*** Bill No. ***

Introduced By *********

By Request of the State Auditor's Office.

Be it enacted by the Legislature of the State of Montana:

A Bill for an Act entitled: "An Act amending the Patient Centered Medical Homes Act to remove the sunset provisions terminating the act; making the standards for qualifying patient centered medical homes more flexible; removing the one time independent study requirement which was met in 2016; and amending sections 33-40-101, 33-40-102, 33-40-104,and 33-40-105.

Section 1. Section 33-40-101, MCA, is amended to read:

"33-40-101. ~~(Temporary)~~ Short title -- legislative findings. (1) This part may be cited as the "Patient-Centered Medical Homes Act".

(2) The legislature finds that the increasing cost of health care makes health plans more difficult for individuals, families, and businesses to afford. These increases in health care costs are attributable in part to inadequate coordination of care among providers, difficulties in accessing primary care, and a lack of

engagement between patients and their primary care providers. The purpose of this part is to enhance care coordination and promote high-quality, cost-effective care through patient-centered medical homes by engaging patients and their primary care providers.

(3) The legislature also finds that chronic diseases are one of the biggest threats to the health of Montana residents. The purpose of this part includes promoting episodic evidence-based care in the community to reduce hospital admissions, enhance chronic disease management, and reduce costs for treating chronic diseases.

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

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

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

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

(8) Notwithstanding any state or federal law that prohibits the collaboration of insurers, other health plans, or providers regarding payment methods, the legislature finds that patient-centered medical homes are likely to result in the delivery of more efficient and effective health care services and are in the public interest. ~~(Terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.~~"

{*Internal References to 33-40-101: 33-40-102*) }

Section 2. Section 33-40-102, MCA, is amended to read:

"33-40-102. ~~(Temporary)~~ State action immunity doctrine. The state action immunity doctrine applies to the patient-centered medical home program in Montana, and federal or state antitrust laws that prohibit collusion do not apply to any standards used by the patient-centered medical home program regarding medical payments. The legislative findings, as provided in 33-40-101, and oversight by the insurance commissioner combine to determine that patient-centered medical homes are in the public interest and are likely to result in the delivery of more efficient and effective health care services sufficient to override concerns about collusion regarding medical payments among insurers, other health plans, or primary care practices. ~~(Terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.~~"

{*Internal References to 33-40-102: None*) }

Section 3. Section 33-40-104, MCA, is amended to read:

"33-40-104. ~~(Temporary)~~ Powers and duties of commissioner -- rulemaking. (1) The commissioner shall:

(a) adopt rules necessary to implement the provisions of this part;

(b) ~~in consultation with interested parties,~~ qualify patient-centered medical homes that have ~~been accredited by a nationally recognized accrediting organization~~ met ~~approved by the commissioner and that meet any other~~ standards established by the commissioner, in consultation with interested parties;

(c) oversee, promote, coordinate, and provide guidance concerning the creation and activities of any patient-centered medical homes doing business in Montana in order to ensure that the requirements of this part are met;

(d) consult with all interested parties in association with carrying out the activities required under this part; and

(e) develop and implement standards as set forth in 33-40-105 in consultation with interested parties.

(2) For the purposes of this section, interested parties include but are not limited to the department, public health agencies, health plans, government health plans, primary health care providers, and health care consumers. Interested parties must be organized as a

stakeholder council with regular meetings, the scheduling of which must be determined by the commissioner.

~~(Terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.~~"

{*Internal References to 33-40-104: 33-40-103*) }

Section 4. Section 33-40-105, MCA, is amended to read:

"**33-40-105. ~~(Temporary)~~ Standards for patient-centered medical homes.** (1) The commissioner shall, in consultation with the stakeholder council of interested parties, set standards from the list provided in subsection (2).

(2) Standards may be set for one or more of the following or for other topics determined by the commissioner in consultation with stakeholders:

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

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

individuals attributed to the participation in the patient-centered medical homes;

(c) a uniform set of health care quality and performance measures that include prevention services; and

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

(3) A patient-centered medical home must meet the standards in this section in full or in part by providing proof to the commissioner that it has ~~been accredited by a nationally recognized accrediting organization~~ met the standards for qualification established ~~approved~~ by the commissioner.

(4) The commissioner may, in consultation with stakeholders, set standards that are specific to Montana ~~and may be required in addition to nationally recognized accreditation standards~~.

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

(a) health plans and other payors with which the patient-centered medical home contracts;

(b) the commissioner; and

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

(6) A health plan and other payors shall report to the patient-centered medical home regarding their compliance with the uniform set of cost and utilization measures adopted by the commissioner for patients covered under the health plan.

(7) In developing the standards described in subsection (2), the commissioner may consider:

(a) the use of health information technology, including electronic medical records;

(b) the relationship between the primary care practice, specialists, other health care providers, and hospitals;

(c) the access standards for individuals covered by a health plan to receive primary medical care in a timely manner;

(d) the ability of the primary care practice to foster a partnership with patients; and

(e) the use of comprehensive medication management to improve clinical outcomes.

~~(8) All health care providers and payors who participate in a patient-centered medical home shall, as a condition of participation, collectively commission one independent study on savings generated by the patient-centered medical home program and report to the~~

~~children, families, health, and human services interim committee no later than September 30, 2016. (Terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.~~"

{*Internal References to 33-40-105:*
33-40-104 *53-6-113*) }

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