

1 SENATE BILL NO. 84

2 INTRODUCED BY C. KAUFMANN

3 BY REQUEST OF THE STATE AUDITOR

4
5 A BILL FOR AN ACT ENTITLED: "AN ACT CREATING A COMMISSION AND STANDARDS FOR
6 PATIENT-CENTERED MEDICAL HOMES; PROVIDING THAT ACTIVITIES OF THE MONTANA COMMISSION
7 ON PATIENT-CENTERED MEDICAL HOMES HAVE A STATE PURPOSE THAT PROVIDES STATE ACTION
8 IMMUNITY ON ANTICOMPETITION CONCERNS; PROVIDING FOR USE OF PATIENT-CENTERED MEDICAL
9 HOMES IN THE MEDICAID AND HEALTHY MONTANA KIDS PROGRAMS; INCLUDING ALL STATE,
10 UNIVERSITY, LOCAL GOVERNMENT, STATE-REGULATED MULTIPLE-WELFARE ARRANGEMENTS,
11 THIRD-PARTY ADMINISTRATORS, AND SELF-INSURED STUDENT HEALTH PLANS AS POTENTIAL
12 HEALTH PLAN PARTICIPANTS IN A PATIENT-CENTERED MEDICAL HOME PROGRAM; PROVIDING
13 RULEMAKING AUTHORITY FOR THE STATE AUDITOR'S OFFICE AND THE DEPARTMENT OF PUBLIC
14 HEALTH AND HUMAN SERVICES; AMENDING SECTIONS 20-25-1403, 33-1-102, 33-31-111, 33-35-306, AND
15 53-6-113, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

16
17 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

18
19 NEW SECTION. **Section 1. Short title -- legislative findings.** (1) [Sections 1 through 7] may be cited
20 as the "Patient-Centered Medical Homes Act".

21 (2) The legislature finds that the increasing cost of health care makes health plans more difficult for
22 individuals, families, and businesses to afford. These increases in health care costs are attributable in part to
23 inadequate coordination of care among providers, difficulties in accessing primary care, and a lack of engagement
24 between patients and their primary care providers. The purpose of [sections 1 through 7] is to enhance care
25 coordination and promote high-quality, cost-effective care through patient-centered medical homes by engaging
26 patients and their primary care providers.

27 (3) The legislature also finds that chronic diseases are one of the biggest threats to the health of
28 Montana residents. The purpose of [sections 1 through 7] includes promoting episodic evidence-based care in
29 the community to reduce hospital admissions, enhance chronic disease management, and reduce costs for
30 treating chronic diseases.

1 (4) The legislature finds that there is a shortage of primary care providers in areas of Montana and that
2 inconsistent access to health care services and variable quality of care have been shown to result in poorer health
3 outcomes and health care disparities but that patient-centered medical homes offer a model of primary care that
4 may attract new providers to Montana because the model is effective, sustainable, and replicable in small
5 communities and provides a process to achieve higher quality health care for Montana citizens and a way to help
6 slow the continuing escalation of health care costs as well as improve health outcomes for Montana citizens.

7 (5) The legislature further finds that a single definition and common set of quality measures as well as
8 a uniform payment methodology provide the best chance of success for the patient-centered medical homes
9 model by increasing consistency in reporting across health plans and primary care practices.

10 (6) The legislature finds that best practices are most likely to be recognized and adopted by primary care
11 practices if a state-structured patient-centered medical home program works with programs that may be
12 developed for health plans and primary care practices and for any programs in Title 53 for medicaid and in Title
13 53, chapter 4, part 11, for the healthy Montana kids plan.

14 (7) The legislature also finds that an ongoing process is desirable to evaluate the effectiveness of
15 patient-centered medical homes.

16 (8) Notwithstanding any state or federal law that prohibits the collaboration of insurers, other health
17 plans, or providers regarding payment methods, the legislature finds that patient-centered medical homes are
18 likely to result in the delivery of more efficient and effective health care services and are in the public interest.

19
20 **NEW SECTION. Section 2. Commission for patient-centered medical homes established --**
21 **purpose.** (1) There is established the Montana commission for patient-centered medical homes, which is subject
22 to the supervision of the commissioner.

23 (2) A board, appointed as provided in [section 4], shall govern the commission.

24 (3) The commission shall establish itself as a nonprofit corporation and file articles of incorporation with
25 the secretary of state as provided in Title 35, chapter 2. The provisions of Title 35, chapter 2, apply to the
26 commission unless disapproved by the commissioner under the authority provided in [section 5].

27 (4) The commission shall abide by open meeting laws as provided under Title 2, chapter 3, and laws
28 implementing the public's right to know under Article II, section 9.

29 (5) The state action immunity doctrine applies to the commission's activities relating to medical
30 payments, and federal or state antitrust laws that prohibit collusion do not apply to commission activities regarding

1 medical payments. The legislative findings, as provided in [section 1], and oversight by the insurance
2 commissioner combine to determine that patient-centered medical homes are in the public interest and are likely
3 to result in the delivery of more efficient and effective health care services sufficient to override concerns about
4 collusion regarding medical payments among insurers, other health plans, or primary care practices.

5
6 **NEW SECTION. Section 3. Definitions.** As used in sections [1 through 7], the following definitions
7 apply:

8 (1) "Commission" means the Montana commission for patient-centered medical homes established
9 under [section 2].

10 (2) "Covered medical services" means the health care services that are included as benefits under a
11 health plan.

12 (3) "Department" means the department of public health and human services provided for in 2-15-2201.

13 (4) "Health plan" means any public or private program that pays for medical care, including but not limited
14 to a health benefit plan issued by or administered by an insurer, a health service corporation, a health
15 maintenance organization, a multiple employer welfare arrangement, or a third-party administrator or a plan
16 described under 33-1-102(7), (9), or (12).

17 (5) "Patient-centered medical home" means a model of health care that is:

18 (a) directed by a primary care provider offering family-centered, culturally effective care that is
19 coordinated, comprehensive, continuous, and, whenever possible, located in the patient's community and
20 integrated across systems;

21 (b) characterized by enhanced access, with an emphasis on prevention, improved health outcomes, and
22 satisfaction;

23 (c) qualified by the commission under [section 6] as meeting the standards of a patient-centered medical
24 home; and

25 (d) reimbursed under a payment system that recognizes the value of services determined by the
26 commission to meet the standards of a patient-centered medical home.

27 (6) "Primary care practice" means a solo health care provider, a health care practice, or a federally
28 qualified health center as defined in 42 U.S.C. 254b that is organized by or includes licensees under Title 37 who
29 provide primary medical care, including but not limited to pediatricians, internal medicine physicians, family
30 medicine physicians, nurse practitioners, and physician assistants.

1 (7) "Qualified individual" means a policyholder, certificate holder, member, subscriber, enrollee, or other
2 individual who is participating in a health plan and who is enrolled in a patient-centered medical home program.

3
4 **NEW SECTION. Section 4. Board of directors -- composition -- appointment -- compensation.** (1)
5 There is a board of directors of the Montana commission for patient-centered medical homes consisting of nine
6 members appointed as provided in subsection (2) and two nonvoting members appointed as provided in
7 subsection (3).

8 (2) (a) The commissioner shall appoint five members and stagger their appointments. Of these five
9 members, two must represent health plans, one must be a representative of a health-related or consumer
10 advocacy organization with significant experience in health care issues, and two must be health care providers
11 and represent the perspective of primary health care providers.

12 (b) The governor shall appoint four members and stagger their appointments. Of these four members,
13 one must be the director of the state health plan, one must be a health care provider and represent the
14 perspective of primary health care providers, and two must be representatives of a health-related consumer
15 advocacy organization with significant experience in health care issues.

16 (3) The commissioner shall appoint as one nonvoting member a representative of the commissioner's
17 staff who has experience in health insurance and health care issues. The governor shall appoint as one nonvoting
18 member a representative from the department with experience in medicaid health care delivery systems. The
19 nonvoting members shall participate in all board meetings.

20 (4) Each member appointed under subsection (2) has one vote on the board and shall serve a 3-year
21 term.

22 (5) Compensation, including travel expenses, is as provided under 2-15-124, except that the expenses
23 for the nonvoting members appointed pursuant to subsection (3) must be paid by their respective offices.

24 (6) The cost of conducting meetings of the commission must be paid by the commission.

25 (7) In case of a vacancy or if a member or nonvoting member is not actively participating in the
26 commission's duties as determined by the person who made the original appointment, a replacement appointment
27 must be made in the same manner as the original appointment. A replacement appointee is to serve for the
28 unexpired term but may be reappointed after the term expires.

29 (8) Initial board appointments must be made at least 1 month prior to the commission's first meeting.

30 (9) The commissioner shall meet at least twice each year, beginning in June 2013.

1 (10) Board members may be reappointed.

2

3 **NEW SECTION. Section 5. Powers and duties of commissioner -- rulemaking.** The commissioner
4 shall:

5 (1) adopt rules necessary to implement the provisions of [sections 1 through 7];

6 (2) approve or disapprove any fees that the commission proposes to impose for the purpose of paying
7 for the ongoing activities of the commission. The general fund may not be used to fund this program.

8 (3) approve or disapprove the plan of operation that the commission proposes; and

9 (4) investigate and refer for further action, if appropriate, any complaints received from the public
10 concerning the activities of the commission.

11

12 **NEW SECTION. Section 6. Powers and duties of the commission.** The commission shall, according
13 to the provisions of [sections 1 through 7]:

14 (1) in consultation with the commissioner, health plans, and primary health care providers, qualify
15 patient-centered medical homes that meet the standards established by the commission;

16 (2) oversee, promote, coordinate, and provide guidance concerning the creation and activities of any
17 patient-centered medical homes doing business in Montana in order to ensure that the requirements of [sections
18 1 through 7] are met;

19 (3) consult with all interested parties in association with carrying out the activities required under
20 [sections 1 through 7], including but not limited to primary health care providers, health plans, public health plans,
21 the department, and health care consumers;

22 (4) keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the
23 commissioner and the governor a report containing this accounting;

24 (5) adopt bylaws for the regulation of its affairs and the conduct of its business;

25 (6) develop a plan of operation that includes procedures and criteria detailing the implementation of the
26 activities and duties assigned to the commission under [sections 1 through 7];

27 (7) develop and implement strategies that encourage the participation of health plans in patient-centered
28 medical homes;

29 (8) develop and implement standards in consultation with the commissioner and the department as set
30 forth in [section 7];

- 1 (9) seek and receive appropriate grant funding available from private or government sources;
- 2 (10) impose appropriate participation fees on primary care practices and health plans that participate in
3 patient-centered medical homes;
- 4 (11) evaluate and report on health outcomes, patient satisfaction, and health care costs using nationally
5 accepted, evidence-based evaluation tools and techniques; and
- 6 (12) conduct public education activities to raise awareness of the availability of patient-centered medical
7 homes.

8

9 **NEW SECTION. Section 7. Standards for patient-centered medical homes.** (1) The commission
10 shall, in consultation with the commissioner, health plans, the department, and providers in primary care
11 practices, set standards from the list provided in subsection (2).

12 (2) Standards may be set for one or more of the following or for other topics determined by the
13 commission:

14 (a) payment methods used by health plans to pay patient-centered medical homes for services
15 associated with the coordination of covered health care services;

16 (b) bonuses, fee-based incentives, bundled fees, or other incentives that a health plan may use to pay
17 a patient-centered medical home based on the savings from reduced health care expenditures associated with
18 improved health outcomes and care coordination by qualified individuals attributed to the participation in the
19 patient-centered medical homes;

20 (c) a uniform set of health care quality and performance measures; and

21 (d) a uniform set of measures related to cost and medical usage.

22 (3) A patient-centered medical home shall report on its compliance with the uniform set of health care
23 quality and performance measures adopted by the commission to:

24 (a) health plans with which the patient-centered medical home contracts;

25 (b) the commission; and

26 (c) the department, if the department is a participant.

27 (4) A health plan shall report to the patient-centered medical home regarding its compliance with the
28 uniform set of cost and utilization measures adopted by the commission for patients covered under the health
29 plan.

30 (5) In developing the standards described in subsection (2), the commission may consider:

- 1 (a) the use of health information technology, including electronic medical records;
- 2 (b) the relationship between the primary care practice, specialists, other health care providers, and
3 hospitals;
- 4 (c) the access standards for individuals covered by a health plan to receive primary medical care in a
5 timely manner;
- 6 (d) the ability of the primary care practice to foster a partnership with patients; and
- 7 (e) the use of comprehensive medication management to improve clinical outcomes.
- 8 (6) The initial set of standards developed pursuant to this section must be completed and approved
9 within 30 days of the commission's first meeting in June 2013. The commission shall review standards developed
10 under this section every 2 years and reaffirm retained standards every 2 years after adoption.
- 11 (7) (a) The department is not obligated to abide by payment methods for paying patient-centered medical
12 homes that may be prescribed by the commission as provided in subsection (2)(a) or to use any bonuses or
13 incentives prescribed by the commission as provided in subsection (2)(b), but the department shall comply with
14 all other standards and quality and performance measures adopted by the commission.
- 15 (b) The department may not recognize as a patient-centered medical home any health care provider
16 group that has not achieved recognition as a patient-centered medical home under [sections 1 through 7].

17

18 **Section 8.** Section 20-25-1403, MCA, is amended to read:

19 **"20-25-1403. Authorization to establish self-insured health plan for students -- requirements --**
20 **exemption.** (1) The commissioner may establish a self-insured student health plan for enrolled students of the
21 system and their dependents, including students of a community college district. In developing a self-insured
22 student health plan, the commissioner shall:

- 23 (a) maintain the plan on an actuarially sound basis;
- 24 (b) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the plan;
- 25 and
- 26 (c) deposit all reserve funds, contributions and payments, interest earnings, and premiums paid to the
27 plan. The deposits must be expended for claims under the plan and for the costs of administering the plan,
28 including but not limited to the costs of hiring staff, consultants, actuaries, and auditors, purchasing necessary
29 reinsurance, and repaying debts.

30 (2) Prior to the implementation of a self-insured student health plan, the commissioner shall consult with

1 affected parties, including but not limited to the board of regents and representatives of enrolled students of the
2 system.

3 (3) A self-insured student health plan developed under this part is not responsible for and may not cover
4 any services or pay any expenses for which payment has been made or is due under an automobile, premises,
5 or other private or public medical payment coverage plan or provision or under a workers' compensation plan or
6 program, except when the other payor is required by federal law to be a payor of last resort. The term "services"
7 includes but is not limited to all medical services, procedures, supplies, medications, or other items or services
8 provided to treat an injury or medical condition sustained by a member of the plan.

9 (4) ~~The~~ Except for the provisions of [sections 1 through 7], the provisions of Title 33 do not apply to the
10 commissioner when exercising the duties provided for in this part."
11

12 **Section 9.** Section 33-1-102, MCA, is amended to read:

13 **"33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance**
14 **organizations -- governmental insurance programs -- service contracts.** (1) A person may not transact a
15 business of insurance in Montana or a business relative to a subject resident, located, or to be performed in
16 Montana without complying with the applicable provisions of this code.

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

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

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

23 (4) ~~This~~ Except as provided in [sections 1 through 7], this code does not apply to health maintenance
24 organizations to the extent that the existence and operations of those organizations are governed by chapter 31.

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

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

1 (7) This Except as provided in [sections 1 through 7], this code does not apply to the state employee
2 group insurance program established in Title 2, chapter 18, part 8, or the Montana university system group
3 benefits plans established in Title 20, chapter 25, part 13.

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

6 (9) (a) Except as otherwise provided in Title 33, chapter 22, and [sections 1 through 7], this code does
7 not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state in which
8 the political subdivisions undertake to separately or jointly indemnify one another by way of a pooling, joint
9 retention, deductible, or self-insurance plan.

10 (b) Except as otherwise provided in Title 33, chapter 22, and [sections 1 through 7], this code does not
11 apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state or any
12 arrangement, plan, or program of a single political subdivision of this state in which the political subdivision
13 provides to its officers, elected officials, or employees disability insurance or life insurance through a self-funded
14 program.

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

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

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

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

30 (12) This Except as provided in [sections 1 through 7], this code does not apply to the self-insured student

1 health plan established in Title 20, chapter 25, part 14.

2 (13) This code does not apply to private air ambulance services that are in compliance with 50-6-320 and
3 that solicit membership subscriptions, accept membership applications, charge membership fees, and provide
4 air ambulance services to subscription members and designated members of their households."
5

6 **Section 10.** Section 33-31-111, MCA, is amended to read:

7 **"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise provided
8 in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization
9 authorized to transact business under this chapter. This provision does not apply to an insurer or health service
10 corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state
11 except with respect to its health maintenance organization activities authorized and regulated pursuant to this
12 chapter.

13 (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its
14 representatives is not a violation of any law relating to solicitation or advertising by health professionals.

15 (3) A health maintenance organization authorized under this chapter is not practicing medicine and is
16 exempt from Title 37, chapter 3, relating to the practice of medicine.

17 (4) This chapter does not exempt a health maintenance organization from the applicable certificate of
18 need requirements under Title 50, chapter 5, parts 1 and 3.

19 (5) This section does not exempt a health maintenance organization from the prohibition of pecuniary
20 interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704.
21 A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701
22 through 33-3-704.

23 (6) This section does not exempt a health maintenance organization from:

24 (a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

25 (b) the provisions of Title 33, chapter 22, part 19;

26 (c) the requirements of 33-22-134 and 33-22-135;

27 (d) network adequacy and quality assurance requirements provided under chapter 36; or

28 (e) the requirements of Title 33, chapter 18, part 9.

29 (7) Title 33, chapter 1, parts 12 and 13, sections 1 through 7, Title 33, chapter 2, part 19, 33-2-1114,
30 33-2-1211, 33-2-1212, 33-3-401, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19,

1 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-137, 33-22-141, 33-22-142, 33-22-152, 33-22-244,
 2 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply
 3 to health maintenance organizations."

4

5 **Section 11.** Section 33-35-306, MCA, is amended to read:

6 **"33-35-306. Application of insurance code to arrangements.** (1) In addition to this chapter,
 7 self-funded multiple employer welfare arrangements are subject to the following provisions:

8 (a) 33-1-111;

9 (b) [sections 1 through 7];

10 ~~(b)~~(c) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare
 11 arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

12 ~~(c)~~(d) Title 33, chapter 1, part 7;

13 ~~(d)~~(e) 33-3-308;

14 ~~(e)~~(f) Title 33, chapter 18, except 33-18-242;

15 ~~(f)~~(g) Title 33, chapter 19;

16 ~~(g)~~(h) 33-22-107, 33-22-131, 33-22-134, 33-22-135, 33-22-141, 33-22-142, and 33-22-152; and

17 ~~(h)~~(i) 33-22-512, 33-22-515, 33-22-525, and 33-22-526.

18 (2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple
 19 employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

20

21 **Section 12.** Section 53-6-113, MCA, is amended to read:

22 **"53-6-113. Department to adopt rules.** (1) The department shall adopt appropriate rules necessary for
 23 the administration of the Montana medicaid program as provided for in this part and that may be required by
 24 federal laws and regulations governing state participation in medicaid under Title XIX of the Social Security Act,
 25 42 U.S.C. 1396, et seq., as amended.

26 (2) The department shall adopt rules that are necessary to further define for the purposes of this part the
 27 services provided under 53-6-101 and to provide that services being used are medically necessary and that the
 28 services are the most efficient and cost-effective available. The rules may establish the amount, scope, and
 29 duration of services provided under the Montana medicaid program, including the items and components
 30 constituting the services.

1 (3) The department shall establish by rule the rates for reimbursement of services provided under this
2 part. The department may in its discretion set rates of reimbursement that it determines necessary for the
3 purposes of the program. In establishing rates of reimbursement, the department may consider but is not limited
4 to considering:

- 5 (a) the availability of appropriated funds;
- 6 (b) the actual cost of services;
- 7 (c) the quality of services;
- 8 (d) the professional knowledge and skills necessary for the delivery of services; and
- 9 (e) the availability of services.

10 (4) The department shall specify by rule those professionals who may deliver or direct the delivery of
11 particular services.

12 (5) The department may provide by rule for payment by a recipient of a portion of the reimbursements
13 established by the department for services provided under this part.

14 (6) The department may adopt rules consistent with this part to govern eligibility for the Montana
15 medicaid program, including the medicaid program provided for in 53-6-195. Rules may include but are not limited
16 to financial standards and criteria for income and resources, treatment of resources, nonfinancial criteria, family
17 responsibilities, residency, application, termination, definition of terms, confidentiality of applicant and recipient
18 information, and cooperation with the state agency administering the child support enforcement program under
19 Title IV-D of the Social Security Act, 42 U.S.C. 651, et seq. The department may not apply financial criteria below
20 \$15,000 for resources other than income in determining the eligibility of a child under 19 years of age for poverty
21 level-related children's medicaid coverage groups, as provided in 42 U.S.C. 1396a(l)(1)(B) through (l)(1)(D).

22 (7) The department may adopt rules limiting eligibility based on criteria more restrictive than that provided
23 in 53-6-131 if required by Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, or
24 if funds appropriated are not sufficient to provide medical care for all eligible persons.

25 (8) The department may adopt rules necessary for the administration of medicaid managed care
26 systems. Rules to be adopted may include but are not limited to rules concerning:

- 27 (a) participation in managed care;
- 28 (b) selection and qualifications for providers of managed care; and
- 29 (c) standards for the provision of managed care.

30 (9) Subject to subsection (6), the department shall establish by rule income limits for eligibility for

1 extended medical assistance of persons receiving section 1931 medicaid benefits, as defined in 53-4-602, who
2 lose eligibility because of increased income to the assistance unit, as that term is defined in the rules of the
3 department, as provided in 53-6-134, and shall also establish by rule the length of time for which extended
4 medical assistance will be provided. The department, in exercising its discretion to set income limits and duration
5 of assistance, may consider the amount of funds appropriated by the legislature.

6 (10) The department may adopt rules authorizing the use under Title 53 of a patient-centered medical
7 home program established under [sections 1 through 7] and may adopt rules necessary for administering the
8 program, including but not limited to rules setting payment rates and fees. A patient-centered medical home
9 program under Title 53 is excepted from payment provisions as provided in [section 7(7)] but shall use
10 patient-centered medical homes that have been qualified by the commission."

11
12 **NEW SECTION. Section 13. Codification instruction.** [Sections 1 through 7] are intended to be
13 codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 1 through 7].

14
15 **NEW SECTION. Section 14. Effective date.** [This act] is effective on passage and approval.

16 - END -