HOUSE BILL NO. 839

INTRODUCED BY M. CAFERRO

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING THE MONTANA KIDS CARE PROGRAM TO PROVIDE HEALTH CARE TO ALL MONTANA CHILDREN; CREATING A GOVERNING BOARD TO ESTABLISH AND OVERSEE THE PROGRAM; PROVIDING RULEMAKING AUTHORITY; INCREASING VIDEO GAMBLING TAXES TO FUND THE PROGRAM; PROVIDING A STATUTORY APPROPRIATION; AMENDING SECTIONS 17-7-502, 23-5-610, 53-2-215, 53-4-1004, AND 53-6-131, MCA; AND PROVIDING AN EFFECTIVE DATE AND A TERMINATION DATE."

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

NEW SECTION. **Section 1. Short title.** [Sections 1 through 11] may be cited as the "Montana Kids Care Program".

NEW SECTION. **Section 2. Purpose -- funding.** (1) The purpose of [sections 1 through 11] is to create a program to provide health care services to all Montana children by:

(a) maximizing the federal dollars available for children's health care services;

(b) increasing the income eligibility for children served by the medicaid program and the children's health insurance program;

(c) expanding state health care services to cover all other Montana children; and

(d) administering the program in a seamless manner that:

(i) covers payment of claims through a single entity; and

(ii) allows children enrolled in the program to use a single application and carry a single insurance card, regardless of the source of money covering their health care costs.

(2) The program is funded through the following means:

(a) taxes and other revenue deposited in the special revenue account established in [section 10];

(b) federal and state funds appropriated for medicaid services for children 18 years of age or younger;

(c) federal and state funds appropriated for the children's health insurance program; and

(d) money from the health and medicaid initiatives account as allowed under 53-6-1201 for increased medicaid services for children or increased enrollment in the children's health insurance program.

NEW SECTION. **Section 3. Definitions.** As used in [sections 1 through 11], the following definitions apply:

(1) "Board" means the governing board of the Montana kids care program.

(2) "Child" means a child 18 years of age or younger.

(3) "Children's health insurance program" means the state-federal program established in Title 53, chapter 4, part 10.

(4) "Department" means the department of public health and human services established in 2-15-2201.

(5) "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession.

(6) "Program" means the Montana kids care program established in [sections 1 through 11].

NEW SECTION. **Section 4. Board -- purpose -- membership -- compensation.** (1) There is a board for the program, consisting of seven members and two nonvoting members serving 3-year staggered terms and appointed as follows:

(a) three members appointed by the commissioner of insurance, one of whom must be a person who has specialized knowledge regarding health insurance and one of whom must be a consumer representing the public interest; and

(b) four members appointed by the governor, one of whom must be a direct provider of children's health care services, one of whom must be employed by a mental health care facility, one of whom must be a person who has specialized knowledge regarding health insurance, and one of whom shall represent the interests of uninsured and underinsured children.

(2) The members must be appointed in a manner that achieves geographic representation of all regions of the state, including urban, rural, and reservation communities.

(3) Each member is entitled to one vote on the board.

(4) The commissioner of insurance shall appoint a representative from the office of the commissioner of insurance and the governor shall appoint a representative from the department to participate in all board meetings as nonvoting members.

(5) A board member must be replaced in the same manner as the original appointment if that board member is not actively participating in the affairs of the board.

(6) The members must be compensated and receive travel expenses in the same manner as members of the quasi-judicial boards under 2-15-124(7). The costs of conducting the meetings of the board and the

compensation for board members must be paid for from the special revenue account established in [section 10].

(7) The board is attached to the department for administrative purposes.

NEW SECTION. **Section 5. Eligibility for program.** To be considered eligible for the program, a child must be living in Montana with the intent to reside in Montana permanently or for an indefinite period of time.

NEW SECTION. **Section 6. Benefits provided.** (1) Benefits provided to participants in the program must include but are not limited to:

(a) inpatient and outpatient hospital services;

(b) services offered by a health care provider;

(c) laboratory and x-ray services;

(d) well-child and well-baby services;

(e) immunizations;

(f) clinic services;

(g) dental services;

(h) prescription drugs;

(i) mental health and substance abuse treatment services;

(j) hearing and vision exams; and

(k) eyeglasses.

(2) Copayments and fees may not be applied to well-baby, well-child, or immunization services that are provided as recommended by the American academy of pediatrics and the advisory committee on immunization practices.

(3) The provisions of this section may not limit the health care services provided to children eligible for and served by any previously existing state-operated health care program.

NEW SECTION. **Section 7. Powers and duties of board.** (1) The board shall:

(a) establish a program designed to provide health care to all Montana children in a manner that makes the best use of available federal and state funds by:

(i) increasing the income eligibility for medicaid and the children's health insurance program as allowed under law;

(ii) applying for medicaid waivers that would allow the department to serve additional children;

(iii) using revenue from the special revenue account established in [section 10]; and

(iv) identifying other potential funding sources for health care services;

(b) establish an operating plan that includes but is not limited to:

(i) the administrative structure necessary to serve all Montana children through an umbrella program that uses:

(A) federal and state medicaid funds to serve children with a family income up to 133% of the federal poverty level;

(B) federal and state children's health insurance program funds to serve children with a family income up to the maximum level allowed under federal law and who are not served by medicaid;

(C) money from the health and medicaid initiatives account established in 53-6-1201 to cover, as allowed by law, increased medicaid services for children or increased enrollment in the children's health insurance program; and

(D) money from the special revenue account, established in [section 10], to serve all other children in the program;

(ii) the extent to which preexisting conditions will be covered for children who terminate enrollment in a private insurance plan to enroll in the state program;

(iii) the amount, scope, and duration of the specific services to be provided;

(iv) a schedule of premiums, copayments, and fees that uses:

(A) the children's health insurance program copayments and fees in place in January 2007 for children with a family income at the maximum level allowed under federal law and who are not eligible for medicaid. The copayments or fees may be adjusted for inflation each biennium.

(B) a sliding scale based on family income for children with a family income above the level of eligibility for services paid for with public funds; and

(v) the ability to provide health care services in a manner that allows the greatest percentage of the total budget to be spent on direct patient care and that may include but is not limited to:

(A) a program operated by the department; or

(B) a contract for health care services;

(c) establish a process to ensure that the services are medically necessary and cost-effective; and

(d) determine the types of professionals who may deliver services or direct the delivery of services and the qualifications required of those professionals.

(2) The board may:

(a) hire employees to perform the administrative tasks of the board;

(b) request that funds be transferred from the special revenue account, established in [section 10], to cover program costs;

(c) seek other federal, state, and private funding sources; and

(d) establish criteria for the children to be served first if a waiting list must be created for the program.

NEW SECTION. **Section 8. Department -- rulemaking authority.** (1) The department shall adopt rules necessary for the administration of the program, including rules governing the application process, termination of enrollment, and confidentiality. The rules may include, as necessary:

(a) criteria to ensure that the services provided are medically necessary and cost-effective;

(b) criteria for placing children with high medical costs into a treatment plan designed to manage costs;

(c) a process to handle appeals involving payment or covered services; and

(d) a process for terminating enrollment in the program for good cause. Good cause does not include an adverse change in health status.

(2) In adopting rules, the department shall consider the federal requirements governing the receipt of the federal share of program funds and may not include any provision that places federal funding at risk.

NEW SECTION. **Section 9. Sharing of information.** The department, health care providers, insurance companies, and other entities may share only health care information, medical records, income, and other participant eligibility information for the purposes of administering the program. The limitations on disclosure of information provided in 33-19-306 do not apply if they conflict with [sections 1 through 11]. To the extent possible, the information may not be disclosed in a manner that would violate the privacy of an individual or be released to any entity that is not necessary for the administration of the program.

NEW SECTION. **Section 10. Special revenue account.** (1) There is an account in the state special revenue fund to the credit of the department to pay for developing and putting into effect a plan to provide health care services to all Montana children. The money in the account is statutorily appropriated, as provided in 17-7-502, to the department to pay:

(a) the costs of providing health care services to children enrolled in the program; and

(b) the costs incurred by the board and employees of the program.

(2) Revenue from the following sources must be credited to the account:

(a) the amount of the tax established in 23-5-610(1)(b), as specified in 23-5-610(4);

(b) any private money raised for the program; and

(c) any other source approved by the legislature.

NEW SECTION. **Section 11. Report to legislature.** The department shall report to the legislature, as provided for in 5-11-210, the following information for each year of the biennium:

(1) the number of children served by the program;

(2) the number of children, if any, on the waiting list for services;

(3) the number of Montana children estimated to be uninsured;

(4) the total amount expended each year to provide health care services;

(5) the total amount expended each year for administrative expenses; and

(6) any additional amount of money that may be necessary to cover children on a waiting list for services.

Section 12. Section 17-7-502, MCA, is amended to read:

"17-7-502. Statutory appropriations -- definition -- requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations: 2-17-105; 5-11-407; 5-13-403; 10-2-603; 10-3-203; 10-3-310; 10-3-312; 10-3-314; 10-4-301; 15-1-111; 15-1-113; 15-1-121; 15-23-706; 15-31-906; 15-35-108; 15-36-332; 15-37-117; 15-38-202; 15-65-121; 15-70-101; 15-70-369; 15-70-601; 16-11-509; 17-3-106; 17-3-212; 17-3-222; 17-3-241; 17-6-101; 17-7-304; 18-11-112; 19-3-319; 19-6-404; 19-6-410; 19-9-702; 19-13-604; 19-17-301; 19-18-512; 19-19-305; 19-19-506; 19-20-604; 20-8-107; 20-9-534; 20-9-622; 20-26-1503; 22-3-1004; 23-4-105; 23-4-202; 23-4-204; 23-4-302; 23-4-304; 23-5-306; 23-5-409; 23-5-612; 23-7-301; 23-7-402; 37-43-204; 37-51-501; 39-71-503; 41-5-2011; 42-2-105; 44-1-504; 44-12-206; 44-13-102; 50-4-623; 53-1-109; [section 10]; 53-6-703; 53-24-108; 53-24-206; 60-11-115; 61-3-415; 69-3-870; 75-1-1101; 75-5-1108; 75-6-214; 75-11-313; 77-2-362; 80-2-222; 80-4-416; 80-5-510; 80-11-518;

82-11-161; 87-1-513; 90-1-115; 90-1-205; 90-3-1003; and 90-9-306.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for the payments. (In subsection (3): pursuant to Ch. 422, L. 1997, the inclusion of 15-1-111 terminates on July 1, 2008, which is the date that section is repealed; pursuant to sec. 10, Ch. 360, L. 1999, the inclusion of 19-20-604 terminates when the amortization period for the teachers' retirement system's unfunded liability is 10 years or less; pursuant to sec. 4, Ch. 497, L. 1999, the inclusion of 15-38-202 terminates July 1, 2014; pursuant to sec. 10(2), Ch. 10, Sp. L. May 2000, and secs. 3 and 6, Ch. 481, L. 2003, the inclusion of 15-35-108 terminates June 30, 2010; pursuant to sec. 7, Ch. 314, L. 2005, the inclusion of 23-4-105, 23-4-202, 23-4-204, 23-4-302, and 23-4-304 becomes effective July 1, 2007; and pursuant to sec. 17, Ch. 593, L. 2005, the inclusion of 15-31-906 terminates January 1, 2010.)"

Section 13. Section 23-5-610, MCA, is amended to read:

"23-5-610. Video gambling machine gross income tax -- records -- distribution -- quarterly statement and payment. (1) A licensed machine owner shall pay to the department a video gambling machine tax ~~of 15%~~ based on a percentage of the gross income from each video gambling machine issued a permit under this part. A licensed machine owner may deduct from the gross income amounts equal to amounts stolen from machines if the amounts stolen are not repaid by insurance or under a court order, if a law enforcement agency investigated the theft, and if the theft is the result of either unauthorized entry and physical removal of the money from the machines or of machine tampering and the amounts stolen are documented. The tax imposed by this subsection is:

(a) 15% of the gross income from each machine with gross quarterly income below $10,000;

(b) 30% of the gross income from each machine with gross quarterly income of $10,000 or more.

(2) A licensed machine owner shall keep a record of the gross income from each video gambling machine issued a permit under this part in the form the department requires. The records must at all times during the business hours of the licensee be subject to inspection by the department.

(3) For each video gambling machine issued a permit under this part, a licensed machine owner shall, within 15 days after the end of each quarter and in the manner prescribed by the department, complete and

deliver to the department a statement showing the total gross income, together with the total amount due the state as video gambling machine gross income tax for the preceding quarter. The statement must contain other relevant information that the department requires.

(4) The ~~department shall, in accordance with the provisions of 15-1-501, forward the~~ tax collected under subsection (3) ~~to the general fund~~ must be deposited as follows:

(a) the tax imposed under subsection (1)(a) must be deposited in the general fund; and

(b) fifty percent of the tax imposed under subsection (1)(b) must be deposited in the general fund, and 50% of the tax must be deposited in the special revenue account established in [section 10]."

Section 14. Section 53-2-215, MCA, is amended to read:

"53-2-215. Social Security Act section 1115 waiver. (1) The department may pursue approval from the U.S. department of health and human services for implementation in Montana of a health insurance flexibility and accountability demonstration initiative and other demonstration projects through section 1115 waivers.

(2) The department may implement a demonstration project upon approval of a section 1115 waiver by the U.S. department of health and human services. The department may:

(a) coordinate a demonstration project with a program approved through a section 1915 waiver; or

(b) terminate and subsume in a new section 1115 waiver an existing managed care or access program approved through a section 1915(b) waiver, an optional state plan medicaid service authorized under 53-6-101, an optional state plan eligibility group authorized under 53-6-131, or an existing program approved by a section 1115 waiver, inclusive of the demonstration program authorized by 53-4-202 and Title 53, chapter 4, part 6, that is administered by the department.

(3) The department may amend the existing section 1115 demonstration project authorized in 53-4-601 and 53-6-101 to expand the demonstration project to implement the purposes of this section.

(4) The department may initiate and administer section 1115 waivers to more efficiently apply available state general fund money, other available state and local public and private funding, and federal money to the development and maintenance of medicaid-funded programs of health services and of other public assistance services and to structure those programs or services for more efficient and effective delivery to specific populations.

(5) (a) In establishing programs or services in a demonstration project approved through a section 1115 waiver, the department shall administer the expenditures under each demonstration project within the state spending authority that is available for that demonstration project. The department may limit enrollments in each

program within a demonstration project, reduce the per capita expenditures available to enrollees, and modify and reduce the types and amounts of services available through each program when the department determines that expenditures can be reasonably expected to exceed the available state spending authority.

(b) The department shall develop a contingency plan if there is a spending cap as a condition of the waiver and the spending cap is exceeded. The contingency plan must address the effects on new programs, services, or eligibility groups.

(6) The department may coordinate the state children's health insurance program authorized under Title 53, chapter 4, part 10, or the Montana kids care program authorized under [sections 1 through 11] with a section 1115 waiver for the purpose of increasing the state funding match available under the waiver and expanding the number of participants in the state children's health insurance program or the Montana kids care program.

(7) The department, subject to the terms and conditions of the section 1115 waiver:

(a) shall establish the eligibility groups based upon the funding principles stated in 53-6-101(2);

(b) may provide medicaid coverage for one or more optional medicaid eligibility groups;

(c) may provide medicaid coverage for one or more specific populations of persons who are not within the federally authorized medicaid eligibility groups but who are within the requirements of subsection (8);

(d) may establish the service coverage, eligibility requirements, financial participation requirements, and other features for the administration and delivery of services to each section 1115 waiver eligibility group;

(e) shall set limits on the number of participants for each section 1115 waiver eligibility group;

(f) shall set limits on the total expenditures under each demonstration project; and

(g) shall set the limits on the total expenditures on the services to be provided to each section 1115 waiver eligibility group.

(8) The categories of persons that the department may consider for establishment as a section 1115 waiver eligibility group include but are not limited to:

(a) low-income parents of children who are eligible to participate in medicaid under 53-6-131 or in the state children's health insurance program authorized under Title 53, chapter 4, part 10;

(b) persons who because of low income and health-care needs are unable to procure health insurance coverage and are eligible to participate in a comprehensive health association plan authorized under Title 33, chapter 22, part 15;

(c) children who because of limits on enrollment may not be covered through the state children's health insurance program authorized under Title 53, chapter 4, part 10;

(d) children who are eligible to participate in the state children's health insurance program authorized

under Title 53, chapter 4, part 10; and

(e) other specific groups of persons who are participants in programs or services funded solely or primarily through state general funds or who the department determines are in need of specific types of health care and related services, such as prescription drugs, reproductive health care, and mental health services, and are without adequate financial means to procure health insurance coverage of those needs.

(9) Children participating in a section 1115 waiver eligibility group or children who would be eligible to participate in the state children's health insurance program are subject to the eligibility criteria applicable under 53-4-1004, except as provided in subsection (10) of this section, for participation in the state children's health insurance program and must receive benefits as provided through the state children's health insurance program under 53-4-1005.

(10) (a) Except as provided in this subsection (10), the eligibility for the section 1115 waiver eligibility groups may not exceed 150% of the federal poverty level.

(b) The department may establish eligibility at greater than 150% but no more than 200% of the federal poverty level for any of the following groups established for purposes of a section 1115 waiver:

~~(i) participants in the state children's health insurance program~~;

~~(ii) participants in a group that may be covered under the state children's health insurance program;~~

~~(iii)~~(i) participants in a family planning program;

~~(iv)~~(ii) participants in a group composed of persons previously served through a program funded with state general fund money and other nonmedicaid money; or

~~(v)~~(iii) participants in a group composed of persons with a significant need for particular services that are not readily available to that population through insurance products or because of personal financial limitations.

(c) The department shall establish eligibility at the maximum level allowed under federal law for the following groups established for purposes of a section 1115 waiver:

(i) participants in the state children's health insurance program as provided in 53-4-1004; and

(ii) participants in a group that may be covered under the state children's health insurance program.

~~(c)~~(d) In establishing the eligibility criteria based upon federal poverty levels, the department shall select levels to ensure that the resulting expenditures will remain within the available funding and will conform with the terms and conditions of approval by the U.S. department of health and human services.

~~(d)~~(e) The department may adopt additional programmatic and financial eligibility criteria for a section 1115 waiver eligibility group in order to appropriately define the subject population, to limit use for fiscal and programmatic purposes, to prevent improper use, and to conform the administration of the program with the terms

and conditions of the section 1115 waiver.

~~(e)~~(f) Eligibility criteria applicable to a section 1115 waiver eligibility group need not conform to the criteria applicable to another section 1115 waiver eligibility group or to a medicaid eligibility group that is not encompassed within the demonstration project.

(11) (a) For each section 1115 waiver eligibility group, the department shall establish the program benefit or benefits to be available to the participants in the group.

(b) Program benefits may be in the form of:

(i) assistance in the payment of health insurance premiums for health care coverage through an employer or other existing group coverage available to the program enrollee;

(ii) assistance in the payment of health insurance premiums for health care coverage that meets a set of defined standards and limitations adopted by the department in consultation with the commissioner of insurance and obtained from participating private insurers or through self-insured pools;

(iii) premium purchase for insurance coverage on behalf of children who are 18 years of age or younger for the defined set of health care and related services adopted by the department for the state children's health insurance program authorized in Title 53, chapter 4, part 10; or

(iv) coverage of a defined set of health care and related services administered directly by the department on a fee-for-service basis.

(c) The department may limit the types of program benefits available to enrollees in a program. For programs in which the department provides for more than one type of program benefit, the department may require that enrollees, either as a whole or on an individual basis based on certain circumstances, use certain types of program benefits in lieu of using other types of program benefits.

(d) The department shall, as necessary to maintain expenditures for a program within the available funding for that program, set monetary limitations on the total benefit amounts available on a periodic basis for an enrollee through that program, whether that benefit is in the form of premium assistance, premium purchase, or a set of covered services.

(12) The benefits for a section 1115 waiver eligibility group may be in the form of a defined set of covered services consisting of one or more of the mandatory and optional medicaid state plan services specified in 53-6-101 or other health-care related services. The department may select the types of services that constitute a defined set of covered services for a section 1115 waiver eligibility group. The department may provide coverage of a service not specified in 53-6-101 if the department determines the service to be appropriate for the particular section 1115 waiver eligibility group. The department may define the nature, components, scope,

amount, and duration of each covered service to be made available to a section 1115 waiver eligibility group. The nature, components, scope, amount, and duration of a covered service made available to a section 1115 waiver eligibility group need not conform to those aspects of that service as defined by the department for delivery as a covered service to another section 1115 waiver eligibility group or to a medicaid eligibility group that is not encompassed within a section 1115 waiver.

(13) The department may adopt financial participation requirements for enrollees in a section 1115 eligibility group to foster appropriate use among enrollees and to maintain the fiscal accountability of the program. The department may adopt financial participation requirements, including but not limited to copayments, payment of monthly or yearly enrollment fees, or deductibles. The requirements may vary among the section 1115 waiver eligibility groups. In adopting financial participation requirements for enrollees selecting coverage as provided in subsection (11)(b)(iv), the department may not adopt cost-sharing amounts that exceed the nominal deductible, coinsurance, copayment, or similar charges adopted by the department to apply to categorically or medically needy persons for a service pursuant to the state medicaid plan.

(14) The department shall adopt rules as necessary for the implementation of a section 1115 waiver. Rules may include but are not limited to:

(a) designation of programs and activities for implementation of a section 1115 waiver;

(b) features and benefit coverage of the programs;

(c) the nature, components, scope, amount, and duration of each program service;

(d) appropriate insurance products and coverage as benefits;

(e) required enrollee eligibility information;

(f) enrollee eligibility categories, criteria, requirements, and related measures;

(g) limits upon enrollment;

(h) requirements and limitations for service costs and expenditures;

(i) measures to ensure the appropriateness and quality of services to be delivered;

(j) provider requirements and reimbursement;

(k) financial participation requirements for enrollees;

(l) use measures; and

(m) other appropriate provisions necessary for administration of a demonstration project and for implementation of the conditions placed upon approval of a section 1115 waiver by the U.S. department of health and human services.

(15) The department shall administer the programs and activities that are subject to a section 1115 waiver

in accordance with the terms and conditions of approval by the U.S. department of health and human services. The department may modify aspects of established programs and activities administered by the department as may be necessary to implement a section 1115 waiver as provided in this section.

(16) The department may seek an initial duration and durational extensions for a section 1115 waiver as the department determines appropriate for demonstration and fiscal considerations.

(17) The department shall provide a report to the legislature, as provided in 5-11-210, on the conditions of approval and the status of implementation for each section 1115 waiver approved by the U.S. department of health and human services. For any proposed section 1115 waiver not approved by the U.S. department of health and human services, the department shall provide to the next legislative session a report on the basis for disapproval and an analysis of the fiscal costs and programmatic impacts of serving the persons within the proposed section 1115 waiver eligibility groups through eligibility under one of the optional medicaid eligibility categories established in federal law and authorized by 53-6-131.

(18) The department shall present a section 1115 waiver proposal to the appropriate medicaid advisory council, which must include consumer advocates, prior to the submission of the proposal to the federal government.

(19) The department shall present a section 1115 waiver proposal to the house appropriations committee or, during the interim, the children, families, health, and human services interim committee for review and comment at a public hearing prior to the submission of the proposal to the federal government for formal approval and shall also present the section 1115 waiver after final approval from the federal government.

(20) (a) The department shall provide for a public comment period on the proposed section 1115 waiver at least 60 days before the submission of the section 1115 waiver application to the federal government for formal approval.

(b) The department shall give notice of the proposal by announcing the pending submittal, stating its general purpose, and informing the public that information on the proposal is available on the department's website.

(c) The department shall provide for public comment through electronic means or mail and shall provide for a public forum in at least one location at which members of the public can submit views on the proposal. The department shall consider comments received and make any appropriate changes to the waiver request before submitting it to the federal government.

(d) The department shall post on its website the waiver concept paper, formal correspondence regarding a waiver proposal, and the final approved waiver, including documents received from the center for medicare and

medicaid services."

Section 15. Section 53-4-1004, MCA, is amended to read:

"53-4-1004. (Temporary) Eligibility for program -- rulemaking. (1) To be considered eligible for the program, a child:

(a) must be 18 years of age or younger;

(b) must have a combined family income at or below ~~150% of the federal poverty~~ the maximum level allowed under federal law or at a lower level determined by the department of public health and human services as provided in subsection (4);

(c) may not already be covered by private insurance that offers creditable coverage, as defined in 42 U.S.C. 300gg(c);

(d) may not be eligible for medicaid benefits; and

(e) must be a United States citizen or qualified alien and a Montana resident.

(2) The department of public health and human services shall adopt rules that establish the program's criteria for residency. The criteria must conform as nearly as practicable with the residency requirements for medicaid eligibility.

(3) Subject to 53-4-1009(3), rules governing eligibility may also include financial standards and criteria for income and resources, treatment of resources, and nonfinancial criteria.

(4) If the department determines that there is insufficient funding for the program, it may lower the percentage of the federal poverty level established in subsection (1)(b) in order to reduce the number of persons who may be eligible to participate ~~or may limit the amount, scope, or duration of specific services provided~~. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999.)"

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) has resources that are within the resource standards of the federal supplemental security income program.

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

(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.

(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~~ children under 19 years of age and pregnant women whose family income does not exceed 133% of the federal poverty threshold, as provided in 42 U.S.C. 1396a(a)(10)(A)(ii)(IX) and 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."

NEW SECTION. **Section 17. Codification instruction.** [Sections 1 through 11] are intended to be codified as an integral part of Title 53, chapter 4, and the provisions of Title 53, chapter 4, apply to [sections 1 through 11].

NEW SECTION. **Section 18. Effective date.** [This act] is effective July 1, 2007.

NEW SECTION. **Section 19. Termination.** (1) [Section 15] terminates on the date that the director of the department of public health and human services certifies to the governor that the federal government has terminated the program or that federal funding for the program has been discontinued.

(2) The governor shall transmit a copy of the certification to the code commissioner.

(3) Any excess funds remaining upon the termination of the program must be transferred to the general fund.

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