

SENATE BILL NO. 395

INTRODUCED BY D. WANZENRIED

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3
4 A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS RELATED TO HEALTH CARE TO
5 EXPAND MEDICAID TO CERTAIN NONDISABLED, NONELDERLY, AND NONPREGNANT INDIVIDUALS ~~AND~~
6 ~~TO IMPROVE THE DELIVERY OF HEALTH CARE SERVICES IN MONTANA~~ AND TO IMPROVE THE
7 DELIVERY OF HEALTH CARE SERVICES IN MONTANA; ESTABLISHING MEDICAID ELIGIBILITY CRITERIA;
8 ~~REQUIRING A REVIEW OF THE MONTANA MEDICAID PROGRAM AND THE HEALTH CARE DELIVERY~~
9 ~~SYSTEM; ESTABLISHING A MEDICAID WELLNESS PILOT PROJECT; ESTABLISHING WORKFORCE~~
10 ~~REPORTING REQUIREMENTS FOR CERTAIN HEALTH CARE PROFESSIONALS; PROVIDING FOR USE OF~~
11 ~~UNEXPENDED MEDICAID FUNDS; PROVIDING DEFINITIONS; CREATING A SPECIAL REVENUE ACCOUNT;~~
12 REQUIRING A REVIEW OF THE MONTANA MEDICAID PROGRAM AND THE HEALTH CARE DELIVERY
13 SYSTEM; ESTABLISHING A MEDICAID WELLNESS PILOT PROJECT; ESTABLISHING WORKFORCE
14 REPORTING REQUIREMENTS FOR CERTAIN HEALTH CARE PROFESSIONALS; PROVIDING FOR USE OF
15 UNEXPENDED MEDICAID FUNDS; PROVIDING DEFINITIONS; CREATING A SPECIAL REVENUE ACCOUNT;
16 ~~AMENDING SECTIONS ~~37-8-202, 37-8-204,~~ 37-8-202, 37-8-204, 53-6-131, 53-6-132, ~~AND~~ 53-6-133, ~~AND~~~~
17 ~~53-6-155, AND 53-6-155, MCA; AND PROVIDING ~~EFFECTIVE DATES AND~~ EFFECTIVE DATES AND~~
18 ~~TERMINATION DATES."~~

19
20 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

21 (Refer to Second Reading - Yellow Bill)

22 Strike everything after the enacting clause and insert:

23
24 NEW SECTION. Section 1. Short title. [Sections 1 through 5] may be cited as the "Montana Health
25 Care Reform and Cost Containment Act".

26
27 NEW SECTION. Section 2. Legislative findings and intent. (1) The intent of [sections 1 through 5]
28 is to modify and enhance Montana's health care delivery system to provide access to quality and affordable health
29 care for all Montana citizens.

30 (2) The legislature finds that to achieve the purposes of [sections 1 through 5], it will be necessary for



1 state government, health care providers, patient advocates, and other parties interested in quality and affordable
2 health care to collaborate in order to:

- 3 (a) increase the number of Montanans with health insurance coverage;
- 4 (b) provide greater value for the tax dollars spent on the medicaid program by exploring options for
5 delivering services in a more efficient and cost-effective manner, including but not limited to:
- 6 (i) offering incentives to encourage health care providers to achieve measurable performance outcomes;
- 7 (ii) improving the coordination of care among health care providers and health care payers;
- 8 (iii) reducing preventable hospital readmissions; and
- 9 (iv) exploring medicaid payment methodologies that promote quality of care and efficiencies;
- 10 (c) contain growth in health care costs by:
- 11 (i) curbing wasteful spending;
- 12 (ii) avoiding unnecessary use of health care services;
- 13 (iii) reducing the instances in which health care practitioners provide health care services in order to avoid
14 the risk of litigation; and
- 15 (iv) reducing fraud;
- 16 (d) ensure that there is an adequate number of health care professionals throughout the state;
- 17 (e) provide incentives that result in Montanans taking greater responsibility for their personal health;
- 18 (f) boost Montana's economy by reducing the costs of uncompensated care; and
- 19 (g) reduce or minimize the shifting of payment for unreimbursed health care costs to patients with private
20 insurance.

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

26

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

- 29 (1) "Department" means the department of public health and human services provided for in 2-15-2201.
- 30 (2) "Recipient" means a person:

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

3 (b) who receives medicaid benefits, whether or not the person is determined to be eligible.
4

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

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

12 (3) The advisory committee shall:

13 (a) review the way in which the implementation of the expansion of the medicaid program is being carried
14 out;

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

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

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

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

24 (f) examine ways to:

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

27 (ii) increase the availability of mental health services;

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

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

1 (g) receive regular reports from the department on the department's efforts to pursue contracting options
 2 for administration of services to individuals eligible for medicaid as allowed under Public Law 111-148 and Public
 3 Law 111-152.

4 (4) The department shall:

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

7 (b) summarize and present the findings and recommendations of the advisory committee in a final report
 8 to the governor and to the children, families, health, and human services interim committee no later than August
 9 15 of each even-numbered year.

10
 11 **NEW SECTION. Section 5. Medicaid wellness pilot project.** (1) Subject to any necessary approval
 12 from the centers for medicare and medicaid, the department shall administer a pilot project designed to assess
 13 whether providing incentives for a recipient's participation in disease management and wellness activities
 14 improves the recipient's management of chronic disease.

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

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

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

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

27 (a) participants who did not meet the goals; and

28 (b) recipients with similar medical conditions in counties that were not included in the pilot project.

29
 30 **NEW SECTION. Section 6. Short title.** [Sections 6 through 8] may be cited as the "Montana Health

1 Care Workforce Data Collection Act".

2

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

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

10 (a) the applicant's gender and date of birth;

11 (b) the applicant's employment and practice status, including but not limited to:

12 (i) active practices in Montana and other locations;

13 (ii) the area of practice, including areas of specialty;

14 (iii) the office, hospital, or clinical setting in which the applicant practices;

15 (c) the applicant's education, training, and specialty and subspecialty board certification;

16 (d) the locations where the applicant practices and the average number of hours the applicant works
17 each week providing patient care at each location;

18 (e) the average number of weeks the applicant worked during the past full year in the licensed
19 profession;

20 (f) the percentage of time the applicant spends engaged in direct patient care and in other activities,
21 including but not limited to teaching, research, and administration in the licensed profession; and

22 (g) other data as proposed to and approved by the board.

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

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

26 (a) the department of public health and human services provided for in 2-15-2201; and

27 (b) Montana professional associations representing physicians and physician assistants.

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

30 (b) The provisions of subsection (5)(a) do not apply to the release of information to a state agency or a

1 Montana medical professional association for state program, workforce, or health planning purposes.

2

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

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

9 (a) establish and maintain the database;

10 (b) analyze data contained in the database;

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

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

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

16

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

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

22 (i) the legislature; or

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

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

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

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

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

1 (iii) use of medicaid funds to purchase a qualified health plan as defined in 42 U.S.C. 18021(a); and
2 (iv) offering incentives that would allow individuals to obtain insurance coverage through the health
3 exchange.

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

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

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

9 (b) the average cost of medical services provided to those individuals;

10 (c) the average length of time the individuals remained eligible for medical assistance under this section;

11 (d) the total cost of providing services under this section, including related administrative costs; and

12 (e) the status of efforts that the department has undertaken pursuant to subsection (1)(c) to contract for
13 providing or paying for medical services.

14

15 **NEW SECTION. Section 10. Education and outreach on insurance coverage options.** (1) The
16 department shall undertake activities to increase public awareness of and knowledge about the options for
17 obtaining health insurance coverage, including but not limited to the expansion of the medicaid program, the
18 availability of tax credits for purchasing insurance, and the ways in which the health exchange may be used to
19 review and decide on insurance options.

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

22 (a) each meeting of the advisory committee provided for in [section 4]; and

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

24

25 **NEW SECTION. Section 11. Management of medicaid program.** In order to ensure that medical
26 assistance under this part is provided in an efficient and effective manner, the department shall strengthen
27 existing programs that manage the way in which recipients obtain approval for medical services and shall
28 establish additional programs designed to reduce costs and improve medical outcomes for recipients. The efforts
29 may include but are not limited to:

30 (1) establishing by rule requirements that are designed to strengthen the relationship between physicians

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

20

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

24

25 **NEW SECTION. Section 13. Medicaid expansion mitigation account -- report.** (1) There is an
26 account in the state special revenue fund for the deposit of:

- 27 (a) any general fund appropriated for medicaid services that is unexpended 12 months after the close
28 of the fiscal year for which it was appropriated; and
- 29 (b) money transferred from the general fund and the state special revenue fund that is the equivalent
30 of the:

1 (i) reduction in state expenditures for health care services that occurs because the Montana medicaid
2 program is expanded to provide coverage to individuals eligible pursuant to Public Law 111-148 and Public Law
3 111-152; and

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

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

8 (3) Money in the account must be used to pay the state share of expenditures for medical services for
9 recipients who are eligible for medicaid pursuant to Public Law 111-148 and Public Law 111-152. Money may
10 not be spent from the account before January 1, 2017.

11 (4) The department shall identify the reductions in expenditures that occurred in the following programs
12 because the medicaid program was expanded to individuals eligible pursuant to Public Law 111-148 and Public
13 Law 111-152:

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

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

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

17 (i) pregnant women;

18 (ii) individuals with breast or cervical cancer;

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

20 (iv) any other individual who:

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

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

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

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

29 (f) other sources as identified by the department.

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

1 on:

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

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

5

6 **Section 14.** Section 37-8-202, MCA, is amended to read:

7 **"37-8-202. Organization -- meetings -- powers and duties.** (1) The board shall:

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

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

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

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

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

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

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

17 (h) adopt rules regarding authorization for prescriptive authority of advanced practice registered nurses.

18 If considered appropriate for an advanced practice registered nurse who applies to the board for authorization,
19 prescriptive authority must be granted.

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

22 (j) establish a medical assistance program to assist licensed nurses who are found to be physically or
23 mentally impaired by habitual intemperance or the excessive use of addictive drugs, alcohol, or any other drug
24 or substance or by mental illness or chronic physical illness. The program must provide for assistance to
25 licensees in seeking treatment for mental illness or substance abuse and monitor their efforts toward
26 rehabilitation. The board shall ensure that a licensee who is required or volunteers to participate in the medical
27 assistance program as a condition of continued licensure or reinstatement of licensure must be allowed to enroll
28 in a qualified medical assistance program within this state and may not require a licensee to enroll in a qualified
29 treatment program outside the state unless the board finds that there is no qualified treatment program in this
30 state. For purposes of funding this medical assistance program, the board shall adjust the renewal fee to be

1 commensurate with the cost of the program.

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

6 (2) The board may:

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

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

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

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

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

21 (f) fund additional staff, hired by the department, to administer the provisions of this chapter."
22

23 **Section 15.** Section 37-8-204, MCA, is amended to read:

24 **"37-8-204. Executive director.** (1) The department shall hire an executive director to provide services
25 to the board in connection with the board's duties of:

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

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

29 (c) reviewing qualifications of applicants for licensure; and

30 (d) collecting workforce data.

- 1 (2) The department shall hire as the executive director an individual who:
- 2 (a) is a graduate of an approved school of nursing and who has at least a master's degree with
- 3 postgraduate courses in nursing;
- 4 (b) is licensed as a registered professional nurse in Montana; and
- 5 (c) has experience in teaching or administration in an approved school of nursing and who has
- 6 completed at least 3 years in the clinical practice of nursing."

7

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

9 **"53-6-131. Eligibility requirements.** (1) Medical assistance under the Montana medicaid program may

10 be granted to a person who is determined by the department of public health and human services, in its

11 discretion, to be eligible as follows:

12 (a) The person receives or is considered to be receiving supplemental security income benefits under

13 Title XVI of the Social Security Act, 42 U.S.C. 1381, et seq., and does not have income or resources in excess

14 of the applicable medical assistance limits.

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

16 person were to apply for that assistance.

17 (c) The person is in a medical facility that is a medicaid provider and, but for residence in the facility, the

18 person would be receiving assistance under the program in subsection (1)(a).

19 (d) The person is under 21 years of age and in foster care under the supervision of the state or was in

20 foster care under the supervision of the state and has been adopted as a child with special needs.

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

22 (i) the person's income does not exceed the income level specified for federally aided categories of

23 assistance and the person's resources are within the resource standards of the federal supplemental security

24 income program; or

25 (ii) the person, while having income greater than the medically needy income level specified for federally

26 aided categories of assistance:

27 (A) has an adjusted income level, after incurring medical expenses, that does not exceed the medically

28 needy income level specified for federally aided categories of assistance or, alternatively, has paid in cash to the

29 department the amount by which the person's income exceeds the medically needy income level specified for

30 federally aided categories of assistance; and

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

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

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

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

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

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

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

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

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

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

28 (5) In accordance with waivers of federal law that are granted by the secretary of the U.S. department
29 of health and human services, the department of public health and human services may grant eligibility for basic
30 medicaid benefits as described in 53-6-101 to an individual receiving section 1931 medicaid benefits, as defined

1 in 53-4-602, as the specified caretaker relative of a dependent child under the section 1931 medicaid program.
2 A recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C.
3 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage, as provided in 53-6-101.

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

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

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

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

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

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

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

26 (c) is not otherwise covered under creditable coverage, as provided by federal law or regulation;

27 (d) is not eligible for medical assistance under any mandatory categorically needy eligibility group; and

28 (e) has not attained 65 years of age.

29 (11) Subject to the limitation in 53-6-195, the department shall provide medicaid coverage to workers with
30 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

1 U.S.C. 1396o.

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

4

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

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

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

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

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

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

17

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

19 **"53-6-133. Eligibility determination.** (1) ~~The local office of public assistance shall promptly determine~~
 20 ~~the eligibility of each applicant under this part must be determined~~ in accordance with the rules of the department.
 21 Each applicant must be informed of the right to a fair hearing appeal a determination and of the confidential nature
 22 of the information given. ~~The department, through the local office of public assistance, shall, after the hearing,~~
 23 ~~determine whether or not~~ If the applicant is eligible for assistance under this part, and aid must be furnished
 24 promptly to eligible persons. Each applicant must receive written notice of the decision concerning the applicant's
 25 application; and the right of appeal ~~is secured to the applicant under the procedures of 53-2-606.~~

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

29

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

1 **"53-6-155. Definitions.** As used in this part, unless expressly provided otherwise, the following
2 definitions apply:

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

8 (2) "Applicant" means a person:

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

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

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

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

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

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

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

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

27 ~~(8)~~(9) "Medicaid" means the Montana medical assistance program established under Title 53, chapter
28 6.

29 ~~(9)~~(10) "Medicaid agency" means any agency or entity of state, county, or local government that
30 administers any part of the medicaid program, whether under direct statutory authority or under contract with an

1 authorized agency of the state or federal government. The term includes but is not limited to the department, the
 2 department of corrections, local offices of public assistance, and other local and state agencies and their agents,
 3 contractors, and employees, when acting with respect to medicaid eligibility, claims processing or payment,
 4 utilization review, case management, provider certification, investigation, or other administration of the medicaid
 5 program.

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

10 ~~(11)~~(12) "Patient abuse" means the willful infliction of physical or mental injury of a patient or
 11 unreasonable confinement, intimidation, or punishment that results in pain, physical or mental harm, or mental
 12 anguish of a patient. Patient abuse includes but is not limited to any conduct with respect to a patient that would
 13 constitute a criminal offense under Title 45, chapter 5.

14 ~~(12)~~(13) "Patient neglect" means a failure, through inattentiveness, carelessness, or other omission, to
 15 provide to a patient goods and services necessary to avoid physical harm, mental anguish, or mental illness when
 16 an omission is not caused by factors beyond the person's control or by good faith errors in judgment. Patient
 17 neglect includes but is not limited to any conduct with respect to a patient that would constitute a criminal offense
 18 under 45-5-208.

19 ~~(13)~~(14) "Provider" means an individual, company, partnership, corporation, institution, facility, or other
 20 entity or business association that has enrolled or applied to enroll as a provider of services or items under the
 21 medical assistance program established under this part.

22 ~~(14)~~(15) "Recipient" means a person:

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

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

26 ~~(15)~~(16) (a) "Records" means medical, professional, business, or financial information and documents,
 27 whether in written, electronic, magnetic, microfilm, or other form:

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

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

30 (iii) otherwise relating to or pertaining to a determination of eligibility for or entitlement to payment or

1 reimbursement under the medicaid program.

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

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

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

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

12
13 **COORDINATION SECTION. Section 21. Coordination instruction.** If both House Bill No. 2 and [this
14 act] are passed and approved and if House Bill No. 2 contains any appropriations designated as medicaid
15 expansion savings, then the appropriations in House Bill No. 2 that are designated as medicaid expansion
16 savings must be transferred to the special revenue account provided for in [section 13 of this act].

17
18 **NEW SECTION. Section 22. Severability.** If a part of [this act] is invalid, all valid parts that are
19 severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications,
20 the part remains in effect in all valid applications that are severable from the invalid applications.

21
22 **NEW SECTION. Section 23. Effective dates.** (1) Except as provided in subsection (2), [this act] is
23 effective October 1, 2013.

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

25
26 **NEW SECTION. Section 24. Contingent termination.** (1) [Sections 9, 12, and 16(1)(h)] terminate on
27 the date that the federal medical assistance percentage for medical services provided to individuals eligible for
28 medicaid pursuant to 53-6-131(1)(h) is set below the level provided for in 42 U.S.C. 1396d(y) on [the effective
29 date of this act].

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

1 occurs.

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

4
5 **NEW SECTION. Section 25. Termination.** (1) Except as provided in [section 24], [sections 1 through
6 4, 9 through 13, 16(1)(h), and 19] terminate June 30, 2017.

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

8 - END -