

2013 Montana Legislature

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SENATE BILL NO. 395

INTRODUCED BY D. WANZENRIED

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS RELATED TO HEALTH CARE TO ~~EXPAND ALLOW USE OF MEDICAID TO FUNDS TO PURCHASE INSURANCE AND PROVIDE COVERAGE TO CERTAIN NONDISABLED, NONELDERLY, AND NONPREGNANT INDIVIDUALS AND TO IMPROVE THE DELIVERY OF HEALTH CARE SERVICES IN MONTANA~~ AND TO IMPROVE THE DELIVERY OF HEALTH CARE SERVICES IN MONTANA; ESTABLISHING ~~MEDICAID~~ ELIGIBILITY CRITERIA ~~FOR INDIVIDUALS PURCHASING HEALTH INSURANCE WITH MEDICAID FUNDS~~; REQUIRING A REVIEW OF THE MONTANA MEDICAID PROGRAM AND THE HEALTH CARE DELIVERY SYSTEM; ESTABLISHING A MEDICAID WELLNESS PILOT PROJECT; ESTABLISHING WORKFORCE REPORTING REQUIREMENTS FOR CERTAIN HEALTH CARE PROFESSIONALS; PROVIDING FOR USE OF UNEXPENDED MEDICAID FUNDS; PROVIDING DEFINITIONS; CREATING A SPECIAL REVENUE ACCOUNT; REQUIRING A REVIEW OF THE MONTANA MEDICAID PROGRAM AND THE HEALTH CARE DELIVERY SYSTEM; ESTABLISHING A MEDICAID WELLNESS PILOT PROJECT; ESTABLISHING WORKFORCE REPORTING REQUIREMENTS FOR CERTAIN HEALTH CARE PROFESSIONALS; PROVIDING FOR USE OF UNEXPENDED MEDICAID FUNDS; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; CREATING A SPECIAL REVENUE ACCOUNT; AMENDING SECTIONS ~~37-8-202, 37-8-204, 37-8-202, 37-8-204, 15-66-101, 15-66-102, 15-66-103, 15-66-201, 15-66-204, 15-66-206, 53-6-131, 53-6-132, AND 53-6-133, AND 53-6-155 53-6-149~~, MCA; AND PROVIDING ~~EFFECTIVE DATES AND~~ EFFECTIVE DATES AND TERMINATION DATES."

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

(Refer to Second Reading - Yellow Bill)

Strike everything after the enacting clause and insert:

NEW SECTION. Section 1. Short title. [Sections 1 through 5] may be cited as the "Montana Health Care Reform and Cost Containment Act".

NEW SECTION. Section 2. Legislative findings and intent. (1) The intent of [sections 1 through 5] is to modify and enhance Montana's health care delivery system to provide access to quality and affordable health care for all Montana citizens.

(2) The legislature finds that to achieve the purposes of [sections 1 through 5], it will be necessary for state government, health care providers, patient advocates, and other parties interested in quality and affordable health care to collaborate in order to:

(a) increase the number of Montanans with health insurance coverage;

(b) provide greater value for the tax dollars spent on the medicaid program by exploring options for delivering services in a more efficient and cost-effective manner, including but not limited to:

- (i) offering incentives to encourage health care providers to achieve measurable performance outcomes;
- (ii) improving the coordination of care among health care providers and health care payers;
- (iii) reducing preventable hospital readmissions; and
- (iv) exploring medicaid payment methodologies that promote quality of care and efficiencies;

(c) contain growth in health care costs by:

- (i) curbing wasteful spending;
- (ii) avoiding unnecessary use of health care services;
- (iii) reducing the instances in which health care practitioners provide health care services in order to avoid

the risk of litigation; and

(iv) reducing fraud;

(d) ensure that there is an adequate number of health care professionals throughout the state;

(e) provide incentives that result in Montanans taking greater responsibility for their personal health;

(f) boost Montana's economy by reducing the costs of uncompensated care; and

(g) reduce or minimize the shifting of payment for unreimbursed health care costs to patients with private insurance.

(3) The legislature further finds that state policymakers have an interest in testing the effectiveness of wellness incentives in order to collect and analyze information about the correlation between wellness incentives and health status. It is the intent of the legislature to establish a pilot project in the medicaid program to evaluate whether incentives to improve a recipient's management of chronic disease improves overall health outcomes and reduces the long-term costs of health care for the recipient.

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

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

(2) "Recipient" means a person:

(a) who has been determined by a medicaid agency to be eligible for medicaid benefits, whether or not the person has received any benefits; or

(b) who receives medicaid benefits, whether or not the person is determined to be eligible.

NEW SECTION. Section 4. Review of medicaid and health care delivery systems -- advisory committee -- reports. (1) The department shall review state activities related to the medicaid program and delivery of health care services in Montana in order to make recommendations to the legislature on ways to make the medicaid program and the health care delivery system more efficient and cost-effective.

(2) The department shall establish an advisory committee made up of health care providers, health care consumers, and other parties interested in the way in which health care services are provided to Montanans. The committee may consist of up to 12 members.

(3) The advisory committee shall:

(a) review ~~the way in which~~ the implementation of ~~the expansion of the medicaid program is being carried out~~ any waiver granted to the department to authorize use of Medicaid funds to purchase insurance coverage for eligible individuals as defined in [section 10];

(b) evaluate the manner in which health care services are delivered and whether new approaches could improve delivery of care, including but not limited to the use of medical homes and coordinated care organizations;

(c) review ideas for reducing or minimizing the shifting of the payment of unreimbursed health care costs to patients with private insurance;

(d) evaluate whether providing incentives to health care providers for meeting measurable benchmarks may improve the delivery of health care services;

(e) review options for reducing inappropriate use of emergency department services, including ways to monitor for the excessive or inappropriate use of prescription drugs;

(f) examine ways to:

(i) promote the appropriate use of health care services, particularly laboratory and diagnostic imaging services;

(ii) increase the availability of mental health services;

(iii) reduce fraud and waste in the medicaid program; and

(iv) improve the sharing of data among health care providers in order to identify patterns in the usage of health care services across payment sources; and

(g) receive regular reports from the department on the department's efforts to ~~pursue contracting options for administration of services to individuals eligible for medicaid as allowed under Public Law 111-148 and Public Law 111-152~~ obtain and implement a waiver pursuant to [sections 9 through 14].

(4) The department shall:

(a) coordinate its efforts with any legislative committees that are working on matters related to health care and the delivery of health care services; and

(b) summarize and present the findings and recommendations of the advisory committee in a final report to the governor and to the children, families, health, and human services interim committee no later than August 15 of each even-numbered year.

NEW SECTION. Section 5. Medicaid wellness pilot project. (1) Subject to any necessary approval from the centers for medicare and Medicaid ~~services~~, the department shall administer a pilot project designed to assess whether providing incentives for a recipient's participation in disease management and wellness activities improves the recipient's management of chronic disease.

(2) The department shall offer an incentive to adult recipients for meeting established targets for managing chronic disease. Subject to subsection (4), the department shall establish by rule the individuals to be covered by the pilot project, the chronic diseases to be included in the pilot project, the criteria that must be met to receive the incentive, and the duration and amount of the incentive to be offered.

(3) The department may undertake the pilot project in up to five counties, at least one of which must have a significant Indian population. The pilot project must begin with 60 days of receipt of federal approval, if required.

(4) The department may not require participation by recipients who reside in a long-term care facility as defined in 50-5-101 or a community residential facility as defined in 76-2-411.

(5) The department shall collect and analyze information related to the pilot project to determine if the project resulted in better health outcomes for participants. The analysis may include but is not limited to the incentives provided, the health conditions of the participants, the number of participants who met established goals, and to the extent possible, whether participants who met the goals used fewer medicaid services than:

- (a) participants who did not meet the goals; and
- (b) recipients with similar medical conditions in counties that were not included in the pilot project.

NEW SECTION. Section 6. Short title. [Sections 6 through 8] may be cited as the "Montana Health Care Workforce Data Collection Act".

NEW SECTION. Section 7. Collecting and reporting of data -- requirement for licensure -- confidentiality. (1) The board shall collect information related to the physician and physician assistant workforce in Montana in order to evaluate whether Montanans have access to health care services based on the location where licensees are practicing, the medical specialties of the licensees, and the amount of time that licensees devote to patient care.

(2) At the time an individual applies to obtain or renew a license under Title 37, chapter 20, or this chapter, the board shall collect through electronic means information that includes at a minimum:

- (a) the applicant's gender and date of birth;
- (b) the applicant's employment and practice status, including but not limited to:
 - (i) active practices in Montana and other locations;
 - (ii) the area of practice, including areas of specialty;
 - (iii) the office, hospital, or clinical setting in which the applicant practices;
- (c) the applicant's education, training, and specialty and subspecialty board certification;
- (d) the locations where the applicant practices and the average number of hours the applicant works each week providing patient care at each location;
- (e) the average number of weeks the applicant worked during the past full year in the licensed profession;
- (f) the percentage of time the applicant spends engaged in direct patient care and in other activities, including but not limited to teaching, research, and administration in the licensed profession; and
- (g) other data as proposed to and approved by the board.

(3) The board may not approve an application for a license or a renewal of a license for an applicant who fails to provide information as required under this section.

(4) The board shall report the information collected under this section to:

- (a) the department of public health and human services provided for in 2-15-2201; and
- (b) Montana professional associations representing physicians and physician assistants.

(5) (a) Except as provided in subsection (5)(b), the board may not release personally identifiable data collected under this section for any person licensed by the board.

(b) The provisions of subsection (5)(a) do not apply to the release of information to a state agency or a Montana medical professional association for state program, workforce, or health planning purposes.

NEW SECTION. Section 8. Health care workforce database -- sharing and use of data. (1) Subject to available funding, the department of public health and human services may create and maintain a database of health care workforce information collected by the board. The board shall provide the department of public health and human services with information collected pursuant to [sections 6 through 8] for the database.

(2) The department of public health and human services may contract or enter into other agreements with a private or public entity to:

(a) establish and maintain the database;

(b) analyze data contained in the database;

(c) develop reports to be used by the legislature, the governor, and the public related to health care workforce needs; and

(d) perform other activities to carry out the purposes of [sections 6 through 8].

(3) The department of public health and human services may seek federal and private funds to create and maintain the database.

NEW SECTION. Section 9. Benefit plan for medicaid expansion population -- copayments and deductibles -- options for administration. (1) ~~In providing medical services to individuals eligible for the Montana medicaid program pursuant to 53-6-131(1)(h), the department shall:~~

~~(a) use as the benchmark plan allowed for under 42 U.S.C. 1936u-7(b)(1)(D) the essential health benefit that is selected by:~~

~~(i) the legislature; or~~

~~(ii) the secretary of the U.S. department of health and human services pursuant to 42 U.S.C. 18022 and related federal regulations;~~

~~(b) establish cost-sharing requirements for recipients as allowed by federal law and regulations;~~

~~(c) pursue options for contracting with a private vendor to provide or pay for medical services, including but not limited to:~~

~~(i) use of a third-party administrator to operate the program;~~

~~(ii) use of a capitated payment model instead of a fee-for-service payment model for some health care providers or services, including a predetermined bundled payment for specific health conditions or time periods;~~

~~(iii) use of medicaid funds to purchase a qualified health plan as defined in 42 U.S.C. 18021(a); and~~

~~(iv) offering incentives that would allow individuals to obtain insurance coverage through the health exchange.~~

~~(2) The department shall apply to the centers for medicare and medicaid services for any waivers necessary to contract for services or to use medicaid funds as provided in subsection (1)(c).~~

~~(3) The department shall report the following information to the children, families, health, and human services interim committee no later than August 15 of each year:~~

~~(a) the number of individuals who were determined eligible for medicaid pursuant to 53-6-131(1)(h);~~

- ~~(b) the average cost of medical services provided to those individuals;~~
- ~~(c) the average length of time the individuals remained eligible for medical assistance under this section;~~
- ~~(d) the total cost of providing services under this section, including related administrative costs; and~~
- ~~(e) the status of efforts that the department has undertaken pursuant to subsection (1)(c) to contract for providing or paying for medical services.~~

"NEW SECTION. Section 9. Health coverage options for low-income individuals -- legislative findings and intent. (1) The legislature finds that providing expanded health care coverage to low-income Montanans through an integrated market-based medicaid benefits program has the potential to:

- (a) provide new coverage opportunities for additional Montanans;
- (b) stimulate market competition; and
- (c) offer alternatives to existing medicaid coverage.

(2) The legislature further finds that a market-based medicaid benefits program may offer fiscally sustainable and cost-effective health care, as well as allow for greater personal responsibility in the use of health care services.

(3) The legislature further finds that a program offered under a waiver:

- (a) is not a perpetual federal or state right or a guaranteed entitlement; and
- (b) is subject to cancellation upon appropriate notice.

(4) It is the intent of the legislature that the department shall apply to the secretary of the U.S. department of health and human services for authority under 42 U.S.C. 1315 to provide health care services through a program operated in accordance with the provisions of [sections 9 through 14] for eligible individuals.

(5) The intent of the proposed program is to increase participation and competition in the health insurance market, intensify price pressures, and reduce costs for both publicly and privately funded health care.

NEW SECTION. Section 10. Definitions. As used in [sections 9 through 14], the following definitions apply:

(1) "Carrier" means a private entity offering qualified health plans through the health insurance exchange.

(2) "Cost sharing" means the portion of the cost of a covered medical service that must be paid by or on behalf of eligible individuals.

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

(4) "Eligible individual" means an individual who meets the requirements of 42 U.S.C. 1396a(a)10(A)(i)(VIII).

(5) "Health insurance exchange" or "exchange" means the American health benefit exchange established pursuant to 42 U.S.C. 18031.

(6) "Premium" means the charge established as a condition of enrolling in a qualified health plan.

(7) "Program" means the waiver program established under [sections 9 through 14];

(8) "Qualified health plan" means a health insurance plan as defined in 42 U.S.C. 18021(a).

(9) "Secretary" means the secretary of the U.S. department of health and human services.

(10) "Waiver" means a waiver of medicaid state plan requirements, subject to approval by the secretary of the U.S. department of health and human services, authorized by:

- (a) 42 U.S.C. 1315;
- (b) 42 U.S.C. 1315 in combination with 42 U.S.C. 1396n; or
- (c) any other federal statutes the secretary considers necessary for implementation of [sections 9 through 14].

NEW SECTION. Section 11. Design of waiver program -- rulemaking authority. (1) The department shall submit, as may be necessary in seeking approval, one or more requests to the secretary of the U.S. department of health and human services for a waiver that provides health insurance coverage to eligible individuals who have a low risk of needing extensive medical services by primarily using a private insurance option.

- (2) A waiver request must seek to:
 - (a) improve access to quality health care;
 - (b) attract insurance carriers and enhance competition in the insurance marketplace;
 - (c) promote individually owned health insurance;
 - (d) strengthen personal responsibility through cost-sharing;
 - (e) improve continuity of coverage;
 - (f) maximize available service options;
 - (g) reduce growth in the state-administered Medicaid program;
 - (h) encourage appropriate care, including early intervention, prevention, and wellness;
 - (i) increase quality and delivery system efficiencies;
 - (j) facilitate Montana's continued payment innovation, delivery system reform, and market-driven improvements;
 - (k) discourage overutilization of health care services;
 - (l) reduce waste, fraud, and abuse;
 - (m) encourage and reward health outcomes and responsible choices; and
 - (n) promote efficiencies that will deliver value to the taxpayer.
- (3) Any proposal to be submitted to the secretary shall:
 - (a) result in a federal medical assistance percentage that is commensurate with the percentage authorized for eligible individuals by Public Law 111-148 and Public Law 111-152 on [the effective date of this act];
 - (b) use the health insurance exchange to purchase qualified health plans for eligible individuals;
 - (c) require that eligible individuals participate in cost sharing on a basis that is comparable to the cost sharing required of persons in the same income range in the private insurance market and that is structured to enhance the ability of eligible individuals to invest in their health care purchasing decisions; and
 - (d) allow the department to provide payment to carriers for the premiums and cost sharing of eligible individuals enrolled in plans offered by the carriers.

(4) The department shall propose that participation in the program be limited to adults who are:

- (a) currently employed or actively seeking employment;
- (b) the primary caregiver for a family member; or
- (c) the spouse of an adult who is employed or actively seeking employment.

(5) The department may propose that the program exempt from purchase of a qualified health plan any eligible individuals for whom obtaining a qualified health plan is determined to be impractical, overly complex, or contrary to continuity or effectiveness of health care because the individuals:

- (a) have exceptional health care needs, including but not limited to medical, mental health, or developmental conditions; or
- (b) live in a geographical area, including an Indian reservation, that lacks health care providers who are participating in a qualified plan available to the individuals.

(6) To the greatest extent possible, the department shall negotiate with the U.S. department of health and human services to develop waiver provisions that limit the extent to which the waiver would apply to eligible individuals who are able-bodied and who are not actively seeking employment.

(7) The department shall implement the program as allowed under the waiver approved by the secretary. The department may adopt rules to carry out the program, including but not limited to rules establishing procedures for:

- (a) determining eligibility; and
- (b) payment of premiums and cost-sharing requirements.

(8) The implementation of a program authorized under this section and the authority of 42 U.S.C. 1315 is not subject to Title 53, chapter 6, part 7, or any other state law pertaining to managed care that would adversely affect:

- (a) approval of the program by the secretary; or
- (b) timely implementation of the program."

NEW SECTION. Section 40 12. Education and outreach on insurance coverage options. (1) The department shall undertake activities to increase public awareness of and knowledge about the options for obtaining health insurance coverage, including but not limited to the ~~expansion of the medicaid program option of participating in the program provided for in [sections 9 through 14],~~ the availability of tax credits for purchasing insurance, and the ways in which the health exchange may be used to review and decide on insurance options.

(2) The department shall report on the activities planned and undertaken as part of the outreach and education effort at:

- (a) each meeting of the advisory committee provided for in [section 4]; and
- (b) at least twice a year to the children, families, health, and human services interim committee.

~~**NEW SECTION. Section 11. Management of medicaid program.** In order to ensure that medical assistance under this part is provided in an efficient and effective manner, the department shall strengthen existing programs that manage the way in which recipients obtain approval for medical services and shall~~

~~establish additional programs designed to reduce costs and improve medical outcomes for recipients. The efforts may include but are not limited to:~~

- ~~(1) establishing by rule requirements that are designed to strengthen the relationship between physicians and recipients who are enrolled in existing primary care case management programs;~~
- ~~(2) requiring recipients enrolled in a primary care case management program to see the physician responsible for their care before receiving services other than emergency care;~~
- ~~(3) strengthening data-sharing arrangements with providers in order to reduce inappropriate use of emergency room services and overuse of other services;~~
- ~~(4) creating a patient-centered medical home model for recipients in which providers receive an enhanced reimbursement for closely monitoring and managing a recipient's medical condition;~~
- ~~(5) expanding to additional recipients any existing programs in which case managers and providers work with recipients with high-risk medical conditions to provide preventive care and advice and to make referrals for medical services;~~
- ~~(6) requiring a recipient to enroll in a program offering pain management services if the recipient is identified as using narcotic prescription drugs at a substantially higher level than indicated by medical need;~~
- ~~(7) reviewing current care management programs to evaluate and improve their effectiveness;~~
- ~~(8) providing incentives as allowed by federal law and regulation to recipients who are identified by their health care providers as complying with established preventive care and wellness standards that may reduce the overall costs of health care provided to recipients; and~~
- ~~(9) submitting to the children, families, health, and human services interim committee any proposals developed under this section for review and recommendation by the committee before implementation of the proposal.~~

NEW SECTION. Section 42 13 . Deposit of unexpended medicaid funds. The department shall deposit into the ~~medicaid expansion insurance assistance~~ mitigation account provided for in [section 13 14] any general fund appropriated for medicaid services that is unexpended 12 months after the close of the fiscal year for which it was appropriated.

NEW SECTION. Section 43 14. Medicaid expansion Insurance assistance mitigation account -- report. (1) There is an account in the state special revenue fund for the deposit of:

- (a) any general fund appropriated for medicaid services that is unexpended 12 months after the close of the fiscal year for which it was appropriated; ~~and~~
- (b) money transferred from the general fund and the state special revenue fund that is the equivalent of the:
 - (i) reduction in state expenditures for health care services that occurs because ~~the Montana medicaid program is expanded to provide coverage to individuals eligible pursuant to Public Law 111-148 and Public Law 111-152~~ of the use of Medicaid funds to purchase health insurance and provide coverage for eligible individuals as allowed under [sections 9 through 14] ; and

(ii) amount of general fund replaced by receipt of the enhanced federal medical assistance percentage provided pursuant to 42 U.S.C. 1397ee(b) for the children's health insurance program; and

(c) the hospital utilization surcharge provided for in 15-66-103(3).

(2) The department may accept contributions, gifts, and grants for deposit into the account and for use as provided in subsection (3).

(3) Money in the account must be used by the department to pay the state share of expenditures for ~~medical services for recipients who are eligible for medicaid pursuant to Public Law 111-148 and Public Law 111-452~~ eligible individuals as allowed under [sections 9 through 14]. Money may not be spent from the account before January 1, 2017.

(4) The department shall identify the reductions in expenditures that occurred in the following programs because ~~the medicaid program was expanded to individuals eligible pursuant to Public Law 111-148 and Public Law 111-452~~ medicaid funds were used to cover eligible individuals as allowed under [sections 9 through 14] :

(a) the Montana comprehensive health association plan provided for in Title 33, chapter 22, part 15;

(b) the small business health insurance purchasing pool provided for in Title 33, chapter 22, part 20;

(c) services offered under the state medicaid program provided for in this part to:

(i) pregnant women;

(ii) individuals with breast or cervical cancer;

(iii) individuals undergoing chemical dependency and substance abuse treatment; and

(iv) any other eligible individual who:

~~(A) is not enrolled in medicaid because the individual is able to obtain insurance through the health exchange; or~~

~~(B) is eligible for medicaid and is~~ no longer obtaining services from a program paid for with general fund money;

(d) the mental health services program provided for in 53-21-702;

(e) health care services for individuals who have been ordered by a court of competent jurisdiction into a correctional facility or program as described in 53-1-202 when the health care services are provided outside of a correctional facility and paid for by the medicaid program rather than the general fund; and

(f) other sources as identified by the department.

(5) No later than January 1 of each odd-numbered year, the department shall report to the legislature on:

(a) the reductions identified pursuant to subsection (4); and

(b) the amount of federal funds the state received that are attributable to the enhanced federal medical assistance percentage provided pursuant to 42 U.S.C. 1397ee(b) for the children's health insurance program.

NEW SECTION. Section 15. Medicaid program reforms. (1) The department shall undertake efforts to redesign and reform the Montana medicaid program as outlined in this section. The department shall include parties interested in the operation of the programs in the process of developing and implementing the reforms.

(2) As part of its efforts under this section, the department shall:

(a) implement a patient-centered medical home model of care; and

(b) design and implement a plan to reduce use of hospital emergency departments for nonemergency care, using methods that include but are not limited to:

(i) allowing nurses to evaluate the level of care a patient may need;

(ii) providing targeted patient education; and

(iii) increasing the monitoring of excessive emergency room use and behavior that may indicate that an individual is seeking prescription drugs from multiple sources; and

(iv) requiring providers participating in any primary care case management program to see a medicaid recipient assigned to their care within the timeframe established by the department by rule. The department shall establish by rule timeframes that may differ based on the urgency of a patient's medical condition.

(3) To the greatest extent possible, the department shall undertake the activities in subsection (2) no later than January 1, 2014.

NEW SECTION. Section 16. Value-based purchasing. (1) The department shall establish a value-based purchasing system for the medicaid program. The program shall allow for incentive payments to the following providers if the providers meet established performance standards:

(a) hospitals;

(b) physicians;

(c) advanced practice registered nurses;

(d) long-term care facilities; and

(e) home health care agencies.

(2) The department shall identify quality indicators and benchmarks using standards established by the medicare value-based purchasing program authorized pursuant to 42 U.S.C. 1395ww.

(3) The department shall require the providers listed in subsection (1) to begin reporting by July 1, 2014, the data required for quality indicators identified by the department.

(4) Medicaid payments to providers may be adjusted beginning in fiscal year 2016 to recognize a provider's compliance with quality indicators and benchmarks established pursuant to this section.

Section 17. Section 15-66-101, MCA, is amended to read:

"15-66-101. (Temporary) Definitions. For purposes of this chapter, the following definitions apply:

(1) (a) "Hospital" means a facility licensed as a hospital pursuant to Title 50, chapter 5, and includes a critical access hospital.

(b) The term does not include Montana state hospital.

(2) (a) "Inpatient bed day" means a day of inpatient care provided to a patient in a hospital. A day begins at midnight and ends 24 hours later. A part of a day, including the day of admission, counts as a full day. The day of discharge or death is not counted as a day. If admission and discharge or death occur on the same day, the day is considered a day of admission and is counted as one inpatient bed day. Inpatient bed days include all inpatient hospital benefit days as defined for medicare reporting purposes in section 20.1 of chapter 3 of the

centers for medicare and medicaid services publication 100-02, the Medicare Benefit Policy Manual. Inpatient bed days also include all nursery days during which a newborn infant receives care in a nursery.

(b) The term does not include observation days or days of care in a swing bed, as defined in 50-5-101.

(3) "Patient" means an individual obtaining skilled medical and nursing services in a hospital. The term includes newborn infants.

(4) "Report" means the report of inpatient bed days required in 15-66-201.

(5) "Utilization ~~fee~~ assessment" or "~~fee~~" assessment" means the utilization fee and utilization surcharge required to be paid for each inpatient bed day, as provided in 15-66-102~~(4)~~.

Section 18. Section 15-66-102, MCA, is amended to read:

"15-66-102. (Temporary) Utilization ~~fee~~ assessments for inpatient bed days. (1) Each hospital in the state shall pay to the department a utilization fee in the amount of \$50 for each inpatient bed day.

(2) All proceeds from the collection of utilization fees, including penalties and interest, must, in accordance with the provisions of 17-2-124, be deposited to the credit of the department of public health and human services in a state special revenue account as provided in 53-6-149. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)

(3) Each hospital in the state shall pay to the department a utilization surcharge in the amount of:

(a) \$2 for each bed day from July 1, 2013, through December 31, 2013;

(b) \$3 for each bed day from January 1, 2014, through December 31, 2015; and

(c) \$25 for each bed day on or after January 1, 2016.

(4) All proceeds from the collection of the utilization surcharge established in subsection (3), including penalties and interest, must, in accordance with the provisions of 17-2-124, be deposited to the credit of the department of public health and human services in the state special revenue account provided for in [section 15].

Section 19. Section 15-66-103, MCA, is amended to read:

"15-66-103. (Temporary) Relation to other taxes and fees. The utilization ~~fee~~ assessments imposed under 15-66-102 ~~is~~ are in addition to any other taxes and fees required to be paid by hospitals.

"Section 20. Section 15-66-201, MCA, is amended to read:

"15-66-201. (Temporary) Reporting and collection of ~~fee~~ assessment. (1) On or before January 31 of each year, a hospital shall file with the department an annual report of the number of inpatient bed days during the preceding year beginning January 1 and ending December 31. The report must be in the form prescribed by the department. The report must be accompanied by a payment in an amount equal to the ~~fee~~ assessments required to be paid under 15-66-102.

(2) On or before January 31 of each year, the department of public health and human services shall provide the department with a list of hospitals licensed and operating in the state during the preceding year beginning January 1 and ending December 31. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 21. Section 15-66-202, MCA, is amended to read:

"15-66-202. (Temporary) Audit -- records. (1) The department may audit the records and other documents of any hospital to ensure that the proper utilization ~~fee~~ assessments have been collected.

(2) The department may require the hospital to provide records and other documentation, including books, ledgers, and registers, necessary for the department to verify the proper amount of the ~~utilization-fee assessment~~ assessment paid.

(3) A hospital shall maintain and make available for inspection by the department sufficient records and other documentation to demonstrate the number of inpatient bed days in the facility subject to the utilization ~~fee assessments~~ assessments. The facility shall maintain these records for a period of at least 5 years from the date the report is due. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)

Section 22. Section 15-66-203, MCA, is amended to read:

"15-66-203. (Temporary) Periods of limitation. (1) Except as otherwise provided in this section, a deficiency may not be assessed or collected with respect to the year for which a report is filed unless the notice of additional ~~fees~~ amount proposed to be assessed is mailed within 5 years from the date the report was filed. For the purposes of this section, a report filed before the last day prescribed for filing is considered filed on the last day. If, before the expiration of the period prescribed for assessment of the ~~fee~~ additional amount, the hospital consents in writing to an assessment after the 5-year period, the ~~fee~~ additional amount may be assessed at any time prior to the expiration of the period agreed upon.

(2) A refund or credit may not be paid or allowed with respect to the year for which a report is filed after 5 years from the last day prescribed for filing the report or after 1 year from the date of the overpayment, whichever period expires later, unless before the expiration of the period, the hospital files a claim or the department has determined the existence of the overpayment and has approved the refund or credit. If the hospital has agreed in writing under the provisions of subsection (1) to extend the time within which the department may propose an additional assessment, the period within which a claim for refund or credit is filed or a credit or refund is allowed if a claim is not filed is automatically extended. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)

Section 23. Section 15-66-204, MCA, is amended to read:

"15-66-204. (Temporary) Penalty and interest for delinquent ~~fees~~ assessments -- waiver. If the ~~fee assessment~~ assessment for any hospital is not paid on or before the due date of the report as provided in 15-66-201, penalty and interest, as provided in 15-1-216, must be added to the ~~fee~~ assessment. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)

Section 24. Section 15-66-206, MCA, is amended to read:

"15-66-206. (Temporary) Deficiency assessment -- penalty and interest -- hearing. (1) If the department determines that the amount of ~~fees~~ assessments due is greater than the amount disclosed by the report, it shall mail to the hospital a notice of the additional ~~fees~~ amount proposed to be assessed. Within 30 days

after the mailing of the notice, the hospital may file with the department a written protest against the proposed additional ~~fees~~ assessments, setting forth the grounds upon which the protest is based, and may request in its protest an oral hearing or an opportunity to present additional evidence relating to its ~~fees~~ assessment liability. If a protest is not filed, the amount of the ~~additional fees~~ proposed to be assessed becomes final upon the expiration of the 30-day period. If a protest is filed, the department shall reconsider the proposed assessment and, if the hospital has requested, shall grant the hospital an oral hearing. After consideration of the protest and the evidence presented at an oral hearing, the department's action upon the protest is final when it mails notice of its action to the hospital.

(2) When a deficiency is determined and the ~~fees~~ assessments become final, the department shall mail notice and demand for payment to the hospital. Penalty and interest must be added to any deficiency assessment as provided in 15-1-216 from the date specified in 15-66-201 for payment of the ~~fees~~ assessments. A certificate by the department of the mailing of the notices specified in this section is prima facie evidence of the computation and levy of the deficiency in the ~~fees~~ assessments and of the giving of the notice. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)

Section 25. Section 15-66-207, MCA, is amended to read:

"15-66-207. (Temporary) Closing agreements. (1) The director of the department or any person authorized in writing by the director may enter into an agreement with a hospital relating to the liability of the hospital with respect to the ~~fees~~ assessments imposed by this chapter for any period.

(2) An agreement under this section is final and conclusive and, except upon a showing of fraud or malfeasance or misrepresentation of a material fact:

(a) in a case involving the agreement, the agreement may not be reopened as to matters agreed upon or modified by any officer, employee, or agent of this state; and

(b) the agreement may not be annulled, modified, set aside, or disregarded in any suit, action, or proceeding concerning the agreement or concerning any determination, assessment, collection, payment, abatement, refund, or credit made in accordance with the agreement. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)

Section 26. Section 15-66-208, MCA, is amended to read:

"15-66-208. (Temporary) Credit for overpayment -- interest on overpayment. (1) If the department determines that the amount of ~~fees~~ assessments, penalty, or interest due for any period is less than the amount paid, the amount of the overpayment must be credited against any ~~fees~~ assessments, penalty, or interest due from the hospital at that time and the balance must be refunded to the hospital or its successor through reorganization, merger, or consolidation or to its shareholders upon dissolution.

(2) Except as provided in subsection (3), interest is allowed on overpayments at the same rate as is charged on unpaid taxes, as provided in 15-1-216, from the due date of the report or from the date of overpayment, whichever date is later, to the date the department approves refunding or crediting of the overpayment. Interest does not accrue during any period during which the processing of a claim for refund is

delayed more than 30 days by reason of failure of the hospital to furnish information requested by the department for the purpose of verifying the amount of the overpayment.

(3) Interest is not allowed:

(a) if the overpayment is refunded within 6 months from the date the report is due or from the date the return is filed, whichever is later; or

(b) if the amount of interest is less than \$1.

(4) A payment not made incident to a discharge of actual utilization ~~fee~~ assessment liability or a payment reasonably assumed to be imposed by this chapter is not considered an overpayment with respect to which interest is allowable. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)

Section 27. Section 15-66-209, MCA, is amended to read:

"15-66-209. (Temporary) Warrant for distraint. If ~~the utilization fee~~ an assessment is not paid when due, the department may issue a warrant for distraint as provided in Title 15, chapter 1, part 7. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)

Section 44 28. Section 37-8-202, MCA, is amended to read:

"37-8-202. Organization -- meetings -- powers and duties. (1) The board shall:

(a) meet annually and elect from among the members a president and a secretary;

(b) hold other meetings when necessary to transact its business;

(c) prescribe standards for schools preparing persons for registration and licensure under this chapter;

(d) provide for surveys of schools at times the board considers necessary;

(e) approve programs that meet the requirements of this chapter and of the board;

(f) conduct hearings on charges that may call for discipline of a licensee, revocation of a license, or removal of schools of nursing from the approved list;

(g) cause the prosecution of persons violating this chapter. The board may incur necessary expenses for prosecutions.

(h) adopt rules regarding authorization for prescriptive authority of advanced practice registered nurses. If considered appropriate for an advanced practice registered nurse who applies to the board for authorization, prescriptive authority must be granted.

(i) adopt rules to define criteria for the recognition of registered nurses who are certified through a nationally recognized professional nursing organization as registered nurse first assistants; ~~and~~

(j) establish a medical assistance program to assist licensed nurses who are found to be physically or mentally impaired by habitual intemperance or the excessive use of addictive drugs, alcohol, or any other drug or substance or by mental illness or chronic physical illness. The program must provide for assistance to licensees in seeking treatment for mental illness or substance abuse and monitor their efforts toward rehabilitation. The board shall ensure that a licensee who is required or volunteers to participate in the medical assistance program as a condition of continued licensure or reinstatement of licensure must be allowed to enroll in a qualified medical assistance program within this state and may not require a licensee to enroll in a qualified treatment program

outside the state unless the board finds that there is no qualified treatment program in this state. For purposes of funding this medical assistance program, the board shall adjust the renewal fee to be commensurate with the cost of the program.

(k) pursuant to rules adopted by the board, periodically collect workforce data for the purposes of creating a statewide strategy for promoting efforts to develop a nursing workforce that will best meet the health care needs of Montanans. Except as otherwise provided by law, the data collected may not be disclosed in a manner that reveals individually identifiable information.

(2) The board may:

(a) participate in and pay fees to a national organization of state boards of nursing to ensure interstate endorsement of licenses;

(b) define the educational requirements and other qualifications applicable to recognition of advanced practice registered nurses. Advanced practice registered nurses are nurses who must have additional professional education beyond the basic nursing degree required of a registered nurse. Additional education must be obtained in courses offered in a university setting or the equivalent. The applicant must be certified or in the process of being certified by a certifying body for advanced practice registered nurses. Advanced practice registered nurses include nurse practitioners, nurse-midwives, nurse anesthetists, and clinical nurse specialists.

(c) establish qualifications for licensure of medication aides, including but not limited to educational requirements. The board may define levels of licensure of medication aides consistent with educational qualifications, responsibilities, and the level of acuity of the medication aides' patients. The board may limit the type of drugs that are allowed to be administered and the method of administration.

(d) adopt rules for delegation of nursing tasks by licensed nurses to unlicensed persons;

(e) adopt rules necessary to administer this chapter; and

(f) fund additional staff, hired by the department, to administer the provisions of this chapter."

Section 45 29. Section 37-8-204, MCA, is amended to read:

"37-8-204. Executive director. (1) The department shall hire an executive director to provide services to the board in connection with the board's duties of:

(a) prescribing curricula and standards for nursing schools and making surveys of and approving schools and courses;

(b) evaluating and approving courses for affiliation of student nurses; ~~and~~

(c) reviewing qualifications of applicants for licensure; and

(d) collecting workforce data.

(2) The department shall hire as the executive director an individual who:

(a) is a graduate of an approved school of nursing and who has at least a master's degree with postgraduate courses in nursing;

(b) is licensed as a registered professional nurse in Montana; and

(c) has experience in teaching or administration in an approved school of nursing and who has completed at least 3 years in the clinical practice of nursing."

Section 16. Section 53-6-131, MCA, is amended to read:

"53-6-131. Eligibility requirements. (1) Medical assistance under the Montana medicaid program may be granted to a person who is determined by the department of public health and human services, in its discretion, to be eligible as follows:

(a) The person receives or is considered to be receiving supplemental security income benefits under Title XVI of the Social Security Act, 42 U.S.C. 1381, et seq., and does not have income or resources in excess of the applicable medical assistance limits.

(b) The person would be eligible for assistance under the program described in subsection (1)(a) if that person were to apply for that assistance.

(c) The person is in a medical facility that is a medicaid provider and, but for residence in the facility, the person would be receiving assistance under the program in subsection (1)(a).

(d) The person is under 21 years of age and in foster care under the supervision of the state or was in foster care under the supervision of the state and has been adopted as a child with special needs.

(e) The person meets the nonfinancial criteria of the categories in subsections (1)(a) through (1)(d) and:

(i) the person's income does not exceed the income level specified for federally aided categories of assistance and the person's resources are within the resource standards of the federal supplemental security income program; or

(ii) the person, while having income greater than the medically needy income level specified for federally aided categories of assistance:

(A) has an adjusted income level, after incurring medical expenses, that does not exceed the medically needy income level specified for federally aided categories of assistance or, alternatively, has paid in cash to the department the amount by which the person's income exceeds the medically needy income level specified for federally aided categories of assistance; and

(B) (I) in the case of a person who meets the nonfinancial criteria for medical assistance because the person is aged, blind, or disabled, has resources that do not exceed the resource standards of the federal supplemental security income program; or

(II) in the case of a person who meets the nonfinancial criteria for medical assistance because the person is pregnant, is an infant or child, or is the caretaker of an infant or child, has resources that do not exceed the resource standards adopted by the department.

(f) The person is a qualified pregnant woman or a child as defined in 42 U.S.C. 1396d(n).

(g) The person is under 19 years of age and lives with a family having a combined income that does not exceed 185% of the federal poverty level. The department may establish lower income levels to the extent necessary to maximize federal matching funds provided for in 53-4-1104.

(h) The person meets the eligibility requirements of 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) as enacted by Public Law 111-148, Public Law 111-152, and federal regulations implementing those laws.

(2) The department may establish income and resource limitations. Limitations of income and resources must be within the amounts permitted by federal law for the medicaid program. Any otherwise applicable eligibility resource test prescribed by the department does not apply to enrollees in the healthy Montana kids plan provided for in 53-4-1104.

~~(3) The Montana medicaid program shall pay, as required by federal law, the premiums necessary for medicaid-eligible persons participating in the medicare program and may, within the discretion of the department, pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified medicare-eligible person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, who:~~

~~(a) has income that does not exceed income standards as may be required by the Social Security Act; and~~

~~(b) has resources that do not exceed standards that the department determines reasonable for purposes of the program.~~

~~(4) The department may pay a medicaid-eligible person's expenses for premiums, coinsurance, and similar costs for health insurance or other available health coverage, as provided in 42 U.S.C. 1396b(a)(1).~~

~~(5) In accordance with waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department of public health and human services may grant eligibility for basic medicaid benefits as described in 53-6-101 to an individual receiving section 1931 medicaid benefits, as defined in 53-4-602, as the specified caretaker relative of a dependent child under the section 1931 medicaid program. A recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage, as provided in 53-6-101.~~

~~(6) The department, under the Montana medicaid program, may provide, if a waiver is not available from the federal government, medicaid and other assistance mandated by Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, and not specifically listed in this part to categories of persons that may be designated by the act for receipt of assistance.~~

~~(7) Notwithstanding any other provision of this chapter, medical assistance must be provided to infants and pregnant women whose family income does not exceed income standards adopted by the department that comply with the requirements of 42 U.S.C. 1396a(l)(2)(A)(i) and whose family resources do not exceed standards that the department determines reasonable for purposes of the program.~~

~~(8) Subject to appropriations, the department may cooperate with and make grants to a nonprofit corporation that uses donated funds to provide basic preventive and primary health care medical benefits to children whose families are ineligible for the Montana medicaid program and who are ineligible for any other health care coverage, are under 19 years of age, and are enrolled in school if of school age.~~

~~(9) A person described in subsection (7) must be provided continuous eligibility for medical assistance, as authorized in 42 U.S.C. 1396a(e)(5) through a(e)(7).~~

~~(10) Full medical assistance under the Montana medicaid program may be granted to an individual during the period in which the individual requires treatment of breast or cervical cancer, or both, or of a precancerous condition of the breast or cervix, if the individual:~~

~~(a) has been screened for breast and cervical cancer under the Montana breast and cervical health program funded by the centers for disease control and prevention program established under Title XV of the Public Health Service Act, 42 U.S.C. 300k, or in accordance with federal requirements;~~

~~(b) needs treatment for breast or cervical cancer, or both, or a precancerous condition of the breast or cervix;~~

- ~~(c) is not otherwise covered under creditable coverage, as provided by federal law or regulation;~~
- ~~(d) is not eligible for medical assistance under any mandatory categorically needy eligibility group; and~~
- ~~(e) has not attained 65 years of age.~~

~~(11) Subject to the limitation in 53-6-195, the department shall provide medicaid coverage to workers with disabilities as provided in 53-6-195 and in accordance with 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII) and (r)(2) and 42 U.S.C. 1396e.~~

~~(12) The department shall establish medicaid eligibility consistent with the modified adjusted gross income criteria allowed by federal regulations."~~

Section 17 30. Section 53-6-132, MCA, is amended to read:

"53-6-132. Application for assistance --exception. (1) Subject to subsection (2), application for assistance under this part may be made in any local office of public assistance. The department shall adopt medicaid eligibility procedures and criteria that are consistent with federal requirements.

(2) The An application for medical assistance under this part must be presented in the manner and on the form prescribed by the department.

(3) All individuals wishing to apply must have the opportunity to do so.

~~(2) Notwithstanding the provisions of subsection (1), the department may designate an entity other than the local office of public assistance to determine eligibility for medicaid managed care services.~~

(4) The department may participate with federal and state programs and agencies in the coordination of procedures and criteria for eligibility determination, including use of interactive electronic networks and databases and other appropriate measures."

Section 18 31. Section 53-6-133, MCA, is amended to read:

"53-6-133. Eligibility determination. (1) ~~The local office of public assistance shall promptly determine the eligibility of each applicant under this part~~ must be determined in accordance with the rules of the department. Each applicant must be informed of the right to ~~a fair hearing~~ appeal a determination and of the confidential nature of the information given. ~~The department, through the local office of public assistance, shall, after the hearing, determine whether or not~~ If the applicant is eligible for assistance under this part, and aid must be furnished promptly to eligible persons. Each applicant must receive written notice of the decision concerning the applicant's application, and the right of appeal ~~is secured to the applicant under the procedures of 53-2-606.~~

(2) The local office of public assistance and the department may accept the federal social security administration's determination of eligibility for supplemental security income, Title XVI of the Social Security Act, as qualifying the eligible individuals to receive medical assistance under this part."

Section 37. Section 53-6-149, MCA, is amended to read:

"53-6-149. State special revenue fund account -- administration. (1) There is a hospital medicaid reimbursement account in the state special revenue fund provided for in 17-2-102.

(2) All money collected under 15-66-102(2) must be deposited in the account.

(3) Money in the account must be used by the department of public health and human services to provide funding for increases in medicaid payments to hospitals and for the costs of collection of the fee and other administrative activities associated with the implementation of increases in the medicaid payments to hospitals.

Section 19. ~~Section 53-6-155, MCA, is amended to read:~~

"53-6-155. Definitions. ~~As used in this part, unless expressly provided otherwise, the following definitions apply:~~

~~(1) "Abuse" means conduct by an applicant, recipient, provider, or other person involving disregard of and an unreasonable failure to conform with the statutes, regulations, and rules governing the medical assistance program when the disregard or failure results or may result in an incorrect determination that a person is eligible for medical assistance or payment by a medicaid agency of medical assistance payments to which the provider is not entitled.~~

~~(2) "Applicant" means a person:~~

~~(a) who has submitted an application for determination of medicaid eligibility to a medicaid agency on the person's own behalf or on behalf of another person; or~~

~~(b) on whose behalf an application has been submitted.~~

~~(3) "Benefit" means the provision of anything of pecuniary value to or on behalf of a recipient under the medicaid program.~~

~~(4) "Claim" means a communication, whether in oral, written, electronic, magnetic, or other form, that is used to claim specific services or items as payable or reimbursable under the medicaid program or that states income, expense, or other information that is or may be used to determine entitlement to or the rate of payment under the medicaid program. The term includes any documents submitted as part of or in support of the claim.~~

~~(5) "Department" means the department of public health and human services provided for in 2-15-2201.~~

~~(6) "Document" means any application, claim, form, report, record, writing, or correspondence, whether in written, electronic, magnetic, or other form.~~

~~(7) "Fraud" means any conduct or activity prohibited by statute, regulation, or rule involving purposeful or knowing conduct or omission to perform a duty that results in or may result in medicaid payments or benefits to which the applicant, recipient, or provider is not entitled. Fraud includes but is not limited to any conduct or omission under the medicaid program that would constitute a criminal offense under Title 45, chapter 6 or 7.~~

~~(8) "Health exchange" means the American health benefit exchange provided for in Public Law 111-148 and Public Law 111-152.~~

~~(8)(9) "Medicaid" means the Montana medical assistance program established under Title 53, chapter 6.~~

~~(9)(10) "Medicaid agency" means any agency or entity of state, county, or local government that administers any part of the medicaid program, whether under direct statutory authority or under contract with an authorized agency of the state or federal government. The term includes but is not limited to the department, the department of corrections, local offices of public assistance, and other local and state agencies and their agents, contractors, and employees, when acting with respect to medicaid eligibility, claims processing or payment, utilization review, case management, provider certification, investigation, or other administration of the medicaid program.~~

~~(10)(11) "Misappropriation of patient property" means exploitation, deliberate misplacement, or wrongful use or taking of a patient's property, whether temporary or permanent, without authorization by the patient or the patient's designated representative. Misappropriation of patient property includes but is not limited to any conduct with respect to a patient's property that would constitute a criminal offense under Title 45, chapter 6, part 3.~~

~~(11)(12) "Patient abuse" means the willful infliction of physical or mental injury of a patient or unreasonable confinement, intimidation, or punishment that results in pain, physical or mental harm, or mental anguish of a patient. Patient abuse includes but is not limited to any conduct with respect to a patient that would constitute a criminal offense under Title 45, chapter 5.~~

~~(12)(13) "Patient neglect" means a failure, through inattentiveness, carelessness, or other omission, to provide to a patient goods and services necessary to avoid physical harm, mental anguish, or mental illness when an omission is not caused by factors beyond the person's control or by good faith errors in judgment. Patient neglect includes but is not limited to any conduct with respect to a patient that would constitute a criminal offense under 45-5-208.~~

~~(13)(14) "Provider" means an individual, company, partnership, corporation, institution, facility, or other entity or business association that has enrolled or applied to enroll as a provider of services or items under the medical assistance program established under this part.~~

~~(14)(15) "Recipient" means a person:~~

~~(a) who has been determined by a medicaid agency to be eligible for medicaid benefits, whether or not the person actually has received any benefits; or~~

~~(b) who actually receives medicaid benefits, whether or not determined eligible.~~

~~(15)(16) (a) "Records" means medical, professional, business, or financial information and documents, whether in written, electronic, magnetic, microfilm, or other form:~~

~~(i) pertaining to the provision of treatment, care, services, or items to a recipient;~~

~~(ii) pertaining to the income and expenses of the provider; or~~

~~(iii) otherwise relating to or pertaining to a determination of eligibility for or entitlement to payment or reimbursement under the medicaid program.~~

~~(b) The term includes all records and documents, regardless of whether the records are required by medicaid laws, regulations, rules, or policies to be made and maintained by the provider."~~

NEW SECTION. Section 20 23. Codification instruction. (1) [Sections 1 through 5] are intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, part 1, apply to [sections 1 through 5].

(2) [Sections 6 through 8] are intended to be codified as an integral part of Title 37, chapter 3, and the provisions of Title 37, chapter 3, apply to [sections 6 through 8].

(3) [Sections 9 through ~~13~~ 14] are intended to be codified as an integral part of Title 53, chapter 6, ~~part 1,~~ and the provisions of Title 53, chapter 6, ~~part 1,~~ apply to [sections 9 through ~~13~~ 14].

(4) [Sections 15 and 16] are intended to be codified as an integral part of Title 53, chapter 6, part 1, and the provisions of Title 53, chapter 6, part 1, apply to [sections 15 and 16].

COORDINATION SECTION. Section 21. Coordination instruction. If both House Bill No. 2 and [this act] are passed and approved and if House Bill No. 2 contains any appropriations designated as medicaid expansion savings, then the appropriations in House Bill No. 2 that are designated as medicaid expansion savings must be transferred to the special revenue account provided for in [section 13 of this act].

NEW SECTION. Section 22 34. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. Section 35. Contingent voidness. (1) If the secretary of the U.S. department of health and human services gives notice to the state that the U.S. department of health and human services will not consider for approval or would not approve the purchase of health insurance with medicaid funds for eligible individuals pursuant to [sections 9 through 14], then [sections 9 through 14] are void and the state may not obtain or use medicaid funds for individuals who would be eligible for medicaid under 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).

(2) The director of the department of public health and human services shall notify the code commissioner of the occurrence of the contingency within 10 days of its occurrence.

NEW SECTION. Section 23 31. Effective dates. (1) Except as provided in ~~subsection (2)~~ subsections (2) and (3), [this act] is effective October 1, 2013.

(2) ~~[Sections 1 through 13, 20 through 22, 24, and 25] and this section~~ [Sections 1 through 8, 17 through 27, and 32] are effective July 1, 2013.

(3) [Sections 9 through 16 and 33 through 38] are effective on passage and approval.

NEW SECTION. Section 24 32. Contingent termination. (1) ~~[Sections 9, 12, and 16(1)(h)]~~ [Sections 9 through 13, 17 through 27, and 32] terminate on the date that the federal medical assistance percentage for medical services provided to individuals eligible for medicaid pursuant to ~~53-6-131(1)(h)~~ 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) is set below the level provided for in 42 U.S.C. 1396d(y) on [the effective date of this act].

(2) [Section ~~13 14~~] terminates 15 months after the contingency provided for in subsection (1) of this section occurs.

(3) The director of the department of public health and human services shall certify to the governor the occurrence of the contingency. The governor shall transmit a copy of the certification to the code commissioner.

NEW SECTION. Section 25 33. Termination. (1) Except as provided in [section 24 32], ~~[sections 1 through 4, 9 through 13, 16(1)(h), and 19]~~ [sections 9 through 13, 17 through 27, and 32] terminate June 30, 2017.

(2) Except as provided in [section 32(1)], [section 14] terminates 15 months after the contingency provided for in subsection (1) of this section occurs.

~~(2)~~ (3) [Section 5] terminates June 30, 2019.

- END -