SENATE BILL NO. 223

INTRODUCED BY [signature]

BY REQUEST OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

[signature] [signature]

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO MANAGED CARE MENTAL HEALTH SERVICES PROVIDED UNDER THE MONTANA MEDICAID PROGRAM; PROVIDING FOR THE AWARD, MANAGEMENT, PAYMENT, AND AVAILABILITY OF THOSE SERVICES; PROVIDING FOR EXCEPTIONS TO LAWS GOVERNING INSURANCE CONTRACTS AND HEALTH MAINTENANCE ORGANIZATIONS; PROVIDING FOR ELIGIBILITY DETERMINATIONS AND LIMITATIONS; REVISING THE PROCEDURES FOR VOLUNTARY ADMISSION TO THE MONTANA STATE HOSPITAL; AMENDING SECTIONS 33-1-102, 33-31-202, 33-31-301, 53-1-401, 53-1-402, 53-1-413, 53-2-603, 53-6-131, 53-6-132, 53-21-111, AND 53-21-206, MCA."

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

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

"**33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance organizations -- governmental insurance programs.** (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 to the extent that the existence and operations of those organizations are authorized by chapter 31.

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

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

~~(6)~~(7) This code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8.

~~(7)~~(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided for in 2-9-202.

~~(8)~~(9) (a) 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) 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."

Section 2. Section 33-31-202, MCA, is amended to read:

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

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

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

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

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

(ii) the adequacy of working capital;

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

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

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

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

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

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

(2) The commissioner may ~~in his discretion~~ deny a certificate of authority only if ~~he complies with~~ the requirements of 33-31-404 are complied with."

Section 3. Section 33-31-301, MCA, is amended to read:

"**33-31-301. Evidence of coverage -- schedule of charges for health care services.** (1) ~~Every~~ Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence

of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area;.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and

nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or ~~his~~ the enrollee's dependents;

(f) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for ~~such~~ treatment and referral services, the enrollee's designated provider ~~must~~ shall limit ~~his~~ treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(f) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(g) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is ~~hereby~~ amended to conform to the minimum requirements of those statutes."

(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, ~~his~~ dependents, or family members continuing coverage on the enrollee, ~~his~~ dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, ~~his~~ dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of ~~his~~ membership in the class or classes eligible for coverage under the policy or because ~~his~~ the employer discontinues ~~his~~ the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months

preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or ~~his~~ dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee ~~must~~ may not be individually determined based on the status of ~~his~~ the enrollee's health.

(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1)

through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, ~~he~~ the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for ~~his~~ the disapproval. The commissioner shall grant a hearing within 30 days after ~~he receives~~ receipt of a written request by the filer.

(8) The commissioner may ~~in his discretion~~ require a health maintenance organization to submit any relevant information ~~he considers~~ considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

Section 4. Section 53-1-401, MCA, is amended to read:

"**53-1-401. Definitions.** As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "All-inclusive rate" means a fixed charge that is computed on a daily basis or on the basis of another time period for inpatients, that is computed on a per visit basis for outpatients, and that is applicable uniformly to each patient without regard to the extent of the services required by the patient and without regard to a distinction between physician services and hospital services.

~~(1)~~ (2) "Ancillary charge" means the expense of providing identifiable, direct, resident services, including but not limited to:

(a) physicians' services;

(b) x-ray and laboratory services;

(c) dental services;

(d) speech-language pathology and audiology services;

(e) occupational and physical therapy;

(f) medical supplies;

(g) prescribed drugs; and

(h) specialized medical equipment.

~~(2)~~ (3) "Care" means the care, treatment, support, maintenance, and other services rendered by the department to a resident.

~~(3)~~ (4) "Department" means the department of corrections and human services provided for in Title 2, chapter 15, part 23.

~~(4)~~ (5) "Financially responsible person" means a spouse of a resident, the natural or adoptive

parents of a resident under 18 years of age, or a guardian or conservator to the extent of the guardian's or conservator's responsibility for the financial affairs of the person who is a resident under applicable Montana law establishing the duties and limitations of guardianships or conservatorships.

~~(5)~~ (6) "Full-time equivalent resident load" means the total daily resident count for the fiscal year divided by the number of days in the year.

~~(6)~~ (7) "Long-term resident" means a resident in an institution listed in 53-1-402 for a continuous period in excess of 120 days. ~~No~~ The absence of a resident from the institution due to a temporary or trial visit may not be counted as interrupting the accrual of the 120 days required to attain the status of a long-term resident.

~~(7)~~ (8) "Per diem" means the gross daily budgeted cost of operating an institution or an individual unit of an institution (including certain contracted medical services, depreciation, and associated department costs but excluding the cost of educational programs, federal grants, ancillary charges, and costs not directly identified with patient care) divided by the full-time equivalent resident load.

~~(8)~~ (9) "Resident" means any person who is receiving care from or who is a resident of an institution listed in 53-1-402.

~~(9)~~ (10) "Third-party resource" means but is not limited to applicable medicare, medicaid, and personal health care benefits."

Section 5. Section 53-1-402, MCA, is amended to read:

"**53-1-402. Residents subject to per diem and ancillary charges.** (1) The department shall assess and collect per diem and ancillary charges for the care of residents in the following institutions:

(a) Montana state hospital;

(b) Montana developmental center;

(c) Montana veterans' home;

(d) eastern Montana veterans' home;

(e) Montana center for the aged;

(f) Eastmont human services center.

(2) This section does not apply to the eastern Montana veterans' home if the department contracts with a private vendor to operate the facility as provided for in 10-2-416.

(3) This section does not apply to residents of the Montana state hospital or to the Montana center

for the aged to the extent that either of these institutions assesses and collects charges through an all-inclusive rate rather than per diem and ancillary charges."

Section 6. Section 53-1-413, MCA, is amended to read:

"**53-1-413. Deposit of payments.** (1) Except as provided in 90-7-220 and subsection (2) of this section, the department shall deposit payments of per diem and ancillary charges in the state treasury to the credit of the general fund.

(2) Payments from the Montana veterans' home ~~shall~~ must be deposited in the federal special revenue fund for the benefit of the home, and payments from the Montana state hospital alcohol program ~~shall~~ must be deposited to an alcohol state special revenue account.

(3) Payments from a managed care contractor, provided for in 53-6-116, for services provided by the Montana state hospital and the Montana center for the aged must be deposited in the state special revenue fund, subject to appropriation by the legislature for the benefit of those institutions."

Section 7. Section 53-2-603, MCA, is amended to read:

"**53-2-603. Award of public assistance determined after investigation.** (1) Upon completion of an investigation, the county board shall determine whether the applicant is eligible for public assistance under the provisions of this title, the type and amount of public assistance ~~he~~ the applicant ~~shall~~ must receive, and the date upon which ~~such~~ the public assistance ~~shall~~ must begin. This subsection does not apply to any form of public assistance managed by a managed care contractor, as provided in 53-6-116, when a determination of eligibility is made by the managed care contractor.

(2) The department, if necessary to conform with the United States Social Security Act, may issue rules to the county welfare departments requiring the use of the declaration method, in ~~such~~ a form ~~as~~ that the department may prescribe, for the purpose of determining eligibility, regardless of any other investigative provisions under this title, and for all types of assistance. These rules may include any additional investigations the department may require."

Section 8. Section 53-6-131, MCA, is amended to read:

"**53-6-131. Eligibility requirements.** (1) Medical assistance under the Montana medicaid program may be granted to a person who is determined by the department of social and rehabilitation services, in

its discretion, to be eligible as follows:

(a) The person receives or is considered to be receiving supplemental security income benefits under Title XVI of the federal Social Security Act (42 U.S.C. 1381, et seq.) or aid to families with dependent children under Title IV of the federal Social Security Act (42 U.S.C. 601, et seq.).

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

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

(d) The person is under 19 years of age and meets the conditions of eligibility in the state plan for aid to families with dependent children, other than with respect to school attendance.

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

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

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

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

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

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

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

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

(3) The Montana medicaid program shall pay, as required by federal law, the premiums necessary for medicaid-eligible persons participating in the medicare program and may, within the discretion of the

department, pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified medicare-eligible person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, who:

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

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

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

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

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

(7) A person described in subsection (6) must be provided continuous eligibility for medical assistance, as authorized in 42 U.S.C. 1396a(e)(5) through a(e)(7).

(8) The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards for eligibility for mental health services may provide for eligibility for households with family income that does not exceed 200% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department. The department may by rule specify under what circumstances deductions for medical expenses should be used to reduce countable family income in determining eligibility. The department may also adopt rules establishing fees to be charged recipients for services. The fees may vary according to family income."

Section 9. Section 53-6-132, MCA, is amended to read:

"**53-6-132. Application for assistance -- exception.** (1) ~~Application~~ Except as provided in

subsection (2), application for assistance under this part ~~shall~~ must be made to the office of the county department in the county in which the person is residing. The application ~~shall~~ must be presented in the manner and on the form prescribed by the department of social and rehabilitation services. All individuals wishing to apply ~~shall~~ have the opportunity to do so.

(2) Notwithstanding the provisions of subsection (1), the department may designate an entity other than the county department to determine eligibility for medicaid managed care services."

Section 10. Section 53-21-111, MCA, is amended to read:

"**53-21-111. Voluntary admission.** (1) Nothing in this part may be construed ~~in any way as limiting~~ to limit the right of any person to make voluntary application for admission at any time to any mental health facility or professional person. An application for admission to a mental health facility ~~shall~~ must be in writing on a form prescribed by the facility and approved by the department. ~~It~~ An application is not valid unless it is approved by a professional person and a copy is given to the person being voluntarily ~~admitting himself~~ admitted. A statement of the rights of the person voluntarily applying for admission, as set out in this part, including the right to release, ~~shall~~ must be furnished to the patient within 12 hours.

(2) Any applicant who wishes to voluntarily apply for admission to the state hospital shall first obtain certification from a professional person that the applicant is suffering from a mental disorder. The professional person ~~must~~ shall then obtain confirmation from ~~a community mental health center~~ the department or the department's designee that the facilities available to the mental health region in which the applicant resides are unable to provide adequate evaluation and treatment. The department shall adopt rules to establish a procedure whereby a professional person shall obtain the confirmation from ~~a community mental health center~~ the department or the department's designee as required in this section.

(3) An application for voluntary admission ~~shall~~ must give the facility the right to detain the applicant for no more than 5 days, excluding weekends and holidays, past ~~his~~ the applicant's written request for release. A mental health facility may adopt rules providing for detention of the applicant for less than 5 days. The facility ~~must~~ shall notify all applicants of ~~such~~ the rules and post ~~such~~ the rules as provided in 53-21-168.

(4) Any person voluntarily entering or remaining in any mental health facility shall enjoy all the rights secured to a person involuntarily committed to the facility."

Section 11. Section 53-21-206, MCA, is amended to read:

"**53-21-206. Availability of services.** (1) The services of the department and of the incorporated regional mental health centers are available without discrimination on the basis of race, color, creed, religion, or ability to pay and shall comply with Title VI of the Civil Rights Act of 1964.

(2) Services available to individuals unable to pay for the services may be limited by the department based upon availability of funding."

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0223, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:
A bill relating to managed care mental health services provided under the Montana Medicaid program.

ASSUMPTIONS:

1. Eligibility for mental health benefits for children and adults under the managed care system will be expanded to those with annual gross incomes less than 200% of poverty.
2. A federal waiver will be granted to Montana by the federal Health Care Financing Administration (HCFA) to implement this program. Upon approval of the waiver, Medicaid federal funds will become available for reimbursement for services provided at Montana State Hospital (MSH) and the Center for the Aged (CFA).
3. The waiver request will be approved in time for the program to be implemented July 1, 1996.
4. Medicaid services are funded at the FMAP matching rate of 30.26% general fund and 69.74% federal funds in FY96 and 31.00% general fund and 69.00% federal funds in FY97.
5. The Executive Budget present law base contains anticipated savings of $622,789 (where $188,456 is general fund and $434,333 is federal funds) during FY96 and $701,628 (where $217,393 is general fund and $484,235 is federal funds) during FY97 due to implementation of managed care mental health. However, delays in getting approval of the waiver and getting the program started will delay implementation to FY97. Regardless of whether this legislation passes or fails, the savings for FY96 will need to be added back into the Medicaid primary care budget, since these savings will not be realized. If this proposed legislation does not pass, then the savings for FY97 will also need to be added back into the Medicaid primary care budget, since those savings will not be realized either.
6. An Executive Budget new proposal regarding Medicaid primary care reflects an additional anticipated savings of $2,100,000 general fund during FY97. This is an impact in addition to the Executive Budget present law base discussed in assumption 5 above, and is shown below as a reduction in expenditures in FY97.
7. The Department of Corrections and Human Services (DCHS) assumes the managed care contractor would guarantee a specific number of beds which would be used at MSH and at CFA, and be reimbursed through the managed care mental health contract during the next five years. The number of beds is still to be negotiated.
8. In FY97, DCHS would transfer $36,950,019 general fund and $1,023,073 in federal funds to SRS which would contract for and reimburse mental health services on behalf of DCHS.
9. In the event that this legislation is passed and the waiver is received, DCHS will need $20,773,720 in state special revenue spending authority in FY97 in order to receive payments from the managed care contractor.

(continued)

Dave Lewis 1-30-95

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Keating

TOM KEATING, PRIMARY SPONSOR DATE

10. The expenditures shown below would be included in HB2 as a line item with language included that states in the event the waiver is delayed or not approved, the savings reflected in FY97 will be adjusted or added back to the primary care budget, since the mechanism for generating the savings will not exist. (Please see assumptions 5, 6 and 9 above.)

FISCAL IMPACT:

	FY96 Difference	FY97 Difference
Expenditures:		
Medicaid Primary Care Benefits	622,789	(2,801,628)
Funding:		
General Fund	188,456	(2,317,393)
Federal Fund	434,333	(484,235)
Total Funds	622,789	(2,801,628)
Net Impact:		
General Fund Cost/(Savings)	188,456	(2,317,393)

APPROVED BY COM ON PUBLIC HEALTH, WELFARE & SAFETY

SENATE BILL NO. 223

INTRODUCED BY

BY REQUEST OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

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SECOND READING

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

~~(6)~~(7) This code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8.

~~(7)~~(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided for in 2-9-202.

~~(8)~~(9) (a) 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) 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."

Section 2. Section 33-31-202, MCA, is amended to read:

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

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

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

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

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

(ii) the adequacy of working capital;

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

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

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

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

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

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

(2) The commissioner may ~~in his discretion~~ deny a certificate of authority only if ~~he complies with~~ the requirements of 33-31-404 are complied with."

Section 3. Section 33-31-301, MCA, is amended to read:

"**33-31-301. Evidence of coverage -- schedule of charges for health care services.** (1) ~~Every~~ Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence

of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area;

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and

nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or ~~his~~ the enrollee's dependents;

(f) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for ~~such~~ treatment and referral services, the enrollee's designated provider ~~must~~ shall limit ~~his~~ treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(f) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(g) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is ~~hereby~~ amended to conform to the minimum requirements of those statutes."

(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, ~~his~~ dependents, or family members continuing coverage on the enrollee, ~~his~~ dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, ~~his~~ dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of ~~his~~ membership in the class or classes eligible for coverage under the policy or because ~~his~~ the employer discontinues ~~his~~ the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months

preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or ~~his~~ dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee ~~must~~ may not be individually determined based on the status of ~~his~~ the enrollee's health.

(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1)

through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, ~~he~~ the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for ~~his~~ the disapproval. The commissioner shall grant a hearing within 30 days after ~~he receives~~ receipt of a written request by the filer.

(8) The commissioner may ~~in his discretion~~ require a health maintenance organization to submit any relevant information ~~he considers~~ considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

Section 4. Section 53-1-401, MCA, is amended to read:

"**53-1-401. Definitions.** As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "All-inclusive rate" means a fixed charge that is computed on a daily basis or on the basis of another time period for inpatients, that is computed on a per visit basis for outpatients, and that is applicable uniformly to each patient without regard to the extent of the services required by the patient and without regard to a distinction between physician services and hospital services.

~~(1)~~ (2) "Ancillary charge" means the expense of providing identifiable, direct, resident services, including but not limited to:

(a) physicians' services;

(b) x-ray and laboratory services;

(c) dental services;

(d) speech-language pathology and audiology services;

(e) occupational and physical therapy;

(f) medical supplies;

(g) prescribed drugs; and

(h) specialized medical equipment.

~~(2)~~ (3) "Care" means the care, treatment, support, maintenance, and other services rendered by the department to a resident.

~~(3)~~ (4) "Department" means the department of corrections and human services provided for in Title 2, chapter 15, part 23.

~~(4)~~ (5) "Financially responsible person" means a spouse of a resident, the natural or adoptive

parents of a resident under 18 years of age, or a guardian or conservator to the extent of the guardian's or conservator's responsibility for the financial affairs of the person who is a resident under applicable Montana law establishing the duties and limitations of guardianships or conservatorships.

~~(5)~~ (6) "Full-time equivalent resident load" means the total daily resident count for the fiscal year divided by the number of days in the year.

~~(6)~~ (7) "Long-term resident" means a resident in an institution listed in 53-1-402 for a continuous period in excess of 120 days. ~~No~~ The absence of a resident from the institution due to a temporary or trial visit may not be counted as interrupting the accrual of the 120 days required to attain the status of a long-term resident.

~~(7)~~ (8) "Per diem" means the gross daily budgeted cost of operating an institution or an individual unit of an institution (including certain contracted medical services, depreciation, and associated department costs but excluding the cost of educational programs, federal grants, ancillary charges, and costs not directly identified with patient care) divided by the full-time equivalent resident load.

~~(8)~~ (9) "Resident" means any person who is receiving care from or who is a resident of an institution listed in 53-1-402.

~~(9)~~ (10) "Third-party resource" means but is not limited to applicable medicare, medicaid, and personal health care benefits."

Section 5. Section 53-1-402, MCA, is amended to read:

"53-1-402. Residents subject to per diem and ancillary charges. (1) The department shall assess and collect per diem and ancillary charges for the care of residents in the following institutions:

(a) Montana state hospital;

(b) Montana developmental center;

(c) Montana veterans' home;

(d) eastern Montana veterans' home;

(e) Montana center for the aged;

(f) Eastmont human services center.

(2) This section does not apply to the eastern Montana veterans' home if the department contracts with a private vendor to operate the facility as provided for in 10-2-416.

(3) This section does not apply to residents of the Montana state hospital or to the Montana center

for the aged to the extent that either of these institutions assesses and collects charges through an all-inclusive rate rather than per diem and ancillary charges."

Section 6. Section 53-1-413, MCA, is amended to read:

"**53-1-413. Deposit of payments.** (1) Except as provided in 90-7-220 and subsection (2) of this section, the department shall deposit payments of per diem and ancillary charges in the state treasury to the credit of the general fund.

(2) Payments from the Montana veterans' home ~~shall~~ must be deposited in the federal special revenue fund for the benefit of the home, and payments from the Montana state hospital alcohol program ~~shall~~ must be deposited to an alcohol state special revenue account.

(3) Payments from a managed care contractor, provided for in 53-6-116, for services provided by the Montana state hospital and the Montana center for the aged must be deposited in the state special revenue fund, subject to appropriation by the legislature for the benefit of those institutions."

Section 7. Section 53-2-603, MCA, is amended to read:

"**53-2-603. Award of public assistance determined after investigation.** (1) Upon completion of an investigation, the county board shall determine whether the applicant is eligible for public assistance under the provisions of this title, the type and amount of public assistance ~~he~~ the applicant ~~shall~~ must receive, and the date upon which ~~such~~ the public assistance ~~shall~~ must begin. This subsection does not apply to any form of public assistance managed by a managed care contractor, as provided in 53-6-116, when a determination of eligibility is made by the managed care contractor.

(2) The department, if necessary to conform with the United States Social Security Act, may issue rules to the county welfare departments requiring the use of the declaration method, in ~~such~~ a form ~~as~~ that the department may prescribe, for the purpose of determining eligibility, regardless of any other investigative provisions under this title, and for all types of assistance. These rules may include any additional investigations the department may require."

Section 8. Section 53-6-131, MCA, is amended to read:

"**53-6-131. Eligibility requirements.** (1) Medical assistance under the Montana medicaid program may be granted to a person who is determined by the department of social and rehabilitation services, in

its discretion, to be eligible as follows:

(a) The person receives or is considered to be receiving supplemental security income benefits under Title XVI of the federal Social Security Act (42 U.S.C. 1381, et seq.) or aid to families with dependent children under Title IV of the federal Social Security Act (42 U.S.C. 601, et seq.).

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

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

(d) The person is under 19 years of age and meets the conditions of eligibility in the state plan for aid to families with dependent children, other than with respect to school attendance.

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

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

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

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

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

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

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

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

(3) The Montana medicaid program shall pay, as required by federal law, the premiums necessary for medicaid-eligible persons participating in the medicare program and may, within the discretion of the

department, pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified medicare-eligible person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, who:

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

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

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

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

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

(7) A person described in subsection (6) must be provided continuous eligibility for medical assistance, as authorized in 42 U.S.C. 1396a(e)(5) through a(e)(7).

(8) The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards for eligibility for mental health services may provide for eligibility for households with family income that does not exceed 200% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department. The department may by rule specify under what circumstances deductions for medical expenses should be used to reduce countable family income in determining eligibility. The department may also adopt rules establishing fees to be charged recipients for services. The fees may vary according to family income."

Section 9. Section 53-6-132, MCA, is amended to read:

"**53-6-132. Application for assistance -- exception.** (1) ~~Application~~ Except as provided in

subsection (2), application for assistance under this part ~~shall~~ must be made to the office of the county department in the county in which the person is residing. The application ~~shall~~ must be presented in the manner and on the form prescribed by the department of social and rehabilitation services. All individuals wishing to apply ~~shall~~ have the opportunity to do so.

(2) Notwithstanding the provisions of subsection (1), the department may designate an entity other than the county department to determine eligibility for medicaid managed care services."

Section 10. Section 53-21-111, MCA, is amended to read:

"**53-21-111. Voluntary admission.** (1) Nothing in this part may be construed ~~in any way as limiting~~ to limit the right of any person to make voluntary application for admission at any time to any mental health facility or professional person. An application for admission to a mental health facility ~~shall~~ must be in writing on a form prescribed by the facility and approved by the department. ~~It~~ An application is not valid unless it is approved by a professional person and a copy is given to the person being voluntarily ~~admitting himself~~ admitted. A statement of the rights of the person voluntarily applying for admission, as set out in this part, including the right to release, ~~shall~~ must be furnished to the patient within 12 hours.

(2) Any applicant who wishes to voluntarily apply for admission to the state hospital shall first obtain certification from a professional person that the applicant is suffering from a mental disorder. The professional person ~~must~~ shall then obtain confirmation from ~~a community mental health center~~ the department or the department's designee that the facilities available to the mental health region in which the applicant resides are unable to provide adequate evaluation and treatment. The department shall adopt rules to establish a procedure whereby a professional person shall obtain the confirmation from ~~a community mental health center~~ the department or the department's designee as required in this section.

(3) An application for voluntary admission ~~shall~~ must give the facility the right to detain the applicant for no more than 5 days, excluding weekends and holidays, past ~~his~~ the applicant's written request for release. A mental health facility may adopt rules providing for detention of the applicant for less than 5 days. The facility ~~must~~ shall notify all applicants of ~~such~~ the rules and post ~~such~~ the rules as provided in 53-21-168.

(4) Any person voluntarily entering or remaining in any mental health facility shall enjoy all the rights secured to a person involuntarily committed to the facility."

Section 11. Section 53-21-206, MCA, is amended to read:

"53-21-206. Availability of services. (1) The services of the department and of the incorporated regional mental health centers are available without discrimination on the basis of race, color, creed, religion, or ability to pay and shall comply with Title VI of the Civil Rights Act of 1964.

(2) Services available to individuals unable to pay for the services may be limited by the department based upon availability of funding."

-END-

SENATE BILL NO. 223

INTRODUCED BY

BY REQUEST OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO MANAGED CARE MENTAL HEALTH SERVICES PROVIDED UNDER THE MONTANA MEDICAID PROGRAM; PROVIDING FOR THE AWARD, MANAGEMENT, PAYMENT, AND AVAILABILITY OF THOSE SERVICES; PROVIDING FOR EXCEPTIONS TO LAWS GOVERNING INSURANCE CONTRACTS AND HEALTH MAINTENANCE ORGANIZATIONS; PROVIDING FOR ELIGIBILITY DETERMINATIONS AND LIMITATIONS; REVISING THE PROCEDURES FOR VOLUNTARY ADMISSION TO THE MONTANA STATE HOSPITAL; AMENDING SECTIONS 33-1-102, 33-31-202, 33-31-301, 53-1-401, 53-1-402, 53-1-413, 53-2-603, 53-6-131, 53-6-132, 53-21-111, AND 53-21-206, MCA."

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

THERE ARE NO CHANGES IN THIS BILL AND IT WILL NOT BE REPRINTED. PLEASE REFER TO SECOND READING COPY (YELLOW) FOR COMPLETE TEXT.

HOUSE COMMITTEE OF THE WHOLE AMENDMENT

Senate Bill 223
Representative Cobb

March 29, 1995 7:29 am

Mr. Chairman: I move to amend **Senate Bill 223** (third reading copy -- blue).

Signed: Cobb
Representative Cobb

And, that such amendments to Senate Bill 223 read as follows:

1. Page 11, lines 20 through 24.
Following: "(8)" on line 20
Strike: remainder of line 20 through "." on line 24

-END-

ADOPT 54-14 1

REJECT

SB 223

HOUSE

SENATE BILL NO. 223

INTRODUCED BY KEATING, WATERMAN, SIMON, BECK, SWYSGOOD, BURNETT, T. NELSON

BY REQUEST OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO MANAGED CARE MENTAL HEALTH SERVICES PROVIDED UNDER THE MONTANA MEDICAID PROGRAM; PROVIDING FOR THE AWARD, MANAGEMENT, PAYMENT, AND AVAILABILITY OF THOSE SERVICES; PROVIDING FOR EXCEPTIONS TO LAWS GOVERNING INSURANCE CONTRACTS AND HEALTH MAINTENANCE ORGANIZATIONS; PROVIDING FOR ELIGIBILITY DETERMINATIONS AND LIMITATIONS; REVISING THE PROCEDURES FOR VOLUNTARY ADMISSION TO THE MONTANA STATE HOSPITAL; AMENDING SECTIONS 33-1-102, 33-31-202, 33-31-301, 53-1-401, 53-1-402, 53-1-413, 53-2-603, 53-6-131, 53-6-132, 53-21-111, AND 53-21-206, MCA."

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

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

"**33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance organizations -- governmental insurance programs.** (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 to the extent that the existence and operations of those organizations are authorized by chapter 31.

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

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

~~(6)~~(7) This code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8.

~~(7)~~(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided for in 2-9-202.

~~(8)~~(9) (a) 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) 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."

Section 2. Section 33-31-202, MCA, is amended to read:

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

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

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

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

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

(ii) the adequacy of working capital;

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

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

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

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

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

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

(2) The commissioner may ~~in his discretion~~ deny a certificate of authority only if ~~he complies with~~ the requirements of 33-31-404 are complied with."

Section 3. Section 33-31-301, MCA, is amended to read:

"**33-31-301. Evidence of coverage -- schedule of charges for health care services.** (1) ~~Every~~ Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence

of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area~~;~~.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and

nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or ~~his~~ the enrollee's dependents;

(f) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for ~~such~~ treatment and referral services, the enrollee's designated provider ~~must~~ shall limit ~~his~~ treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(f) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(g) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is ~~hereby~~ amended to conform to the minimum requirements of those statutes."

(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, ~~his~~ dependents, or family members continuing coverage on the enrollee, ~~his~~ dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, ~~his~~ dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of ~~his~~ membership in the class or classes eligible for coverage under the policy or because ~~his~~ the employer discontinues ~~his~~ the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months

preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or ~~his~~ dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee ~~must~~ may not be individually determined based on the status of ~~his~~ the enrollee's health.

(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1)

through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, ~~he~~ the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for ~~his~~ the disapproval. The commissioner shall grant a hearing within 30 days after ~~he receives~~ receipt of a written request by the filer.

(8) The commissioner may ~~in his discretion~~ require a health maintenance organization to submit any relevant information ~~he considers~~ considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

Section 4. Section 53-1-401, MCA, is amended to read:

"53-1-401. Definitions. As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "All-inclusive rate" means a fixed charge that is computed on a daily basis or on the basis of another time period for inpatients, that is computed on a per visit basis for outpatients, and that is applicable uniformly to each patient without regard to the extent of the services required by the patient and without regard to a distinction between physician services and hospital services.

~~(1)~~ (2) "Ancillary charge" means the expense of providing identifiable, direct, resident services, including but not limited to:

(a) physicians' services;

(b) x-ray and laboratory services;

(c) dental services;

(d) speech-language pathology and audiology services;

(e) occupational and physical therapy;

(f) medical supplies;

(g) prescribed drugs; and

(h) specialized medical equipment.

~~(2)~~ (3) "Care" means the care, treatment, support, maintenance, and other services rendered by the department to a resident.

~~(3)~~ (4) "Department" means the department of corrections and human services provided for in Title 2, chapter 15, part 23.

~~(4)~~ (5) "Financially responsible person" means a spouse of a resident, the natural or adoptive

parents of a resident under 18 years of age, or a guardian or conservator to the extent of the guardian's or conservator's responsibility for the financial affairs of the person who is a resident under applicable Montana law establishing the duties and limitations of guardianships or conservatorships.

~~(5)~~ (6) "Full-time equivalent resident load" means the total daily resident count for the fiscal year divided by the number of days in the year.

~~(6)~~ (7) "Long-term resident" means a resident in an institution listed in 53-1-402 for a continuous period in excess of 120 days. ~~No~~ The absence of a resident from the institution due to a temporary or trial visit may not be counted as interrupting the accrual of the 120 days required to attain the status of a long-term resident.

~~(7)~~ (8) "Per diem" means the gross daily budgeted cost of operating an institution or an individual unit of an institution (including certain contracted medical services, depreciation, and associated department costs but excluding the cost of educational programs, federal grants, ancillary charges, and costs not directly identified with patient care) divided by the full-time equivalent resident load.

~~(8)~~ (9) "Resident" means any person who is receiving care from or who is a resident of an institution listed in 53-1-402.

~~(9)~~ (10) "Third-party resource" means but is not limited to applicable medicare, medicaid, and personal health care benefits."

Section 5. Section 53-1-402, MCA, is amended to read:

"**53-1-402. Residents subject to per diem and ancillary charges.** (1) The department shall assess and collect per diem and ancillary charges for the care of residents in the following institutions:

(a) Montana state hospital;

(b) Montana developmental center;

(c) Montana veterans' home;

(d) eastern Montana veterans' home;

(e) Montana center for the aged;

(f) Eastmont human services center.

(2) This section does not apply to the eastern Montana veterans' home if the department contracts with a private vendor to operate the facility as provided for in 10-2-416.

(3) This section does not apply to residents of the Montana state hospital or to the Montana center

for the aged to the extent that either of these institutions assesses and collects charges through an all-inclusive rate rather than per diem and ancillary charges."

Section 6. Section 53-1-413, MCA, is amended to read:

"**53-1-413. Deposit of payments.** (1) Except as provided in 90-7-220 and subsection (2) of this section, the department shall deposit payments of per diem and ancillary charges in the state treasury to the credit of the general fund.

(2) Payments from the Montana veterans' home ~~shall~~ must be deposited in the federal special revenue fund for the benefit of the home, and payments from the Montana state hospital alcohol program ~~shall~~ must be deposited to an alcohol state special revenue account.

(3) Payments from a managed care contractor, provided for in 53-6-116, for services provided by the Montana state hospital and the Montana center for the aged must be deposited in the state special revenue fund, subject to appropriation by the legislature for the benefit of those institutions."

Section 7. Section 53-2-603, MCA, is amended to read:

"**53-2-603. Award of public assistance determined after investigation.** (1) Upon completion of an investigation, the county board shall determine whether the applicant is eligible for public assistance under the provisions of this title, the type and amount of public assistance ~~he~~ the applicant ~~shall~~ must receive, and the date upon which ~~such~~ the public assistance ~~shall~~ must begin. This subsection does not apply to any form of public assistance managed by a managed care contractor, as provided in 53-6-116, when a determination of eligibility is made by the managed care contractor.

(2) The department, if necessary to conform with the United States Social Security Act, may issue rules to the county welfare departments requiring the use of the declaration method, in ~~such~~ a form ~~as~~ that the department may prescribe, for the purpose of determining eligibility, regardless of any other investigative provisions under this title, and for all types of assistance. These rules may include any additional investigations the department may require."

Section 8. Section 53-6-131, MCA, is amended to read:

"**53-6-131. Eligibility requirements.** (1) Medical assistance under the Montana medicaid program may be granted to a person who is determined by the department of social and rehabilitation services, in

its discretion, to be eligible as follows:

(a) The person receives or is considered to be receiving supplemental security income benefits under Title XVI of the federal Social Security Act (42 U.S.C. 1381, et seq.) or aid to families with dependent children under Title IV of the federal Social Security Act (42 U.S.C. 601, et seq.).

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

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

(d) The person is under 19 years of age and meets the conditions of eligibility in the state plan for aid to families with dependent children, other than with respect to school attendance.

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

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

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

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

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

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

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

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

(3) The Montana medicaid program shall pay, as required by federal law, the premiums necessary for medicaid-eligible persons participating in the medicare program and may, within the discretion of the

department, pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified medicare-eligible person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, who:

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

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

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

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

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

(7) A person described in subsection (6) must be provided continuous eligibility for medical assistance, as authorized in 42 U.S.C. 1396a(e)(5) through a(e)(7).

(8) ~~The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards for eligibility for mental health services may provide for eligibility for households with family income that does not exceed 200% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department.~~ The department may by rule specify under what circumstances deductions for medical expenses should be used to reduce countable family income in determining eligibility. The department may also adopt rules establishing fees to be charged recipients for services. The fees may vary according to family income."

Section 9. Section 53-6-132, MCA, is amended to read:

"**53-6-132. Application for assistance -- exception.** (1) ~~Application~~ Except as provided in

subsection (2), application for assistance under this part ~~shall~~ must be made to the office of the county department in the county in which the person is residing. The application ~~shall~~ must be presented in the manner and on the form prescribed by the department of social and rehabilitation services. All individuals wishing to apply ~~shall~~ have the opportunity to do so.

(2) Notwithstanding the provisions of subsection (1), the department may designate an entity other than the county department to determine eligibility for medicaid managed care services."

Section 10. Section 53-21-111, MCA, is amended to read:

"**53-21-111. Voluntary admission.** (1) Nothing in this part may be construed ~~in any way as limiting~~ to limit the right of any person to make voluntary application for admission at any time to any mental health facility or professional person. An application for admission to a mental health facility ~~shall~~ must be in writing on a form prescribed by the facility and approved by the department. ~~It~~ An application is not valid unless it is approved by a professional person and a copy is given to the person being voluntarily ~~admitting himself~~ admitted. A statement of the rights of the person voluntarily applying for admission, as set out in this part, including the right to release, ~~shall~~ must be furnished to the patient within 12 hours.

(2) Any applicant who wishes to voluntarily apply for admission to the state hospital shall first obtain certification from a professional person that the applicant is suffering from a mental disorder. The professional person ~~must~~ shall then obtain confirmation from ~~a community mental health center~~ the department or the department's designee that the facilities available to the mental health region in which the applicant resides are unable to provide adequate evaluation and treatment. The department shall adopt rules to establish a procedure whereby a professional person shall obtain the confirmation from a ~~community mental health center~~ the department or the department's designee as required in this section.

(3) An application for voluntary admission ~~shall~~ must give the facility the right to detain the applicant for no more than 5 days, excluding weekends and holidays, past ~~his~~ the applicant's written request for release. A mental health facility may adopt rules providing for detention of the applicant for less than 5 days. The facility ~~must~~ shall notify all applicants of ~~such~~ the rules and post ~~such~~ the rules as provided in 53-21-168.

(4) Any person voluntarily entering or remaining in any mental health facility shall enjoy all the rights secured to a person involuntarily committed to the facility."

Section 11. Section 53-21-206, MCA, is amended to read:

"**53-21-206. Availability of services.** (1) The services of the department and of the incorporated regional mental health centers are available without discrimination on the basis of race, color, creed, religion, or ability to pay and shall comply with Title VI of the Civil Rights Act of 1964.

(2) Services available to individuals unable to pay for the services may be limited by the department based upon availability of funding."

-END-

Conference Committee
on SB 223
Report No. 1, April 7, 1995

Mr. President and Mr. Speaker:

We, your Conference Committee on SB 223, met April 7, 1995, and considered:

House Committee of the Whole amendment to the third reading copy dated March 29, 1995.

We recommend that SB 223 (reference copy - salmon) be amended as follows:

1. Page 11, line 24.
Following: "~~department.~~"
Insert: "The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards for eligibility for mental health services may provide for eligibility for households with family income that does not exceed 200% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department."

And that this Conference Committee report be adopted.

For the Senate:

Keating
Chair

Baer

Waterman

Amd. Coord.

Sec. of Senate

For the House:

Royal Johnson
Chair

Soft

Barnhart

SB 223
CCR#1

ADOPT

REJECT

801459CC.SPV

Free Conference Committee
on SB 223
Report No. 1, April 12, 1995

Mr. President and Mr. Speaker:

We, your Free Conference Committee on SB 223, met and considered:

SB 223 in its entirety

We recommend that SB 223 (reference copy as amended - salmon) be amended as follows:

1. Page 11, line 24.
Following: "~~department.~~"
Insert: "The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards for eligibility for mental health services may provide for eligibility for households with family income that does not exceed 200% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department."

And that this Free Conference Committee report be adopted.

For the Senate:

Keating
Chair

Baer

Waterman

Amd. Coord.

Sec. of Senate

For the House:

R. Johnson
Chair

Soft

Barnhart

ADOPT

REJECT

SB 223
FCCR #1
841716CC.SPV

SENATE BILL NO. 223

INTRODUCED BY KEATING, WATERMAN, SIMON, BECK, SWYSGOOD, BURNETT, T. NELSON

BY REQUEST OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO MANAGED CARE MENTAL HEALTH SERVICES PROVIDED UNDER THE MONTANA MEDICAID PROGRAM; PROVIDING FOR THE AWARD, MANAGEMENT, PAYMENT, AND AVAILABILITY OF THOSE SERVICES; PROVIDING FOR EXCEPTIONS TO LAWS GOVERNING INSURANCE CONTRACTS AND HEALTH MAINTENANCE ORGANIZATIONS; PROVIDING FOR ELIGIBILITY DETERMINATIONS AND LIMITATIONS; REVISING THE PROCEDURES FOR VOLUNTARY ADMISSION TO THE MONTANA STATE HOSPITAL; AMENDING SECTIONS 33-1-102, 33-31-202, 33-31-301, 53-1-401, 53-1-402, 53-1-413, 53-2-603, 53-6-131, 53-6-132, 53-21-111, AND 53-21-206, MCA."

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

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

"33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance organizations -- governmental insurance programs. (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 to the extent that the existence and operations of those organizations are authorized by chapter 31.

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

REFERENCE BILL: INCLUDES FREE CONFERENCE COMMITTEE REPORT DATED 4-12-95

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

~~(6)~~(7) This code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8.

~~(7)~~(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided for in 2-9-202.

~~(8)~~(9) (a) 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) 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."

Section 2. Section 33-31-202, MCA, is amended to read:

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

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

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

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

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

(ii) the adequacy of working capital;

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

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

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

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

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

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

(2) The commissioner may ~~in his discretion~~ deny a certificate of authority only if ~~he complies with~~ the requirements of 33-31-404 are complied with."

Section 3. Section 33-31-301, MCA, is amended to read:

"**33-31-301. Evidence of coverage -- schedule of charges for health care services.** (1) ~~Every~~ Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence

of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area~~;~~.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and

nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or ~~his~~ the enrollee's dependents;

(f) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for ~~such~~ treatment and referral services, the enrollee's designated provider ~~must~~ shall limit ~~his~~ treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(f) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(g) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is ~~hereby~~ amended to conform to the minimum requirements of those statutes."

(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, ~~his~~ dependents, or family members continuing coverage on the enrollee, ~~his~~ dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, ~~his~~ dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of ~~his~~ membership in the class or classes eligible for coverage under the policy or because ~~his~~ the employer discontinues ~~his~~ the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months

preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or ~~his~~ dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee ~~must~~ may not be individually determined based on the status of ~~his~~ the enrollee's health.

(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1)

through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, ~~he~~ the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for ~~his~~ the disapproval. The commissioner shall grant a hearing within 30 days after ~~he receives~~ receipt of a written request by the filer.

(8) The commissioner may ~~in his discretion~~ require a health maintenance organization to submit any relevant information ~~he considers~~ considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

Section 4. Section 53-1-401, MCA, is amended to read:

"**53-1-401. Definitions.** As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "All-inclusive rate" means a fixed charge that is computed on a daily basis or on the basis of another time period for inpatients, that is computed on a per visit basis for outpatients, and that is applicable uniformly to each patient without regard to the extent of the services required by the patient and without regard to a distinction between physician services and hospital services.

~~(1)~~ (2) "Ancillary charge" means the expense of providing identifiable, direct, resident services, including but not limited to:

(a) physicians' services;

(b) x-ray and laboratory services;

(c) dental services;

(d) speech-language pathology and audiology services;

(e) occupational and physical therapy;

(f) medical supplies;

(g) prescribed drugs; and

(h) specialized medical equipment.

~~(2)~~ (3) "Care" means the care, treatment, support, maintenance, and other services rendered by the department to a resident.

~~(3)~~ (4) "Department" means the department of corrections and human services provided for in Title 2, chapter 15, part 23.

~~(4)~~ (5) "Financially responsible person" means a spouse of a resident, the natural or adoptive

parents of a resident under 18 years of age, or a guardian or conservator to the extent of the guardian's or conservator's responsibility for the financial affairs of the person who is a resident under applicable Montana law establishing the duties and limitations of guardianships or conservatorships.

~~(5)~~ (6) "Full-time equivalent resident load" means the total daily resident count for the fiscal year divided by the number of days in the year.

~~(6)~~ (7) "Long-term resident" means a resident in an institution listed in 53-1-402 for a continuous period in excess of 120 days. ~~No~~ The absence of a resident from the institution due to a temporary or trial visit may not be counted as interrupting the accrual of the 120 days required to attain the status of a long-term resident.

~~(7)~~ (8) "Per diem" means the gross daily budgeted cost of operating an institution or an individual unit of an institution (including certain contracted medical services, depreciation, and associated department costs but excluding the cost of educational programs, federal grants, ancillary charges, and costs not directly identified with patient care) divided by the full-time equivalent resident load.

~~(8)~~ (9) "Resident" means any person who is receiving care from or who is a resident of an institution listed in 53-1-402.

~~(9)~~ (10) "Third-party resource" means but is not limited to applicable medicare, medicaid, and personal health care benefits."

Section 5. Section 53-1-402, MCA, is amended to read:

"**53-1-402. Residents subject to per diem and ancillary charges.** (1) The department shall assess and collect per diem and ancillary charges for the care of residents in the following institutions:

(a) Montana state hospital;

(b) Montana developmental center;

(c) Montana veterans' home;

(d) eastern Montana veterans' home;

(e) Montana center for the aged;

(f) Eastmont human services center.

(2) This section does not apply to the eastern Montana veterans' home if the department contracts with a private vendor to operate the facility as provided for in 10-2-416.

(3) This section does not apply to residents of the Montana state hospital or to the Montana center

for the aged to the extent that either of these institutions assesses and collects charges through an all-inclusive rate rather than per diem and ancillary charges."

Section 6. Section 53-1-413, MCA, is amended to read:

"**53-1-413. Deposit of payments.** (1) Except as provided in 90-7-220 and subsection (2) of this section, the department shall deposit payments of per diem and ancillary charges in the state treasury to the credit of the general fund.

(2) Payments from the Montana veterans' home ~~shall~~ must be deposited in the federal special revenue fund for the benefit of the home, and payments from the Montana state hospital alcohol program ~~shall~~ must be deposited to an alcohol state special revenue account.

(3) Payments from a managed care contractor, provided for in 53-6-116, for services provided by the Montana state hospital and the Montana center for the aged must be deposited in the state special revenue fund, subject to appropriation by the legislature for the benefit of those institutions."

Section 7. Section 53-2-603, MCA, is amended to read:

"**53-2-603. Award of public assistance determined after investigation.** (1) Upon completion of an investigation, the county board shall determine whether the applicant is eligible for public assistance under the provisions of this title, the type and amount of public assistance ~~he~~ the applicant ~~shall~~ must receive, and the date upon which ~~such~~ the public assistance ~~shall~~ must begin. This subsection does not apply to any form of public assistance managed by a managed care contractor, as provided in 53-6-116, when a determination of eligibility is made by the managed care contractor.

(2) The department, if necessary to conform with the United States Social Security Act, may issue rules to the county welfare departments requiring the use of the declaration method, in ~~such~~ a form ~~as~~ that the department may prescribe, for the purpose of determining eligibility, regardless of any other investigative provisions under this title, and for all types of assistance. These rules may include any additional investigations the department may require."

Section 8. Section 53-6-131, MCA, is amended to read:

"**53-6-131. Eligibility requirements.** (1) Medical assistance under the Montana medicaid program may be granted to a person who is determined by the department of social and rehabilitation services, in

its discretion, to be eligible as follows:

(a) The person receives or is considered to be receiving supplemental security income benefits under Title XVI of the federal Social Security Act (42 U.S.C. 1381, et seq.) or aid to families with dependent children under Title IV of the federal Social Security Act (42 U.S.C. 601, et seq.).

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

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

(d) The person is under 19 years of age and meets the conditions of eligibility in the state plan for aid to families with dependent children, other than with respect to school attendance.

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

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

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

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

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

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

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

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

(3) The Montana medicaid program shall pay, as required by federal law, the premiums necessary for medicaid-eligible persons participating in the medicare program and may, within the discretion of the

department, pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified medicare-eligible person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, who:

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

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

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

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

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

(7) A person described in subsection (6) must be provided continuous eligibility for medical assistance, as authorized in 42 U.S.C. 1396a(e)(5) through a(e)(7).

(8) ~~The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards for eligibility for mental health services may provide for eligibility for households with family income that does not exceed 200% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department.~~ THE DEPARTMENT MAY ESTABLISH RESOURCE AND INCOME STANDARDS OF ELIGIBILITY FOR MENTAL HEALTH SERVICES THAT ARE MORE LIBERAL THAN THE RESOURCE AND INCOME STANDARDS OF ELIGIBILITY FOR PHYSICAL HEALTH SERVICES. THE STANDARDS FOR ELIGIBILITY FOR MENTAL HEALTH SERVICES MAY PROVIDE FOR ELIGIBILITY FOR HOUSEHOLDS WITH FAMILY INCOME THAT DOES NOT EXCEED 200% OF THE FEDERAL POVERTY THRESHOLD OR THAT DOES NOT EXCEED A LESSER AMOUNT DETERMINED IN THE DISCRETION OF THE DEPARTMENT. The department may by rule specify under what circumstances

deductions for medical expenses should be used to reduce countable family income in determining eligibility. The department may also adopt rules establishing fees to be charged recipients for services. The fees may vary according to family income."

Section 9. Section 53-6-132, MCA, is amended to read:

"**53-6-132. Application for assistance -- exception.** (1) ~~Application~~ Except as provided in subsection (2), application for assistance under this part ~~shall~~ must be made to the office of the county department in the county in which the person is residing. The application ~~shall~~ must be presented in the manner and on the form prescribed by the department of social and rehabilitation services. All individuals wishing to apply ~~shall~~ have the opportunity to do so.

(2) Notwithstanding the provisions of subsection (1), the department may designate an entity other than the county department to determine eligibility for medicaid managed care services."

Section 10. Section 53-21-111, MCA, is amended to read:

"**53-21-111. Voluntary admission.** (1) Nothing in this part may be construed ~~in any way as limiting~~ to limit the right of any person to make voluntary application for admission at any time to any mental health facility or professional person. An application for admission to a mental health facility ~~shall~~ must be in writing on a form prescribed by the facility and approved by the department. ~~It~~ An application is not valid unless it is approved by a professional person and a copy is given to the person being voluntarily ~~admitting himself~~ admitted. A statement of the rights of the person voluntarily applying for admission, as set out in this part, including the right to release, ~~shall~~ must be furnished to the patient within 12 hours.

(2) Any applicant who wishes to voluntarily apply for admission to the state hospital shall first obtain certification from a professional person that the applicant is suffering from a mental disorder. The professional person ~~must~~ shall then obtain confirmation from ~~a community mental health center~~ the department or the department's designee that the facilities available to the mental health region in which the applicant resides are unable to provide adequate evaluation and treatment. The department shall adopt rules to establish a procedure whereby a professional person shall obtain the confirmation from ~~a community mental health center~~ the department or the department's designee as required in this section.

(3) An application for voluntary admission ~~shall~~ must give the facility the right to detain the applicant for no more than 5 days, excluding weekends and holidays, past ~~his~~ the applicant's written

request for release. A mental health facility may adopt rules providing for detention of the applicant for less than 5 days. The facility ~~must~~ shall notify all applicants of ~~such~~ the rules and post ~~such~~ the rules as provided in 53-21-168.

(4) Any person voluntarily entering or remaining in any mental health facility shall enjoy all the rights secured to a person involuntarily committed to the facility."

Section 11. Section 53-21-206, MCA, is amended to read:

"**53-21-206. Availability of services.** (1) The services of the department and of the incorporated regional mental health centers are available without discrimination on the basis of race, color, creed, religion, or ability to pay and shall comply with Title VI of the Civil Rights Act of 1964.

(2) Services available to individuals unable to pay for the services may be limited by the department based upon availability of funding."

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