**** Bill No. ****

Introduced By **********

By Request of the Children, Families, Health, and Human Services Interim Committee

A Bill for an Act entitled: "An Act eliminating certain advisory councils and reports that are required by law for the department of public health and human services but have been inactive or have not been published; amending sections 40-5-906, 50-4-803, 50-4-805, 53-1-703, 53-1-711, 53-6-705, 53-6-1005, and 53-21-1002, MCA; repealing sections 50-4-810, 50-4-811, 53-1-704, 53-1-714, 53-10-201, 53-10-202, 53-10-203, 53-10-204, 53-10-211, and 53-10-212, MCA; and providing an effective date."

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

Section 1. Section 40-5-906, MCA, is amended to read:

"40-5-906. Child support information and processing unit. (1) The department shall establish and maintain a centralized child support case registry and payment processing unit. The purpose of this unit is to facilitate mass case processing by utilizing computer technology to identify parents and their income and to initiate automated procedures to collect child support as it becomes due and payable.

(2) The case registry must include a database of information concerning child support orders, all cases receiving IV-D services, and all district court and administrative cases

with support orders entered or modified after October 1, 1998.

(3) The case registry must use automated systems to obtain information from federal, state, and local databases with regard to the location of obligors and their income and assets. This information must be shared with the courts of this state and, upon request, may be shared with other IV-D agencies for the purpose of establishing paternity and establishing and enforcing child support obligations.

(4) To assist creditors, credit managers, and others who need timely verification of the existence of child support liens in IV-D cases, the case registry must include a directory of liens, which must include liens against an obligor's real and personal property filed by the department with other agencies and lien registries. Information in the lien registry may be made available through automated systems, which may include voice response units.

(5) Each IV-D case with a child support order must be electronically monitored so that when a timely payment of support is not made, enforcement action may be taken. To accomplish this purpose, payments due under a child support order must be paid to the department for processing and disbursement.

(6) In either a IV-D income-withholding case in this state or a state non IV-D case, if immediate income withholding is authorized after January 1, 1994, an employer or other payor of income shall pay all support withheld from an obligor's income to one centralized location as specified by the department.

(7) To facilitate automated disbursement of support

payments, automated enforcement actions, and service of notice when required, an obligor or obligee must be directed to provide, and update as necessary, information sufficient to locate the obligor and obligee and to locate the obligor's income and assets.

[(8) An employer or labor organization shall report a newly hired or rehired employee. Information reported by an employer must be electronically compared to the information database to align an obligor who owes a duty of support with a source of income. When a match is revealed in a IV-D case, a notice must, if appropriate to the case, be promptly transmitted to the employer directing the employer to commence withholding for the payment of the obligor's support obligation.]

(9) The department may enter into contracts or cooperative agreements with any person, business, firm, corporation, or state agency to establish, operate, or maintain the case registry and payment processing unit or any function or service afforded by the unit, provided that:

(a) the department is ultimately responsible for operation of the case registry and payment processing unit, including any function or service afforded by the unit; and

~~(b) there is a board to act in an advisory capacity to the case registry and payment processing unit. The board shall advise the department in the policy, direction, control, and management of the case registry and payment processing unit and in determining forms, data processing needs, terms of contracts and cooperative agreements, and other similar technical requirements.~~

~~Board members who are not employed by the department shall serve without pay, but are entitled to reimbursement for travel, meals, and lodging while engaged in board business, as provided in 2-18-501 through 2-18-503. Except for members who represent the department, appointed board members shall serve for terms of 2 years. The board consists of six members as follows:~~

~~(i) a district court judge nominated by the district court judges' association;~~

~~(ii) a clerk of court nominated by the association of clerks of the district courts;~~

~~(iii) the supreme court administrator or the administrator's designee;~~

~~(iv) two members, appointed by the department director, one from the child support enforcement division and one from the operations and technology division; and~~

~~(v) a representative of a county data processing unit, nominated by the association of clerks of the district courts.~~

~~(c)~~(b) the costs charged to the department under the contract or cooperative agreement may not exceed the actual costs that the department would have incurred without the contract or cooperative agreement.

(10) The department may adopt rules to implement 19-2-909, 19-20-306, 40-5-291, 40-5-1046 through 40-5-1051, and this part. Rules must be drafted, adopted, and applied in a manner that:

(a) minimizes the personal intrusiveness on the employer or employee of any requested information;

(b) minimizes the costs to the department and any employer

or employee with respect to obtaining and submitting any requested information; and

(c) maximizes the confidentiality and security of any employer or employee information that the department gathers under 19-2-909, 19-20-306, 40-5-291, 40-5-1046 through 40-5-1051, and this part. (Bracketed language terminates on occurrence of contingency--sec. 1, Ch. 27, L. 1999.)"

{*Internal References to 40-5-906:*
40-5-234x *40-5-248x* *40-5-248x* *40-5-248x* }

Section 2. Section 50-4-803, MCA, is amended to read:

"50-4-803. Definitions. As used in this part, the following definitions apply:

~~(1) "Advisory group" means the community health centers advisory group provided for in 50-4-810.~~

~~(2)~~(1) "Department" means the department of public health and human services provided for in Title 2, chapter 15, part 22.

~~(3)~~(2) "Federally qualified community health center" means a facility providing primary and preventive medical, dental, mental health, and substance abuse services to medically underserved, disadvantaged, or hard-to-reach populations on a sliding-scale fee basis, operating under federal regulations, and receiving federal funds under the Public Health Service Act, 42 U.S.C. 254b.

~~(4)~~(3) "Federally qualified health center look-alike" means a facility that meets all of the expectations established for the federally funded community health center program but does not

receive federal operating funds under the Public Health Service Act, 42 U.S.C. 254b.

~~(5)~~(4) "Preventive care" means comprehensive care that emphasizes prevention, early detection, and early treatment of conditions, including but not limited to routine physical examinations, health screenings, immunizations, and health education.

~~(6)~~(5) "Primary care" means the type of medical care that provides a patient with a broad spectrum of preventive and curative health care services over a long period of time and that coordinates all of the care a patient receives.

~~(7)~~(6) "Section 330 funds" means the federal funds commonly known by that name and awarded by the health resources and services administration of the U.S. department of health and human services to health centers that qualify for funding under the Public Health Service Act, 42 U.S.C. 254b."

{*Internal References to 50-4-803: None.x*}

Section 3. Section 50-4-805, MCA, is amended to read:

"50-4-805. Program expenditures ~~-- report to legislature~~. (1) Subject to appropriation by the legislature, the department shall provide competitive grants in accordance with 50-4-806 and this section to community or tribal boards operating as a nonprofit entity in accordance with the Public Health Service Act, 42 U.S.C. 254b, to increase access to primary care and preventive health services for uninsured, underinsured, low-income, or underserved Montanans.

(2) Grants must be made each year to accomplish any of the following goals:

(a) to create and support new nonfederally funded community health centers with state funding for a maximum of 6 years or until federal funds are granted. Successful applicants for the state grants shall also apply for federally qualified health center look-alike status and federal community health center grants at the first available opportunity.

(b) to expand the medical, mental health, or dental services offered by existing federally qualified community health centers or other facilities that have received federally qualified health center look-alike status; and

(c) to provide one-time grants for capital expenditures to existing federally qualified community health centers and facilities with federally qualified health center look-alike status.

(3) The department shall contract with an entity that is able to:

(a) provide technical assistance to new and existing federally qualified community health centers in their efforts to apply for federal funds;

(b) assist new and existing centers in their efforts to expand services; and

(c) collect standardized data on the provision of services to low-income and uninsured Montanans.

(4) The department shall require the contractor to provide an annual report on the services it has provided, the data it has

collected, and the status of applications for federal community health center funding.

~~(5) The department shall report to the legislature, as provided for in 5-11-210, the following information for each year of the biennium:~~

~~(a) the status of the expenditures made pursuant to this part;~~

~~(b) the number of people served by the expenditure of funds; and~~

~~(c) the costs to the state of the services provided pursuant to this part.~~"

{*Internal References to 50-4-805:*
50-4-806x *50-4-811r* *50-4-815x* }

Section 4. Section 53-1-703, MCA, is amended to read:

"53-1-703. Definitions. As used in this part, the following definitions apply:

(1) "Approved 2-1-1 service provider" means a public or nonprofit agency or organization designated by the department to provide 2-1-1 services.

~~(2) "Coalition" means the Montana 2-1-1 community coalition provided for in 53-1-704.~~

~~(3)~~(2) "Department" means the department of public health and human services.

~~(4)~~(3) "2-1-1" means the abbreviated dialing code assigned by the federal communications commission on July 21, 2000, for consumer access to community information and referral services.

~~(5)~~(4) "2-1-1 service area" means an area of the state of Montana identified by the department as an area in which an approved 2-1-1 service provider will provide 2-1-1 services."

{*Internal References to 53-1-703: None.x*}

Section 5. Section 53-1-711, MCA, is amended to read:

"53-1-711. Scope of 2-1-1 service. (1) The statewide 2-1-1 system shall ensure provision of services in all counties of the state.

(2) The statewide 2-1-1 system must be administered by the department ~~in consultation with the coalition~~. The department~~, in consultation with the coalition,~~ shall approve a strategic plan for service delivery and divide the state into no more than 8 regions.

(3) The statewide 2-1-1 system shall ensure that all approved 2-1-1 service providers provide the following scope of service:

(a) provide information and referral services to each inquirer for the inquirer's designated geographic area through well-trained staff or volunteers who are knowledgeable about local resources;

(b) create and maintain a database of community resources and referrals for the service provider's designated geographic area;

(c) provide appropriate services to crisis callers, which includes stabilization or safety assessment and connection to further resources such as crisis lines, domestic violence

shelters, and rape victim advocates;

(d) provide information to the department regarding 2-1-1 service usage including data on callers, service needs, and resource gaps;

(e) provide support to community and disaster and emergency services providers in the case of a disaster or emergency; and

(f) participate in any publicity plan for the statewide 2-1-1 system in Montana."

{*Internal References to 53-1-711: None.x*}

Section 6. Section 53-6-705, MCA, is amended to read:

"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 maintain a network of health care

providers that is sufficient in number and type to ensure that the services approved by the department for delivery to medicaid recipients covered by the entity are available without unreasonable delay as required under the network adequacy and quality assurance provisions of Title 33, chapter 36, and any rules promulgated under that chapter.

(4) 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.

(5) 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.

(6) 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.

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

(8) For purposes of participation in the medicaid program, the entity shall comply with quality assurance and utilization review requirements established in Title 33, chapter 36, and by the department by rule.

(9) 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.~~

(10) The entity shall maintain, retain, and make available to the department records, data, and information, in a uniform manner determined by the department, that are:

(a) sufficient for the department, the legislative auditor's office, and the state auditor's office to monitor utilization, accessibility, and quality of care; and

(b) consistent with accepted practices in the health care industry.

(11) 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.

(12) 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.

(13) 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.

(14) A managed health care entity that provides written notice pursuant to subsection (5)(c) to an enrollee of medicaid-covered services available from another provider is responsible for payment for those services by another provider.

(15) A managed health care entity 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."

{*Internal References to 53-6-705:*
53-6-707x *53-6-707x* }

Section 7. Section 53-6-1005, MCA, is amended to read:

"53-6-1005. Department administration -- pharmacy access. ~~(1)~~ The department shall administer the pharmacy access program. The department shall provide for outreach and enrollment in the pharmacy access program. The department shall integrate the enrollment and outreach procedures with other services provided to individuals and families eligible for other related programs.

~~(2) The department shall report on Montana's prescription drug use, needs, and trends and submit a report with recommendations to the governor and to the legislature by September 15, 2006.~~"

{*Internal References to 53-6-1005: None.x*}

Section 8. Section 53-21-1002, MCA, is amended to read:

"53-21-1002. Duties of department. The department:

(1) shall take cognizance of matters affecting the mental health of the citizens of the state;

(2) shall initiate mental health care and treatment, prevention, and research as can best be accomplished by

community-centered services. The department shall initiate and operate services in cooperation with local agencies, service area authorities, mental health professionals, and other entities providing services to persons with mental illness.

(3) shall specifically address:

(a) provider contracting;

(b) service planning;

(c) preadmission screening and discharge planning;

(d) quality management;

(e) utilization management and review;

(f) consumer and family education; and

(g) rights protection;

(4) shall collect and disseminate information relating to mental health;

(5) shall prepare and maintain a comprehensive plan to develop public mental health services in the state and to establish service areas;

(6) must receive from agencies of the United States and other state agencies, persons or groups of persons, associations, firms, or corporations grants of money, receipts from fees, gifts, supplies, materials, and contributions for the development of mental health services within the state;

(7) shall establish qualified provider certification standards by rule, which may include requirements for national accreditation for mental health programs that receive funds from the department;

(8) shall perform an annual review and evaluation of mental

health needs and services within the state by region and evaluate the performance of programs that receive funds from the department for compliance with federal and state standards;

(9) shall coordinate state and community resources to ensure comprehensive delivery of services to children with emotional disturbances, as provided in Title 52, chapter 2, part 3~~, and submit at least a biennial report to the governor and the legislature concerning the activities and recommendations of the department and service providers~~; and

(10) shall coordinate the establishment of service area authorities, as provided in 53-21-1006, to collaborate with the department in the planning and oversight of mental health services in a service area."

{*Internal References to 53-21-1002: None.x*}

NEW SECTION. **Section 9. {standard} Repealer.** The following sections of the Montana Code Annotated are repealed:

50-4-810. Advisory group.

50-4-811. Advisory group -- purpose and role.

53-1-704. Montana 2-1-1 community coalition -- advisory capacity.

53-1-714. Reporting.

53-10-201. Legislative findings, purpose, and intent.

53-10-202. Definitions.

53-10-203. Commission on provider rates and services.

53-10-204. Duties of commission on provider rates and services.

53-10-211. Department to assist and cooperate with commission on provider rates and services -- records privacy.

53-10-212. Commission findings, recommendations, and reports.

{*Internal References to 50-4-810: 50-4-803a*
Internal References to 50-4-811: None.
Internal References to 53-1-704: 53-1-703a
Internal References to 53-1-714: None.
Internal References to 53-10-201: None.
Internal References to 53-10-202: None.
Internal References to 53-10-203: 53-10-202r
Internal References to 53-10-204: None.
Internal References to 53-10-211: None.
Internal References to 53-10-212: None.}

NEW SECTION. **Section 10. {standard} Effective date.** [This act] is effective July 1, 2017.

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{Name : Sue O'Connell
Title : Research Analyst
Agency: Legislative Services Division-136B
Phone : (406) 444-3597
E-Mail: soconnell@mt.gov}