Montana Legislative Services Division

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DATE: November 15, 2010

TO: Legislative Finance Committee

FROM: Jaret Coles, Staff Attorney

RE: Montana Statutes Regarding Managed Care and Medicaid Waivers

SUMMARY

This information memorandum provides the Legislative Finance Committee (LFC) with a brief summary of some Montana statutes that the Department of Public Health and Human Services (DPHHS) should consider when it develops a managed care system. In order to pursue managed care, DPHHS may need to obtain a federal Medicaid waiver. There are two types of waivers that can apply in a managed care setting, including Section 1115 and Section 1915(b) waivers. Additionally, there are two statutory procedures that DPHHS can choose when developing a managed care system. One exists under section 53-6-116, MCA, and it contains few statutory restrictions regarding implementation. A second exists under Title 53, chapter 6, part 7, MCA (referred to as Part 7 in this memorandum), and it has multiple statutory requirements. DPHHS has permissive authority to develop managed care under the first procedure, and it is required to develop managed care under the second procedure.

In the event that DPHHS seeks to set up a managed care system under section 53-6-116, MCA, it should provide the LFC with an opportunity to review the proposed system. Additionally, in the event that the federal government requires a waiver, DPHHS should hold public hearings and seek review and comment from the House Appropriations Committee or, during the interim, the Children, Families, Health, and Human Services Interim Committee. Lastly, since DPHHS would be establishing the program on a voluntary basis, it would most likely need to follow the privatization statutes under Title 2, chapter 8, part 3, MCA.

In the event that DPHHS follows the statutory mandate of setting up a managed care system under Part 7, then LFC review is not mandated and the privatization statutes should not apply. However, the Legislative Auditor is required to oversee the managed care covered under Part 7.

FEDERAL MEDICAID WAIVERS

The Center for Medicare and Medicaid Services (CMS) allows states to seek waivers for certain Medicaid requirements. Three common federal waivers are Section 1115 waivers, Section 1915(b) waivers, and Section 1915(c) waivers. For the purpose of this information memorandum, a basic understanding of Section 1115 and 1915(b) waivers is helpful.

Section 1115 waivers give states the authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute.[1] Projects are generally approved to operate for a 5-year period, and states may submit renewal requests. There is a sufficient level of flexibility in developing a project, and states can "test substantially new ideas that show policy merit including all the options possible under the more limited 1915(b) [see below] waiver authority".[2] A project must be "budget neutral" over the life of the project.

Section 1915(b) waivers give states the authority to implement managed care delivery systems or otherwise limit individuals' choice of provider under Medicaid.[3] Section 1915(b) waivers can seek a waiver of "state wideness", comparable services, and freedom of choice.[4] A project must be cost-effective.[5]

Section 1915(c) waivers give states the authority to allow long-term care services to be delivered in community settings.[6] The program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.[7]

MONTANA STATUTES REGARDING A MANAGED CARE SYSTEM

Montana statutes allow the creation of a managed care health care system using two statutory procedures. To create a system, DPHHS can follow section 53-6-116, MCA, or it can follow nine specific statutes, all of which are located in Part 7. It is unclear what set of statutory procedures DPHHS plans on pursuing in the future. However, section 53-6-116, MCA, does not contain significant restrictions other than legislative oversight and public comment in regard to obtaining a federal waiver.

Section 53-6-116, MCA.

Pursuant to section 53-6-116, MCA, DPHHS has considerable discretion to "develop managed care and capitated health care systems for medicaid recipients".[8] A managed care system is "a

[1] *See* U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), *at* https://www.cms.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp.
[2] DMA Health Strategies, *Report to the State of Montana: Legislative Mental Health Study,* at 94 (Oct. 7, 2008).
[3] CMS, *at* https://www.cms.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp.
[4] DMA Health Strategies, *supra* note 2.
[5] CMS, *at* https://www.cms.gov/MedicaidStWaivProgDemoPGI/06_Combined1915bc.asp.
[6] CMS, *supra* note 3.
[7] *Id.*
[8] § 53-6-116(1), MCA.

program organized to serve the medical needs of medicaid recipients in an efficient and cost-effective manner by managing the receipt of medical services for a geographical or otherwise defined population of recipients through appropriate health care professionals".[9] The system can cover both "physical health services" and "mental health services".[10] DPHHS "may require the participation of medicaid recipients in managed care systems based upon geographical, financial, social, medical, and other factors as the department may determine are relevant to the development and efficient management of managed care systems".[11]

Title 53, Chapter 6, Part 7 – Medicaid Managed Care.

Part 7 contains nine specific statutes that outline the requirements of Medicaid managed care. Unlike section 53-6-116, MCA, there are several limitations in Part 7. However, the limitations apply only to programs created under Part 7.[12] As such, DPHHS is not required to follow Part 7 if it implements a system under section 53-6-116, MCA. Some of the major limitations are as follows:

- The managed care network must have a risk of financial loss. (§ 53-6-702(3)(a), MCA)
- DPHHS is required to adopt by rule "criteria for assessing the financial solvency of a network". (§ 53-6-703(3), MCA)
- DPHHS is required to "provide for independent review of any contract provisions and contract compliance with the financial solvency rules". (§ 53-6-703(3), MCA)
- A network may not begin operation before the approval of necessary federal waivers and the completion of the review of an application submitted to DPHHS. (§ 53-6-703(4), MCA)
- DPHHS may charge an applicant an application review fee if the fee is adopted by rule. (§ 53-6-703(4), MCA)
- A health care delivery system 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. (§ 53-6-703(5), MCA)
- Health care providers that provide emergency care can seek reimbursement regardless of the provider's affiliation with the health care entity. (§ 53-6-705(2), MCA)
- Contracts for services beyond 125 miles from the boarders of Montana may not be entered into if services of comparable cost and quality are available within the state. (§ 53-6-705(5), MCA)
- DPHHS is required to prepare an annual report regarding the effectiveness of the standards on ensuring access and quality of care to enrollees. (§ 53-6-705(8), MCA)

[9] § 53-6-116(3), MCA.
[10] § 53-6-116(2), MCA.
[11] § 53-6-117(3), MCA.
[12] §53-6-701, MCA.

- DPHHS is required to maintain a toll-free number for reporting problems with managed care entities. (§ 53-6-706(1), MCA)
- DPHHS is required to establish by rule rates for managed health care entities that are in accordance with federal requirements, that take into account differences in cost to provide health care to different populations based on age and eligibility, and that are based on treatment settings reasonable available to enrollees. (§ 53-6-706(3), MCA)
- DPHHS is required to establish by rule a method to reduce payments to managed health care entities to take into consideration a variety of factors in section 53-6-707, MCA.
- 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 the managed care covered by [Part 7]". (§53-6-709, MCA).

The relevant statutes that cover the limitations and requirements are provided in Appendix A.

MONTANA STATUTES REGARDING AUTHORITY TO PURSUE WAIVERS

Regardless of whether DPHHS follows section 53-6-116, MCA, or Part 7, CMS may determine that DPHHS needs a federal waiver. Montana statutes give DPHHS authority to obtain waivers under Section 1115 and Section 1915.[13] Section 53-2-215(1), MCA, provides that DPHHS can "pursue approval from the U.S. department of health and human services for implementation in Montana of . . . demonstration projects through Section 1115 waivers". Additionally, section 53-6-708, MCA, pertaining to Part 7 managed care programs, provides that DPHHS "may seek and obtain any necessary authorization provided under federal law to implement the [Part 7] program, including the waiver of any federal statutes or regulations".

An observation that can be made is that DPHHS has legislative authority to seek a Section 1115 waiver, which includes experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. This may or may not include managed care.[14] In the event that DPHHS receives a Section 1115 waiver for managed care or if CMS determines that a waiver is not required, then DPHHS also has authority to develop a managed care system under the less restrictive section 53-6-116, MCA.

DPHHS's authority to obtain a Section 1915(b) waiver is more restrictive. In order to receive a Section 1915(b) waiver for managed care, DPHHS would need to follow Part 7. The waiver provision in Part 7, which is contained in section 53-6-708, MCA, provides that:

[13] *See, e.g.,* §§ 53-2-101(5)-(6), 53-2-215, 53-2-216, 53-6-146, 53-6-708, MCA.

[14] A search on the CMS website using the term "managed care" produced 23 hits where managed care waivers exist. Out of these 23 hits, 22 of the hits listed Section 1915(b) as waiver authority, and only the state of Missouri listed Section 1115 as waiver authority.

> The department may seek and obtain any necessary authorization provided under federal law to implement the [Part 7] 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. 1396a(a)(13) even if the federal agency responsible for administering Title XIX determines that 42 U.S.C. 1396a(a)(13) applies to managed health care systems.

It is unclear whether DPHHS will seek a Section 1115 waiver or a Section 1915(b) waiver in the future or if DPHHS is taking the position that a waiver is not required. However, the Legislature and the public are entitled to comment on any Section 1115 waivers as discussed in the next section.

LEGISLATIVE OVERSIGHT AND PUBLIC COMMENT

Section 1115 Waivers – Medicaid Advisory Concil, House Appropriations or Children, Families, Health, and Human Services Interim Committee, and Public Comment.

Section 53-2-215(18)-(20), MCA, pertaining to legislative oversight and public comment provide that:

> (18) The department shall present a section 1115 waiver proposal to the appropriate medicaid advisory council, which must include consumer advocates, prior to the submission of the proposal to the federal government.
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> (19) The department shall present a section 1115 waiver proposal to the house appropriations committee or, during the interim, the children, families, health, and human services interim committee for review and comment at a public hearing prior to the submission of the proposal to the federal government for formal approval and shall also present the section 1115 waiver after final approval from the federal government.
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> (20) (a) The department shall provide for a public comment period on the proposed section 1115 waiver at least 60 days before the submission of the section 1115 waiver application to the federal government for formal approval.
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> (b) The department shall give notice of the proposal by announcing the pending submittal, stating its general purpose, and

> informing the public that information on the proposal is available on the department's website.
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> (c) The department shall provide for public comment through electronic means or mail and shall provide for a public forum in at least one location at which members of the public can submit views on the proposal. The department shall consider comments received and make any appropriate changes to the waiver request before submitting it to the federal government.
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> (d) The department shall post on its website the waiver concept paper, formal correspondence regarding a waiver proposal, and the final approved waiver, including documents received from the center for medicare and medicaid services.

Section 53-2-215, MCA, is included in Appendix A.

Legislative Finance Committee Comment.

In the event that DPHHS pursues a "managed care and capitated health care systems for medicaid recipients" under section 53-6-116, MCA, it is required to submit the proposed system to the LFC.[15] The LFC, in turn, is required to "review the proposed systems at its next regularly scheduled meeting and shall provide any comments concerning the proposed systems to the department".[16] Section 53-6-116, MCA, is included in Appendix A.

Legislative Audit Oversight.

In the event that DPHHS pursues Medicaid managed care under Part 7 or a Section 1915(b) waiver, or both, then the Legislative Auditor is required to "oversee the managed care". Additionally, as stated above, there are a variety of statutory requirements. Section 53-6-709, MCA, reads as follows:

> (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 the managed care covered by this part.
>
> (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.
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> (3) All 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

[15] § 53-6-116(1), (5), MCA.
[16] § 53-6-116(5), MCA.

present for prosecution the findings of any 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) This part does 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.

PRIVATIZATION STATUTES

One question that may arise is whether DPHHS is required to prepare a privatization plan. Section 2-8-302, MCA, provides that before an agency may privatize a program, it shall prepare a privatization plan. Privatize means "an agency contracting with the private sector to provide services that are currently or normally conducted directly by the employees of the state".[17] The privatization review statutes create an administrative process for evaluating privatization proposals prior to implementation by an agency. An agency proposing to privatize a program must prepare a privatization plan and release it to the public and any involved labor unions and submit it to the Legislative Audit Committee at least 180 days in advance of the implementation of the proposal.[18] The Legislative Audit Committee must hold a public hearing on the proposal at least 90 days before implementation, release a summary of the hearing and its findings and conclusions at least 45 days before implementation, and vote on an advisory recommendation to approve or disapprove the proposal and transmit its recommendation to the Governor at least 30 days before implementation.[19] The Governor then must approve or disapprove the proposal no less than 15 days prior to its proposed implementation date.[20]

In 2006, Attorney General McGrath was presented with the question of whether the Department of Corrections (DOC) was required to undergo the privatization process when it contracts with a Montana private nonprofit corporation to establish residential methamphetamine treatment programs pursuant to section 53-1-203(1)(c), MCA.[21] In concluding that the privatization statutes did not apply, Attorney General McGrath reasoned that the Legislature required the DOC to contract with private nonprofit corporations by using the word "shall" in section 53-1-203, MCA.[22] Given this mandatory duty, it was the Legislature and not the agency that was

[17] § 2-8-301(3)(a), MCA.
[18] § 2-8-302(2), MCA.
[19] § 2-8-302(3)-(5), MCA.
[20] § 2-8-302(6), MCA.
[21] 51 A.G. Op. 13 (2006).
[22] *Id.* at 3.

requiring the usage of a private vendor.[23] Moreover, the privatization statutes "cannot be construed to add mandatory procedural requirements that the legislature must meet in exercising its own power to make law".[24]

As applied here, DPHHS has two duties in regard to establishing managed care programs. Pursuant to section 53-6-116, MCA, DPHHS "***in its discretion, may*** develop managed care".[25] However, pursuant to section 53-6-701, MCA, in Part 7, DPHHS ***shall develop*** and implement integrated health care programs.[26] Applying the reasoning of Attorney General McGrath, DPHHS may have a statutory duty to follow the privatization statutes if it attempts to establish a managed care program pursuant to section 53-6-116, MCA, but it clearly does not have a duty to follow the privatization statutes if it develops a program under Part 7.

[23] *Id.* at 4.
[24] *Id.*
[25] § 53-6-116(1), MCA (emphasis added).
[26] § 53-6-701, MCA (emphasis added).

APPENDIX A

53-2-215. Social Security Act section 1115 waiver. (1) The department may pursue approval from the U.S. department of health and human services for implementation in Montana of a health insurance flexibility and accountability demonstration initiative and other demonstration projects through section 1115 waivers.

(2) The department may implement a demonstration project upon approval of a section 1115 waiver by the U.S. department of health and human services. The department may:

(a) coordinate a demonstration project with a program approved through a section 1915 waiver; or

(b) terminate and subsume in a new section 1115 waiver an existing managed care or access program approved through a section 1915(b) waiver, an optional state plan medicaid service authorized under 53-6-101, an optional state plan eligibility group authorized under 53-6-131, or an existing program approved by a section 1115 waiver, inclusive of the demonstration program authorized by 53-4-202 and Title 53, chapter 4, part 6, that is administered by the department.

(3) The department may amend the existing section 1115 demonstration project authorized in 53-4-601 and 53-6-101 to expand the demonstration project to implement the purposes of this section.

(4) The department may initiate and administer section 1115 waivers to more efficiently apply available state general fund money, other available state and local public and private funding, and federal money to the development and maintenance of medicaid-funded programs of health services and of other public assistance services and to structure those programs or services for more efficient and effective delivery to specific populations.

(5) (a) In establishing programs or services in a demonstration project approved through a section 1115 waiver, the department shall administer the expenditures under each demonstration project within the state spending authority that is available for that demonstration project. The department may limit enrollments in each program within a demonstration project, reduce the per capita expenditures available to enrollees, and modify and reduce the types and amounts of services available through each program when the department determines that expenditures can be reasonably expected to exceed the available state spending authority.

(b) The department shall develop a contingency plan if there is a spending cap as a condition of the waiver and the spending cap is exceeded. The contingency plan must address the effects on new programs, services, or eligibility groups.

(6) The department may coordinate the state children's health insurance program authorized under Title 53, chapter 4, part 10, with a section 1115 waiver for the purpose of increasing the state funding match available under the waiver and expanding the number of participants in the state children's health insurance program.

(7) The department, subject to the terms and conditions of the section 1115 waiver:

(a) shall establish the eligibility groups based upon the funding principles stated in 53-6-101(2);

(b) may provide medicaid coverage for one or more optional medicaid eligibility groups;

(c) may provide medicaid coverage for one or more specific populations of persons who are not within the federally authorized medicaid eligibility groups but who are within the requirements of subsection (8);

(d) may establish the service coverage, eligibility requirements, financial participation requirements, and other features for the administration and delivery of services to each section 1115 waiver eligibility group;

(e) shall set limits on the number of participants for each section 1115 waiver eligibility group;

(f) shall set limits on the total expenditures under each demonstration project; and

(g) shall set the limits on the total expenditures on the services to be provided to each section 1115 waiver eligibility group.

(8) The categories of persons that the department may consider for establishment as a section 1115 waiver eligibility group include but are not limited to:

(a) low-income parents of children who are eligible to participate in medicaid under 53-6-131 or in the state children's health insurance program authorized under Title 53, chapter 4, part 10;

(b) persons who because of low income and health-care needs are unable to procure health insurance coverage and are eligible to participate in a comprehensive health association plan authorized under Title 33, chapter 22, part 15;

(c) children who because of limits on enrollment may not be covered through the state children's health insurance program authorized under Title 53, chapter 4, part 10;

(d) children who are eligible to participate in the state children's health insurance program authorized under Title 53, chapter 4, part 10; and

(e) other specific groups of persons who are participants in programs or services funded solely or primarily through state general funds or who the department determines are in need of specific types of health care and related services, such as prescription drugs, reproductive health care, and mental health services, and are without adequate financial means to procure health insurance coverage of those needs.

(9) Children participating in a section 1115 waiver eligibility group or children who would be eligible to participate in the state children's health insurance program are subject to the eligibility criteria applicable under 53-4-1004, except as provided in subsection (10) of this section, for participation in the state children's health insurance program and must receive benefits as provided through the state children's health insurance program under 53-4-1005.

(10) (a) Except as provided in this subsection (10), the eligibility for the section 1115 waiver eligibility groups may not exceed 150% of the federal poverty level.

(b) The department may establish eligibility at greater than 150% but no more than 200% of the federal poverty level for any of the following groups established for purposes of a section 1115 waiver:

(i) participants in the state children's health insurance program;

(ii) participants in a group that may be covered under the state children's health insurance program;

(iii) participants in a family planning program;

(iv) participants in a group composed of persons previously served through a program funded with state general fund money and other nonmedicaid money; or

(v) participants in a group composed of persons with a significant need for particular services that are not readily available to that population through insurance products or because of personal financial limitations.

(c) In establishing the eligibility criteria based upon federal poverty levels, the department shall select levels to ensure that the resulting expenditures will remain within the available funding and will conform with the terms and conditions of approval by the U.S. department of health and human services.

(d) The department may adopt additional programmatic and financial eligibility criteria for a section 1115 waiver eligibility group in order to appropriately define the subject population, to limit use for fiscal and programmatic purposes, to prevent improper use, and to conform the administration of the program with the terms and conditions of the section 1115 waiver.

(e) Eligibility criteria applicable to a section 1115 waiver eligibility group need not conform to the criteria applicable to another section 1115 waiver eligibility group or to a medicaid eligibility group that is not encompassed within the demonstration project.

(11) (a) For each section 1115 waiver eligibility group, the department shall establish the program benefit or benefits to be available to the participants in the group.

(b) Program benefits may be in the form of:

(i) assistance in the payment of health insurance premiums for health care coverage through an employer or other existing group coverage available to the program enrollee;

(ii) assistance in the payment of health insurance premiums for health care coverage that meets a set of defined standards and limitations adopted by the department in consultation with the commissioner of insurance and obtained from participating private insurers or through self-insured pools;

(iii) premium purchase for insurance coverage on behalf of children who are 18 years of age or younger for the defined set of health care and related services adopted by the department for the state children's health insurance program authorized in Title 53, chapter 4, part 10; or

(iv) coverage of a defined set of health care and related services administered directly by the department on a fee-for-service basis.

(c) The department may limit the types of program benefits available to enrollees in a program. For programs in which the department provides for more than one type of program benefit, the department may require that enrollees, either as a whole or on an individual basis based on certain circumstances, use certain types of program benefits in lieu of using other types of program benefits.

(d) The department shall, as necessary to maintain expenditures for a program within the available funding for that program, set monetary limitations on the total benefit amounts available on a periodic basis for an enrollee through that program, whether that benefit is in the form of premium assistance, premium purchase, or a set of covered services.

(12) The benefits for a section 1115 waiver eligibility group may be in the form of a defined set of covered services consisting of one or more of the mandatory and optional medicaid state plan services specified in 53-6-101 or other health-care related services. The department may select the types of services that constitute a defined set of covered services for a section 1115 waiver eligibility group. The department may provide coverage of a service not specified in 53-6-101 if the department determines the service to be appropriate for the particular section 1115 waiver eligibility group. The department may define the nature, components, scope, amount, and duration of each covered service to be made available to a section 1115 waiver eligibility group. The nature, components, scope, amount, and duration of a covered service

made available to a section 1115 waiver eligibility group need not conform to those aspects of that service as defined by the department for delivery as a covered service to another section 1115 waiver eligibility group or to a medicaid eligibility group that is not encompassed within a section 1115 waiver.

(13) The department may adopt financial participation requirements for enrollees in a section 1115 eligibility group to foster appropriate use among enrollees and to maintain the fiscal accountability of the program. The department may adopt financial participation requirements, including but not limited to copayments, payment of monthly or yearly enrollment fees, or deductibles. The requirements may vary among the section 1115 waiver eligibility groups. In adopting financial participation requirements for enrollees selecting coverage as provided in subsection (11)(b)(iv), the department may not adopt cost-sharing amounts that exceed the nominal deductible, coinsurance, copayment, or similar charges adopted by the department to apply to categorically or medically needy persons for a service pursuant to the state medicaid plan.

(14) The department shall adopt rules as necessary for the implementation of a section 1115 waiver. Rules may include but are not limited to:

(a) designation of programs and activities for implementation of a section 1115 waiver;

(b) features and benefit coverage of the programs;

(c) the nature, components, scope, amount, and duration of each program service;

(d) appropriate insurance products and coverage as benefits;

(e) required enrollee eligibility information;

(f) enrollee eligibility categories, criteria, requirements, and related measures;

(g) limits upon enrollment;

(h) requirements and limitations for service costs and expenditures;

(i) measures to ensure the appropriateness and quality of services to be delivered;

(j) provider requirements and reimbursement;

(k) financial participation requirements for enrollees;

(l) use measures; and

(m) other appropriate provisions necessary for administration of a demonstration project and for implementation of the conditions placed upon approval of a section 1115 waiver by the U.S. department of health and human services.

(15) The department shall administer the programs and activities that are subject to a section 1115 waiver in accordance with the terms and conditions of approval by the U.S. department of health and human services. The department may modify aspects of established programs and activities administered by the department as may be necessary to implement a section 1115 waiver as provided in this section.

(16) The department may seek an initial duration and durational extensions for a section 1115 waiver as the department determines appropriate for demonstration and fiscal considerations.

(17) The department shall provide a report to the legislature, as provided in 5-11-210, on the conditions of approval and the status of implementation for each section 1115 waiver approved by the U.S. department of health and human services. For any proposed section 1115 waiver not approved by the U.S. department of health and human services, the department shall provide to the next legislative session a report on the basis for disapproval and an analysis of the fiscal costs and programmatic impacts of serving the persons within the proposed section 1115

waiver eligibility groups through eligibility under one of the optional medicaid eligibility categories established in federal law and authorized by 53-6-131.

(18) The department shall present a section 1115 waiver proposal to the appropriate medicaid advisory council, which must include consumer advocates, prior to the submission of the proposal to the federal government.

(19) The department shall present a section 1115 waiver proposal to the house appropriations committee or, during the interim, the children, families, health, and human services interim committee for review and comment at a public hearing prior to the submission of the proposal to the federal government for formal approval and shall also present the section 1115 waiver after final approval from the federal government.

(20) (a) The department shall provide for a public comment period on the proposed section 1115 waiver at least 60 days before the submission of the section 1115 waiver application to the federal government for formal approval.

(b) The department shall give notice of the proposal by announcing the pending submittal, stating its general purpose, and informing the public that information on the proposal is available on the department's website.

(c) The department shall provide for public comment through electronic means or mail and shall provide for a public forum in at least one location at which members of the public can submit views on the proposal. The department shall consider comments received and make any appropriate changes to the waiver request before submitting it to the federal government.

(d) The department shall post on its website the waiver concept paper, formal correspondence regarding a waiver proposal, and the final approved waiver, including documents received from the center for medicare and medicaid services.

History: En. Sec. 3, Ch. 350, L. 2005.

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

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

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

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

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

History: En. Sec. 1, Ch. 460, L. 1991; amd. Sec. 2, Ch. 31, Sp. L. November 1993; amd. Sec. 449, Ch. 546, L. 1995; amd. Sec. 2, Ch. 466, L. 2001.

53-6-117. Participation requirements. (1) The department of public health and human services may require medicaid recipients to participate in a managed care system.

(2) Recipients who are required by the department to participate in a managed care system shall participate as required in order to remain eligible for medicaid.

(3) The department may require the participation of medicaid recipients in managed care systems based upon geographical, financial, social, medical, and other factors as the department may determine are relevant to the development and efficient management of managed care systems.

History: En. Sec. 2, Ch. 460, L. 1991; amd. Sec. 450, Ch. 546, L. 1995.

53-6-701. 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 system that encourages the integration of health care services and that manages the health care of 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 integrated health care programs consistent with the provisions of this part. The provisions of this part apply only to programs created under this part. The department shall by rule identify persons eligible for enrollment in a program. The department shall inform enrollees of their choice, if any, among health care delivery systems. Persons enrolled in a program may also be offered cost-effective indemnity insurance plans, subject to availability.

History: En. Sec. 1, Ch. 502, L. 1995; amd. Sec. 4, Ch. 466, L. 2001.

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

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

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

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

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

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

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

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

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

History: En. Sec. 2, Ch. 502, L. 1995; amd. Sec. 5, Ch. 466, L. 2001; amd. Sec. 3, Ch. 401, L. 2003; amd. Sec. 4, Ch. 403, L. 2003; amd. Sec. 3, Ch. 195, L. 2009.

53-6-703. Managed care community network. (1) A managed care community network shall comply with 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) The department, prior to entering into a contract, shall require that a managed care community network demonstrate to the department its ability to bear the level of financial risk being assumed by servicing enrollees under a contract for comprehensive physical or mental health care services. The department shall by rule adopt criteria for assessing the financial solvency of a network. The rules must consider risk-bearing and management techniques and protections against financial insolvency if a managed care community network is declared insolvent or bankrupt, as determined appropriate by the department. The rules must also consider whether a network has sufficiently demonstrated its financial solvency and net worth. The department's criteria must be based on sound actuarial, financial, and accounting principles. The department is responsible for monitoring compliance with the rules. The department shall provide for independent review of any contract provisions and contract compliance with the financial solvency rules.

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

(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 53-6-705(4)(c).

History: En. Sec. 3, Ch. 502, L. 1995; amd. Sec. 9, Ch. 577, L. 1999; amd. Sec. 6, Ch. 466, L. 2001; amd. Sec. 64, Ch. 130, L. 2005; amd. Sec. 10, Ch. 426, L. 2009.

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

(2) The program established by this part may be implemented by the department in various contracting areas at various times. The health care delivery systems and providers

available under the program may vary throughout the state. Except as otherwise provided in a contract for mental health services, 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.

History: En. Sec. 4, Ch. 502, L. 1995; amd. Sec. 10, Ch. 577, L. 1999.

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

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

(3) The entity shall 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. This part does 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 this part 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.

History: En. Sec. 5, Ch. 502, L. 1995.

53-6-706. 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, but is not required to, enroll the individual in the program prior to the individual's discharge 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 in accordance with federal requirements and 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.

History: En. Sec. 6, Ch. 502, L. 1995; amd. Sec. 11, Ch. 577, L. 1999.

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

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

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

(2) For key services provided by a hospital 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 at the time the payments are made.

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

History: En. Sec. 7, Ch. 502, L. 1995.

53-6-708. 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. 1396a(a)(13) even if the federal agency responsible for administering Title XIX determines that 42 U.S.C. 1396a(a)(13) applies to managed health care systems.

History: En. Sec. 8, Ch. 502, L. 1995; amd. Sec. 239, Ch. 42, L. 1997.

53-6-709. 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 the managed care covered by this part.

(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 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 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) This part does 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.

History: En. Sec. 9, Ch. 502, L. 1995; amd. Sec. 12, Ch. 577, L. 1999.

APPENDIX B

2-8-301. Definitions. As used in this part, the following definitions apply:

(1) "Agency" means an office, position, commission, committee, board, department, council, division, bureau, section, or any other entity or instrumentality of the executive, legislative, or judicial branch of state government.

(2) "Private sector" means any entity or individual not principally a part of or associated with a governmental unit that is associated with or involved in commercial activity.

(3) (a) "Privatize" means an agency contracting with the private sector to provide services that are currently or normally conducted directly by the employees of the state.

(b) The term does not include contracting with the private sector to provide services on a temporary or emergency basis.

(4) "Program" means a legislatively or administratively created function, project, or duty of an agency.

History: En. Sec. 1, Ch. 762, L. 1991; amd. Sec. 1, Ch. 285, L. 2005.

2-8-302. Privatization plan -- hearing -- role of legislative audit committee -- action by governor. (1) Before an agency may privatize a program, it shall prepare a privatization plan as provided in 2-8-303.

(2) The privatization plan must be released to the public and to all unions that represent state employees and must be submitted to the legislative audit committee at least 180 days prior to the proposed implementation date.

(3) At least 90 days prior to the proposed implementation date, the legislative audit committee shall conduct a public hearing on the proposed privatization plan at which public comments and testimony must be received.

(4) At least 45 days prior to the proposed implementation date, the legislative audit committee shall release to the public a summary of the results of the hearing and the findings and conclusions of the legislative audit committee.

(5) (a) At least 30 days prior to the proposed implementation date, the legislative audit committee shall vote to recommend approval or disapproval of the privatization plan to the governor and transmit the recommendation in writing to the governor.

(b) The recommendation of the legislative audit committee is advisory only.

(6) At least 15 days prior to the proposed implementation date, the governor shall approve or disapprove the privatization plan, stating in writing the reasons for approval or disapproval.

History: En. Sec. 2, Ch. 762, L. 1991; amd. Sec. 2, Ch. 285, L. 2005.

2-8-303. Privatization plan -- contents. (1) An agency proposing to privatize a program shall prepare a privatization plan that includes the following:

(a) a description of the program to be privatized, including references to the legal authority under which the program was created;

(b) detailed budget information that includes a list of expenditures for the 2 most recent fiscal years and the sources of revenue for the program;

(c) a list of all personnel currently employed in the program and the estimated effect of the proposed privatization on the employment status of each employee affected;

(d) a listing of the assets of the program and their proposed disposition if the plan is implemented;

(e) an estimate of the cost savings or any additional costs resulting from privatizing the program, compared to the costs of the existing, nonprivatized program. Additional costs must include the estimated cost to the state of inspection, supervision, and monitoring of the proposed privatization and the costs incurred in the discontinuation of such a contract.

(f) the estimated current and future economic impacts of the implementation of the plan on other state programs, including public assistance programs, unemployment insurance programs, retirement programs, and agency personal services budgets used to pay out accrued vacation and sick leave benefits;

(g) the estimated increases or decreases in costs and quality of goods or services to the public if the plan is implemented;

(h) the estimated changes in individual wages and benefits resulting from the proposed privatization;

(i) the ways in which the proposed privatization will deliver the same or better services at a lower cost; and

(j) a narrative explanation and justification for the proposed privatization.

(2) To implement the privatization plan, an agency may transfer funds between budget categories.

History: En. Sec. 3, Ch. 762, L. 1991; amd. Sec. 3, Ch. 285, L. 2005.