



ADMINISTRATIVE RULES OF MONTANA



37.86.5014 HEALTH MAINTENANCE ORGANIZATIONS: REIMBURSEMENT OF HMOS

- (1) In consideration for all services rendered by an HMO under a contract with the department, the HMO will receive a payment each month for each enrollee. This payment is the capitation rate. Except as otherwise provided in this rule, the capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to each enrollee under the contract.
 - (a) The capitation rate must be actuarially determined.
 - (b) The capitation rate must be:
 - (i) based on medicaid fee-for-service expenses incurred in the provision of the HMO-covered services to a non-HMO population of similar characteristics during the base fiscal year; and
 - (ii) based on services that are reasonably available to the enrollees of the HMO.
 - (c) The capitation rate may not exceed the cost to the department of providing the same services to an actuarially equivalent nonenrolled population group.
 - (d) The capitation rate may be updated annually.
 - (e) The capitation rate does not include:
 - (i) any amounts for the recoupment of losses suffered by an HMO for risks assumed under the contract or any previous risk contract;
 - (ii) any disproportionate share payments;
 - (iii) any payments made by the department reflecting the difference between the amounts paid to participating federally qualified health centers and rural health clinics by the HMO and the reasonable cost of providing services to enrollees; and
 - (iv) any payments made as a result of reinsurance purchased by an HMO from the department.
 - (f) At a minimum, the capitation rate must be 5% less than the upper payment limit. The department may reduce the capitation rates under the conditions set forth in the contract if there is a funding shortfall.
- (2) The HMO may retain any savings realized by the HMO from the expenditures for necessary health services by the enrolled population totaling less than the capitation rate paid by the department.

- (3) The department reimburses to federally qualified health centers and rural health clinics that are participating providers the difference between the amounts paid to them by the HMO and the reasonable cost of providing services to enrolled recipients.
 - (a) The department recoups from federally qualified health centers and rural health clinics that are participating providers any excess between the amounts paid to them by the HMO and the reasonable cost of providing services to enrollees, unless the provider notifies both the HMO and the department in writing that it forfeits cost-based reimbursement for enrollees in favor of the reimbursement paid by the HMO.
 - (b) If an HMO becomes a subcontractor to a federally qualified health center or rural health clinic, the department is under no obligation to pay reasonable costs to the HMO. Only the federally qualified health center or rural health clinic itself remains eligible for reasonable cost settlement for federally qualified health center and rural health clinic services.
- (4) The department reimburses disproportionate share payments for inpatient hospital services provided to enrollees.
- (5) The department will recoup the TANF-based capitation payments made for a newborn enrollee retroactively determined SSI eligible within 4 months of life and instead pay the SSI-based capitation rate for each month of enrollment.
- (6) The department reimburses an HMO for 80% of regular medicaid reimbursement for cost above the reinsurance threshold chosen by the HMO if an HMO chooses to purchase reinsurance from the department.

Authorizing statute(s): Sec. 53-2-201 and 53-6-113, MCA

Implementing statute(s): Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA

History: NEW, 1995 MAR p. 1974, Eff. 9/29/95; AMD, 1997 MAR p. 503, Eff. 3/11/97; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.