a fee-for-service basis or a PACE organization, as defined in 42 CFR 460.6, that has received a waiver under

1 33-31-201.

2 (~~5~~)(4) "Program" means an element of the integrated health care system created by this part."

3

4 **Section 7.** Section 53-6-704, MCA, is amended to read:

5 **"53-6-704. Different benefit packages.** (1) The department may by rule provide for different benefit
6 packages for different categories of persons enrolled in the program. Alcohol and substance abuse services,
7 services for mental disorders, services related to children with chronic or acute conditions requiring longer-term
8 treatment and followup, and rehabilitation care provided by a freestanding rehabilitation hospital or a rehabilitation
9 unit may be excluded from a benefit package and those services may be made available through a separate
10 delivery system. If a service is excluded from the program but made available in a separate delivery system by
11 a managed health care entity, that managed health care entity is subject to this part. An exclusion does not
12 prohibit the department from developing and implementing demonstration projects for categories of persons or
13 services. Benefit packages for persons eligible for medical assistance under Title 53, chapter 6, parts 1 and 4,
14 may be based on the requirements of those parts and must be consistent with the Title XIX of the Social Security
15 Act. This part applies only to services purchased by the department.

16 (2) The program established by this part may be implemented by the department in various contracting
17 areas at various times. The health care delivery systems and providers available under the program may vary
18 throughout the state. Except as otherwise provided in a contract for mental health services and subject to the
19 public comment and review provisions of [sections 1 and 2], a licensed managed health care entity must be
20 permitted to contract in any geographic area for which it has a sufficient provider network and that otherwise
21 meets the requirements of the state contract."

22

23 **Section 8.** Section 53-6-705, MCA, is amended to read:

24 **"53-6-705. Requirements for managed health care entities.** (1) A managed health care entity that
25 contracts with the department for the provision of services under the program shall comply with the requirements
26 of this section for purposes of the program.

27 (2) The entity shall provide for reimbursement for health care providers for emergency care, as defined
28 by the department by rule, that must be provided to its enrollees, including emergency room screening services
29 and urgent care that it authorizes for its enrollees, regardless of the provider's affiliation with the managed health
30 care entity. Health care providers must be reimbursed for emergency care in an amount not less than the

1 department's rates for those medical services rendered by health care providers who are not under contract with
2 the entity to enrollees of the entity.

3 (3) The entity shall maintain a network of health care providers that is sufficient in number and type to
4 ensure that all services available to medicaid recipients covered by the entity are available without unreasonable
5 delay as required under the network adequacy and quality assurance provisions of Title 33, chapter 36, and any
6 rules promulgated under that chapter.

7 ~~(3)~~(4) The entity shall provide that any health care provider affiliated with a managed health care entity
8 may also provide services on a fee-for-service basis to department clients who are not enrolled in a managed
9 health care entity.

10 ~~(4)~~(5) The entity shall provide client education services as determined and approved by the department,
11 including but not limited to the following services:

12 (a) education regarding appropriate use of health care services in a managed care system;

13 (b) written disclosure of treatment policies and any restrictions or limitations on health services, including
14 but not limited to physician services, clinical laboratory tests, hospital and surgical procedures, prescription drugs
15 and biologicals, and radiological examinations; and

16 (c) written notice that the enrollee may receive from another provider those medicaid-covered services
17 that are not provided by the managed health care entity but that are the financial responsibility of the entity.

18 ~~(5)~~(6) The entity shall provide that enrollees within its system will be informed of the full panel of health
19 care providers. Contracts for the provision of services beyond 125 miles from the borders of Montana may not
20 be entered into if services of comparable cost and quality are available within the state of Montana.

21 ~~(6)~~(7) The entity may not discriminate in its enrollment or disenrollment practices among recipients of
22 medical services or program enrollees based on health status.

23 ~~(7)~~(8) For purposes of participation in the medicaid program, the entity shall comply with quality
24 assurance and utilization review requirements established in Title 33, chapter 36, and by the department by rule.

25 ~~(8)~~(9) The entity shall require that each provider meets the standards for accessibility and quality of care
26 established by law. The department shall prepare an annual report regarding the effectiveness of the standards
27 on ensuring access and quality of care to enrollees.

28 ~~(9)~~(10) The entity shall maintain, retain, and make available to the department records, data, and
29 information, in a uniform manner determined by the department, that ~~is~~ are:

30 (a) sufficient for the department, the legislative auditor's office, and the state auditor's office to monitor

1 utilization, accessibility, and quality of care; and ~~that is~~

2 (b) consistent with accepted practices in the health care industry.

3 ~~(10)~~(11) Except for health care providers who are prepaid, the entity shall pay all approved claims for
4 covered services that are correctly completed and submitted to the entity within 30 days after receipt of the claim
5 or receipt of the appropriate capitation payment or payments by the entity from the state for the month in which
6 the services included on the claim were rendered, whichever is later. If payment is not made or mailed to the
7 provider by the entity by the due date under this subsection, an interest penalty of 1% of any amount unpaid must
8 be added for each month or fraction of a month after the due date until final payment is made. This part does not
9 prohibit managed health care entities and health care providers from mutually agreeing to terms that require more
10 timely payment.

11 ~~(11)~~(12) The entity shall seek cooperation with community-based programs provided by local health
12 departments, such as the women, infants, and children food supplement program, childhood immunization
13 programs, health education programs, case management programs, and health screening programs.

14 ~~(12)~~(13) The entity shall seek cooperation with community-based organizations, as defined by rule of the
15 department, that may continue to operate under a contract with the department or a managed health care entity
16 under this part to provide case management services to medicaid clients.

17 ~~(13)~~(14) A managed health care entity that provides written notice pursuant to subsection ~~(4)(e)~~ (5)(c)
18 to an enrollee of medicaid-covered services available from another provider is responsible for payment for those
19 services by another provider.

20 (15) A managed health care entity may not begin operation before the approval of any necessary federal
21 waivers and the completion of the review of an application submitted to the department. The department may
22 charge the applicant an application review fee for the department's actual cost of review of the application. The
23 fee must be adopted by rule by the department. Fees collected by the department must be deposited in an
24 account in the special revenue fund to be used by the department to defray the cost of application review."

25

26 **Section 9.** Section 53-6-707, MCA, is amended to read:

27 **"53-6-707. Payment reductions and adjustments -- freedom to contract.** (1) The department shall
28 by rule establish a method to reduce its payments to managed health care entities to take the following into
29 consideration:

30 (a) any adjustment payments paid to health care facilities under subsection (2)(b) to the extent that those

1 payments or any part of those payments have been taken into account in establishing capitated rates under
2 53-6-705; and

3 (b) the implementation of methodologies to limit financial liability for managed health care entities under
4 53-6-705.

5 (2) For key services provided by a hospital or nursing home that contracts with an entity, adjustment
6 payments that are not included in capitated rates must be paid directly to the hospital or nursing home by the
7 department. Adjustment payments ~~may~~ include but ~~need not be~~ are not limited to:

8 (a) adjustment payments to disproportionate share hospitals as defined by department rule;

9 (b) perinatal center payments; ~~and~~

10 (c) payments for ~~capital~~, direct medical education, indirect medical education, and certified registered
11 nurse anesthetists;

12 (d) supplemental medicaid payments to hospitals made pursuant to 53-6-149; and

13 (e) supplemental medicaid payments to nursing homes made pursuant to 15-60-211.

14 (3) For any hospital or nursing home eligible for the adjustment payments described in this section, the
15 department shall maintain, through the period ending June 30, 1996, reimbursement levels in accordance with
16 statutes and rules in effect at the time the payments are made.

17 (4) The department may not assign an existing agreement with a medicaid provider to a managed health
18 care entity. The managed health care entity shall enter into a new agreement with a provider in order for the
19 provider to be considered a part of the managed health care entity's network of providers.

20 ~~(4)(5)~~ This part does not limit or otherwise impair the authority of the department to enter into a contract,
21 negotiated pursuant to this part, with a managed health care entity, including a health maintenance organization,
22 that provides for termination or nonrenewal of the contract without cause upon notice as provided in the contract
23 and without a hearing. If available funds are not sufficient to provide medical assistance for all eligible persons,
24 the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the
25 medical services made available under the Montana medicaid program and managed care."
26

27 **Section 10.** Section 53-21-701, MCA, is amended to read:

28 **"53-21-701. Mental health managed care allowed -- contract.** (1) The department of public health and
29 human services may contract with one or more persons for the management of comprehensive mental health
30 services for medicaid recipients, as provided in 53-6-116, and for persons in households not eligible for medicaid

1 with family income that does not exceed 160% of the federal poverty threshold or that does not exceed a lesser
2 amount determined in the discretion of the department. The department shall determine whether or not a potential
3 contractor that will serve medicaid enrollees is a managed health care ~~community network~~ entity, as defined in
4 53-6-702, prior to entering into a contract and shall ensure that each contractor that qualifies as a managed health
5 care ~~community network~~ entity complies with the provisions of Title 53, chapter 6, part 7, for the medicaid portion
6 of the program.

7 (2) A managed care system is a program organized to serve the mental health needs of recipients in an
8 efficient and cost-effective manner by managing the receipt of comprehensive mental health care and services
9 for a geographical or otherwise defined population of recipients through appropriate health care professionals.
10 The management of mental health care services must provide for services in the most cost-effective manner
11 through coordination and management of the appropriate level of care and appropriate level of services.

12 (3) The department may enter into one or more contracts with a managed health care entity, ~~as defined~~
13 ~~in 53-6-702~~, for the administration or delivery of mental health services. These contracts may be based upon a
14 fixed monetary amount or a capitated amount for each individual, and a contractor may assume all or a part of
15 the financial risk of providing and making payment for services to a set population of eligible individuals if the
16 contractor has complied with Title 33, chapter 31, and Title 53, chapter 6, part 7. The department may require
17 the participation of recipients in managed care systems based upon geographical, financial, medical, or other
18 factors that the department may determine are relevant to the development and efficient operation of the
19 managed care systems. Any contract for delivery of mental health care services that includes hospitalization or
20 physician services, or both, must include a provision that, prior to final award of a contract, a successful bidder
21 that serves adults shall enter into an agreement regarding the Montana state hospital and the Montana mental
22 health nursing care center that is consistent with 53-1-402, 53-1-413, and 90-7-312 and that includes financial
23 incentives for the development and use of community-based services, rather than the use of the state institutional
24 services.

25 (4) The department shall formally evaluate contract performance with regard to specific outcome
26 measures. The department shall explicitly identify performance and outcome measures that contractors are
27 required to achieve in order to comply with contract requirements and to continue the contract. The contract must
28 provide for progressive intermediate sanctions that may be imposed for nonperformance. The contract
29 performance evaluation must include a section concerning contract enforcement, including any sanctions
30 imposed along with the rationale for not imposing a sanction when the imposition is authorized. The evaluation

1 must be performed at least annually."

2

3 NEW SECTION. **Section 11. Repealer.** The following section of the Montana Code Annotated is

4 repealed:

5 53-6-703. Managed care community network.

6

7 NEW SECTION. **Section 12. Codification instruction.** [Sections 1 and 2] are intended to be codified

8 as an integral part of Title 53, chapter 6, part 7, and the provisions of Title 53, chapter 6, part 7, apply to [sections

9 1 and 2].

10

11 NEW SECTION. **Section 13. Effective date.** [This act] is effective on passage and approval.

12

13 NEW SECTION. **Section 14. Retroactive applicability.** [This act] applies retroactively, within the

14 meaning of 1-2-109, to February 1, 2011.

15

- END -