HOUSE BILL NO. 658

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A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING HEALTH CARE LAWS; MAKING THE MEDICAID EXPANSION PROGRAM PERMANENT BY REPEALING THE TERMINATION DATE OF THE MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP ACT; ESTABLISHING COMMUNITY ENGAGEMENT ~~AND HEALTH RISK AND JOB READINESS ASSESSMENT~~ REQUIREMENTS FOR HELP ACT PARTICIPANTS; REVISING MEDICAID ELIGIBILITY VERIFICATION PROCEDURES; ESTABLISHING A HELP ACT EMPLOYER GRANT PROGRAM; ~~ESTABLISHING LIMITATIONS ON MEDICAL MALPRACTICE CLAIMS WHEN A DOCUMENTED RATIONALE EXISTS FOR A MEDICAL TREATMENT;~~ ENACTING A FEE ON HEALTH SERVICE CORPORATIONS; APPLYING THE INSURANCE PREMIUM TAX TO THE MONTANA STATE FUND; ESTABLISHING A FEE ON HOSPITAL OUTPATIENT REVENUE; REVISING TAXPAYER INTEGRITY FEES; CREATING A SPECIAL REVENUE ACCOUNT; EXTENDING RULEMAKING AUTHORITY; PROVIDING APPROPRIATIONS; REMOVING STATUTORY APPROPRIATIONS; AMENDING SECTIONS 15-30-2660, 15-66-101, 15-66-102, 15-66-103, 15-66-201, 15-66-202, 15-66-203, 15-66-204, 15-66-205, 17-7-502, 33-1-115, 33-2-705, 33-2-708, 33-30-102, 39-12-101, 39-12-103, 39-71-2375, 53-4-1110, 53-4-1115, 53-6-131, 53-6-133, 53-6-149, 53-6-160, 53-6-1302, 53-6-1303, 53-6-1304, 53-6-1305, 53-6-1306, 53-6-1307, 53-6-1311, AND 53-6-1317, MCA; REPEALING SECTION 53-6-1316, MCA; AMENDING AND REPEALING SECTION 28, CHAPTER 368, LAWS OF 2015; AND PROVIDING EFFECTIVE DATES AND AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Community engagement requirements -- countable activities -- exemptions -- self-attestation.** (1) Except as provided in subsections (3) through (5), an individual receiving coverage under this part shall participate in 80 hours of community engagement activities each month if the individual is at least 19 years of age but no more than ~~59~~ 55 years of age.

(2) Time spent in one or more of the following activities may be counted toward the monthly requirement for community engagement:

(a) employment ~~as evidenced through reportable wages~~;

~~(b) activities required to obtain unemployment insurance pursuant to Title 39, chapter 51;~~

~~(c) a workforce training program approved by the state;~~

~~(d) part-time enrollment for credit in a postsecondary institution, with one credit unit equaling 3 hours a week of time counted toward the community engagement requirements;~~

~~(e) active treatment in a behavioral health or substance use disorder treatment program approved by the department;~~

~~(f) a community corrections program providing the services listed in 53-30-303(2)(b); or~~

(B) WORK READINESS OR WORKFORCE TRAINING ACTIVITIES;

(C) SECONDARY, POSTSECONDARY, OR VOCATIONAL EDUCATION;

(D) SUBSTANCE ABUSE EDUCATION OR SUBSTANCE USE DISORDER TREATMENT;

(E) OTHER WORK OR COMMUNITY ENGAGEMENT ACTIVITIES THAT PROMOTE WORK OR WORK READINESS OR ADVANCE THE HEALTH PURPOSE OF THE MEDICAID PROGRAM;

~~(g)~~(F) a community service or volunteer opportunity ~~that is approved by the department~~; OR

(G) ANY OTHER ACTIVITY REQUIRED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES FOR THE PURPOSE OF OBTAINING NECESSARY WAIVERS UNDER THIS PART.

(3) A program participant is exempt from the requirements of this section if ~~the participant attests that~~ the participant is:

(a) medically frail as defined in 42 CFR 440.315;

~~(b) receiving temporary or permanent disability benefits from a government or private source;~~

~~(c) a full-time caregiver for a dependent child under the age of compulsory school attendance;~~

~~(d) a full-time caregiver for a disabled child or adult who is receiving temporary or permanent disability benefits from a government or private source;~~

~~(e) a full-time student enrolled in:~~

~~(i) a secondary school; or~~

~~(ii) a postsecondary institution that does not offer a health care plan to students;~~

~~(f) incarcerated in a state prison as defined in 53-30-101 or held in a county jail for a period of 30 days or more;~~

~~(g) (i) pregnant and determined by the individual's health care provider to be unable to fulfill the community engagement requirements because of risks or complications associated with the pregnancy; or~~

~~(ii) less than 60 days postpartum;~~

~~(h) a member of a population for whom the federal government generally pays the cost of health care services covered under this part; or~~

(B) BLIND OR DISABLED;

(C) PREGNANT;

(D) EXPERIENCING AN ACUTE MEDICAL CONDITION REQUIRING IMMEDIATE MEDICAL TREATMENT;

(E) MENTALLY OR PHYSICALLY UNABLE TO WORK;

(F) A PRIMARY CAREGIVER FOR A PERSON WHO IS UNABLE TO PROVIDE SELF-CARE;

(G) A FOSTER PARENT;

(H) A FULL-TIME STUDENT IN A SECONDARY SCHOOL;

(I) A STUDENT ENROLLED IN THE EQUIVALENT OF AT LEAST SIX CREDITS IN A POSTSECONDARY OR VOCATIONAL INSTITUTION;

(J) PARTICIPATING IN OR EXEMPT FROM THE WORK REQUIREMENTS OF THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM OR THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM;

(K) UNDER SUPERVISION OF THE DEPARTMENT OF CORRECTIONS, A COUNTY JAIL, OR ANOTHER ENTITY AS DIRECTED BY A COURT, THE DEPARTMENT OF CORRECTIONS, OR THE BOARD OF PARDONS AND PAROLE;

(L) EXPERIENCING CHRONIC HOMELESSNESS;

(M) A VICTIM OF DOMESTIC VIOLENCE AS DEFINED BY THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996, 42 U.S.C. 601, ET SEQ.;

(N) LIVING IN AN AREA WITH A HIGH-POVERTY DESIGNATION;

~~(i)~~(O) a member of an entity subject to the fee provided for in 15-30-2660(3); OR

(P) OTHERWISE EXEMPT UNDER FEDERAL LAW.

(4) A program participant is exempt from the requirements of this section if the department ~~is able to verify that the individual is employed and that the individual's wages are equal to or greater than 100% of the federal poverty level for the household size reported for the purposes of qualifying for medicaid under this part. The department shall verify the participant's wages on a quarterly basis~~ DETERMINES THAT THE PARTICIPANT'S INCOME EXCEEDS AN AMOUNT EQUAL TO THE AVERAGE OF 80 HOURS PER MONTH MULTIPLIED BY THE MINIMUM WAGE.

(5) A program participant is exempt from the requirements of this section in any ~~month~~ REPORTING PERIOD

in which the participant ~~attests that the participant~~:

(a) is hospitalized or caring for an immediate family member who has been hospitalized; ~~or~~

(b) has a documented serious illness or incapacity or is caring for an immediate family member with a documented serious illness or incapacity; OR

(C) IS IMPACTED BY A CATASTROPHIC EVENT OR HARDSHIP AS DEFINED BY THE DEPARTMENT BY RULE THAT PREVENTS THE PARTICIPANT FROM COMPLYING WITH THE COMMUNITY ENGAGEMENT REQUIREMENTS OF THIS SECTION.

~~(6) A program participant who accepts an opportunity to participate in a community service or volunteer opportunity to satisfy the requirements of this section:~~

~~(a) consents to any risks that may be inherent in the opportunity; and~~

~~(b) is a volunteer as defined in 39-71-118(2)(b) and not eligible for workers' compensation under Title 39, chapter 71.~~

~~(7) (a)~~(6) The department may ~~certify~~ DETERMINE, through use of available ADMINISTRATIVE data ~~systems~~, that a program participant:

~~(i)~~(A) meets the community engagement requirements of this section; or

~~(ii)~~(B) is exempt from meeting the community engagement requirements.

~~(b) The department shall notify program participants for whom it can verify community engagement requirements or exemptions that the participants do not have to comply with the attestation requirements of [section 1] or the reporting requirements of [section 2], as applicable.~~

NEW SECTION. **Section 2. Community engagement -- ~~self-reporting of compliance -- disenrollment~~ REPORTING -- SUSPENSION -- AUDIT.** ~~(1) (a) Unless a program participant is exempt from the community engagement requirements of [section 1] or has been certified by the department as meeting the requirements, the participant shall report on a quarterly basis that the participant has met the requirements. The department shall adopt rules establishing reporting requirements. The rules must:~~

~~(i) specify the manner in which hours are calculated to determine compliance with the community engagement requirements; and~~

~~(ii) take into account a participant's customary hours of employment if the participant is employed in an occupation for which hours vary based on demand for the services provided.~~

~~(b) The participant may report on community engagement activities verbally, in writing, or electronically. The department shall develop a means for providing the report electronically.~~ (1) THE DEPARTMENT SHALL ADOPT

RULES ESTABLISHING:

(A) REQUIREMENTS FOR REPORTING COMMUNITY ENGAGEMENT REQUIREMENTS;

(B) REQUIREMENTS FOR OBTAINING AN EXEMPTION FROM THE COMMUNITY ENGAGEMENT REQUIREMENTS AS ALLOWED UNDER [SECTION 1]; AND

(C) A PROGRAM TO AUDIT INFORMATION PROVIDED BY PROGRAM PARTICIPANTS TO THE DEPARTMENT TO ENSURE COMPLIANCE WITH THE REQUIREMENTS OF [SECTION 1].

(2) The department shall notify a program participant who is not in compliance with the community engagement requirements that:

(a) the participant has ~~90~~ 180 days to come into compliance; and

(b) failure to comply within the ~~90-day~~ 180-DAY period will be considered a voluntary ~~disenrollment~~ SUSPENSION from the program unless the participant attests AND THE DEPARTMENT CONFIRMS that the participant is exempt from the community engagement requirements as allowed under [section 1].

(3) A participant who is ~~disenrolled~~ SUSPENDED from the program for noncompliance may ~~apply to reenroll~~ BE REINSTATED 180 days after the date of ~~disenrollment.~~ SUSPENSION OR UPON A DETERMINATION BY THE DEPARTMENT THAT THE PROGRAM PARTICIPANT:

(A) IS EXEMPT FROM THE COMMUNITY ENGAGEMENT REQUIREMENTS; OR

(B) HAS BEEN IN COMPLIANCE WITH THE REQUIREMENTS FOR 30 DAYS. A PARTICIPANT REINSTATED PURSUANT TO THIS SUBSECTION (3)(B) MUST REMAIN UNDER HEIGHTENED MONITORING BY THE DEPARTMENT DURING THE REMAINDER OF THE SUSPENSION PERIOD.

~~(4) An individual newly enrolled in coverage under this part has 90 days from the time of enrollment to comply with the community engagement requirements.~~

~~(5) If a program participant has attested to an exemption from the requirements as allowed under [section 1(5)], the department shall verify on a quarterly basis that the participant continues to meet the conditions for an exemption.~~

(4) (A) IF SUSPENSIONS FOR NONCOMPLIANCE WITH COMMUNITY ENGAGEMENT REQUIREMENTS REACH A LEVEL EXCEEDING 5% OF PROGRAM PARTICIPANTS, THE DEPARTMENT SHALL NOTIFY THE LEGISLATIVE FINANCE COMMITTEE. THE LEGISLATIVE FINANCE COMMITTEE SHALL SELECT AN INDEPENDENT THIRD-PARTY AUDITOR TO CONDUCT A STATISTICALLY RELEVANT AUDIT OF THE PARTICIPANTS WHO WERE SUBJECT TO SUSPENSION.

(B) (I) THE AUDIT MUST BE COMPLETED WITHIN 90 DAYS AND THE REPORT MADE AVAILABLE TO THE LEGISLATIVE FINANCE COMMITTEE.

(II) IF THE AUDIT IS NOT COMPLETED WITHIN 90 DAYS, THE DEPARTMENT SHALL IMMEDIATELY CEASE SUSPENSIONS UNTIL THE AUDIT IS COMPLETE AND THE LEGISLATIVE FINANCE COMMITTEE HAS RECEIVED THE AUDIT REPORT.

(C) IF THE AUDIT FINDS THAT MORE THAN 10% OF THE PARTICIPANTS IN THE AUDIT SAMPLE WERE SUSPENDED ERRONEOUSLY, THE DEPARTMENT SHALL CEASE FURTHER SUSPENSIONS UNTIL THE CONCLUSION OF THE NEXT GENERAL LEGISLATIVE SESSION.

(D) IF THE AUDIT FINDS THAT 10% OR FEWER OF THE PARTICIPANTS IN THE AUDIT SAMPLE WERE SUSPENDED ERRONEOUSLY, THE DEPARTMENT SHALL CONTINUE TO SUSPEND THE ENROLLMENT OF PROGRAM PARTICIPANTS WHO FAIL TO MEET THE COMMUNITY ENGAGEMENT REQUIREMENTS.

~~NEW SECTION.~~ **~~Section 3. Health risk and employment readiness assessments -- exceptions -- disenrollment for failure to complete.~~** ~~(1) Within 6 months of enrolling in the program, a program participant shall complete:~~

~~(a) a form assessing health risks; and~~

~~(b) a form assessing employment readiness.~~

~~(2) The department shall:~~

~~(a) develop the assessment forms, consulting with the department of labor and industry to develop the employment readiness assessment form;~~

~~(b) allow a program participant to complete the assessments verbally by phone, in writing, or through an electronic means;~~

~~(c) provide the results of both assessments to the participant; and~~

~~(d) provide the results of the employment readiness assessment to the department of labor and industry to assist with carrying out the workforce development activities provided for in Title 39, chapter 12.~~

~~(3) Except as provided in subsection (4), a participant shall complete a health risk assessment and an employment readiness assessment each year.~~

~~(4) (a) A participant is exempt from completing a health risk assessment in any year in which the participant has a preventive care visit as defined by the department by rule.~~

~~(b) A participant is exempt from completing an employment readiness assessment other than the initial assessment in any year in which the participant is exempt, under [section 1(3)], from meeting the community engagement requirements of this part.~~

~~(5) The department shall disenroll a program participant who fails to complete an initial assessment~~

~~within 6 months of receiving benefits under this part or who fails to complete an additional assessment as required during any subsequent year of continuous coverage under this part. The individual may apply to reenroll 6 months after the date of disenrollment.~~

~~NEW SECTION.~~ **Section 4. Department auditing of self- attestations and self-reporting -- agency sharing of information.** ~~(1) The department shall audit on a quarterly basis the reports and attestations of program participants relating to their participation in or exemption from community engagement requirements, unless the department has verified that the participant is earning 100% or more of the federal poverty level for the household size reported for the purposes of qualifying for medicaid under this part.~~

~~(2) The department shall audit a statistically valid sample of program participants to determine, with a confidence interval of 95% and a level of precision of 3%, whether the error rate on self-reporting and self-attestation is 10% or less.~~

~~(3) If the audit shows that more than 10% of program participants may have provided incorrect information, the department shall double the number of audits conducted each quarter until the audits find that fewer than 10% of program participants are incorrectly reporting their community engagement activities or exemptions.~~

~~(4) A participant found to have intentionally filed an incorrect report of community engagement activities or to have intentionally claimed an exemption to which the participant was not entitled must be disenrolled from the program. The individual may apply to reenroll 12 months after the date of disenrollment.~~

~~(5) (a) State agencies shall share information as allowed under this section if requested by the department for an audit of a program participant's reporting of community engagement activities or attestation of an exemption, only to the extent necessary to verify the accuracy of the reporting or attestation.~~

~~(b) The department of labor and industry shall provide information related to quarterly wage reports, unemployment-related activities, participation in workforce training programs operated or approved by the department of labor and industry, or determinations of a permanent, partial, or temporary disability for which a person is receiving workers' compensation benefits.~~

~~(c) The department of corrections shall provide information about participation in a community corrections program or the incarceration status or length of incarceration for a program participant.~~

~~(6) The Montana university system may share information about a program participant's educational status and credit hours if requested by the department for the purposes of an audit under this section.~~

NEW SECTION. **SECTION 3. HEALTH RISK ANALYSIS.** (1) WITHIN 1 YEAR OF A PROGRAM PARTICIPANT'S ENROLLMENT IN THE PROGRAM, THE DEPARTMENT SHALL USE AVAILABLE CLAIMS DATA AND OTHER INFORMATION COLLECTED DIRECTLY FROM THE PARTICIPANT TO ASSESS WHETHER THE PARTICIPANT WOULD BE BETTER SERVED IN A COORDINATED CARE OR OTHER TREATMENT MODEL APPROVED BY THE DEPARTMENT.

(2) COORDINATED CARE MODELS MAY INCLUDE BUT ARE NOT LIMITED TO A:

(A) MEDICAID HEALTH HOME;

(B) PATIENT-CENTERED OR ADVANCED PRIMARY CARE MEDICAL HOME;

(C) SUBSTANCE USE DISORDER OR MENTAL HEALTH TREATMENT OR OTHER TREATMENT OR PREVENTION PROGRAMS;

(D) CARE COORDINATION PROGRAM;

(E) TRIBAL HEALTH IMPROVEMENT PROGRAM; OR

(F) PRIMARY CARE CASE MANAGEMENT ARRANGEMENT.

(3) THE DEPARTMENT IS NOT REQUIRED TO COMPLETE A SEPARATE ANALYSIS FOR A PARTICIPANT WHO:

(A) IS ALREADY BEING SERVED THROUGH A COORDINATED CARE MODEL LISTED IN SUBSECTION (2); OR

(B) HAS RECEIVED PRIMARY CARE OR PREVENTATIVE CARE SERVICES WITHIN THE LAST 12 MONTHS.

NEW SECTION. **Section 4. Disenrollment for failure to report change in circumstances.** (1) (a) A program participant shall report to the department a permanent increase in income that would affect the participant's eligibility for the program. The change must be reported within ~~10~~ 30 days of the change in income.

(b) A short-term increase in income that is caused by overtime pay or other nonregular payments and that will not be sustained over time does not qualify as a permanent increase in income for the purposes of this section.

(2) Disenrollment may occur only after the state conducts an administrative review and determines the participant is ineligible for medicaid coverage under any eligibility category.

~~(3) Except as provided in subsection (4), a program participant who is disenrolled for failure to report an increase in income is prohibited from applying for reenrollment under this part for 6 months.~~

~~(4) A disenrolled individual is eligible for early reenrollment at any time before the end of the 6-month noneligibility period if required by:~~

~~(a) federal law or regulation; or~~

~~(b) the special terms and conditions of any waiver approved by the centers for medicare and medicaid services for carrying out the provisions of this part.~~

NEW SECTION. **Section 5. Montana HELP Act special revenue account.** (1) There is a Montana HELP Act account in the state special revenue fund to the credit of the department.

(2) Money from the following sources must be deposited in the account:

(a) the taxpayer integrity fees provided for in 15-30-2660;

(b) the outpatient hospital utilization fee provided for in 15-66-102(3)(b);

(c) the premium tax paid under 33-2-705 by the state fund provided for in 39-71-2313;

(d) the health service corporation fee provided for in [section ~~8~~ 6]; and

(e) premiums paid by members pursuant to 53-6-1307.

(3) Money in the account must be used to pay for:

(a) the state share of costs, including benefits and administrative costs, of providing health care services under this part; and

(b) grants made under the HELP Act employer grant program provided for in [section ~~9~~ 7].

(4) Money from the account must be used for the benefits and administrative costs of providing health care services under this part before any general fund is expended on the costs.

~~NEW SECTION. **Section 7. Health care provider negligence claims prohibited when using medical judgment.** (1) A health care provider, including a provider practicing telemedicine as defined in 37-3-102, may not be found negligent in a medical malpractice claim if in exercising the health care provider's medical judgment the provider:~~

~~(a) selects a reasonably prudent course of treatment, after discussion with the patient or the patient's guardian or representative, if applicable; and~~

~~(b) includes the documented rationale for the decision in the patient's medical record.~~

~~(2) For the purposes of this section, a selected course of treatment may be reasonably prudent even if it ultimately was not successful or the patient did not experience the desired outcome or result.~~

~~(3) This section may not be construed to impose any additional duties on a health care provider.~~

~~(4) As used in this section, the following definitions apply:~~

~~(a) "Documented rationale" means a brief statement written by a health care provider at the time of~~

~~treatment that includes the provider's medical rationale for prescribing or not prescribing, recommending or not recommending, or ordering or not ordering a given test, procedure, treatment, consultation, or other therapeutic intervention.~~

~~(b) "Health care provider" means:~~

~~(i) a physician, dentist, podiatrist, optometrist, advanced practice registered nurse, or physician assistant licensed under Title 37; or~~

~~(ii) a health care facility licensed under Title 50, chapter 5.~~

NEW SECTION. **Section 6. Health service corporation fee.** (1) An authorized health service corporation as defined in 33-30-101 shall file with the commissioner, on or before March 1 of each year, a report in a format prescribed by the commissioner showing the total direct premium income DURING THE PRECEDING CALENDAR YEAR from all sources after deducting from the income applicable cancellations, returned premiums, or the amount of reduction in or refund of premiums.

(2) At the time the report is filed, and subject to 33-2-709, the health service corporation shall pay a fee to the commissioner on net premium income computed at the rate of 1%.

(3) If a health service corporation fails to pay the fee required under this section, the commissioner may:

(a) suspend or revoke the certificate of authority for the health service corporation; and

(b) impose a fine of $100 plus interest on the delinquent amount at an annual interest rate of 12%.

(4) The commissioner may provide by rule a quarterly schedule for the payment of the fee.

(5) The commissioner shall deposit money collected from the fee into the Montana HELP Act special revenue account provided for in [section ~~6~~ 5].

(6) The fee required under this section applies to a formerly authorized health service corporation ~~with respect to premiums~~ IF THE CORPORATION received PREMIUMS DURING THE PRECEDING CALENDAR YEAR while DOING BUSINESS AS an authorized health service corporation in this state.

NEW SECTION. **Section 7. Montana HELP Act employer grant program.** (1) There is a Montana HELP Act employer grant program to encourage employers to hire or train program participants in skills that will allow them to:

(a) obtain new or improved employment;

(b) obtain employment with health care benefits;

(c) earn a wage that allows them to purchase their own health insurance coverage; or

(d) improve their long-term financial security.

(2) The department shall establish criteria for awarding grants. The criteria must take into consideration, at a minimum, the number of program participants affected and the likelihood that the proposed grant activity will improve:

(a) the chances that program participants will succeed in obtaining employment meeting the goals of subsection (1); or

(b) the financial security of program participants through efforts that include:

(i) financial and credit counseling; and

(ii) educational opportunities related to managing finances and setting and reaching financial goals.

(3) The department shall adopt rules establishing grant application, evaluation, and award criteria and processes.

Section 8. Section 15-30-2660, MCA, is amended to read:

"15-30-2660. ~~(Temporary)~~ Taxpayer integrity ~~fee~~ fees. (1) (a) The department shall assess a fee as provided in subsection (2) for a taxpayer who~~:~~

~~(a)~~ is a participant in the Montana Health and Economic Livelihood Partnership Act provided for in Title 53, chapter 6, part 13, and Title 39, chapter 12;, and owns:

~~(b) has assets that exceed:~~

(i) ~~a primary residence and attached property~~ EQUITY IN real property or improvements to real property, or both, ~~valued above~~ THAT EXCEEDS the limit established for homesteads under 70-32-104 BY $5,000 OR MORE, if the real property is not agricultural land;

(ii) more than one light vehicle~~, and the additional vehicles have a~~ WHEN THE combined depreciated value of the manufacturer's suggested retail price ~~of~~ TOTALS $20,000 OR MORE AND THE PARTICIPANT'S EQUITY IN THE VEHICLES EXCEEDS THAT COMBINED DEPRECIATED VALUE BY $5,000 OR MORE; ~~and~~ or

~~(iii) a total of $50,000 in cash and cash equivalent~~

(iii) agricultural land with a taxable value in excess of $1,500 a year.

(b) For the purposes of subsection (1)(a)~~(ii),~~:

(I) "REAL PROPERTY OR IMPROVEMENTS TO REAL PROPERTY" DOES NOT INCLUDE PROPERTY HELD IN TRUST BY THE UNITED STATES FOR THE BENEFIT OF A MONTANA FEDERALLY RECOGNIZED INDIAN TRIBE; AND

(II) the depreciated value of the manufacturer's suggested retail price must be computed as provided in 61-3-503(2).

(2) The fee is $100 a month plus an amount equal to an additional $4 a month for:

(a) each $1,000 in ~~assets above the amounts established in subsection (1)(b)~~ EQUITY value above the ~~limit~~ LIMITS established ~~for homesteads under 70-32-104, if the individual has real property or improvements to real property, or both, that exceed the value for homesteads;~~ IN SUBSECTIONS (1)(A)(I) AND (1)(A)(II); AND

~~(b) each $1,000 above the combined depreciated value allowed for vehicles in subsection (1)(a)(ii), if the taxpayer owns more than one vehicle; and~~

~~(c)~~(B) each $100 of taxable value ~~of any~~ IN agricultural land ~~the taxpayer owns in excess of the taxable value threshold provided in subsection (1)(a)(iii)~~ ABOVE $1,500.

(3) (a) The department shall assess a fee for an entity organized under 26 U.S.C. 501(d) and subject to taxes as provided in Title 15, chapter 31, if the entity has members who are receiving medicaid coverage under Title 53, chapter 6, part 13.

(b) The fee is equal to the state's share of the average annual cost per program participant, as defined in 53-6-1303, multiplied by the number of individuals in the 26 U.S.C. 501(d) organization who are receiving medicaid coverage because they are eligible under 53-6-1304, less the total annual amount the entity's members have paid in premiums.

(4) (a) For the purposes of calculating the fee required under subsection (3), the department of public health and human services shall provide the department of revenue by February 1 of each year with:

(i) the percentage of medicaid claims costs of program participants for which the state was responsible in the previous calendar year; and

(ii) the average annual cost of medical claims for program participants in the previous calendar year.

(b) The department of public health and human services shall post the average annual cost for a program participant on the department's website by February 15 of each year.

(5) An organization shall pay the fee provided for in subsection (3) as follows:

(a) on or before the last day of each month, the organization shall pay an estimated fee equal to one-twelfth of the most recently published annual cost per program participant; and

(b) on or before April 15 of each year, the organization shall report and pay any additional amount owed for the prior year or request a refund of any overpayment made in the prior year.

~~(3)~~(6) (a) The department of public health and human services shall ~~coordinate with~~ provide the

department of ~~public health and human services to obtain the information necessary to administer~~ revenue with the names of program participants and other necessary information to assist the department of revenue in administering and enforcing this section.

(b) The department of justice shall provide the department of revenue with vehicle registration information for the administration of this section.

~~(4)~~(7) Fees collected pursuant to this section must be deposited in the ~~general fund~~ Montana HELP Act special revenue account provided for in [section ~~6~~ 5].

~~(5)~~(8) ~~The~~ A fee remains until paid and may be collected through assessments against future income tax returns or through a civil action initiated by the state.

~~(6)~~(9) For the purposes of this section, the following definitions apply:

~~(a) (i) "Cash equivalent" means cash, including any money issued by the United States or by the sovereign government of another country, and, if reasonably convertible into cash with 1 year:~~

~~(A) personal property, including but not limited to vehicles, precious metal as defined in 30-10-103, jewelry, artwork, and gemstones; and~~

~~(B) personal property, including but not limited to certificates of deposit, certificates of stock, government or corporate bonds or notes, promissory notes, licenses, copyrights, patents, trademarks, contracts, software, and franchises.~~

~~(ii) Real estate and improvements to real estate are not cash equivalents.~~

(a) (i) "Agricultural land" means agricultural land as described in 15-7-202 that is taxed as class three property at the rate provided in 15-6-133.

(ii) The term does not include:

(A) parcels of land that are considered nonqualified agricultural land as provided in 15-6-133(1)(c) ~~or~~;

(B) improvements to real property; OR

(C) LAND HELD IN TRUST BY THE UNITED STATES FOR THE BENEFIT OF A MONTANA FEDERALLY RECOGNIZED INDIAN TRIBE.

(b) "Light vehicle" has the meaning provided in 61-1-101.

(c) "Manufacturer's suggested retail price" has the meaning provided in 61-3-503(3). ~~(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 9. Section 15-66-101, MCA, is amended to read:

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

(1) (a) "Hospital" ~~means a facility licensed as a hospital pursuant to Title 50, chapter 5,~~ has the meaning provided in 50-5-101 and includes a critical access hospital as defined in 50-5-101.

(b) The term does not include the Montana state hospital or a ~~government hospital not owned by the state~~ HOSPITAL OR FACILITY OPERATED BY THE STATE, A POLITICAL SUBDIVISION OF THE STATE, THE UNITED STATES, OR AN INDIAN TRIBE OR ANY FACILITY AUTHORIZED UNDER THE INDIAN HEALTH CARE IMPROVEMENT ACT.

(2) (a) "Hospital outpatient revenue" means the gross revenue from a hospital's charges for services provided on an outpatient basis.

(b) The term does not include charges for professional services provided as part of the outpatient treatment.

~~(2)~~(3) (a) "Inpatient bed day" means a day of inpatient care provided to a patient in a hospital. A day begins at midnight and ends 24 hours later. A part of a day, including the day of admission, counts as a full day. The day of discharge or death is not counted as a day. If admission and discharge or death occur on the same day, the day is considered a day of admission and is counted as one inpatient bed day. Inpatient bed days include all inpatient hospital benefit days as defined for medicare reporting purposes in section 20.1 of chapter 3 of the centers for medicare and medicaid services publication 100-02, the Medicare Benefit Policy Manual. Inpatient bed days also include all nursery days during which a newborn infant receives care in a nursery.

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

~~(3)~~(4) "Patient" means an individual obtaining skilled medical and nursing services in a hospital. The term includes newborn infants.

~~(4)~~(5) "Report" means the report of inpatient bed days and hospital outpatient revenue required in 15-66-201.

~~(5)~~(6) "Utilization fee" or "fee" means the ~~fee~~ fees required to be paid ~~for each inpatient bed day,~~ as provided in 15-66-102. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 10. Section 15-66-102, MCA, is amended to read:

"15-66-102. (Temporary) Utilization ~~fee for~~ fees -- inpatient bed days -- hospital outpatient revenue. (1) Each hospital in the state shall pay to the department a utilization fee in the amount of ~~$50~~ $70 for each inpatient bed day.

(2) Each hospital shall pay to the department a utilization fee in the amount of 0.825% of hospital outpatient revenue.

~~(2)~~(3) (a) ~~All~~ Except as provided in subsection (3)(b), all proceeds from the collection of utilization fees, including penalties and interest, must, in accordance with the provisions of 17-2-124, be deposited to the credit of the department of public health and human services in ~~a~~ the state special revenue account ~~as~~ provided for in 53-6-149.

(b) The department shall deposit 50% of the amount paid in accordance with subsection (2) in the Montana HELP Act special revenue account provided for in [section ~~6~~ 5]. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 11. Section 15-66-103, MCA, is amended to read:

"15-66-103. (Temporary) Relation to other taxes and fees. The utilization ~~fee~~ fees imposed under 15-66-102 ~~is~~ are in addition to any other taxes and fees required to be paid by hospitals. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 12. Section 15-66-201, MCA, is amended to read:

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

(2) On or before January 31 of each year, the department of public health and human services shall provide the department with a list of hospitals licensed and operating in the state and subject to the provisions of 15-66-102 during the preceding year beginning January 1 and ending December 31. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 13. Section 15-66-202, MCA, is amended to read:

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

(2) The department may require the hospital to provide records and other documentation, including

books, ledgers, and registers, necessary for the department to verify the proper amount of the utilization fee paid.

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

Section 14. Section 15-66-203, MCA, is amended to read:

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

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

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

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

Section 16. Section 15-66-205, MCA, is amended to read:

"15-66-205. (Temporary) ~~Estimated fee on failure to file~~ Department authority to request information. For the purpose of ascertaining the correctness of any report or for the purpose of making an estimate of inpatient bed day use or hospital outpatient revenue of any hospital for which information has been obtained, the department may:

(1) examine or cause to have examined by any designated agent or representative any books, papers, records, or memoranda bearing ~~upon~~ on the matters required to be included in the report;

(2) require the attendance of any officer or employee of the facility rendering the report or the attendance of any other person in the premises having relevant knowledge; and

(3) take testimony and require production of any other material for its information. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

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

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

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

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

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

(3) The following laws are the only laws containing statutory appropriations: 2-17-105; 5-11-120; 5-11-407; 5-13-403; 7-4-2502; 10-1-108; 10-1-1202; 10-1-1303; 10-2-603; 10-2-807; 10-3-203; 10-3-310; 10-3-312; 10-3-314; 10-3-1304; 10-4-304; 15-1-121; 15-1-218; 15-35-108; 15-36-332; 15-37-117; 15-39-110; 15-65-121; 15-70-101; 15-70-130; 15-70-433; 16-11-119; 16-11-509; 17-3-106; 17-3-112; 17-3-212; 17-3-222; 17-3-241; 17-6-101; 17-7-215; 18-11-112; 19-3-319; 19-3-320; 19-6-404; 19-6-410; 19-9-702; 19-13-604; 19-17-301; 19-18-512; 19-19-305; 19-19-506; 19-20-604; 19-20-607; 19-21-203; 20-8-107; 20-9-534; 20-9-622; 20-9-905; 20-26-617; 20-26-1503; 22-1-327; 22-3-116; 22-3-117; 22-3-1004; 23-4-105; 23-5-306; 23-5-409; 23-5-612; 23-7-301; 23-7-402; 30-10-1004; 37-43-204; 37-50-209; 37-51-501; 37-54-113; 39-71-503; 41-5-2011; 42-2-105; 44-4-1101; 44-12-213; 44-13-102; 50-1-115; 53-1-109; 53-6-148; ~~53-6-1304~~; 53-9-113; 53-24-108;

53-24-206; 60-11-115; 61-3-321; 61-3-415; 69-3-870; 69-4-527; 75-1-1101; 75-5-1108; 75-6-214; 75-11-313; 75-26-308; 76-13-150; 76-13-416; 76-17-103; 76-22-109; 77-1-108; 77-2-362; 80-2-222; 80-4-416; 80-11-518; 80-11-1006; 81-1-112; 81-1-113; 81-7-106; 81-10-103; 82-11-161; 85-20-1504; 85-20-1505; [85-25-102]; 87-1-603; 90-1-115; 90-1-205; 90-1-504; 90-3-1003; 90-6-331; and 90-9-306.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for the payments.(In subsection (3): pursuant to sec. 10, Ch. 360, L. 1999, the inclusion of 19-20-604 terminates contingently when the amortization period for the teachers' retirement system's unfunded liability is 10 years or less; pursuant to sec. 10, Ch. 10, Sp. L. May 2000, secs. 3 and 6, Ch. 481, L. 2003, and sec. 2, Ch. 459, L. 2009, the inclusion of 15-35-108 terminates June 30, 2019; pursuant to sec. 73, Ch. 44, L. 2007, the inclusion of 19-6-410 terminates contingently upon the death of the last recipient eligible under 19-6-709(2) for the supplemental benefit provided by 19-6-709; pursuant to sec. 6, Ch. 61, L. 2011, the inclusion of 76-13-416 terminates June 30, 2019; pursuant to sec. 11(2), Ch. 17, L. 2013, the inclusion of 17-3-112 terminates on occurrence of contingency; pursuant to sec. 27, Ch. 285, L. 2015, and sec. 1, Ch. 292, L. 2015, the inclusion of 53-9-113 terminates June 30, 2021; pursuant to sec. 6, Ch. 291, L. 2015, the inclusion of 50-1-115 terminates June 30, 2021; ~~pursuant to sec. 28, Ch. 368, L. 2015, the inclusion of 53-6-1304 terminates June 30, 2019;~~ pursuant to sec. 5, Ch. 383, L. 2015, the inclusion of 85-25-102 is effective on occurrence of contingency; pursuant to sec. 5, Ch. 422, L. 2015, the inclusion of 17-7-215 terminates June 30, 2021; pursuant to sec. 6, Ch. 423, L. 2015, the inclusion of 22-3-116 and 22-3-117 terminates June 30, 2025; pursuant to sec. 10, Ch. 427, L. 2015, the inclusion of 37-50-209 terminates September 30, 2019; pursuant to sec. 33, Ch. 457, L. 2015, the inclusion of 20-9-905 terminates December 31, 2023; pursuant to sec. 12, Ch. 55, L. 2017, the inclusion of 37-54-113 terminates June 30, 2023; pursuant to sec. 4, Ch. 122, L. 2017, the inclusion of 10-3-1304 terminates September 30, 2025; pursuant to sec. 55, Ch. 151, L. 2017, the inclusion of 30-10-1004 terminates June 30, 2021; pursuant to sec. 1, Ch. 213, L. 2017, the inclusion of 90-6-331 terminates June 30, 2027; pursuant to secs. 5, 8, Ch. 284, L. 2017, the inclusion of 81-1-112, 81-1-113, and 81-7-106 terminates June 30, 2023; pursuant to sec. 1, Ch. 340, L. 2017, the inclusion of 22-1-327 terminates July 1, 2023, and pursuant to sec. 2, Ch. 340, L. 2017, and sec. 32, Ch. 429, L. 2017, is void for fiscal years 2018 and 2019; and pursuant to sec. 10,

Ch. 374, L. 2017, the inclusion of 76-17-103 terminates June 30, 2027.)"

Section 18. Section 33-1-115, MCA, is amended to read:

"33-1-115. Operation of state fund as authorized insurer -- issuance of certificate of authority -- exceptions -- use of calendar year -- risk-based capital -- reporting requirements. (1) The state fund provided for in 39-71-2313 is an authorized insurer and, except as provided in this section, is subject to the provisions in Title 33 that are generally applicable to authorized workers' compensation insurers in this state and the provisions of Title 39, chapter 71, part 23.

(2) (a) The commissioner shall issue a certificate of authority to the state fund to write workers' compensation insurance coverages, as provided in 39-71-2316, and except as otherwise provided in this section the requirements of Title 33, chapter 2, part 1, do not apply. The certificate of authority must be continuously renewed by the commissioner.

(b) The state fund shall pay the tax on net premiums under 33-2-705 and the annual fee under 33-2-708, provide the surplus funds required under 33-2-109 and 33-2-110, and provide to the commissioner the available documentation and information that is provided by other insurers when applying for a certificate of authority under 33-2-115.

(c) The state fund is subject to the reporting requirements under 33-2-705 ~~but is not subject to the tax on net premiums~~.

(3) (a) The state fund, as the guaranteed market for workers' compensation insurance for employers pursuant to 39-71-2313, is not subject to:

(i) formation requirements of an insurer under Title 33, chapter 3;

(ii) revocation or suspension of its certificate of authority under any provision of Title 33 or any order or any provision that requires forfeiture of the state fund's obligation to insure employers as required in 39-71-2313;

(iii) liquidation or dissolution under Title 33;

(iv) participation in the guaranty association provided for in Title 33, chapter 10;

(v) 33-12-104; or

(vi) any assessment of punitive or exemplary damages.

(b) The state fund is subject to 33-16-1023, except as provided in 39-71-2316(1)(e), (1)(f), and (1)(g).

(4) The state fund shall complete financial reporting and accounting on a calendar year basis.

(5) (a) If the state fund's risk-based capital falls below the company action level RBC as defined in

33-2-1902, the commissioner shall issue a report to the governor, the state fund board of directors, and to the legislature. If the legislature is not in session, the report must go to the economic affairs interim committee and to the legislative auditor. The report must provide a description of the RBC measurement, the regulatory implications of the state fund falling below the RBC criteria, and the state fund's corrective action plan. If the commissioner is reporting on a regulatory action level RBC event, the report must include the state fund's corrective action plan, results of any examination or analysis by the commissioner, and any corrective orders issued by the commissioner.

(b) If the state fund fails to comply with any lawful order of the commissioner, the commissioner may initiate supervision proceedings under Title 33, chapter 2, part 13, against state fund. If the state fund fails to comply with the commissioner's lawful supervision order under this subsection (5)(b), the commissioner may institute rehabilitation proceedings under Title 33, chapter 2, part 13, only if the commissioner is petitioning for rehabilitation based on the grounds provided in 33-2-1321(1) or (2).

(6) The state fund shall annually transfer funds to the commissioner, out of its surplus, for all necessary staffing and related expenses for a full-time attorney licensed to practice law in Montana and a full-time examiner qualified by education, training, experience, and high professional competence to examine the state fund pursuant to Title 33, chapter 1, part 4, and this section. The attorney and examiner must be employees of the commissioner.

(7) For the purposes of this section, the term "guaranteed market" has the definition provided in 39-71-2312."

Section 19. Section 33-2-705, MCA, is amended to read:

"33-2-705. Report on premiums and other consideration -- tax. (1) Each authorized insurer and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state shall file with the commissioner, on or before March 1 each year, a report in a form prescribed by the commissioner showing total direct premium income, including policy, membership, and other fees, premiums paid by application of dividends, refunds, savings, savings coupons, and similar returns or credits to payment of premiums for new or additional or extended or renewed insurance, charges for payment of premium in installments, and all other consideration for insurance from all kinds and classes of insurance, whether designated as a premium or otherwise, received by a life insurer or written by an insurer other than a life insurer during the preceding calendar year on account of policies covering property, subjects, or risks located, resident, or to be performed in Montana,

with proper proportionate allocation of premium as to property, subjects, or risks in Montana insured under policies or contracts covering property, subjects, or risks located or resident in more than one state, after deducting from the total direct premium income applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, the amount of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct to an office of the insurer, all policy dividends, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to the policies. As to title insurance, "premium" includes the total charge for the insurance. A deduction may not be made of the cash surrender values of policies. Considerations received on annuity contracts may not be included in total direct premium income and are not subject to tax.

(2) (a) Except as provided in subsections (2)(b) and (2)(c), coincident with the filing of the tax report referred to in subsection (1) and subject to 33-2-709, each insurer shall pay to the commissioner a tax on the net premiums computed at the rate of 2.75%.

(b) All casualty insurers issuing policies of legal professional liability insurance pursuant to 33-1-206 shall pay to the commissioner a tax on the net premiums derived from legal professional liability insurance computed at a rate of 0.75%.

(c) A dormant captive insurer that has a valid certificate of dormancy shall pay to the commissioner an annual dormancy tax of $1,000 as provided in 33-28-401.

(3) That portion of the tax paid under this section by an insurer on account of premiums received for fire insurance must be separately specified in the report required by the commissioner for apportionment as provided by law. When insurance against fire is included with insurance of property against other perils at an undivided premium, the insurer shall make a reasonable allocation from the entire premium to the fire portion of the coverage as must be stated in the report and as may be approved or accepted by the commissioner.

(4) With respect to authorized insurers, the premium tax provided by this section or the annual dormancy tax under 33-28-401 must be payment in full and in lieu of all other demands for any and all state, county, city, district, municipal, and school taxes, licenses, fees, and excises of whatever kind or character, excepting only those prescribed by this code, taxes on real and tangible personal property located in this state, and taxes payable under 50-3-109.

(5) The commissioner may suspend or revoke the certificate of authority of any insurer that fails to pay its taxes as required under this section.

(6) In addition to the penalty provided for in subsection (5), the commissioner may impose on an insurer

who fails to pay the tax required under this section a fine of $100 plus interest on the delinquent amount at the annual interest rate of 12%.

(7) The commissioner shall:

(a) separately account for taxes paid under this section by the state fund provided for in 39-71-2313; and

(b) deposit the money as provided in 33-2-708.

~~(7)~~(8) The commissioner may by rule provide a quarterly schedule for payment of portions of the premium tax under this section during the year in which tax liability is accrued."

Section 20. Section 33-2-708, MCA, is amended to read:

"33-2-708. Fees and licenses. (1) (a) Except as provided in subsection (5), 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) navigator certification:

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

(B) biennial renewal of certification, $50;

(C) lapsed certification reinstatement fee, $100;

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

(c) The commissioner may adopt rules to determine the date by which a nonresident insurance producer, a surplus lines insurance producer, an insurance adjuster, an insurance public 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:

(i) money from the premium tax paid by the state fund pursuant to 33-2-705 in the Montana HELP ACT special revenue account provided for in [section ~~6~~ 5]; and

(ii) 33% of the remaining 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 [and are subject to legislative fund transfer].

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

(5) The commissioner shall collect a licensing fee of $500 for casualty insurance companies issuing policies of legal professional liability insurance pursuant to 33-1-206. (Bracketed language in subsection (3)(c) terminates June 30, 2019--sec. 28, Ch. 6, Sp. L. November 2017.)"

Section 21. Section 33-30-102, MCA, is amended to read:

"33-30-102. Application of chapter -- construction of other related laws. (1) All health service corporations are subject to the provisions of this chapter. In addition to the provisions contained in this chapter, other chapters and provisions of this title apply to health service corporations as follows: [section ~~8~~ 6]; 33-2-1212; 33-3-307; 33-3-308; 33-3-401; 33-3-431; 33-3-701 through 33-3-704; 33-17-101; Title 33, chapter 2, parts 13, 19, and 23; Title 33, chapter 3, part 6; Title 33, chapter 17, parts 2 and 10 through 12; and Title 33, chapters 1, 15, 18, 19, 22, and 32, except 33-22-111.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict, the provisions of this chapter prevail."

Section 22. Section 39-12-101, MCA, is amended to read:

"39-12-101. ~~(Temporary)~~ Montana HELP Act workforce development -- legislative findings -- purpose. (1) The legislature finds that:

(a) Montana has a disproportionately high number of individuals who are eligible for medicaid compared to surrounding states;

(b) Montanans value independence and self-sufficiency;

(c) investing in Montana citizens is a legislative priority;

(d) participants in the HELP Act program are largely low-wage workers; and

(e) an opportunity exists to match individuals who need self-sustaining employment with the jobs the economy needs, including newly created health care jobs.

(2) The purpose of this chapter is to create a collaborative effort between the department of labor and industry and the department of public health and human services to:

(a) identify workforce development opportunities for program participants;

(b) gather information from state agencies on existing workforce development programs and opportunities; and

(c) establish a comprehensive plan for coordinating efforts and resources to provide workforce development opportunities.

(3) The department of labor and industry shall implement a workforce development program that:

(a) focuses on specific labor force needs within the state of Montana;

(b) has the goal of reducing the number of people depending on social programs, including the HELP Act program; ~~and~~

(c) provides grants to employers who hire and train program participants; and

~~(c)~~(d) increases the earning capacity, economic stability, and self-sufficiency of program participants so that, among other benefits, they are able to purchase their own health insurance coverage. ~~(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 23. Section 39-12-103, MCA, is amended to read:

"39-12-103. ~~(Temporary)~~ Montana HELP Act workforce development -- participation -- report. (1) The department shall provide individuals receiving assistance for health care services pursuant to Title 53, chapter 6, part 13, with the option of participating in an employment or reemployment assessment and in the workforce development program provided for in 39-12-101. The assessment must identify any probable barriers to employment that exist for the member.

(2) THE DEPARTMENT SHALL CONTACT EACH PROGRAM PARTICIPANT SUBJECT TO THE COMMUNITY ENGAGEMENT REQUIREMENTS OF [SECTION 1] AND ASSIST THE PARTICIPANT WITH COMPLETION OF AN EMPLOYMENT OR REEMPLOYMENT ASSESSMENT. BASED ON THE RESULTS OF THE ASSESSMENT, THE DEPARTMENT SHALL IDENTIFY SERVICES TO HELP THE INDIVIDUAL ADDRESS BARRIERS TO EMPLOYMENT.

~~(2)~~(3) (a) The department shall notify the department of public health and human services when a participant has received all services and assistance under subsection (1) that can reasonably be provided to the individual.

(b) The department is not required to provide further services under this section after it has provided the

notification provided for in subsection ~~(2)(a)~~ (3)(A).

(c) A participant who is no longer receiving services under this section does not meet the criteria of 53-6-1307(6)(c) for the exemption granted under 53-6-1307(6).

~~(3)~~(4) The department shall report the following information to the ~~oversight committee provided for in 53-6-1316~~ legislative finance committee and the children, families, health, and human services interim committee:

(a) the activities undertaken to establish a workforce development program for program participants and the employer grant program provided for in [section ~~9~~ 7]; ~~and~~

(b) the number of participants in the workforce development program and the number of participants who have obtained employment or higher-paying employment;

(c) the number of employers receiving grant awards and the number and types of activities, training, or jobs the employers provided; and

(d) the total cost of providing workforce development services under this chapter, including related administrative costs.

~~(4)~~(5) To the extent possible, the department of public health and human services shall offset the cost of workforce development activities provided under this section by using temporary assistance for needy families reserve funds.

~~(5)~~(6) The department shall reduce fraud, waste, and abuse in determining and reviewing eligibility for unemployment insurance benefits by enhancing technology system support to provide knowledge-based authentication for verifying the identity and employment status of individuals seeking benefits, including the use of public records to confirm identity and to flag changes in demographics. ~~(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 24. Section 39-71-2375, MCA, is amended to read:

"39-71-2375. Operation of state fund as authorized insurer -- issuance of certificate of authority -- exceptions -- use of calendar year -- risk-based capital -- reporting requirements. (1) The state fund provided for in 39-71-2313 is an authorized insurer and, except as provided in this section, is subject to the provisions in Title 33 that are generally applicable to authorized workers' compensation insurers in this state and the provisions of Title 39, chapter 71, part 23.

(2) (a) The commissioner shall issue a certificate of authority to the state fund to write workers' compensation insurance coverages, as provided in 39-71-2316, and except as otherwise provided in this section

the requirements of Title 33, chapter 2, part 1, do not apply. The certificate of authority must be continuously renewed by the commissioner.

(b) The state fund shall pay the tax on net premiums under 33-2-705 and the annual fee under 33-2-708, provide the surplus funds required under 33-2-109 and 33-2-110, and provide to the commissioner the available documentation and information that is provided by other insurers when applying for a certificate of authority under 33-2-115.

(c) The state fund is subject to the reporting requirements under 33-2-705 ~~but is not subject to the tax on net premiums~~.

(3) (a) The state fund, as the guaranteed market for workers' compensation insurance for employers pursuant to 39-71-2313, is not subject to:

(i) formation requirements of an insurer under Title 33, chapter 3;

(ii) revocation or suspension of its certificate of authority under any provision of Title 33 or any order or any provision that requires forfeiture of the state fund's obligation to insure employers as required in 39-71-2313;

(iii) liquidation or dissolution under Title 33;

(iv) participation in the guaranty association provided for in Title 33, chapter 10;

(v) 33-12-104; or

(vi) any assessment of punitive or exemplary damages.

(b) The state fund is subject to 33-16-1023, except as provided in 39-71-2316(1)(e), (1)(f), and (1)(g).

(4) The state fund shall complete financial reporting and accounting on a calendar year basis.

(5) (a) If the state fund's risk-based capital falls below the company action level RBC as defined in 33-2-1902, the commissioner shall issue a report to the governor, the state fund board of directors, and to the legislature. If the legislature is not in session, the report must go to the economic affairs interim committee and to the legislative auditor. The report must provide a description of the RBC measurement, the regulatory implications of the state fund falling below the RBC criteria, and the state fund's corrective action plan. If the commissioner is reporting on a regulatory action level RBC event, the report must include the state fund's corrective action plan, results of any examination or analysis by the commissioner, and any corrective orders issued by the commissioner.

(b) If the state fund fails to comply with any lawful order of the commissioner, the commissioner may initiate supervision proceedings under Title 33, chapter 2, part 13, against state fund. If the state fund fails to comply with the commissioner's lawful supervision order under this subsection (5)(b), the commissioner may

institute rehabilitation proceedings under Title 33, chapter 2, part 13, only if the commissioner is petitioning for rehabilitation based on the grounds provided in 33-2-1321(1) or (2).

(6) The state fund shall annually transfer funds to the commissioner, out of its surplus, for all necessary staffing and related expenses for a full-time attorney licensed to practice law in Montana and a full-time examiner qualified by education, training, experience, and high professional competence to examine the state fund pursuant to Title 33, chapter 1, part 4, and this section. The attorney and examiner must be employees of the commissioner.

(7) For the purposes of this section, the term "guaranteed market" has the definition provided in 39-71-2312."

Section 25. Section 53-4-1110, MCA, is amended to read:

"53-4-1110. Exemption from resource test. An otherwise applicable eligibility resource test provided for in 53-6-113(6) and 53-6-131~~(7)~~(8) does not apply to plan applicants."

Section 26. Section 53-4-1115, MCA, is amended to read:

"53-4-1115. Special revenue account. (1) There is an account in the state special revenue fund to the credit of the department for the purposes provided in subsection (2). There must be paid into the account the amounts collected under 33-2-708(3)(b)(ii). Any interest or income derived from the account must be deposited in the account.

(2) Money in the account:

(a) is to be used solely to cover the number of additional enrollees in the plan that exceeds the number of enrollees as of November 4, 2008, within the limits provided in 53-4-1004, 53-6-131, and this part, and to cover the costs of enrollment, including premium assistance, under 53-4-1108(1), and to pay administrative costs associated with expanded eligibility, and to establish and maintain a reserve; and

(b) may be used only to match federal funds available under the children's health insurance program and the Montana medicaid program.

(3) The unexpended balance of an appropriation from the account must remain in the account and may be used only for the purposes stated in subsection (2).

(4) The special revenue account does not affect and is not exclusive of any other sources of funding for the programs described in 53-4-1104(2), including the special revenue account provided for in 53-4-1012.

(5) If the department determines that there is insufficient funding for the purposes of subsection (2), it may reduce eligibility requirements for participants in the children's health insurance program as provided in 53-4-1004(4)."

Section 27. Section 53-6-131, MCA, is amended to read:

"53-6-131. Eligibility requirements. (1) Medical assistance under the Montana medicaid program may be granted to a ~~person~~ U.S. citizen or a qualified alien as defined in 8 U.S.C. 1641 who is determined by the department of public health and human services to be a Montana resident and, in its discretion, to be eligible as follows:

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

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

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

(d) The person is:

(i) under 21 years of age and in foster care under the supervision of the state or was in foster care under the supervision of the state and has been adopted as a child with special needs; or

(ii) under 18 years of age and is in a guardianship subsidized by the department pursuant to 41-3-444.

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

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

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

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

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

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

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

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

(2) The department shall require an applicant to provide proof of the applicant's residency in this state.

~~(2)~~(3) (a) The department may establish income and resource limitations. Limitations of income and resources must be within the amounts permitted by federal law for the medicaid program. Any otherwise applicable eligibility resource test prescribed by the department does not apply to enrollees in the healthy Montana kids plan provided for in 53-4-1104.

(b) The department may not count as a resource an individual retirement account that was established by a person participating in the medicaid program for workers with disabilities provided for in 53-6-195 if:

(i) the person is no longer eligible for coverage under 53-6-195; and

(ii) the individual retirement account was established during the time the person was receiving benefits through the medicaid program for workers with disabilities.

~~(3)~~(4) The Montana medicaid program shall pay, as required by federal law, the premiums necessary for medicaid-eligible persons participating in the medicare program and may, within the discretion of the department, pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified medicare-eligible person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, who:

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

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

~~(4)~~(5) The department may pay a medicaid-eligible person's expenses for premiums, coinsurance, and

similar costs for health insurance or other available health coverage, as provided in 42 U.S.C. 1396b(a)(1).

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

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

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

~~(8)~~(9) Subject to appropriations, the department may cooperate with and make grants to a nonprofit corporation that uses donated funds to provide basic preventive and primary health care medical benefits to children whose families are ineligible for the Montana medicaid program and who are ineligible for any other health care coverage, are under 19 years of age, and are enrolled in school if of school age.

~~(9)~~(10) A person described in subsection ~~(7)~~(8) must be provided continuous eligibility for medical assistance, as authorized in 42 U.S.C. 1396a(e)(5) through (e)(7).

~~(10)~~(11) Full medical assistance under the Montana medicaid program may be granted to an individual during the period in which the individual requires treatment of breast or cervical cancer, or both, or of a precancerous condition of the breast or cervix, if the individual:

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

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

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

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

(e) has not attained 65 years of age.

~~(11)~~(12) Subject to the limitation in 53-6-195, the department shall provide medicaid coverage to workers with disabilities as provided in 53-6-195 and in accordance with 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII) and (r)(2) and 42 U.S.C. 1396o.

(13) NOTHING IN SUBSECTION (1) MAY BE CONSTRUED AS ALLOWING THE DEPARTMENT TO DENY ENROLLMENT FOR A REASON THAT IS IMPERMISSIBLE UNDER FEDERAL LAW OR REGULATION."

Section 28. Section 53-6-133, MCA, is amended to read:

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

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

(3) The department shall verify the information provided on an application for medicaid under this part or under part 13, using data sources allowed under federal law or regulation, to confirm an applicant's eligibility for the program before authorizing payment of benefits under the program.

(4) The department shall establish by rule the documents to be used to verify that an applicant is a Montana resident."

Section 29. Section 53-6-149, MCA, is amended to read:

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

(2) All money collected under 15-66-102, except for the money deposited pursuant to 15-66-102(3)(b) into the Montana HELP Act special revenue account provided for in [section ~~6~~ 5], must be deposited in the

account.

(3) Money in the account must be used by the department of public health and human services to provide funding no later than May 5 of each year for increases in medicaid payments to hospitals and for the costs of collection of the fee and other administrative activities associated with the implementation of increases in the medicaid payments to hospitals."

Section 30. Section 53-6-160, MCA, is amended to read:

"53-6-160. Truthfulness, completeness, and accuracy of submissions to medicaid agencies. (1) (a) A person who submits to a medicaid agency an application, claim, report, document, or other information that is or may be used to determine eligibility for medicaid benefits, eligibility to participate as a provider, or the right to or the amount of payment under the medicaid program is considered to represent to the department, to the best of the person's knowledge and belief, that the item is genuine and that its contents, including all statements, claims, and representations contained in the document, are true, complete, accurate, and not misleading.

(b) This section applies to the ~~self-attestation of program participants claiming~~ INFORMATION PROVIDED BY A PROGRAM PARTICIPANT TO CLAIM an exemption from community engagement requirements under [section 1] ~~and to the self-reporting of~~ OR TO REPORT community engagement ~~requirements required~~ ACTIVITIES under [section 2].

(2) (a) A provider has a duty to exercise reasonable care to ensure the truthfulness, completeness, and accuracy of all applications, claims, reports, documents, and other information and of all statements and representations made or submitted, or authorized by the provider to be made or submitted, to the department for purposes related to the medicaid program. The duty applies whether the applications, claims, reports, documents, other information, statements, or representations were made or submitted, or authorized by the provider to be made or submitted, on behalf of the provider or on behalf of an applicant or recipient being served by the provider.

(b) A provider has a duty to exercise reasonable care to ensure that a claim made or submitted to the department or its agents or employees for payment or reimbursement under the medicaid program is one for which the provider is entitled to receive payment and that the service or item is provided and billed according to all applicable medicaid requirements, including but not limited to identification of the appropriate procedure code or level of service and provision of the service by a person, facility, or other provider entitled to receive medicaid payment for the particular service.

(3) A person is considered to have known that a claim, statement, or representation related to the

medicaid program was false if the person knew, or by virtue of the person's position, authority, or responsibility should have known, of the falsity of the claim, statement, or representation.

(4) A person is considered to have made or to have authorized to be made a claim, statement, or representation if the person:

(a) had the authority or responsibility to:

(i) make the claim, statement, or representation;

(ii) supervise another who made the claim, statement, or representation; or

(iii) authorize the making of the claim, statement, or representation, whether by operation of law, business or professional practice, or office policy or procedure; and

(b) exercised or failed to exercise that authority or responsibility and, as a direct or indirect result, the false statement was made, resulting in a claim for a service or item when the person knew or had reason to know that the person was not entitled under applicable statutes, regulations, rules, or policies to medicaid payment or benefits for the service or item or for the amount of payment requested or claimed.

(5) (a) There is an inference that a person who signs or submits a document to a medicaid agency on behalf of or in the name of a provider is authorized by the provider to do so and is acting under the provider's direction.

(b) For purposes of this section, the term "signs" includes but is not limited to the use of facsimile, computer-generated and typed, or block-letter signatures.

(6) The department shall directly or by contract provide a program of instruction and assistance to persons submitting applications, claims, reports, documents, and other information to the department concerning the completion and submission of the application, claim, report, document, or other information in a manner determined necessary by the department. The program must include:

(a) clear directions for the completion of applications, claims, reports, documents, and other information;

(b) examples of properly completed applications, claims, reports, documents, and other information;

(c) a method by which persons submitting applications, claims, reports, documents, and other information may, on a case-by-case basis, receive accurate, complete, specific, and timely advice and directions from the department before the completed applications, claims, reports, documents, and other information must be submitted to the department; and

(d) a method by which persons submitting applications, claims, reports, documents, and other information may challenge the department's interpretation or application of the manner in which the applications,

claims, reports, documents, and other information must be completed.

(7) This section applies only for the purpose of civil liability under Title 53 and does not apply in a criminal proceeding."

Section 31. Section 53-6-1302, MCA, is amended to read:

"53-6-1302. ~~(Temporary)~~ Montana HELP Act program -- legislative findings and purpose. (1) There is a Montana Health and Economic Livelihood Partnership Act program established through a collaborative effort of the department of public health and human services and the department of labor and industry to:

(a) provide coverage of health care services for low-income Montanans;

(b) improve the readiness of program participants to enter the workforce or obtain better-paying jobs; and

(c) reduce the dependence of Montanans on public assistance programs.

(2) The legislature finds that improving the delivery of health care services to Montanans requires state government, health care providers, patient advocates, and other parties interested in high-quality, affordable health care to collaborate in order to:

(a) increase the availability of high-quality health care to Montanans;

(b) provide greater value for the tax dollars spent on the Montana medicaid program;

(c) reduce health care costs;

(d) provide incentives that encourage Montanans to take greater responsibility for their personal health;

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

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

(3) The legislature further finds that providing greater value for the dollars spent on the medicaid program requires considering options for delivering services in a more efficient and cost-effective manner, including but not limited to:

(a) offering incentives to encourage health care providers to achieve measurable performance outcomes;

(b) improving the coordination of care among health care providers who participate in the medicaid program;

(c) reducing preventable hospital readmissions; and

(d) exploring methods of medicaid payment that promote quality of care and efficiencies.

(4) The legislature further finds that assessing workforce readiness, ~~and~~ providing necessary job training or skill development, and establishing community engagement requirements for individuals who need assistance with health care costs could help those individuals obtain employment that has health care coverage benefits or that would allow them to purchase their own health insurance coverage.

(5) The legislature further finds that:

(a) it is important to implement additional fraud, waste, and abuse safeguards to protect and preserve the integrity of the medicaid program and the unemployment insurance program for individuals who qualify for the programs; and

(b) 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.

(6) The purposes of the act are to:

(a) modify and enhance Montana's health care delivery system to provide access to high-quality, affordable health care for all Montana citizens; and

(b) provide low-income Montanans with opportunities to improve their readiness for work or to obtain higher-paying jobs.

(7) The department of labor and industry and the department of public health and human services shall maximize the use of existing resources in administering the program. ~~(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 32. Section 53-6-1303, MCA, is amended to read:

"53-6-1303. ~~(Temporary)~~ Definitions. As used in this part, the following definitions apply:

(1) "Community engagement" means participation in the activities specified in [section 1] as a means to improve a program participant's well-being and opportunities for self-sufficiency.

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

~~(2)~~(3) "HELP Act" or "act" means the Montana Health and Economic Livelihood Partnership Act provided for in Title 39, chapter 12, and this part.

~~(3)~~(4) "Member" means an individual enrolled in the Montana medicaid program pursuant to 53-6-131 or receiving medicaid-funded services pursuant to 53-6-1304.

~~(4)~~(5) "Program participant" or "participant" means an individual enrolled in the Montana Health and

Economic Livelihood Partnership Act program established in Title 39, chapter 12, and this part. ~~(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 33. Section 53-6-1304, MCA, is amended to read:

"53-6-1304. ~~(Temporary)~~ Montana HELP Act program -- eligibility for coverage of health care services ~~-- statutory appropriations -- federal special revenue~~ -- EXCEPTIONS. ~~(1)~~ (1) An individual is eligible for coverage of health care services provided pursuant to this part if the individual meets the requirements of 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).

(2) THE DEPARTMENT MAY SERVE INDIVIDUALS WHO ARE ELIGIBLE FOR MEDICAID-FUNDED SERVICES PURSUANT TO THIS PART THROUGH THE MEDICAL ASSISTANCE PROGRAM ESTABLISHED IN TITLE 53, CHAPTER 6, PART 1, IF THE INDIVIDUALS WOULD BE SERVED MORE APPROPRIATELY BECAUSE THE INDIVIDUALS:

(A) HAVE EXCEPTIONAL HEALTH CARE NEEDS, INCLUDING BUT NOT LIMITED TO MEDICAL, MENTAL HEALTH, OR DEVELOPMENTAL CONDITIONS;

(B) LIVE IN A GEOGRAPHICAL AREA, INCLUDING AN INDIAN RESERVATION, THAT WOULD NOT BE EFFECTIVELY OR EFFICIENTLY SERVED THROUGH THIS PART;

(C) NEED CONTINUITY OF CARE THAT WOULD NOT BE AVAILABLE OR COST-EFFECTIVE THROUGH THIS PART;

(D) ARE EXEMPT UNDER THE WAIVER IMPLEMENTING THIS PART AS OF JULY 1, 2019; OR

(E) ARE OTHERWISE EXEMPT UNDER FEDERAL LAW.

~~(2) Funds necessary to implement this part, including benefits and administrative costs, are statutorily appropriated, as provided in 17-7-502, from the general fund to the department.~~

~~(3) There is an account in the federal special revenue fund to the credit of the department for the payment of costs, including benefits and administrative costs, of providing health care services to individuals who are eligible for coverage pursuant to subsection (1).~~

~~(4) The federal medical assistance percentage received pursuant to 42 U.S.C. 1396d(y) must be deposited in the account provided for in subsection (3).~~

~~(5) Money in the account is statutorily appropriated, as provided in 17-7-502, to the department for the purpose provided in subsection (3). (Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 34. Section 53-6-1305, MCA, is amended to read:

"53-6-1305. ~~(Temporary)~~ Montana HELP Act program -- delivery of health care services --

third-party administrator -- rulemaking. (1) The department ~~shall~~ may contract as provided in Title 18, chapter 4, with one or more third-party administrators to assist in administering the delivery of health care services to members eligible under 53-6-1304, including but not limited to:

(a) establishing networks of health care providers;

(b) paying claims submitted by health care providers;

(c) collecting the premiums provided for in 53-6-1307;

(d) coordinating care;

(e) helping to administer the program; and

(f) helping to administer the medicaid program reforms as specified in 53-6-1311.

(2) ~~The~~ If the department decides to contract with a third-party administrator, the department shall determine the basic health care services to be provided through the arrangement with ~~a~~ the third-party administrator.

(3) (a) The department may exempt certain individuals who are eligible for medicaid-funded services pursuant to 53-6-1304 from receiving health care services through ~~the~~ an arrangement with a third-party administrator if the individuals would be served more appropriately through the medical assistance program established in Title 53, chapter 6, part 1~~, because the individuals:~~

~~(i) have exceptional health care needs, including but not limited to medical, mental health, or developmental conditions;~~

~~(ii) live in a geographical area, including an Indian reservation, for which the third-party administrator has been unable to make arrangements with sufficient health care providers to offer services to the individuals;~~

~~(iii) need continuity of care that would not be available or cost-effective through the arrangement with the third-party administrator; or~~

~~(iv) are otherwise exempt under federal law~~.

(b) ~~The~~ If the department contracts with a third-party administrator, the department shall:

(i) adopt rules establishing criteria for determining whether a member is exempt from receiving health care services through an arrangement with ~~a~~ the third-party administrator; ~~and~~

(ii) provide coverage for exempted individuals through the medical assistance program established in Title 53, chapter 6, part 1~~.~~; and

~~(4)~~(iii) ~~For~~ for members participating in the arrangement with ~~the~~ a third-party administrator, ~~the department shall~~ directly cover any service required under federal or state law that is not available through the

arrangement with the third-party administrator.

~~(5) The department shall:~~

~~(a) seek federal authorization from the U.S. department of health and human services through a waiver authorized by 42 U.S.C. 1315 and other waivers or through other means, as may be necessary, to implement all of the provisions of Title 39, chapter 12, and this part; and~~

~~(b) implement access to the health care services in accordance with the requirements necessary to receive the federal medical assistance percentage provided for by 42 U.S.C. 1396d(y).~~

(4) The department may contract with a third-party administrator for the services allowed under subsections (1)(a) through (1)(f) only upon receipt of a federal waiver allowing a third-party administrator to provide services in accordance with this part.

~~(6) The department may provide medicaid-funded services to members eligible pursuant to 53-6-1304 only upon federal approval of any necessary waivers.(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 35. Section 53-6-1306, MCA, is amended to read:

"53-6-1306. ~~(Temporary) Copayments -- exemptions -- report~~ Prohibition on copayments. ~~(1) A program participant shall make copayments to health care providers for health care services received pursuant to this part.~~ The department may not require a program participant to make a copayment, to pay a coinsurance amount, or to meet a deductible amount for any service covered under this part.

~~(2) Except as provided in subsection (3), the department shall adopt a copayment schedule that reflects the maximum copayment amount allowed under federal law. The total amount of copayments collected under this section must be capped at the maximum amount allowed by federal law and regulations.~~

~~(3) The department may not require a copayment for:~~

~~(a) preventive health care services;~~

~~(b) generic pharmaceutical drugs;~~

~~(c) immunizations provided according to a schedule established by the department that reflects guidelines issued by the centers for disease control and prevention; or~~

~~(d) medically necessary health screenings ordered by a health care provider.~~

~~(4) Each health care provider participating in the third-party arrangement shall report the following information annually to the oversight committee on the Montana Health and Economic Livelihood Partnership Act:~~

~~(a) the total amount of copayments that the provider was unable to collect from participants; and~~

~~(b) the efforts the health care provider made to collect the copayments. (Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 36. Section 53-6-1307, MCA, is amended to read:

"53-6-1307. ~~(Temporary)~~ Premiums -- collection of overdue premiums -- nonpayment as voluntary disenrollment -- reenrollment -- exemptions. (1) (a) A program participant shall pay an annual premium, billed monthly, equal to ~~2%~~ a percentage of the participant's modified adjusted gross income as determined in accordance with 42 U.S.C. 1396a(e)(14). ~~The~~ EXCEPT AS PROVIDED IN SUBSECTION (1)(B), THE premiums must:

(i) be set at 2% of a participant's income in the first 2 years the participant receives coverage under this part; and

(ii) increase by 0.5% in each subsequent year that a participant receives coverage, up to a maximum of ~~5%~~ 4% of the participant's income.

(B) A PROGRAM PARTICIPANT WHO IS EXEMPT FROM THE COMMUNITY ENGAGEMENT REQUIREMENTS AS ALLOWED UNDER [SECTION 1] IS EXEMPT FROM THE PREMIUM INCREASES IN SUBSECTION (1)(A)(II).

~~(b)~~(C) Premiums paid pursuant to this section must be deposited in the ~~general fund~~ Montana HELP Act special revenue account provided for in [section ~~6~~ 5].

(2) Within 30 days of a participant's failure to make a required payment, the ~~third-party administrator~~ department or a third-party administrator administering the program, if any, shall notify the participant ~~and the department~~ that payment is overdue and that all overdue premiums must be paid within 90 days of the date the notification was sent.

(3) (a) If a participant with an income of 100% of the federal poverty level or less fails to make payment for overdue premiums, the department shall provide notice to the department of revenue of the participant's failure to pay. The department of revenue shall collect the amount due for nonpayment by assessing the amount against the participant's annual income tax in accordance with Title 15, chapters 1 and 30.

(b) The debt remains until paid and may be collected through assessments against future income tax returns or through a civil action initiated by the state.

(4) If a participant with an income of more than 100% but not more than 138% of the federal poverty level fails to make the overdue payments within 90 days of the date the notification was sent, the department shall:

(a) follow the procedure established in subsection (3) for collection of the unpaid premiums; and

(b) consider the failure to pay to be a voluntary disenrollment from the program. The department may

reenroll a participant in the program upon payment of the total amount of overdue payments.

(5) If a participant who has failed to pay the premiums does not indicate that the participant no longer wishes to participate in the program, the department may reenroll the person in the program when the department of revenue assesses the unpaid premium through the participant's income taxes.

(6) Participants who meet two of the following criteria are not subject to the voluntary disenrollment provisions of this section:

(a) discharge from United States military service within the previous 12 months;

(b) enrollment for credit in any Montana university system unit, a tribal college, or any other accredited college within Montana offering at least an associate degree, subject to the provisions of subsection (7);

(c) participation in a workforce program or activity established under Title 39, chapter 12; or

(d) participation in any of the following healthy behavior plans developed by a health care provider or third-party administrator, if any, or approved by the department:

(i) a medicaid health home;

(ii) a patient-centered medical home;

(iii) a cardiovascular disease, obesity, or diabetes prevention program;

(iv) a program restricting the participant to obtaining primary care services from a designated provider and obtaining prescriptions from a designated pharmacy;

(v) a medicaid primary care case management program established by the department;

(vi) a tobacco use prevention or cessation program;

(vii) a medicaid waiver program providing coverage for family planning services;

(viii) a substance abuse treatment program; or

(ix) a care coordination or health improvement plan administered by the third-party administrator.

(7) A participant seeking an exemption under subsection (6) is not eligible for the education exemption provided for in subsection (6)(b) for more than 4 years. ~~(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 37. Section 53-6-1311, MCA, is amended to read:

"53-6-1311. ~~(Temporary)~~ Medicaid program reforms.(1) To ensure that the Montana medicaid program is administered efficiently and effectively, the department shall strengthen existing programs that manage the way members obtain approval for medical services and shall establish additional programs designed to reduce costs and improve medical outcomes. The efforts may include but are not limited to:

(a) establishing by rule requirements designed to strengthen the relationship between physicians and members enrolled in existing primary care case management programs;

(b) strengthening data-sharing arrangements with providers to reduce inappropriate use of emergency room services and overuse of other services;

(c) expanding to additional members any existing programs in which case managers and providers work with members with high-risk medical conditions to provide preventive care and advice and to make referrals for medical services;

(d) establishing, within existing funds, one or more pilot programs to improve the health of members, including but not limited to efforts to increase pain management, decrease emergency department overuse, and prevent drug or alcohol addiction or abuse;

(e) reviewing existing primary care case management programs to evaluate and improve their effectiveness; and

~~(f) reducing fraud, waste, and abuse in the medicaid program before, during, and after enrollment by enhancing technology system support to provide knowledge-based authentication for verifying the identity and financial status of individuals seeking benefits, including the use of public records to confirm identity and flag changes in demographics; and~~

~~(g)~~(f) engaging members with chronic or other medical or behavioral health conditions in coordinated care models that more closely monitor and manage a member's health to reduce costs or improve medical outcomes. These coordinated care models may include but are not limited to:

(i) patient-centered medical homes;

(ii) accountable care organizations;

(iii) managed care organizations as defined in 42 CFR 438.2;

(iv) health improvement programs;

(v) health homes for behavioral health or other chronic conditions; and

(vi) changes to current service delivery methods.

(2) The department shall work to reduce fraud, waste, and abuse in the medicaid program before, during, and after enrollment by enhancing technology system support to provide knowledge-based authentication for verifying the identity and financial status of individuals seeking benefits, including the use of public records to confirm identity and flag changes in demographics.

~~(2)~~(3) The department may ask a third-party administrator under contract with the department to assist

in efforts undertaken pursuant to ~~subsection (1)~~ subsections (1) and (2) when the activity can appropriately be handled by ~~the~~ a third-party administrator.

~~(3)~~(4) A care coordination entity used to deliver medicaid services shall meet all state standards for operation, including but not limited to solvency, consumer protection, nondiscrimination, network adequacy, care model design, and fraud and abuse standards. ~~(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 38. Section 53-6-1317, MCA, is amended to read:

"53-6-1317. ~~(Temporary) Duties of Montana HELP Act oversight committee -- reports~~ Report to legislature. ~~(1) To provide reports and make recommendations to the legislature, the oversight committee on the Montana Health and Economic Livelihood Partnership Act shall review:~~

~~(a) data from and activities by the department of public health and human services and the department of labor and industry related to the health care and workforce development activities undertaken pursuant to the HELP Act;~~

~~(b) the Montana medicaid program; and~~

~~(c) the delivery of health care services in Montana.~~

~~(2)~~ The ~~departments~~ department shall report the following information to the ~~oversight~~ legislative finance committee and the children, families, health, and human services interim committee quarterly:

~~(a)~~(1) the number of individuals who were determined eligible for medicaid-funded services pursuant to 53-6-1304;

~~(b)~~(2) demographic information on program participants;

~~(c)~~(3) the average length of time that participants remained eligible for medical assistance;

~~(d) the number of participants who completed an employment or reemployment assessment;~~

~~(e) the number of participants who took part in workforce development activities;~~

~~(f)~~(4) the number of participants subject to the ~~fee~~ fees provided for in 15-30-2660 and the total amount of fees collected;

(5) the amount of money deposited in the Montana HELP act special revenue account, by source of funding;

~~(g)~~(6) the level of participant engagement in wellness activities or incentives offered ~~by health care providers or the third-party administrator~~ under this part;

(7) the number of participants who took part in community engagement activities and the number who

were disenrolled for failure to take part in community engagement activities;

~~(h)~~(8) the number of participants who reduced their dependency on the HELP Act program, either voluntarily or because of increased income levels; and

~~(i)~~(9) the total cost of providing services under ~~Title 39, chapter 12, and~~ this part, including related administrative costs.

~~(3) The committee shall review and provide comment on administrative rules proposed for carrying out activities under Title 39, chapter 12, and this part. The committee may ask the appropriate administrative rule review committee to object to a proposed rule as provided in 2-4-406.~~

~~(4) The committee shall:~~

~~(a) review how implementation of the act is being carried out, including the collection of copayments and premiums for health care services;~~

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

~~(c) review ideas to reduce or minimize the shifting of the payment of unreimbursed health care costs to patients with health insurance;~~

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

~~(e) review options for reducing the inappropriate use of emergency department services;~~

~~(f) review ways to monitor for the excessive or inappropriate use of prescription drugs;~~

~~(g) 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 to identify patterns in the use of health care services across payment sources;~~

~~(h) receive regular reports from the department on the department's efforts to pursue contracting options for administering services to members eligible for medicaid-funded services pursuant to 53-6-1304;~~

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

~~(j) recommend future funding options for the HELP Act program to future legislatures.~~

~~(5) The committee shall summarize and present its findings and recommendations in a final report to the governor and to the legislative finance committee no later than August 15 of each even-numbered year. Copies of the report must be provided to the children, families, health, and human services interim committee. (Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 39. Section 28, Chapter 368, Laws of 2015, is amended to read:

"**Section 28. Termination.** (1) [This act] terminates ~~June 30, 2019~~ ~~December 31, 2019~~ JANUARY 1, 2020.

(2) The department may reapply for the same waiver received to implement the Montana Health and Economic Livelihood Partnership Act program if the waiver expires before ~~June 30, 2019~~ ~~December 31, 2019~~ JANUARY 1, 2020."

NEW SECTION. **Section 40. Repealer.** The following section of the Montana Code Annotated is repealed:

53-6-1316. Montana HELP Act oversight committee -- membership.

NEW SECTION. **Section 41. Repealer.** Section 28, Chapter 368, Laws of 2015, is repealed.

NEW SECTION. **Section 42. Appropriations.** (1) There is appropriated $3.5 million from the Montana HELP Act special revenue account provided for in [section ~~6~~ 5] to the department of labor and industry for the biennium beginning July 1, 2019, for the HELP Act employer grant program provided for in ~~[section 9]~~ [SECTION 7] AND THE WORKFORCE DEVELOPMENT PROGRAM ACTIVITIES PROVIDED FOR IN 39-12-103.

(2) The following amounts are appropriated to the department of public health and human services for the biennium beginning July 1, 2019, for the payment of costs, including benefits and administrative costs, of providing health care services to individuals who are eligible for coverage under Title 53, chapter 6, part 13:

Fiscal Year 2020	$678,185,000	federal special revenue
	$29,510,000	general fund
	$30,000,000	state special revenue
Fiscal Year 2021	$685,606,000	federal special revenue
	$36,667,000	general fund

	$30,000,000	state special revenue

(3) The following amounts are appropriated to the department of public health and human services for the biennium beginning July 1, 2019, for the payment of costs, including administrative costs, of providing health care services to individuals who are eligible for coverage of health care costs under Title 53, chapter 6, part 1 or part 13.

Fiscal year 2020	$110,000,000	federal special revenue
	$25,000,000	state special revenue
Fiscal year 2021	$110,000,000	federal special revenue
	$25,000,000	state special revenue

(4) (a) Money from the Montana HELP Act special revenue account provided for in [section ~~6~~ 5] must be used for the state special revenue appropriated under subsection (2).

(b) Money from the special revenue account provided for in 53-6-149 must be used for the state special revenue appropriated under subsection (3).

NEW SECTION. **Section 43. Transition -- direction to department of public health and human services -- notification to legislature.** (1) The legislature directs the department of public health and human services to notify the centers for medicare and medicaid services that passage and approval of [this act] constitutes legislative authorization to continue the current research and demonstration project approved under waiver No. 11-W00300/8 for the Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration through December 31, 2020.

(2) The legislature directs the department of public health and human services to:

(a) apply no later than August 30, 2019, to the centers for medicare and medicaid services for any waivers needed to implement the provisions of [this act]; and

(b) carry out any activities before August 30, 2019, that are needed in order to develop and submit waiver proposals by August 30, 2019, including but not limited to:

(i) presenting any section 1115 waiver proposals to the medicaid advisory council and the children, families, health, and human services interim committee prior to submission to the centers for medicare and medicaid services, as required under 53-2-215;

(ii) providing for a public comment period at least 60 days before submission as required under 53-2-215; and

(iii) complying with any other public comment provisions required under federal law or regulation.

(3) The legislature directs the department of public health and human services to notify individuals enrolled in medicaid pursuant to Title 53, chapter 6, part 13, of the proposed changes to the program and the time periods within which the individuals would have to comply with the requirements of [this act] if the centers for medicare and medicaid services approves any waivers submitted to carry out the provisions of [this act]. Notification may be made at the time any waiver proposal is submitted or approved, at the department's discretion.

(4) The director of the department shall notify the legislative finance committee and the children, families, health, and human services interim committee of:

(a) the date on which waiver approval is received or denied; and

(b) if waiver approval is received, the date on which the community engagement requirements are implemented.

NEW SECTION. **Section 44. Notification to tribal governments.** The secretary of state shall send a copy of [this act] to each tribal government located on the seven Montana reservations and to the Little Shell Chippewa tribe.

NEW SECTION. **Section 45. Codification instruction.** (1) [Sections 1 through ~~6~~ 5] are intended to be codified as an integral part of Title 53, chapter 6, part 13, and the provisions of Title 53, chapter 6, part 13, apply to [sections 1 through ~~6~~ 5].

~~(2) [Section 7] is intended to be codified as an integral part of Title 27, chapter 1, part 7, and the provisions of Title 27, chapter 1, part 7, apply to [section 7].~~

~~(3)~~(2) [Section ~~8~~ 6] is intended to be codified as an integral part of Title 33, chapter 2, part 7, and the provisions of Title 33, chapter 2, part 7, apply to [section ~~8~~ 6].

~~(4)~~(3) [Section ~~9~~ 7] is intended to be codified as an integral part of Title 39, chapter 12, and the provisions of Title 39, chapter 12, apply to [section ~~9~~ 7].

~~NEW SECTION. **Section 48. Nonseverability.** It is the intent of the legislature that each part of [this act] is essentially dependent upon every other part, and if one part is held unconstitutional or invalid, all other parts are invalid.~~

NEW SECTION. **SECTION 46. 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 47. Contingent voidness -- notification to code commissioner.** ~~(1) If the centers for medicare and medicaid services fails to approve the waivers needed to implement the provisions of [sections 1, 2, and 5] in the manner approved by the legislature, then [this act] is void.~~

~~(2)~~(1) If the centers for medicare and medicaid services fails to provide any waivers necessary to implement the premium provisions of [section ~~38(1)~~ 36(1)], then the amendments to 53-6-1307(1) in [section ~~38(1)~~ 36(1)] are void.

~~(3)~~(2) The director of the department shall notify the code commissioner of the occurrence of any determination made under this section and the date of the occurrence.

NEW SECTION. **Section 48. Effective dates.** (1) Except as provided in subsections (2) through (4), [this act] is effective July 1, 2019.

~~(2) [Section 7] is effective October 1, 2019.~~

~~(3)~~(2) [Sections 1 through ~~5~~ 4 and sections ~~33, 34, 37, 38, 39, and 43~~ 31, 32, 35, 36, 37, AND 41] are effective January 1, 2020.

~~(4)~~(3) [Sections ~~40 through 42, 45 through 49, and 51] and this section~~ 38 THROUGH 40 AND 43 THROUGH 50] are effective on passage and approval.

NEW SECTION. **Section 49. Applicability.** An individual enrolled in the expanded medicaid program provided for in Title 53, chapter 6, part 13, on the date the centers for medicare and medicaid services approves a waiver authorizing community engagement requirements ~~and health risk and employment readiness assessments shall:~~

~~(1) complete the health risk and employment readiness assessments within 6 months of approval of the waiver; and~~

~~(2)~~ SHALL comply with the community engagement requirements of [this act] within ~~90~~ 180 days of the

date the department of public health and human services has implemented the community engagement requirements.

NEW SECTION. **SECTION 50. TERMINATION -- CONTINGENCY -- INTENT.** (1) IF A COURT OF FINAL DISPOSITION FINDS THAT THE COMMUNITY ENGAGEMENT REQUIREMENTS PROVIDED FOR IN [SECTION 1] ARE INVALID, [THIS ACT] TERMINATES JUNE 30, 2025.

(2) IT IS THE INTENT OF THE LEGISLATURE THAT IF THE CONTINGENCY PROVIDED FOR IN SUBSECTION (1) OCCURS, THE LEGISLATURE HAS AN OPPORTUNITY TO CONSIDER ISSUES OF PROGRAM INTEGRITY, REFORM, AND COST-EFFECTIVENESS TO DETERMINE WHETHER [THIS ACT] SHOULD CONTINUE.

- END -