HOUSE BILL NO. 623

INTRODUCED BY L. BANGERTER

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS RELATED TO HEALTH CARE AND HEALTH INSURANCE TO IMPROVE ACCESS WITHOUT EXPANDING THE MEDICAID PROGRAM AS ALLOWED UNDER PUBLIC LAW 111-148 AND PUBLIC LAW 111-152; ~~ESTABLISHING A CITIZENS COUNCIL ON HEALTH CARE REFORM; PROVIDING GRANTS TO ASSIST CERTAIN INDIVIDUALS WITH THE PURCHASE OF HEALTH INSURANCE;~~ PROVIDING GRANTS TO ASSIST CERTAIN INDIVIDUALS WITH THE ~~PURCHASE OF HEALTH INSURANCE; ESTABLISHING A SELECT COMMITTEE ON MEDICAID INNOVATION, REFORM, AND EXPANSION; ESTABLISHING PRACTICE REQUIREMENTS FOR WWAMI GRADUATES; ESTABLISHING HOSPITAL CHARITY CARE STANDARDS AS A REQUIREMENT FOR EXEMPTION FROM STATE TAXES; PROVIDING FOR REFORMS TO THE STATE MEDICAID PROGRAM; ELIMINATING THE INSURE MONTANA PROGRAM; CREATING SPECIAL REVENUE ACCOUNTS; PROVIDING DEFINITIONS; REVISING THE DISTRIBUTION OF PROCEEDS FROM A CONVERSION TRANSACTION OF A NONPROFIT HEALTH ENTITY; CREATING A SPECIAL REVENUE ACCOUNT; PROVIDING DEFINITIONS; PROVIDING A STATUTORY APPROPRIATION AND~~ PROVIDING ~~AN APPROPRIATION; A STATUTORY APPROPRIATION AND APPROPRIATIONS; TRANSFERRING FUNDS; AMENDING SECTIONS 17-7-502, 15-6-201, 15-30-2110, 15-30-2618, 15-31-102, 15-31-511, 17-6-606, 17-7-502, 33-22-1513, 33-22-1815, 33-22-1816, 45-6-301, 50-4-716, AND, 50-4-720, 53-4-1004, AND 53-6-1201, MCA; REPEALING SECTIONS 15-30-2368, 15-31-130, 33-22-2001, 33-22-2002, 33-22-2003, 33-22-2004, 33-22-2005, 33-22-2006, 33-22-2007, 33-22-2008, 33-22-2009, 53-2-216, AND 53-2-217, MCA;~~ ALLOWING USE OF MEDICAID FUNDS TO PURCHASE INSURANCE FOR CERTAIN NONDISABLED, NONELDERLY, AND NONPREGNANT INDIVIDUALS; ESTABLISHING 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; CREATING A FEE ON MEDICAID PROVIDERS AND INSURERS; CREATING A SPECIAL REVENUE ACCOUNT; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-2-708, 33-31-111, 37-8-202, AND 37-8-204, MCA; AND PROVIDING EFFECTIVE DATES~~,~~ ~~AND APPLICABILITY DATES, AND A TERMINATION DATE,~~ AND ~~A~~ TERMINATION ~~DATE~~ DATES."

~~WHEREAS, STATE GOVERNMENT BUDGETS HAVE COME UNDER PRESSURE IN RECENT YEARS BECAUSE OF PREVAILING NATIONAL ECONOMIC CONDITIONS; AND~~

~~WHEREAS, THE COSTS OF PROVIDING SOCIAL SERVICES MAKE UP A LARGE PORTION OF STATE GOVERNMENT BUDGETS; AND~~

~~WHEREAS, NEW APPROACHES TO FUNDING SOCIAL SERVICES MAY RESULT IN LOWER COSTS AND BETTER OUTCOMES OVER THE COURSE OF TIME; AND~~

~~WHEREAS, THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES HAS THE AUTHORITY TO SEEK WAIVERS FROM THE FEDERAL GOVERNMENT TO PROVIDE MEDICAID SERVICES IN NEW WAYS THAT MAY IMPROVE THE DELIVERY OF THE SERVICES OR REDUCE THE COSTS OF THE SERVICES; AND~~

~~WHEREAS, THE 62ND LEGISLATURE PASSED SENATE BILL NO. 221 TO CONTAIN HEALTH CARE COSTS THROUGH THE AUTHORIZATION OF ACCOUNTABLE CARE ORGANIZATIONS; AND~~

~~WHEREAS, THE 63RD LEGISLATURE PASSED SENATE BILL NO. 84 TO CONTAIN HEALTH CARE COSTS THROUGH THE ESTABLISHMENT OF STANDARDS AND A STRUCTURE FOR PATIENT-CENTERED MEDICAL HOMES; AND~~

~~WHEREAS, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT REQUIRED THE EXPANSION OF THE STATE-FEDERAL MEDICAID PROGRAM TO NONELDERLY, NONDISABLED, AND NONPREGNANT INDIVIDUALS BETWEEN THE AGES OF 18 AND 65 WHO ARE AT OR BELOW 138% OF THE FEDERAL POVERTY LEVEL; AND~~

~~WHEREAS, THE U.S. SUPREME COURT RULING IN NATIONAL FEDERATION OF INDEPENDENT BUSINESS V. SEBELIUS IN ESSENCE GAVE STATES THE OPTION OF CHOOSING WHETHER TO PARTICIPATE IN THE EXPANSION OF THE MEDICAID PROGRAM; AND~~

~~WHEREAS, DEMOCRATIC AND REPUBLICAN GOVERNORS IN SEVERAL STATES ARE EXPLORING ALTERNATIVES TO A STRAIGHT EXPANSION OF THE MEDICAID PROGRAM AS PROVIDED FOR UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT; AND~~

~~WHEREAS, THE CONGRESSIONAL BUDGET OFFICE REPORTED IN FEBRUARY 2013 THAT MEDICAID ACCOUNTED FOR 40% OF THE FEDERAL SPENDING ON GOVERNMENT PROGRAMS ASSISTING LOW-INCOME INDIVIDUALS IN 2012; AND~~

~~WHEREAS, GROWTH IN THE MEDICAID PROGRAM NATIONALLY HAS AVERAGED ABOUT 7% PERCENT A YEAR ABOVE THE RATE OF INFLATION, ACCORDING TO THE CONGRESSIONAL BUDGET OFFICE; AND~~

~~WHEREAS, MEDICAID SPENDING ACCOUNTS FOR 25% OF THE TOTAL PROPOSED STATE BUDGET FOR THE 2015 BIENNIUM AND 14% OF THE TOTAL GENERAL FUND BUDGET.~~

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

(Refer to Second House Second Reading (Tan) Bill)

Strike everything after the enacting clause and insert:

NEW SECTION. **Section 1. Short title.** [Sections 1 through 4] 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 4] 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 4], 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 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. 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) 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;

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

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

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

(e) 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.

(4) The department shall:

(a) provide regular reports to the advisory council on the department's efforts to obtain and implement a waiver pursuant to [sections 8 through 14];

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

(c) 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 4. 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 5. Short title.** [Sections 5 through 7] may be cited as the "Montana Health

Care Workforce Data Collection Act".

NEW SECTION. **Section 6. 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 7. 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 5 through 7] 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 5 through 7].

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

NEW SECTION. **Section 8. 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 or other available waiver authority as necessary

to provide health care services through a program operated in accordance with the provisions of [sections 8 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 9. Definitions.** As used in [sections 8 through 14], the following definitions apply:

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

(2) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.

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

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

(5) "Eligible individual" means an individual who meets the 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.

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

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

(8) "Program" means the waiver program established under [sections 8 through 14].

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

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

(11) "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 8 through 14].

NEW SECTION. **Section 10. 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 must:

(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) primary caregivers for a family member; or

(c) the spouses of adults who are 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 11. 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 option of participating in the program provided for in [sections 8 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:

(a) at each meeting of the advisory committee provided for in [section 3]; and

(b) at least twice a year to the children, families, health, and human services interim committee.

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

NEW SECTION. **Section 13. Insurance assistance mitigation fee.** (1) A provider of medicaid services shall pay an insurance assistance mitigation fee as provided in this section.

(2) The department may establish by rule the amount of fee that each type of provider shall pay. The fee must be proportionate to the amount of medicaid services provided by each provider type.

(3) The fees established by the department must raise a total of $20 million per fiscal year.

(4) The fee is due no later than January 15 of each year. Proceeds from the fee must be deposited in the special revenue account provided for in [section 14].

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

(a) any general fund money appropriated for medicaid services that is unexpended 12 months after the close of the fiscal year for which it was appropriated;

(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 of the use of medicaid funds to purchase health insurance and provide coverage for eligible individuals as allowed under [sections 8 through 14]; and

(ii) amount of general fund money 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 insurance assistance mitigation fee assessed by the department pursuant to [section 13] and by

the commissioner as provided in [section 17].

(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 eligible individuals as allowed under [sections 8 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 medicaid funds were used to cover eligible individuals as allowed under [sections 8 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 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;

(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.

NEW SECTION. **Section 17. Insurance assistance mitigation fee.** (1) As a condition of writing health

care benefits policies or contracts in this state, health insurance issuers licensed or authorized to do business in this state, including those formed under 42 U.S.C. 18042 as a consumer operated and oriented plan, shall pay an insurance assistance mitigation fee as provided in this section.

(2) The commissioner may establish by rule the amount of fee that an insurer shall pay. The fee must be proportionate to the number of policies or contracts that the insurer issues in Montana.

(3) The fees established by the commissioner must raise a total of $10 million per fiscal year.

(4) The fee is due no later than January 15 of each year. Proceeds from the fee must be deposited in the special revenue account provided for in [section 14].

Section 18. Section 33-2-708, MCA, is amended to read:

"33-2-708. (Temporary) Fees and licenses. (1) (a) Except as provided in 33-17-212(2), the commissioner shall collect a fee of $1,900 from each insurer applying for or annually renewing a certificate of authority to conduct the business of insurance in Montana.

(b) The commissioner shall collect certain additional fees as follows:

(i) nonresident insurance producer's license:

(A) application for original license, including issuance of license, if issued, $100;

(B) biennial renewal of license, $50;

(C) lapsed license reinstatement fee, $100;

(ii) resident insurance producer's license lapsed license reinstatement fee, $100;

(iii) surplus lines insurance producer's license:

(A) application for original license and for issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(iv) insurance adjuster's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(v) insurance consultant's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(vi) viatical settlement broker's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(vii) resident and nonresident rental car entity producer's license:

(A) application for original license, including issuance of license, if issued, $100;

(B) quarterly filing fee, $25;

(viii) an original notification fee for a life insurance producer acting as a viatical settlement broker, in accordance with 33-20-1303(2)(b), $50;

(ix) 50 cents for each page for copies of documents on file in the commissioner's office;

(x) the insurance assistance mitigation fee provided for in [section 17].

(c) The commissioner may adopt rules to determine the date by which a nonresident insurance producer, a surplus lines insurance producer, an insurance adjuster, or an insurance consultant is required to pay the fee for the biennial renewal of a license.

(2) (a) The commissioner shall charge a fee of $75 for each course or program submitted for review as required by 33-17-1204 and 33-17-1205, but may not charge more than $1,500 to a sponsoring organization submitting courses or programs for review in any biennium.

(b) Insurers and associations composed of members of the insurance industry are exempt from the charge in subsection (2)(a).

(3) (a) Except as provided in subsection (3)(b), the commissioner shall promptly deposit with the state treasurer to the credit of the general fund all fines and penalties and those amounts received pursuant to 33-2-311, 33-2-705, 33-28-201, and 50-3-109.

(b) The commissioner shall deposit 16.67% of the money collected under 33-2-705 in the special revenue account provided for in 53-4-1115.

(c) All other fees collected by the commissioner pursuant to Title 33 and the rules adopted under Title 33 must be deposited in the state special revenue fund to the credit of the state auditor's office.

(4) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of $10 will be refunded. (Terminates June 30, 2013--sec. 35(2), Ch. 486, L. 2009.)

33-2-708. (Effective July 1, 2013) Fees and licenses. (1) (a) Except as provided in 33-17-212(2), the

commissioner shall collect a fee of $1,900 from each insurer applying for or annually renewing a certificate of authority to conduct the business of insurance in Montana.

(b) The commissioner shall collect certain additional fees as follows:

(i) nonresident insurance producer's license:

(A) application for original license, including issuance of license, if issued, $100;

(B) biennial renewal of license, $50;

(C) lapsed license reinstatement fee, $100;

(ii) resident insurance producer's license lapsed license reinstatement fee, $100;

(iii) surplus lines insurance producer's license:

(A) application for original license and for issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(iv) insurance adjuster's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(v) insurance consultant's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(vi) viatical settlement broker's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(vii) resident and nonresident rental car entity producer's license:

(A) application for original license, including issuance of license, if issued, $100;

(B) quarterly filing fee, $25;

(viii) an original notification fee for a life insurance producer acting as a viatical settlement broker, in accordance with 33-20-1303(2)(b), $50;

(ix) 50 cents for each page for copies of documents on file in the commissioner's office;

(x) the insurance assistance mitigation fee provided for in [section 17].

(c) The commissioner may adopt rules to determine the date by which a nonresident insurance producer, a surplus lines insurance producer, an insurance adjuster, or an insurance consultant is required to pay the fee for the biennial renewal of a license.

(2) (a) The commissioner shall charge a fee of $75 for each course or program submitted for review as required by 33-17-1204 and 33-17-1205, but may not charge more than $1,500 to a sponsoring organization submitting courses or programs for review in any biennium.

(b) Insurers and associations composed of members of the insurance industry are exempt from the charge in subsection (2)(a).

(3) (a) Except as provided in subsection (3)(b), the commissioner shall promptly deposit with the state treasurer to the credit of the general fund all fines and penalties and those amounts received pursuant to 33-2-311, 33-2-705, 33-28-201, and 50-3-109.

(b) The commissioner shall deposit 33% of the money collected under 33-2-705 in the special revenue account provided for in 53-4-1115.

(c) All other fees collected by the commissioner pursuant to Title 33 and the rules adopted under Title 33 must be deposited in the state special revenue fund to the credit of the state auditor's office.

(4) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of $10 will be refunded."

Section 19. Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-401, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-137, 33-22-141, 33-22-142, 33-22-152, [section 17], 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance organizations."

Section 20. 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 purpose 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 21. 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."

NEW SECTION. **Section 22. Codification instruction.** (1) [Sections 1 through 4] are intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, apply to [sections 1 through 4].

(2) [Sections 5 through 7] 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 5 through 7].

(3) [Sections 8 through 14] are intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [sections 8 through 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].

(5) [Section 17] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the

provisions of Title 33, chapter 22, part 1, apply to [section 17].

NEW SECTION. **Section 23. 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 24. 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 8 through 14], then [sections 8 through 14 and 17] 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 25. Effective dates.** (1) Except as provided in subsections (2) and (3), [this act] is effective October 1, 2013.

(2) [Sections 1 through 7, 13, 14, and 17] are effective July 1, 2013.

(3) [Sections 8 through 12 and 22 through 27] are effective on passage and approval.

NEW SECTION. **Section 26. Contingent termination.** (1) [Sections 8 through 13 and 17] terminate on the date that the federal medical assistance percentage for medical services provided to individuals eligible for medicaid pursuant to 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 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 27. Termination.** (1) Except as provided in [sections 24 and 26], [sections

8 through 13 and 17] terminate June 30, 2017.

(2) Except as provided in [section 26(2)], [section 14] terminates September 30, 2017.

(3) [Section 4] terminates June 30, 2019.

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