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

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

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

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

(a) two members appointed by the speaker of the house of representatives, at least one of whom must be a health care provider;

(b) two members appointed by the president of the senate, at least one of whom must be a health care provider; and

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

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

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

(a) hold a public hearing in the geographic area that would be affected by the program or contract in order to:

(i) educate medicaid recipients, health care providers, and the public residing in the area about the provisions of the proposed program or contract and the consumer's options; and

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

(b) submit a report of its findings related to the public comment process to the appropriate interim or

legislative committee, the legislative auditor's office, and the department.

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

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

Section 2. Requests for proposals and contracts -- review requirements -- public notice and comment. (1) Before the department issues a request for proposals or awards a contract for the provision of services through a managed health care entity:

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

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

(i) actuarial soundness;

(ii) network adequacy as provided for in Title 33, chapter 36, part 2; and

(iii) consumer choice; and

(c) within 60 days of receipt of the request for proposal and proposed contract, the legislative auditor's office and state auditor's office shall complete their analyses and publish the findings of their analyses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) The delivery of programs of managed health care services established under Title 53 by a managed health care entity under contract with the department of public health and human services is exempt from the provisions of 33-31-301 and 33-31-321."

Section 5. 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.

(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.

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

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

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

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

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

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

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

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

~~(b) The term does not include a provider of health care services under a contract with the department~~

~~on a fee-for-service basis or a PACE organization, as defined in 42 CFR 460.6, that has received a waiver under 33-31-201.~~

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

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

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

(b) The term does not include:

(i) a provider of health care services under a contract with the department on a fee-for-service basis;

(ii) a medicaid primary care case management service within the meaning of 42 CFR 438; or

(iii) a PACE organization, as defined in 42 CFR 460.6, that has received a waiver under 33-31-201.

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

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

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

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

meets the requirements of the state contract."

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

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

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

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

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

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

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

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

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

~~(5)~~(6) The entity shall provide that enrollees within its system will be informed of the full panel of health care providers. Contracts for the provision of services beyond 125 miles from the borders of Montana may not

be entered into if services of comparable cost and quality are available within the state of Montana.

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

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

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

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

(a) sufficient for the department, the legislative auditor's office, and the state auditor's office to monitor utilization, accessibility, and quality of care; and ~~that is~~

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

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

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

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

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

services by another provider.

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

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

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

(a) any adjustment payments paid to health care facilities under subsection (2)(b) to the extent that those payments or any part of those payments have been taken into account in establishing capitated rates under 53-6-705; and

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

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

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

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

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

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

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

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

(4) The department may not assign an existing agreement with a medicaid provider to a managed health

care entity. The managed health care entity shall enter into a new agreement with a provider in order for the provider to be considered a part of the managed health care entity's network of providers.

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

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

"53-21-701. Mental health managed care allowed -- contract. (1) The department of public health and human services may contract with one or more persons for the management of comprehensive mental health services for medicaid recipients, as provided in 53-6-116, and for persons in households not eligible for medicaid with family income that does not exceed 160% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department. The department shall determine whether or not a potential contractor that will serve medicaid enrollees is a managed health care ~~community network~~ entity, as defined in 53-6-702, prior to entering into a contract and shall ensure that each contractor that qualifies as a managed health care ~~community network~~ entity complies with the provisions of Title 53, chapter 6, part 7, for the medicaid portion of the program.

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

(3) The department may enter into one or more contracts with a managed health care entity~~, as defined in 53-6-702,~~ for the administration or delivery of mental health services. These contracts may be based upon a fixed monetary amount or a capitated amount for each individual, and a contractor may assume all or a part of the financial risk of providing and making payment for services to a set population of eligible individuals if the contractor has complied with Title 33, chapter 31, and Title 53, chapter 6, part 7. The department may require

the participation of recipients in managed care systems based upon geographical, financial, medical, or other factors that the department may determine are relevant to the development and efficient operation of the managed care systems. Any contract for delivery of mental health care services that includes hospitalization or physician services, or both, must include a provision that, prior to final award of a contract, a successful bidder that serves adults shall enter into an agreement regarding the Montana state hospital and the Montana mental health nursing care center that is consistent with 53-1-402, 53-1-413, and 90-7-312 and that includes financial incentives for the development and use of community-based services, rather than the use of the state institutional services.

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

Section 11. Repealer. The following section of the Montana Code Annotated is repealed:

53-6-703. Managed care community network.

Section 12. Codification instruction. [Sections 1 and 2] are intended to be codified as an integral part of Title 53, chapter 6, part 7, and the provisions of Title 53, chapter 6, part 7, apply to [sections 1 and 2].

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

Section 14. Retroactive applicability. [This act] applies retroactively, within the meaning of 1-2-109, to February 1, 2011.

- END -

I hereby certify that the within bill,

SB 0351, originated in the Senate.

Secretary of the Senate

President of the Senate

Signed this _____ day

of _____, 2011.

Speaker of the House

Signed this _____ day

of _____, 2011.

SENATE BILL NO. 351

INTRODUCED BY R. RIPLEY, WANZENRIED, O'HARA, FACEY, CAFERRO, MILBURN, J. PETERSON, TROPILA, KAUFMANN, WINDY BOY, JONES, LEWIS, FLYNN, STAHL, KLOCK

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