SENATE BILL NO. 388

INTRODUCED BY HARP

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR AN INTEGRATED MEDICAID MANAGED CARE PROGRAM; PROVIDING A PUBLIC POLICY ON MEDICAID MANAGED CARE; PROVIDING DEFINITIONS; SPECIFYING REQUIREMENTS FOR MEDICAID MANAGED CARE NETWORKS; AUTHORIZING THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES TO PROVIDE FOR DIFFERING BENEFITS FOR PERSONS ENROLLED IN THE PROGRAM; SPECIFYING REQUIREMENTS FOR MANAGED HEALTH CARE ENTITIES; PROVIDING REQUIREMENTS RELATING TO ENROLLEES OF THE PROGRAM; PROVIDING FOR PAYMENT REDUCTIONS AND ADJUSTMENTS; REQUIRING THE EXCLUSION OF SERVICES FOR TREATMENT OF MENTAL DISORDERS; AUTHORIZING THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES TO SEEK NECESSARY WAIVERS; PROVIDING FOR CAPITATED PAYMENTS; REQUIRING A REPORT; PROVIDING FOR OVERSIGHT BY THE LEGISLATIVE AUDITOR; AND PROVIDING AN EFFECTIVE DATE."

WHEREAS, the State of Montana is experiencing substantial rates of growth in Medicaid expenditures and the rate of growth in Medicaid expenditures is higher than the rate of growth of the state general fund; and

WHEREAS, the increasing cost of Medicaid is limiting the ability of the Legislature to address other needs of the citizens of the state of Montana; and

WHEREAS, it is the intent of the Legislature to promote the delivery of necessary medical care to Medicaid recipients in a cost-effective manner and to encourage providers and insurers to put in place programs that will improve the health of Medicaid recipients; and

WHEREAS, the Legislature desires to promote the development of healthy competition among providers of medical care with respect to cost-effectiveness and innovation in the provision of services.

STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 1,4,5,6, and 7] grant rulemaking authority to the department of social and rehabilitation services and because [section 3] grants rulemaking authority to the commissioner of insurance.

The rules adopted by the department of social and rehabilitation services pursuant to [section 1] must provide for the identification of persons eligible for enrollment in the integrated health care program.

The rules adopted by the commissioner of insurance pursuant to [section 3] may provide for the elimination or reduction of any requirement found in Title 33, chapter 31, if the commissioner of insurance finds the requirement unnecessary for the operation of a managed care community network in a rural area or because of federal requirements for prepaid health plans.

The rules adopted by the commissioner of insurance pursuant to [section 3] must set forth criteria for assessing the financial soundness of a managed care community network and must also establish reserve requirements, as determined appropriate by the commissioner, in the event that a managed care community network is declared insolvent or bankrupt.

The rules adopted by the department of social and rehabilitation services pursuant to [section 4] may provide for different benefit packages for different categories of persons enrolled in a managed health care entity.

The rules adopted by the department of social and rehabilitation services pursuant to [section 5] must provide:

(1) a definition of emergency care for purposes of reimbursing all providers of emergency care to persons enrolled in the program;

(2) quality assurance and utilization review requirements for managed health care entities; and

(3) a definition of community-based organizations with which managed health care entities are encouraged to seek cooperation.

The rules adopted by the department of social and rehabilitation services pursuant to [section 6] must provide for all fee-for-service and managed health care plan options for enrollees.

Under [section 7], the department of social and rehabilitation services is required to adopt rules to provide for a method to reduce payments to managed health care entities, taking into consideration any adjustment payments to health care facilities for certain key services and the implementation of methodologies to limit financial liability for managed health care facilities.

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

NEW SECTION. **Section 1. Policy of medicaid managed care -- system for integrated health care**

services. It is the public policy of the state of Montana to adopt, to the extent practicable, a health care program that encourages the integration of health care services and that manages the health care of program enrollees to improve their health while preserving reasonable choice within a competitive and cost-efficient environment. In furtherance of this public policy, the department shall develop and implement an integrated health care program consistent with the provisions of [sections 1 through 11]. The provisions of [sections 1 through 11] apply only to the program created under [sections 1 through 11]. The department shall by rule identify persons eligible for enrollment in the program. The department shall inform enrollees of their choice, if any, among health care delivery systems. Persons enrolled in the program may also be offered cost-effective indemnity insurance plans, subject to availability.

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through 11], the following definitions apply:

(1) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.

(2) "Department" means the department of social and rehabilitation services.

(3) "Health maintenance organization" means a health maintenance organization as defined in 50-5-101.

(4) "Managed care community network" or "network" means an entity, other than a health maintenance organization, that is owned, operated, or governed by licensed providers of health care services within this state, including physicians and hospitals, and that provides or arranges managed health care services under contract with the department to enrollees of the program.

(5) "Managed health care entity" or "entity" means a health maintenance organization or a managed care community network.

(6) "Program" means the integrated health care program created by [sections 1 through 11].

NEW SECTION. **Section 3. Managed care community network.** (1) A managed care community network shall comply with:

(a) the requirements of Title 33, chapter 31, but the commissioner may by rule reduce or eliminate a requirement of Title 33, chapter 31, if the requirement is demonstrated to be unnecessary for the operation of the managed care community network in a rural area; or

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

(2) A managed care community network may contract with the department to provide any medicaid-covered health care services.

(3) A managed care community network shall demonstrate its ability to bear the financial risk of servicing enrollees under the program. The commissioner shall by rule adopt criteria for assessing the financial soundness of a network. The rules must consider the extent to which a network is composed of providers who directly render health care and are located within the community in which they seek to contract rather than solely arrange or finance the delivery of health care. The rules must consider risk-bearing and management techniques, as determined appropriate by the commissioner. The rules must also consider whether a network has sufficiently demonstrated its financial solvency and net worth. The commissioner's criteria must be based on sound actuarial, financial, and accounting principles. The commissioner is responsible for monitoring compliance with the rules.

(4) A managed care community network may not begin operation before the effective date of rules adopted by the commissioner under [sections 1 through 11], the approval of any necessary federal waivers, and the completion of the review of an application submitted to the commissioner.

(5) A health care delivery system that contracts with the department under the program may not be required to provide or arrange for any health care or medical service, procedure, or product that violates religious or moral teachings and beliefs if that health care delivery system is owned, controlled, or sponsored by or affiliated with a religious institution or religious organization.

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

NEW SECTION. **Section 4. Different benefit packages.** (1) The department may by rule provide for different benefit packages for different categories of persons enrolled in the program. Alcohol and substance abuse services, services related to children with chronic or acute conditions requiring longer-term treatment and followup, and rehabilitation care provided by a freestanding rehabilitation hospital or a rehabilitation unit may be excluded from a benefit package if those services are made available through a separate delivery system. An exclusion does not prohibit the department from developing and implementing demonstration projects for categories of persons or services. Benefit packages for persons eligible for

medical assistance under Title 53, chapter 6, parts 1 and 4, may be based on the requirements of those parts and must be consistent with the Title XIX of the Social Security Act. [Sections 1 through 11] apply only to services purchased by the department.

(2) The program established by [sections 1 through 11] may be implemented by the department in various contracting areas at various times. The health care delivery systems and providers available under the program may vary throughout the state. A managed health care entity must be permitted to contract in any geographic area for which it has a sufficient provider network and that otherwise meets the requirements of the state contract.

NEW SECTION. **Section 5. Requirements for managed health care entities.** (1) A managed health care entity that contracts with the department for the provision of services under the program shall comply with the requirements of this section for purposes of the program.

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

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

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

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

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

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

(5) The entity shall provide that enrollees within its system will be informed of the full panel of

health care providers. Contracts for the provision of services beyond 125 miles from the borders of Montana may not be entered into if services of comparable cost and quality are available within the state of Montana.

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

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

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

(9) The entity shall maintain, retain, and make available to the department records, data, and information, in a uniform manner determined by the department, that is sufficient for the department to monitor utilization, accessibility, and quality of care and that is consistent with accepted practices in the health care industry.

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

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

(12) The entity shall seek cooperation with community-based organizations, as defined by rule of the department, that may continue to operate under a contract with the department or a managed health care entity under [sections 1 through 11] to provide case management services to medicaid clients.

NEW SECTION. **Section 6. Requirements relating to enrollees.** (1) All individuals enrolled in the

program must be provided with a full written explanation of all fee-for-service and managed health care plan options as provided by rule. The department shall provide to enrollees, upon enrollment in the program and at least annually, notice of the process for requesting an appeal under the department's administrative appeal procedures. The department shall maintain a toll-free telephone number for program enrollees' use in reporting problems with managed health care entities.

(2) If an individual becomes eligible for participation in the program while the individual is hospitalized, the department may not enroll the individual in the program until after the individual has been discharged from the hospital. This subsection does not apply to a newborn infant whose mother is enrolled in the program.

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

(a) are certified to be actuarially sound, as determined by an actuary who has expertise and experience in medical insurance and benefit programs, in accordance with the department's current payment system;

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

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

NEW SECTION. **Section 7. Payment reductions and adjustments -- freedom to contract.** (1) The department shall by rule establish a method to reduce its payments to managed health care entities to take the following into consideration:

(a) any adjustment payments paid to health care facilities under subsection (2)(b) to the extent that those payments or any part of those payments have been taken into account in establishing capitated rates under [section 5]; and

(b) the implementation of methodologies to limit financial liability for managed health care entities under [section 5].

(2) For key services provided by a hospital that contracts with an entity, adjustment payments must be paid directly to the hospital by the department. Adjustment payments may include but need not be limited to:

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

(b) perinatal center payments; and

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

(3) For any hospital eligible for the adjustment payments described in this section, the department shall maintain, through the period ending June 30, 1996, reimbursement levels in accordance with statutes and rules in effect on [the effective date of this act].

(4) [Sections 1 through 11] do not limit or otherwise impair the authority of the department to enter into a contract, negotiated pursuant to [sections 1 through 11], with a managed health care entity, including a health maintenance organization, that provides for termination or nonrenewal of the contract without cause upon notice as provided in the contract and without a hearing.

NEW SECTION. **Section 8. Services for mental disorders.** (1) Services provided to treat a mental disorder, as defined in 53-21-102, must be excluded from a benefit package. Medical detoxification may not be excluded. In this subsection, services to treat a mental disorder include, at a minimum, the following services funded by the department or the department of corrections and human services:

(a) inpatient hospital services, including related physician services, related psychiatric interventions, and pharmaceutical services provided to an eligible recipient hospitalized with a primary diagnosis of psychiatric disorder;

(b) any other outpatient mental health services funded by the department pursuant to the Montana medicaid program;

(c) partial hospitalization; and

(d) followup stabilization related to any of these services.

(2) Additional services to treat a mental disorder may be excluded under this section as mutually agreed in writing by the department and the affected state agency or agencies. The exclusion of any service does not prohibit the department from developing and implementing demonstration projects for categories of persons or services. The state shall integrate managed care community networks and affiliated health care providers, to the extent determined practicable by the department, in any separate delivery system for mental health services.

NEW SECTION. **Section 9. Waiver.** The department may seek and obtain any necessary

authorization provided under federal law to implement the program, including the waiver of any federal statutes or regulations. The department may seek a waiver of the federal requirement that the combined membership of medicare and medicaid enrollees in a managed health care entity may not exceed 75% of the managed health care entity's total enrollment. The department may not seek a waiver of the inpatient hospital reimbursement methodology in 42 U.S.C. 1396(a)(13) even if the federal agency responsible for administering Title XIX determines that 42 U.S.C. 1396(a)(13) applies to managed health care systems.

NEW SECTION. **Section 10. Additional requirements.** (1) The department may take all planning and preparatory action necessary to implement [sections 1 through 11], including seeking requests for proposals relating to the program created under [sections 1 through 11].

(2) If a managed health care entity does not receive its appropriate monthly capitation payment within 30 days after the capitation payment due date specified in the contract between the department and the entity and does not pay a health care provider's approved claims for services rendered in that month, which have been received by the managed health care entity by the capitation payment due date, by the 30th day after the capitation payment due date, the department shall pay an interest penalty to the provider in the amount of 1% of the amount owed to the provider by the entity for each month or fraction of a month after the 30th day following the capitation payment due date, until final payment is made.

(3) Upon the written request of a provider, an entity shall provide a written claims status report that includes but is not limited to the following information relating to claims that have been submitted to the entity:

(a) the date of receipt;

(b) the amount claimed;

(c) the approval or disapproval status;

(d) the amount approved; and

(e) whether the entity has received its capitation payment for the month the services were rendered.

(4) A health care provider that requests the payment of an interest penalty from the department under this section shall simultaneously submit a copy of the request to all affected managed health care entities.

(5) On October 1, 1995, and every 6 months after that date, the department shall prepare a report

on the progress of the program. The report must indicate the capacities of the managed health care entities with which the department contracts, the number of clients enrolled by each contractor, the areas of the state in which managed care options do not exist, and the progress toward meeting the enrollment goals of the program. Copies of the report must be sent to the governor and to the legislature.

NEW SECTION. **Section 11. Legislative auditor -- oversight.** (1) In order to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct and to determine that the program is administered fairly and effectively, the legislative auditor shall oversee all aspects of the managed care covered by [sections 1 through 11].

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

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

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

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

(6) [Sections 1 through 11] do not limit investigations by the department that may otherwise be required by law or that may be necessary in the department's capacity as the central administrative authority responsible for administration of public aid programs in this state.

NEW SECTION. **Section 12. Codification instruction.** [Sections 1 through 11] are intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [sections 1 through 11].

NEW SECTION. **Section 13. Effective date.** [This act] is effective July 1, 1995.

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0388, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:
An act providing for an integrated Medicaid managed care program; providing a public policy on Medicaid managed care; providing definitions specifying requirements for Medicaid managed care networks; authorizing the Department of Social and Rehabilitation Services (SRS) to provide for differing benefits for persons enrolled in the program; specifying requirements for managed health care entities; providing requirements relating to enrollees of the program; providing for payment reductions and adjustments; requiring the exclusion of services for treatment of mental disorders; authorizing SRS to seek necessary waivers; providing for capitated payments; requiring a report; and providing for oversight by the legislative auditor.

ASSUMPTIONS:
1. The Executive Budget present law base serves as the starting point from which to calculate any fiscal impact due to this proposed legislation.
2. The Department of Social and Rehabilitation Services (SRS) will contract with an actuarial firm to comply with various provisions of this proposed legislation.

   a. Section 3(5) - Actuarial services needed include determining the cost for certain services that will be required to be paid by Medicaid outside of the managed care system and to set the rates for some managed care entities using different service parameters.
   b. Section 6(3a) - The department contracts to have rates set that are actuarially sound. Federal guidelines do not require that the rates be certified by an actuary, as is required under this bill.
   c. Section 7(1) - Establish a method to reduce payments to managed care entities to remove hospital adjustment payments from the capitated rates.
   d. Section 3(2) - Establish rates for a variety of service packages.

   It is anticipated that this contract will cost $130,000 in FY96 and $30,000 in each year thereafter. The contract will be funded at 50% general fund and 50% federal funds.
3. Several major changes will be needed to the Medicaid claims processing system (MMIS) due to provisions of this bill. These are one-time changes and are anticipated to cost $300,000 in FY96 only. These changes are eligible for a 75% federal match rate.
4. Section 11(2) would require the SRS to pay for medical records under the Government Health Care Information Act. Records would be requested for an estimated 5% of the managed care enrollees, which on average cost $10/record. The estimated cost of this provision is $3,250 in FY96 and $6,500 each year thereafter, funded at 50% general fund and 50% federal funds.
5. The State Auditor Insurance Commissioner would adopt 100 pages of rules and hold one hearing during FY96 to implement this legislation. Total cost would be $6,000 general fund.

(continued)

Dave Lewis 2-20-95

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

JOHN HARP, PRIMARY SPONSOR DATE

FISCAL IMPACT:

Expenditures:

	FY96 Difference	FY97 Difference
Operating Expenses (Auditor)	6,000	0
Operating Expenses (SRS)	433,250	36,500
Total Expenses	439,250	36,500
Funding:		
General Fund	147,625	18,250
Federal Fund	291,625	18,250
Total Funds	439,250	36,500
Net Impact to the General Fund Balance:		
General Fund (Cost) (01)	(147,625)	(18,250)

Technical Notes:
SRS has reviewed several amendments which, if introduced, would reduce or remove the fiscal impact of the bill, except for the cost to the State Auditor for the rules and one hearing.

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0388, second reading

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An act providing for an integrated Medicaid managed care program; providing a public policy on Medicaid managed care; providing definitions specifying requirements for Medicaid managed care networks; authorizing the Department of Social and Rehabilitation Services (SRS) to provide for differing benefits for persons enrolled in the program; specifying requirements for managed health care entities; providing requirements relating to enrollees of the program; providing for payment reductions and adjustments; authorizing SRS to seek necessary waivers; providing for oversight by the legislative auditor; and providing a statutory appropriation.

ASSUMPTIONS:
1. The Executive Budget present law base serves as the starting point from which to calculate any fiscal impact due to this proposed legislation.
2. The State Auditor Insurance Commissioner would adopt 100 pages of rules and hold one hearing during FY96 to implement this legislation. Total cost would be $6,000 general fund.

FISCAL IMPACT:

	FY96 Difference	FY97 Difference
Expenditures:		
Operating Expenses	6,000	0
Funding:		
General Fund	6,000	0
Net Impact to the General Fund Balance:		
General Fund (Cost) (01)	(6,000)	0

Dave Lewis 2-21-95
DAVID LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

2-21-95
JOHN HARP, PRIMARY SPONSOR DATE

Fiscal Note for SB0388, second reading

SB 388
#2

APPROVED BY COM ON PUBLIC
HEALTH, WELFARE & SAFETY

SENATE BILL NO. 388

INTRODUCED BY HARP

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR AN INTEGRATED MEDICAID MANAGED CARE PROGRAM; PROVIDING A PUBLIC POLICY ON MEDICAID MANAGED CARE; PROVIDING DEFINITIONS; SPECIFYING REQUIREMENTS FOR MEDICAID MANAGED CARE NETWORKS; AUTHORIZING THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES TO PROVIDE FOR DIFFERING BENEFITS FOR PERSONS ENROLLED IN THE PROGRAM; SPECIFYING REQUIREMENTS FOR MANAGED HEALTH CARE ENTITIES; PROVIDING REQUIREMENTS RELATING TO ENROLLEES OF THE PROGRAM; PROVIDING FOR PAYMENT REDUCTIONS AND ADJUSTMENTS; ~~REQUIRING THE EXCLUSION OF SERVICES FOR TREATMENT OF MENTAL DISORDERS;~~ AUTHORIZING THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES TO SEEK NECESSARY WAIVERS; ~~PROVIDING FOR CAPITATED PAYMENTS; REQUIRING A REPORT;~~ PROVIDING FOR OVERSIGHT BY THE LEGISLATIVE AUDITOR; PROVIDING A STATUTORY APPROPRIATION; AMENDING SECTIONS 17-7-502 AND 33-1-102, MCA; AND PROVIDING AN EFFECTIVE DATE."

WHEREAS, the State of Montana is experiencing substantial rates of growth in Medicaid expenditures and the rate of growth in Medicaid expenditures is higher than the rate of growth of the state general fund; and

WHEREAS, the increasing cost of Medicaid is limiting the ability of the Legislature to address other needs of the citizens of the state of Montana; and

WHEREAS, it is the intent of the Legislature to promote the delivery of necessary medical care to Medicaid recipients in a cost-effective manner and to encourage providers and insurers to put in place programs that will improve the health of Medicaid recipients; and

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authority to the commissioner of insurance.

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The rules adopted by the commissioner of insurance pursuant to [section 3] may provide for the elimination or reduction of any requirement found in Title 33, chapter 31, if the commissioner of insurance finds the requirement unnecessary for the operation of a managed care community network in a rural area or because of federal requirements for prepaid health plans.

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

NEW SECTION. **Section 1. Policy of medicaid managed care -- system for integrated health care services.** It is the public policy of the state of Montana to adopt, to the extent practicable, a health care program that encourages the integration of health care services and that manages the health care of program enrollees to improve their health while preserving reasonable choice within a competitive and cost-efficient environment. In furtherance of this public policy, the department shall develop and implement an integrated health care program consistent with the provisions of [sections 1 through ~~11~~ 9]. The provisions of [sections 1 through ~~11~~ 9] apply only to the program created under [sections 1 through ~~11~~ 9]. The department shall by rule identify persons eligible for enrollment in the program. The department shall inform enrollees of their choice, if any, among health care delivery systems. Persons enrolled in the program may also be offered cost-effective indemnity insurance plans, subject to availability.

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through ~~11~~ 9], the following definitions apply:

(1) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.

(2) "Department" means the department of social and rehabilitation services.

(3) "Health maintenance organization" means a health maintenance organization as defined in 50-5-101.

(4) "Managed care community network" or "network" means an entity, other than a health maintenance organization, that is owned, operated, or governed by ~~licensed providers of health care services within this state, including physicians and hospitals,~~ A PERSON and that provides or arranges managed health care services under contract with the department to enrollees of the program.

(5) "Managed health care entity" or "entity" means a health maintenance organization or a managed care community network.

(6) "PERSON" MEANS:

(A) AN INDIVIDUAL;

(B) A GROUP OF INDIVIDUALS;

(C) AN INSURER, AS DEFINED IN 33-1-201;

(D) A HEALTH SERVICE CORPORATION, AS DEFINED IN 33-30-101;

(E) A CORPORATION, PARTNERSHIP, FACILITY, ASSOCIATION, OR TRUST; OR

(F) AN INSTITUTION OF A GOVERNMENTAL UNIT OF ANY STATE LICENSED BY THAT STATE

TO PROVIDE HEALTH CARE, INCLUDING BUT NOT LIMITED TO A PHYSICIAN, HOSPITAL, HOSPITAL-RELATED FACILITY, OR LONG-TERM CARE FACILITY.

~~(6)~~(7) "Program" means the integrated health care program created by [sections 1 through ~~11~~ 9].

NEW SECTION. **Section 3. Managed care community network.** (1) A managed care community network shall comply with:

(a) the requirements of Title 33, chapter 31, but the commissioner may by rule reduce or eliminate a requirement of Title 33, chapter 31, if the requirement is demonstrated to be unnecessary for the operation of the managed care community network ~~in a rural area~~; ~~or~~ AND

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

(2) A managed care community network may contract with the department to provide any COMBINATION OF medicaid-covered health care services THAT IS ACCEPTABLE TO THE DEPARTMENT.

(3) A managed care community network shall demonstrate its ability to bear the financial risk of servicing enrollees under the program. The commissioner shall by rule adopt criteria for assessing the financial soundness of a network. The rules must consider the extent to which a network is composed of providers who directly render health care and are located within the community in which they seek to contract rather than solely arrange or finance the delivery of health care. The rules must consider risk-bearing and management techniques, as determined appropriate by the commissioner. The rules must also consider whether a network has sufficiently demonstrated its financial solvency and net worth. The commissioner's criteria must be based on sound actuarial, financial, and accounting principles. The commissioner is responsible for monitoring compliance with the rules.

(4) A managed care community network may not begin operation before the effective date of rules adopted by the commissioner under [sections 1 through ~~11~~ 9], the approval of any necessary federal waivers, and the completion of the review of an application submitted to the commissioner. THE COMMISSIONER MAY CHARGE THE APPLICANT AN APPLICATION REVIEW FEE FOR THE COMMISSIONER'S ACTUAL COST OF REVIEW OF THE APPLICATION. THE FEES MUST BE ADOPTED BY RULE BY THE COMMISSIONER. FEES COLLECTED BY THE COMMISSIONER MUST BE DEPOSITED IN AN ACCOUNT IN THE SPECIAL REVENUE FUND AND ARE STATUTORILY APPROPRIATED, AS PROVIDED IN 17-7-502, TO THE COMMISSIONER TO DEFRAY THE COST OF APPLICATION REVIEW.

(5) A health care delivery system that contracts with the department under the program may not

be required to provide or arrange for any health care or medical service, procedure, or product that violates religious or moral teachings and beliefs if that health care delivery system is owned, controlled, or sponsored by or affiliated with a religious institution or religious organization BUT MUST COMPLY WITH THE NOTICE REQUIREMENTS OF [SECTION 5(4)(C)].

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

NEW SECTION. **Section 4. Different benefit packages.** (1) The department may by rule provide for different benefit packages for different categories of persons enrolled in the program. Alcohol and substance abuse services, SERVICES FOR MENTAL DISORDERS, services related to children with chronic or acute conditions requiring longer-term treatment and followup, and rehabilitation care provided by a freestanding rehabilitation hospital or a rehabilitation unit may be excluded from a benefit package if those services are made available through a separate delivery system. An exclusion does not prohibit the department from developing and implementing demonstration projects for categories of persons or services. Benefit packages for persons eligible for medical assistance under Title 53, chapter 6, parts 1 and 4, may be based on the requirements of those parts and must be consistent with the Title XIX of the Social Security Act. [Sections 1 through ~~11~~ 9] apply only to services purchased by the department.

(2) The program established by [sections 1 through ~~11~~ 9] may be implemented by the department in various contracting areas at various times. The health care delivery systems and providers available under the program may vary throughout the state. A LICENSED managed health care entity must be permitted to contract in any geographic area for which it has a sufficient provider network and that otherwise meets the requirements of the state contract.

NEW SECTION. **Section 5. Requirements for managed health care entities.** (1) A managed health care entity that contracts with the department for the provision of services under the program shall comply with the requirements of this section for purposes of the program.

(2) The entity shall provide for reimbursement for health care providers for emergency care, as defined by the department by rule, that must be provided to its enrollees, including emergency room

screening services and urgent care that it authorizes for its enrollees, regardless of the provider's affiliation with the managed health care entity. Health care providers must be reimbursed for emergency care in an amount not less than the department's rates for those medical services rendered by health care providers who are not under contract with the entity to enrollees of the entity.

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

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

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

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

(c) written notice that the enrollee may receive from another provider those medicaid-covered services that are not provided by the managed health care entity BUT THAT ARE THE FINANCIAL RESPONSIBILITY OF THE ENTITY.

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

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

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

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

(9) The entity shall maintain, retain, and make available to the department records, data, and information, in a uniform manner determined by the department, that is sufficient for the department to monitor utilization, accessibility, and quality of care and that is consistent with accepted practices in the

health care industry.

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

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

(12) The entity shall seek cooperation with community-based organizations, as defined by rule of the department, that may continue to operate under a contract with the department or a managed health care entity under [sections 1 through ~~11~~ 9] to provide case management services to medicaid clients.

(13) A MANAGED HEALTH CARE ENTITY THAT PROVIDES WRITTEN NOTICE PURSUANT TO SUBSECTION (4)(C) TO AN ENROLLEE OF MEDICAID-COVERED SERVICES AVAILABLE FROM ANOTHER PROVIDER IS RESPONSIBLE FOR PAYMENT FOR THOSE SERVICES BY ANOTHER PROVIDER.

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

(2) If an individual becomes eligible for participation in the program while the individual is hospitalized, the department may not enroll the individual in the program until after the individual has been discharged from the hospital. This subsection does not apply to a newborn infant whose mother is enrolled in the program.

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

(a) are certified to be actuarially sound, ~~as determined by an actuary who has expertise and experience in medical insurance and benefit programs,~~ in accordance with the department's current payment system;

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

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

NEW SECTION. **Section 7. Payment reductions and adjustments -- freedom to contract.** (1) The department shall by rule establish a method to reduce its payments to managed health care entities to take the following into consideration:

(a) any adjustment payments paid to health care facilities under subsection (2)(b) to the extent that those payments or any part of those payments have been taken into account in establishing capitated rates under [section 5]; and

(b) the implementation of methodologies to limit financial liability for managed health care entities under [section 5].

(2) For key services provided by a hospital that contracts with an entity, adjustment payments THAT ARE NOT INCLUDED IN CAPITATED RATES must be paid directly to the hospital by the department. Adjustment payments may include but need not be limited to:

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

(b) perinatal center payments; and

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

(3) For any hospital eligible for the adjustment payments described in this section, the department shall maintain, through the period ending June 30, 1996, reimbursement levels in accordance with statutes and rules in effect ~~on [the effective date of this act]~~ AT THE TIME THE PAYMENTS ARE MADE.

(4) [Sections 1 through ~~11~~ 9] do not limit or otherwise impair the authority of the department to enter into a contract, negotiated pursuant to [sections 1 through ~~11~~ 9], with a managed health care entity, including a health maintenance organization, that provides for termination or nonrenewal of the contract without cause upon notice as provided in the contract and without a hearing.

~~NEW SECTION. **Section 8. Services for mental disorders.** (1) Services provided to treat a mental disorder, as defined in 53-21-102, must be excluded from a benefit package. Medical detoxification may not be excluded. In this subsection, services to treat a mental disorder include, at a minimum, the following services funded by the department or the department of corrections and human services:~~

~~(a) inpatient hospital services, including related physician services, related psychiatric interventions, and pharmaceutical services provided to an eligible recipient hospitalized with a primary diagnosis of psychiatric disorder;~~

~~(b) any other outpatient mental health services funded by the department pursuant to the Montana medicaid program;~~

~~(c) partial hospitalization; and~~

~~(d) followup stabilization related to any of these services.~~

~~(2) Additional services to treat a mental disorder may be excluded under this section as mutually agreed in writing by the department and the affected state agency or agencies. The exclusion of any service does not prohibit the department from developing and implementing demonstration projects for categories of persons or services. The state shall integrate managed care community networks and affiliated health care providers, to the extent determined practicable by the department, in any separate delivery system for mental health services.~~

NEW SECTION. **Section 8. Waiver.** The department may seek and obtain any necessary authorization provided under federal law to implement the program, including the waiver of any federal statutes or regulations. The department may seek a waiver of the federal requirement that the combined membership of medicare and medicaid enrollees in a managed health care entity may not exceed 75% of the managed health care entity's total enrollment. The department may not seek a waiver of the inpatient hospital reimbursement methodology in 42 U.S.C. 1396(a)(13) even if the federal agency responsible for administering Title XIX determines that 42 U.S.C. 1396(a)(13) applies to managed health care systems.

~~NEW SECTION. **Section 10. Additional requirements.** (1) The department may take all planning and preparatory action necessary to implement [sections 1 through 11], including seeking requests for proposals relating to the program created under [sections 1 through 11].~~

~~(2) If a managed health care entity does not receive its appropriate monthly capitation payment~~

~~within 30 days after the capitation payment due date specified in the contract between the department and the entity and does not pay a health care provider's approved claims for services rendered in that month, which have been received by the managed health care entity by the capitation payment due date, by the 30th day after the capitation payment due date, the department shall pay an interest penalty to the provider in the amount of 1% of the amount owed to the provider by the entity for each month or fraction of a month after the 30th day following the capitation payment due date, until final payment is made.~~

~~(3) Upon the written request of a provider, an entity shall provide a written claims status report that includes but is not limited to the following information relating to claims that have been submitted to the entity:~~

~~(a) the date of receipt;~~

~~(b) the amount claimed;~~

~~(c) the approval or disapproval status;~~

~~(d) the amount approved; and~~

~~(e) whether the entity has received its capitation payment for the month the services were rendered.~~

~~(4) A health care provider that requests the payment of an interest penalty from the department under this section shall simultaneously submit a copy of the request to all affected managed health care entities.~~

~~(5) On October 1, 1995, and every 6 months after that date, the department shall prepare a report on the progress of the program. The report must indicate the capacities of the managed health care entities with which the department contracts, the number of clients enrolled by each contractor, the areas of the state in which managed care options do not exist, and the progress toward meeting the enrollment goals of the program. Copies of the report must be sent to the governor and to the legislature.~~

NEW SECTION. **Section 9. Legislative auditor -- oversight.** (1) In order to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct and to determine that the program is administered fairly and effectively, the legislative auditor shall oversee all aspects of the managed care covered by [sections 1 through ~~11~~ 9].

(2) A medical provider may not be compelled to provide individual medical records of patients unless the records are provided in accordance with the provisions of the Government Health Care

Information Act. State and local governmental agencies shall provide the requested information, assistance, or cooperation.

(3) All ~~investigations~~ ACTIVITIES conducted by the legislative auditor must be conducted in a manner that ensures the preservation of evidence for use in criminal prosecutions. The legislative auditor may present for prosecution the findings of any ~~investigation~~ ACTIVITY to the office of the attorney general or to United States attorneys in Montana.

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

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

(6) [Sections 1 through ~~11~~ 9] do not limit investigations by the department that may otherwise be required by law or that may be necessary in the department's capacity as the central administrative authority responsible for administration of public aid programs in this state.

NEW SECTION. **SECTION 10. APPLICABILITY TO MANAGED CARE COMMUNITY NETWORKS.** A MANAGED CARE COMMUNITY NETWORK, AS DEFINED IN [SECTION 2], IS GOVERNED BY THE PROVISIONS OF THIS CHAPTER AND BY [SECTIONS 1 THROUGH 9], BUT THE COMMISSIONER MAY BY RULE REDUCE OR ELIMINATE A REQUIREMENT OF THIS CHAPTER IF THE REQUIREMENT IS DEMONSTRATED TO BE UNNECESSARY FOR THE OPERATION OF A MANAGED CARE COMMUNITY NETWORK.

SECTION 11. SECTION 17-7-502, MCA, IS AMENDED TO READ:

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

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

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

(b) The law or portion of the law making a statutory appropriation must specifically state that a

statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations: 2-9-202; 2-17-105; 2-18-812; 3-5-901; 5-13-403; 10-3-203; 10-3-312; 10-3-314; 10-4-301; 15-1-111; 15-23-706; 15-25-123; 15-31-702; 15-36-112; 15-37-117; 15-38-202; 15-65-121; 15-70-101; 16-1-404; 16-1-410; 16-1-411; 17-3-106; 17-3-212; 17-5-404; 17-5-424; 17-5-704; 17-5-804; 17-6-101; 17-6-201; 17-6-409; 17-7-304; 18-11-112; 19-2-502; 19-6-709; 19-9-1007; 19-15-101; 19-17-301; 19-18-512; 19-18-513; 19-18-606; 19-19-205; 19-19-305; 19-19-506; 20-4-109; 20-8-111; 20-9-361; 20-26-1403; 20-26-1503; 23-2-823; 23-5-136; 23-5-306; 23-5-409; 23-5-610; 23-5-612; 23-5-631; 23-7-301; 23-7-402; 27-12-206; 32-1-537; 37-43-204; 37-51-501; 39-71-503; 39-71-907; 39-71-2321; 39-71-2504; 44-12-206; 44-13-102; 50-5-232; 50-40-206; [section 3]; 53-6-150; 53-24-206; 60-2-220; 61-2-107; 67-3-205; 75-1-1101; 75-5-507; 75-5-1108; 75-11-313; 76-12-123; 77-1-808; 80-2-103; 80-2-222; 80-4-416; 80-11-310; 81-5-111; 82-11-136; 82-11-161; 85-1-220; 85-20-402; 90-3-301; 90-4-215; 90-6-331; 90-7-220; 90-9-306; and 90-14-107.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for the payments. (In subsection (3): pursuant to sec. 7, Ch. 567, L. 1991, the inclusion of 19-6-709 terminates upon death of last recipient eligible for supplemental benefit; and pursuant to sec. 15, Ch. 534, L. 1993, the inclusion of 90-14-107 terminates July 1, 1995.)"

SECTION 12. 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 relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

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

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

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

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

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

(4) This code does not apply to health maintenance organizations or to managed care community networks, as defined in [section 2], to the extent that the existence and operations of those organizations are ~~authorized~~ governed by chapter 31 or to the extent that the existence and operations of those networks are governed by [sections 1 through 9].

(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 state employee group insurance program established in Title 2, chapter 18, part 8.

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

(8) (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."

NEW SECTION. **Section 13. Codification instruction.** (1) [Sections 1 through ~~11~~ 9] are intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [sections 1 through ~~11~~ 9].

(2) [SECTION 10] IS INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 33, CHAPTER 31, AND THE PROVISIONS OF TITLE 33, CHAPTER 31, APPLY TO [SECTION 10].

NEW SECTION. **Section 14. Effective date.** [This act] is effective July 1, 1995.

-END-

SENATE BILL NO. 388

INTRODUCED BY HARP

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR AN INTEGRATED MEDICAID MANAGED CARE PROGRAM; PROVIDING A PUBLIC POLICY ON MEDICAID MANAGED CARE; PROVIDING DEFINITIONS; SPECIFYING REQUIREMENTS FOR MEDICAID MANAGED CARE NETWORKS; AUTHORIZING THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES TO PROVIDE FOR DIFFERING BENEFITS FOR PERSONS ENROLLED IN THE PROGRAM; SPECIFYING REQUIREMENTS FOR MANAGED HEALTH CARE ENTITIES; PROVIDING REQUIREMENTS RELATING TO ENROLLEES OF THE PROGRAM; PROVIDING FOR PAYMENT REDUCTIONS AND ADJUSTMENTS; ~~REQUIRING THE EXCLUSION OF SERVICES FOR TREATMENT OF MENTAL DISORDERS;~~ AUTHORIZING THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES TO SEEK NECESSARY WAIVERS; ~~PROVIDING FOR CAPITATED PAYMENTS; REQUIRING A REPORT;~~ PROVIDING FOR OVERSIGHT BY THE LEGISLATIVE AUDITOR; PROVIDING A STATUTORY APPROPRIATION; AMENDING SECTIONS 17-7-502 AND 33-1-102, MCA; AND PROVIDING AN EFFECTIVE DATE."

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 388
Representative Cobb

March 27, 1995 9:04 am

Mr. Chairman: I move to amend **Senate Bill 388** (third reading copy -- blue).

Signed: Cobb
Representative Cobb

And, that such amendments to Senate Bill 388 read as follows:

1. Page 9, line 21.
Following: "."
Insert: "The department may not expand eligibility requirements unless authorized by the legislature."

-END-

ADOPT 90-0

REJECT

SB 388

HOUSE

HOUSE COMMITTEE OF THE WHOLE AMENDMENT

Senate Bill 388
Representative Cobb

March 27, 1995 9:14 am

Mr. Chairman: I move to amend **Senate Bill 388** (third reading copy -- blue).

Signed: Cobb
Representative Cobb

And, that such amendments to Senate Bill 388 read as follows:

1. Page 8, line 30.
Following: "."
Insert: "If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program and managed care."

-END-

SB 388

ADOPT 89-3 (2)

REJECT

HOUSE

SENATE BILL NO. 388

INTRODUCED BY HARP

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR AN INTEGRATED MEDICAID MANAGED CARE PROGRAM; PROVIDING A PUBLIC POLICY ON MEDICAID MANAGED CARE; PROVIDING DEFINITIONS; SPECIFYING REQUIREMENTS FOR MEDICAID MANAGED CARE NETWORKS; AUTHORIZING THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES TO PROVIDE FOR DIFFERING BENEFITS FOR PERSONS ENROLLED IN THE PROGRAM; SPECIFYING REQUIREMENTS FOR MANAGED HEALTH CARE ENTITIES; PROVIDING REQUIREMENTS RELATING TO ENROLLEES OF THE PROGRAM; PROVIDING FOR PAYMENT REDUCTIONS AND ADJUSTMENTS; ~~REQUIRING THE EXCLUSION OF SERVICES FOR TREATMENT OF MENTAL DISORDERS;~~ AUTHORIZING THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES TO SEEK NECESSARY WAIVERS; ~~PROVIDING FOR CAPITATED PAYMENTS; REQUIRING A REPORT;~~ PROVIDING FOR OVERSIGHT BY THE LEGISLATIVE AUDITOR; PROVIDING A STATUTORY APPROPRIATION; AMENDING SECTIONS 17-7-502 AND 33-1-102, MCA; AND PROVIDING AN EFFECTIVE DATE."

WHEREAS, the State of Montana is experiencing substantial rates of growth in Medicaid expenditures and the rate of growth in Medicaid expenditures is higher than the rate of growth of the state general fund; and

WHEREAS, the increasing cost of Medicaid is limiting the ability of the Legislature to address other needs of the citizens of the state of Montana; and

WHEREAS, it is the intent of the Legislature to promote the delivery of necessary medical care to Medicaid recipients in a cost-effective manner and to encourage providers and insurers to put in place programs that will improve the health of Medicaid recipients; and

WHEREAS, the Legislature desires to promote the development of healthy competition among providers of medical care with respect to cost-effectiveness and innovation in the provision of services.

STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 1,4,5,6, and 7] grant rulemaking authority to the department of social and rehabilitation services and because [section 3] grants rulemaking

authority to the commissioner of insurance.

The rules adopted by the department of social and rehabilitation services pursuant to [section 1] must provide for the identification of persons eligible for enrollment in the integrated health care program.

The rules adopted by the commissioner of insurance pursuant to [section 3] may provide for the elimination or reduction of any requirement found in Title 33, chapter 31, if the commissioner of insurance finds the requirement unnecessary for the operation of a managed care community network in a rural area or because of federal requirements for prepaid health plans.

The rules adopted by the commissioner of insurance pursuant to [section 3] must set forth criteria for assessing the financial soundness of a managed care community network and must also establish reserve requirements, as determined appropriate by the commissioner, in the event that a managed care community network is declared insolvent or bankrupt.

The rules adopted by the department of social and rehabilitation services pursuant to [section 4] may provide for different benefit packages for different categories of persons enrolled in a managed health care entity.

The rules adopted by the department of social and rehabilitation services pursuant to [section 5] must provide:

(1) a definition of emergency care for purposes of reimbursing all providers of emergency care to persons enrolled in the program;

(2) quality assurance and utilization review requirements for managed health care entities; and

(3) a definition of community-based organizations with which managed health care entities are encouraged to seek cooperation.

The rules adopted by the department of social and rehabilitation services pursuant to [section 6] must provide for all fee-for-service and managed health care plan options for enrollees.

Under [section 7], the department of social and rehabilitation services is required to adopt rules to provide for a method to reduce payments to managed health care entities, taking into consideration any adjustment payments to health care facilities for certain key services and the implementation of methodologies to limit financial liability for managed health care facilities.

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

NEW SECTION. **Section 1. Policy of medicaid managed care -- system for integrated health care services.** It is the public policy of the state of Montana to adopt, to the extent practicable, a health care program that encourages the integration of health care services and that manages the health care of program enrollees to improve their health while preserving reasonable choice within a competitive and cost-efficient environment. In furtherance of this public policy, the department shall develop and implement an integrated health care program consistent with the provisions of [sections 1 through ~~11~~ 9]. The provisions of [sections 1 through ~~11~~ 9] apply only to the program created under [sections 1 through ~~11~~ 9]. The department shall by rule identify persons eligible for enrollment in the program. The department shall inform enrollees of their choice, if any, among health care delivery systems. Persons enrolled in the program may also be offered cost-effective indemnity insurance plans, subject to availability.

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through ~~11~~ 9], the following definitions apply:

(1) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.

(2) "Department" means the department of social and rehabilitation services.

(3) "Health maintenance organization" means a health maintenance organization as defined in 50-5-101.

(4) "Managed care community network" or "network" means an entity, other than a health maintenance organization, that is owned, operated, or governed by ~~licensed providers of health care services within this state, including physicians and hospitals,~~ A PERSON and that provides or arranges managed health care services under contract with the department to enrollees of the program.

(5) "Managed health care entity" or "entity" means a health maintenance organization or a managed care community network.

(6) "PERSON" MEANS:

(A) AN INDIVIDUAL;

(B) A GROUP OF INDIVIDUALS;

(C) AN INSURER, AS DEFINED IN 33-1-201;

(D) A HEALTH SERVICE CORPORATION, AS DEFINED IN 33-30-101;

(E) A CORPORATION, PARTNERSHIP, FACILITY, ASSOCIATION, OR TRUST; OR

(F) AN INSTITUTION OF A GOVERNMENTAL UNIT OF ANY STATE LICENSED BY THAT STATE

TO PROVIDE HEALTH CARE, INCLUDING BUT NOT LIMITED TO A PHYSICIAN, HOSPITAL, HOSPITAL-RELATED FACILITY, OR LONG-TERM CARE FACILITY.

~~(6)~~(7) "Program" means the integrated health care program created by [sections 1 through ~~11~~ 9].

NEW SECTION. **Section 3. Managed care community network.** (1) A managed care community network shall comply with:

(a) the requirements of Title 33, chapter 31, but the commissioner may by rule reduce or eliminate a requirement of Title 33, chapter 31, if the requirement is demonstrated to be unnecessary for the operation of the managed care community network ~~in a rural area~~; ~~or~~ AND

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

(2) A managed care community network may contract with the department to provide any COMBINATION OF medicaid-covered health care services THAT IS ACCEPTABLE TO THE DEPARTMENT.

(3) A managed care community network shall demonstrate its ability to bear the financial risk of servicing enrollees under the program. The commissioner shall by rule adopt criteria for assessing the financial soundness of a network. The rules must consider the extent to which a network is composed of providers who directly render health care and are located within the community in which they seek to contract rather than solely arrange or finance the delivery of health care. The rules must consider risk-bearing and management techniques, as determined appropriate by the commissioner. The rules must also consider whether a network has sufficiently demonstrated its financial solvency and net worth. The commissioner's criteria must be based on sound actuarial, financial, and accounting principles. The commissioner is responsible for monitoring compliance with the rules.

(4) A managed care community network may not begin operation before the effective date of rules adopted by the commissioner under [sections 1 through ~~11~~ 9], the approval of any necessary federal waivers, and the completion of the review of an application submitted to the commissioner. THE COMMISSIONER MAY CHARGE THE APPLICANT AN APPLICATION REVIEW FEE FOR THE COMMISSIONER'S ACTUAL COST OF REVIEW OF THE APPLICATION. THE FEES MUST BE ADOPTED BY RULE BY THE COMMISSIONER. FEES COLLECTED BY THE COMMISSIONER MUST BE DEPOSITED IN AN ACCOUNT IN THE SPECIAL REVENUE FUND AND ARE STATUTORILY APPROPRIATED, AS PROVIDED IN 17-7-502, TO THE COMMISSIONER TO DEFRAY THE COST OF APPLICATION REVIEW.

(5) A health care delivery system that contracts with the department under the program may not

be required to provide or arrange for any health care or medical service, procedure, or product that violates religious or moral teachings and beliefs if that health care delivery system is owned, controlled, or sponsored by or affiliated with a religious institution or religious organization BUT MUST COMPLY WITH THE NOTICE REQUIREMENTS OF [SECTION 5(4)(C)].

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

NEW SECTION. **Section 4. Different benefit packages.** (1) The department may by rule provide for different benefit packages for different categories of persons enrolled in the program. Alcohol and substance abuse services, SERVICES FOR MENTAL DISORDERS, services related to children with chronic or acute conditions requiring longer-term treatment and followup, and rehabilitation care provided by a freestanding rehabilitation hospital or a rehabilitation unit may be excluded from a benefit package if those services are made available through a separate delivery system. An exclusion does not prohibit the department from developing and implementing demonstration projects for categories of persons or services. Benefit packages for persons eligible for medical assistance under Title 53, chapter 6, parts 1 and 4, may be based on the requirements of those parts and must be consistent with the Title XIX of the Social Security Act. [Sections 1 through ~~11~~ 9] apply only to services purchased by the department.

(2) The program established by [sections 1 through ~~11~~ 9] may be implemented by the department in various contracting areas at various times. The health care delivery systems and providers available under the program may vary throughout the state. A LICENSED managed health care entity must be permitted to contract in any geographic area for which it has a sufficient provider network and that otherwise meets the requirements of the state contract.

NEW SECTION. **Section 5. Requirements for managed health care entities.** (1) A managed health care entity that contracts with the department for the provision of services under the program shall comply with the requirements of this section for purposes of the program.

(2) The entity shall provide for reimbursement for health care providers for emergency care, as defined by the department by rule, that must be provided to its enrollees, including emergency room

screening services and urgent care that it authorizes for its enrollees, regardless of the provider's affiliation with the managed health care entity. Health care providers must be reimbursed for emergency care in an amount not less than the department's rates for those medical services rendered by health care providers who are not under contract with the entity to enrollees of the entity.

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

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

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

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

(c) written notice that the enrollee may receive from another provider those medicaid-covered services that are not provided by the managed health care entity BUT THAT ARE THE FINANCIAL RESPONSIBILITY OF THE ENTITY.

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

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

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

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

(9) The entity shall maintain, retain, and make available to the department records, data, and information, in a uniform manner determined by the department, that is sufficient for the department to monitor utilization, accessibility, and quality of care and that is consistent with accepted practices in the

health care industry.

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

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

(12) The entity shall seek cooperation with community-based organizations, as defined by rule of the department, that may continue to operate under a contract with the department or a managed health care entity under [sections 1 through ~~11~~ 9] to provide case management services to medicaid clients.

(13) A MANAGED HEALTH CARE ENTITY THAT PROVIDES WRITTEN NOTICE PURSUANT TO SUBSECTION (4)(C) TO AN ENROLLEE OF MEDICAID-COVERED SERVICES AVAILABLE FROM ANOTHER PROVIDER IS RESPONSIBLE FOR PAYMENT FOR THOSE SERVICES BY ANOTHER PROVIDER.

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

(2) If an individual becomes eligible for participation in the program while the individual is hospitalized, the department may not enroll the individual in the program until after the individual has been discharged from the hospital. This subsection does not apply to a newborn infant whose mother is enrolled in the program.

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

(a) are certified to be actuarially sound, ~~as determined by an actuary who has expertise and experience in medical insurance and benefit programs,~~ in accordance with the department's current payment system;

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

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

NEW SECTION. **Section 7. Payment reductions and adjustments -- freedom to contract.** (1) The department shall by rule establish a method to reduce its payments to managed health care entities to take the following into consideration:

(a) any adjustment payments paid to health care facilities under subsection (2)(b) to the extent that those payments or any part of those payments have been taken into account in establishing capitated rates under [section 5]; and

(b) the implementation of methodologies to limit financial liability for managed health care entities under [section 5].

(2) For key services provided by a hospital that contracts with an entity, adjustment payments THAT ARE NOT INCLUDED IN CAPITATED RATES must be paid directly to the hospital by the department. Adjustment payments may include but need not be limited to:

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

(b) perinatal center payments; and

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

(3) For any hospital eligible for the adjustment payments described in this section, the department shall maintain, through the period ending June 30, 1996, reimbursement levels in accordance with statutes and rules in effect ~~on [the effective date of this act]~~ AT THE TIME THE PAYMENTS ARE MADE.

(4) [Sections 1 through ~~11~~ 9] do not limit or otherwise impair the authority of the department to enter into a contract, negotiated pursuant to [sections 1 through ~~11~~ 9], with a managed health care entity, including a health maintenance organization, that provides for termination or nonrenewal of the contract without cause upon notice as provided in the contract and without a hearing. IF AVAILABLE FUNDS ARE

NOT SUFFICIENT TO PROVIDE MEDICAL ASSISTANCE FOR ALL ELIGIBLE PERSONS, THE DEPARTMENT MAY SET PRIORITIES TO LIMIT, REDUCE, OR OTHERWISE CURTAIL THE AMOUNT, SCOPE, OR DURATION OF THE MEDICAL SERVICES MADE AVAILABLE UNDER THE MONTANA MEDICAID PROGRAM AND MANAGED CARE.

~~NEW SECTION. **Section 8. Services for mental disorders.** (1) Services provided to treat a mental disorder, as defined in 53-21-102, must be excluded from a benefit package. Medical detoxification may not be excluded. In this subsection, services to treat a mental disorder include, at a minimum, the following services funded by the department or the department of corrections and human services:~~

~~(a) inpatient hospital services, including related physician services, related psychiatric interventions, and pharmaceutical services provided to an eligible recipient hospitalized with a primary diagnosis of psychiatric disorder;~~

~~(b) any other outpatient mental health services funded by the department pursuant to the Montana medicaid program;~~

~~(c) partial hospitalization; and~~

~~(d) followup stabilization related to any of these services.~~

~~(2) Additional services to treat a mental disorder may be excluded under this section as mutually agreed in writing by the department and the affected state agency or agencies. The exclusion of any service does not prohibit the department from developing and implementing demonstration projects for categories of persons or services. The state shall integrate managed care community networks and affiliated health care providers, to the extent determined practicable by the department, in any separate delivery system for mental health services.~~

NEW SECTION. **Section 8. Waiver.** The department may seek and obtain any necessary authorization provided under federal law to implement the program, including the waiver of any federal statutes or regulations. THE DEPARTMENT MAY NOT EXPAND ELIGIBILITY REQUIREMENTS UNLESS AUTHORIZED BY THE LEGISLATURE. The department may seek a waiver of the federal requirement that the combined membership of medicare and medicaid enrollees in a managed health care entity may not exceed 75% of the managed health care entity's total enrollment. The department may not seek a waiver of the inpatient hospital reimbursement methodology in 42 U.S.C. 1396(a)(13) even if the federal agency

responsible for administering Title XIX determines that 42 U.S.C. 1396(a)(13) applies to managed health care systems.

~~NEW SECTION. **Section 10. Additional requirements.** (1) The department may take all planning and preparatory action necessary to implement [sections 1 through 11], including seeking requests for proposals relating to the program created under [sections 1 through 11].~~

~~(2) If a managed health care entity does not receive its appropriate monthly capitation payment within 30 days after the capitation payment due date specified in the contract between the department and the entity and does not pay a health care provider's approved claims for services rendered in that month, which have been received by the managed health care entity by the capitation payment due date, by the 30th day after the capitation payment due date, the department shall pay an interest penalty to the provider in the amount of 1% of the amount owed to the provider by the entity for each month or fraction of a month after the 30th day following the capitation payment due date, until final payment is made.~~

~~(3) Upon the written request of a provider, an entity shall provide a written claims status report that includes but is not limited to the following information relating to claims that have been submitted to the entity:~~

~~(a) the date of receipt;~~

~~(b) the amount claimed;~~

~~(c) the approval or disapproval status;~~

~~(d) the amount approved; and~~

~~(e) whether the entity has received its capitation payment for the month the services were rendered.~~

~~(4) A health care provider that requests the payment of an interest penalty from the department under this section shall simultaneously submit a copy of the request to all affected managed health care entities.~~

~~(5) On October 1, 1995, and every 6 months after that date, the department shall prepare a report on the progress of the program. The report must indicate the capacities of the managed health care entities with which the department contracts, the number of clients enrolled by each contractor, the areas of the state in which managed care options do not exist, and the progress toward meeting the enrollment goals of the program. Copies of the report must be sent to the governor and to the legislature.~~

NEW SECTION. **Section 9. Legislative auditor -- oversight.** (1) In order to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct and to determine that the program is administered fairly and effectively, the legislative auditor shall oversee all aspects of the managed care covered by [sections 1 through ~~11~~ 9].

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

(3) All ~~investigations~~ ACTIVITIES conducted by the legislative auditor must be conducted in a manner that ensures the preservation of evidence for use in criminal prosecutions. The legislative auditor may present for prosecution the findings of any ~~investigation~~ ACTIVITY to the office of the attorney general or to United States attorneys in Montana.

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

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

(6) [Sections 1 through ~~11~~ 9] do not limit investigations by the department that may otherwise be required by law or that may be necessary in the department's capacity as the central administrative authority responsible for administration of public aid programs in this state.

NEW SECTION. **SECTION 10. APPLICABILITY TO MANAGED CARE COMMUNITY NETWORKS.** A MANAGED CARE COMMUNITY NETWORK, AS DEFINED IN [SECTION 2], IS GOVERNED BY THE PROVISIONS OF THIS CHAPTER AND BY [SECTIONS 1 THROUGH 9], BUT THE COMMISSIONER MAY BY RULE REDUCE OR ELIMINATE A REQUIREMENT OF THIS CHAPTER IF THE REQUIREMENT IS DEMONSTRATED TO BE UNNECESSARY FOR THE OPERATION OF A MANAGED CARE COMMUNITY NETWORK.

SECTION 11. SECTION 17-7-502, MCA, IS AMENDED TO READ:

"**17-7-502. Statutory appropriations -- definition -- requisites for validity.** (1) A statutory

appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

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

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

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

(3) The following laws are the only laws containing statutory appropriations: 2-9-202; 2-17-105; 2-18-812; 3-5-901; 5-13-403; 10-3-203; 10-3-312; 10-3-314; 10-4-301; 15-1-111; 15-23-706; 15-25-123; 15-31-702; 15-36-112; 15-37-117; 15-38-202; 15-65-121; 15-70-101; 16-1-404; 16-1-410; 16-1-411; 17-3-106; 17-3-212; 17-5-404; 17-5-424; 17-5-704; 17-5-804; 17-6-101; 17-6-201; 17-6-409; 17-7-304; 18-11-112; 19-2-502; 19-6-709; 19-9-1007; 19-15-101; 19-17-301; 19-18-512; 19-18-513; 19-18-606; 19-19-205; 19-19-305; 19-19-506; 20-4-109; 20-8-111; 20-9-361; 20-26-1403; 20-26-1503; 23-2-823; 23-5-136; 23-5-306; 23-5-409; 23-5-610; 23-5-612; 23-5-631; 23-7-301; 23-7-402; 27-12-206; 32-1-537; 37-43-204; 37-51-501; 39-71-503; 39-71-907; 39-71-2321; 39-71-2504; 44-12-206; 44-13-102; 50-5-232; 50-40-206; [section 3]; 53-6-150; 53-24-206; 60-2-220; 61-2-107; 67-3-205; 75-1-1101; 75-5-507; 75-5-1108; 75-11-313; 76-12-123; 77-1-808; 80-2-103; 80-2-222; 80-4-416; 80-11-310; 81-5-111; 82-11-136; 82-11-161; 85-1-220; 85-20-402; 90-3-301; 90-4-215; 90-6-331; 90-7-220; 90-9-306; and 90-14-107.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for the payments. (In subsection (3): pursuant to sec. 7, Ch. 567, L. 1991, the inclusion of 19-6-709 terminates upon death of last recipient eligible for supplemental benefit; and pursuant to sec. 15, Ch. 534, L. 1993, the inclusion of 90-14-107 terminates July 1, 1995.)"

SECTION 12. 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 relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

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

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

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

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

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

(4) This code does not apply to health maintenance organizations or to managed care community networks, as defined in [section 2], to the extent that the existence and operations of those organizations are ~~authorized~~ governed by chapter 31 or to the extent that the existence and operations of those networks are governed by [sections 1 through 9].

(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 state employee group insurance program established in Title 2, chapter 18, part 8.

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

(8) (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."

NEW SECTION. **Section 13. Codification instruction.** (1) [Sections 1 through ~~11~~ 9] are intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to

[sections 1 through ~~11~~ 9].

(2) [SECTION 10] IS INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 33, CHAPTER 31, AND THE PROVISIONS OF TITLE 33, CHAPTER 31, APPLY TO [SECTION 10].

NEW SECTION. **Section 14. Effective date.** [This act] is effective July 1, 1995.

-END-