



AN ACT CREATING THE MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP ACT TO EXPAND HEALTH CARE COVERAGE TO ADDITIONAL INDIVIDUALS, IMPROVE ACCESS TO HEALTH CARE SERVICES, AND CONTROL HEALTH CARE COSTS; ESTABLISHING A HEALTH CARE COVERAGE PROGRAM TO PROVIDE CERTAIN LOW-INCOME MONTANANS WITH ACCESS TO HEALTH CARE SERVICES USING MEDICAID FUNDS AND AN ARRANGEMENT WITH A THIRD-PARTY ADMINISTRATOR; IMPLEMENTING CERTAIN MEDICAID REFORMS; PROVIDING STATUTORY APPROPRIATIONS FOR COSTS OF PROVIDING HEALTH CARE SERVICES; PROVIDING SUPPORT FOR HEALTH CARE DELIVERY ACROSS MONTANA; PROVIDING WORKFORCE DEVELOPMENT OPPORTUNITIES FOR PROGRAM PARTICIPANTS; ESTABLISHING TIME LIMITS FOR SERVICE OF PROCESS IN MEDICAL MALPRACTICE CLAIMS; ESTABLISHING AN OVERSIGHT COMMITTEE; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; PROVIDING APPROPRIATIONS; AMENDING SECTIONS 17-7-502 AND 27-2-205, MCA; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE.

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

Section 1. Short title. [Sections 1 through 13], [sections 14 through 17], and [section 19] may be cited as the "Montana Health and Economic Livelihood Partnership (HELP) Act".

Section 2. 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 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.

Section 3. Definitions. As used in [sections 1 through 13], the following definitions apply:

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

(2) "HELP Act" or "act" means the Montana Health and Economic Livelihood Partnership Act provided for in [sections 1 through 13] and [sections 14 through 17].

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

(4) "Program participant" or "participant" means an individual enrolled in the Montana Health and Economic Livelihood Partnership Act program established in [sections 1 through 13] and [sections 14 through 17].

Section 4. Montana HELP Act program -- eligibility for coverage of health care services -- statutory appropriations -- federal special revenue. (1) An individual is eligible for coverage of health care services provided pursuant to [sections 1 through 13] if the individual meets the requirements of 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).

(2) Funds necessary to implement [sections 1 through 13], including benefits and administrative costs, are statutorily appropriated, as provided in 17-7-502, from the general fund to the department of public health and human services.

(3) There is an account in the federal special revenue fund to the credit of the department of public health and human services 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 of public

health and human services for the purpose provided in subsection (3).

Section 5. Montana HELP Act program -- delivery of health care services -- third-party administrator -- rulemaking. (1) The department shall 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 [section 4], 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 [section 7];
- (d) coordinating care;
- (e) helping to administer the program; and
- (f) helping to administer the medicaid program reforms as specified in [section 8].

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

(3) (a) The department may exempt certain individuals who are eligible for medicaid-funded services pursuant to [section 4] from receiving health care services through the 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; or

(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 department shall:

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

(ii) provide coverage for exempted individuals through the medical assistance program established in Title

53, chapter 6, part 1.

(4) For members participating in the arrangement with the 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 [sections 1 through 13] and [sections 14 through 17]; 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).

(6) The department may provide medicaid-funded services to members eligible pursuant to [section 4] only upon federal approval of any necessary waivers.

Section 6. Copayments -- exemptions -- report. (1) A program participant shall make copayments to health care providers for health care services received pursuant to [sections 1 through 13].

(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.

Section 7. 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% of the participant's income as determined in accordance with 42 U.S.C. 1396a(e)(14).

(b) Premiums paid pursuant to this section must be deposited in the general fund.

(2) Within 30 days of a participant's failure to make a required payment, the third-party administrator 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 [sections 14 through 17]; or

(d) participation in any of the following healthy behavior plans developed by a health care provider or third-party administrator 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.

Section 8. 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;

(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) 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 may ask a third-party administrator under contract with the department to assist in efforts undertaken pursuant to subsection (1) when the activity can appropriately be handled by the third-party administrator.

(3) 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.

Section 9. Health care services payment schedules. (1) The department of corrections and the department of public health and human services shall reimburse health care service for individuals identified in subsection (2) at the rates adopted by the department for the medicaid program under Title 53, chapter 6, part 1, if the health care services are not otherwise covered by medicaid, medicare, a health insurer, or another private or governmental program that pays for health care costs.

(2) This section applies to individuals:

- (a) in the custody of the department of corrections; or
- (b) who are residents, by commitment or otherwise, of the Montana state hospital, the Montana mental health nursing care center, the Montana chemical dependency center, and the Montana developmental center.

Section 10. Reduction in federal medical assistance percentage. If the federal medical assistance percentage for medical services provided to individuals eligible for medicaid-funded services pursuant to [section 4] is set below the levels established in 42 U.S.C. 1396d(y)(1) on [the effective date of this act], the continuation of coverage under [sections 1 through 13] is contingent on:

- (1) the appropriation of additional state general fund or other action by the legislature;
- (2) the ability of the department to increase premiums assessed under [section 7] to pay the difference;

or

- (3) a combination of legislative action and premium increases as necessary to provide for the increased state match obligation.

Section 11. Montana HELP Act oversight committee -- membership. (1) There is an oversight committee on the Montana Health and Economic Livelihood Partnership Act made up of members of the legislature and of other Montana citizens.

(2) The committee consists of nine voting members appointed no later than May 30, 2015, as follows:

- (a) two senators, one appointed by the president of the senate and one appointed by the senate minority leader;

- (b) two representatives, one appointed by the speaker of the house and one appointed by the house minority leader; and

- (c) five individuals appointed by the governor as follows:

- (i) one representative of a hospital as defined in 50-5-101;
- (ii) one representative of a critical access hospital as defined in 50-5-101;
- (iii) one primary care physician;
- (iv) one representative of the state auditor's office; and
- (v) one member of the general public or a staff member of the governor's office.

(3) The state medicaid director or the director's designee, the commissioner of labor and industry or the commissioner's designee, and a designee of the third-party administrator are ex officio members of the committee.

(4) The presiding officer and vice presiding officer must be elected by a majority of the committee

members.

(5) The presiding officer shall establish the meeting schedule. The council shall meet at least quarterly.

(6) (a) Except as provided in subsection (6)(b), members are entitled to receive compensation and expenses as provided in 5-2-302.

(b) Ex officio members are not entitled to compensation or reimbursement of expenses.

(7) (a) Except as provided in subsection (7)(b), members shall serve 4-year terms. Vacancies on the committee must be filled by the same appointing authority.

(b) A member who was appointed while a senator or a representative but who is no longer serving in the legislature must be replaced by the appointing authority.

(8) The committee is attached to the department for administrative purposes, including staffing.

(9) The committee may contract for services that will help members carry out their duties, subject to available funding and in accordance with the provisions of Title 18, chapter 4.

Section 12. Duties of Montana HELP Act oversight committee -- reports. (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 shall report the following information to the oversight committee quarterly:

(a) the number of individuals who were determined eligible for medicaid-funded services pursuant to [section 4];

(b) demographic information on program participants;

(c) 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) the number of participants subject to the fee provided for in [section 18] and the total amount of fees

collected;

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

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

(i) the total cost of providing services under [sections 1 through 13] and [sections 14 through 17], including related administrative costs.

(3) The committee shall review and provide comment on administrative rules proposed for carrying out activities under [sections 1 through 13] and [sections 14 through 17]. 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 [section 4];

(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.

Section 13. Rulemaking authority. (1) The department may adopt rules as necessary to carry out [sections 1 through 13].

(2) The department and the department of labor and industry may, in coordination, adopt rules as necessary for the implementation of the employment and reemployment assessments and workforce development activities provided for in [sections 14 through 17].

Section 14. 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 [sections 14 through 17] 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) 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.

Section 15. Definitions. As used in [sections 14 through 17], the following definitions apply:

(1) "Department" means the department of labor and industry provided for in 2-15-1701.

(2) "HELP Act" or "act" means the Montana Health and Economic Livelihood Partnership Act provided for in [sections 1 through 13] and [sections 14 through 17].

(3) "Program participant" means an individual participating in the HELP Act program.

Section 16. Montana HELP Act workforce development -- participation -- report. (1) The department shall provide individuals receiving assistance for health care services pursuant to [sections 1 through 13] with the option of participating in an employment or reemployment assessment and in the workforce development program provided for in [section 14]. The assessment must identify any probable barriers to employment that exist for the member.

(2) (a) The department of labor and industry 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 of labor and industry is not required to provide further services under this section after it has provided the notification provided for in subsection (2)(a).

(c) A participant who is no longer receiving services under this section does not meet the criteria of [section 7(6)(c)] for the exemption granted under [section 7(6)].

(3) The department shall report the following information to the oversight committee provided for in [section 11]:

(a) the activities undertaken to establish a workforce development program for program participants; and

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

(4) 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) 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.

Section 17. Rulemaking authority. The department may adopt rules to carry out the purposes of [sections 14 through 17] and may coordinate as necessary with the department of public health and human services in adoption of the rules.

Section 18. Taxpayer integrity fee. (1) 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 [sections 1 through 13] and [sections 14 through 17]; and

(b) has assets that exceed:

(i) a primary residence and attached property valued above the limit established for homesteads under 70-32-104;

(ii) one light vehicle; and

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

(2) The fee is \$100 a month plus an additional \$4 a month for each \$1,000 in assets above the amounts established in subsection (1)(b).

(3) The department shall coordinate with the department of public health and human services to obtain the information necessary to administer this section.

(4) Fees collected pursuant to this section must be deposited in the general fund.

(5) The 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) 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.

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

Section 19. Medical malpractice claims -- time limit. A plaintiff in a medical malpractice action shall accomplish service within 6 months after filing the complaint. If the plaintiff fails to do so, the court, on motion or on its own initiative, shall dismiss the action without prejudice unless the defendant has made an appearance.

Section 20. 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: 2-15-247; 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; 10-3-203; 10-3-310; 10-3-312; 10-3-314; 10-4-301; 15-1-121; 15-1-218; 15-35-108; 15-36-332; 15-37-117; 15-39-110; 15-65-121; 15-70-101; 15-70-369; 15-70-601; 16-11-509; 17-3-106; 17-3-112; 17-3-212; 17-3-222; 17-3-241; 17-6-101;

18-11-112; 19-3-319; 19-6-404; 19-6-410; 19-9-702; 19-13-604; 19-17-301; 19-18-512; 19-19-305; 19-19-506; 19-20-604; 19-20-607; 19-21-203; 20-8-107; 20-9-534; 20-9-622; 20-26-1503; 22-1-327; 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; 37-51-501; 39-1-105; 39-71-503; 41-5-2011; 42-2-105; 44-4-1101; 44-12-206; 44-13-102; 53-1-109; 53-1-215; 53-2-208; [section 4]; 53-9-113; 53-24-108; 53-24-206; 60-11-115; 61-3-415; 69-3-870; 75-1-1101; 75-5-1108; 75-6-214; 75-11-313; 76-13-150; 76-13-416; 77-1-108; 77-2-362; 80-2-222; 80-4-416; 80-11-518; 81-1-112; 81-7-106; 81-10-103; 82-11-161; 85-20-1504; 85-20-1505; 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. 14, Ch. 374, L. 2009, the inclusion of 53-9-113 terminates June 30, 2015; pursuant to sec. 5, Ch. 442, L. 2009, the inclusion of 90-6-331 terminates June 30, 2019; pursuant to sec. 16, Ch. 58, L. 2011, the inclusion of 30-10-1004 terminates June 30, 2017; pursuant to sec. 6, Ch. 61, L. 2011, the inclusion of 76-13-416 terminates June 30, 2019; pursuant to sec. 13, Ch. 339, L. 2011, the inclusion of 81-1-112 and 81-7-106 terminates June 30, 2017; pursuant to sec. 11(2), Ch. 17, L. 2013, the inclusion of 17-3-112 terminates on occurrence of contingency; pursuant to secs. 3 and 5, Ch. 244, L. 2013, the inclusion of 22-1-327 is effective July 1, 2015, and terminates July 1, 2017; and pursuant to sec. 10, Ch. 413, L. 2013, the inclusion of 2-15-247, 39-1-105, 53-1-215, and 53-2-208 terminates June 30, 2015.)"

Section 21. Section 27-2-205, MCA, is amended to read:

"27-2-205. Actions for medical malpractice. (1) Action in tort or contract for injury or death against a

physician or surgeon, physician assistant, dentist, dental hygienist, registered nurse, advanced practice registered nurse, nursing home or hospital administrator, dispensing optician, optometrist, licensed physical therapist, podiatrist, psychologist, osteopath, chiropractor, clinical laboratory bioanalyst, clinical laboratory technologist, pharmacist, veterinarian, a licensed hospital or long-term care facility, or licensed medical professional corporation, based upon alleged professional negligence or for rendering professional services without consent or for an act, error, or omission, must, except as provided in subsection (2), be commenced within 3 2 years after the date of injury or within 3 2 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs last, but in no case may an action be commenced after 5 years from the date of injury. However, this time limitation is tolled for any period during which there has been a failure to disclose any act, error, or omission upon which an action is based and that is known to the defendant or through the use of reasonable diligence subsequent to the act, error, or omission would have been known to the defendant.

(2) Notwithstanding the provisions of 27-2-401, in an action for death or injury of a minor who was under the age of 4 on the date of the minor's injury, the period of limitations in subsection (1) begins to run when the minor reaches the minor's eighth birthday or dies, whichever occurs first, and the time for commencement of the action is tolled during any period during which the minor does not reside with a parent or guardian."

Section 22. Appropriations. (1) There is appropriated from the state general fund for the biennium beginning July 1, 2015, the following:

- (a) \$1,761,476 to the department of labor and industry for the purposes of [sections 14 through 17]; and
- (b) \$393,213 to the department of revenue for the purposes of [section 18].

(2) These appropriations are to be considered base funding for the preparation of the 2019 biennium budget.

Section 23. Transition. (1) For the successful and appropriate implementation of [sections 1 through 13], the department of public health and human services may initiate eligibility processing and other measures necessary for implementation of [sections 4 and 5] prior to the date that health care services provided pursuant to [section 5] are covered.

(2) The department may implement coverage of health care services for individuals eligible pursuant to

[section 4] only after:

(a) the department has obtained the approvals and waivers needed from the U.S. department of health and human services to receive the federal medical assistance percentage provided for in 42 U.S.C. 1396d(y) for individuals eligible for coverage pursuant to [section 4] and to provide services in accordance with [sections 1 through 17]; and

(b) all necessary administrative arrangements, including contract services, are in place.

Section 24. Codification instruction. (1) [Sections 1 through 13] are intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [sections 1 through 13].

(2) [Sections 14 through 17] are intended to be codified as an integral part of Title 39, and the provisions of Title 39 apply to [sections 14 through 17].

(3) [Section 18] is intended to be codified as an integral part of Title 15, chapter 30, and the provisions of Title 15, chapter 30, apply to [section 18].

(4) [Section 19] is intended to be codified as an integral part of Title 25, chapter 3, part 1, and the provisions of Title 25, chapter 3, part 1, apply to [section 19].

Section 25. Saving clause. [Sections 19 and 20] do not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

Section 26. Nonseverability. Except as provided in subsection (2), 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.

(2) If [section 19 or 20] is held unconstitutional, all other parts are valid.

Section 27. Effective date -- contingent effective date. (1) Except as provided in subsection (2), [this act] is effective upon approval by the U.S. department of health and human services of all waivers and approvals necessary to provide medicaid-funded services to individuals eligible pursuant to [section 4] in the manner provided for in [sections 1 through 17].

(2) [Sections 11, 19, 20, and 21] and this section are effective on passage and approval.

(3) The governor shall notify the code commissioner on the occurrence of the contingency provided for in subsection (1).

Section 28. Termination. (1) [This act] terminates June 30, 2019.

(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.

- END -

I hereby certify that the within bill,
SB 0405, originated in the Senate.

Secretary of the Senate

President of the Senate

Signed this _____ day
of _____, 2015.

Speaker of the House

Signed this _____ day
of _____, 2015.

SENATE BILL NO. 405

INTRODUCED BY E. BUTTREY, D. ANKNEY, T. BERRY, T. BROWN, M. CAFERRO, C. CLARK,
P. CONNELL, R. COOK, G. CUSTER, S. FITZPATRICK, F. GARNER, R. HOLLANDSWORTH, B. HOVEN,
C. HUNTER, L. JONES, W. MCKAMEY, G. MEYERS, P. NOONAN, R. RIPLEY, D. SALOMON, J. SESSO,
R. SHAW, N. SWANDAL, B. TUTVEDT, J. WELBORN

AN ACT CREATING THE MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP ACT TO EXPAND HEALTH CARE COVERAGE TO ADDITIONAL INDIVIDUALS, IMPROVE ACCESS TO HEALTH CARE SERVICES, AND CONTROL HEALTH CARE COSTS; ESTABLISHING A HEALTH CARE COVERAGE PROGRAM TO PROVIDE CERTAIN LOW-INCOME MONTANANS WITH ACCESS TO HEALTH CARE SERVICES USING MEDICAID FUNDS AND AN ARRANGEMENT WITH A THIRD-PARTY ADMINISTRATOR; IMPLEMENTING CERTAIN MEDICAID REFORMS; PROVIDING STATUTORY APPROPRIATIONS FOR COSTS OF PROVIDING HEALTH CARE SERVICES; PROVIDING SUPPORT FOR HEALTH CARE DELIVERY ACROSS MONTANA; PROVIDING WORKFORCE DEVELOPMENT OPPORTUNITIES FOR PROGRAM PARTICIPANTS; ESTABLISHING TIME LIMITS FOR SERVICE OF PROCESS IN MEDICAL MALPRACTICE CLAIMS; ESTABLISHING AN OVERSIGHT COMMITTEE; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; PROVIDING APPROPRIATIONS; AMENDING SECTIONS 17-7-502 AND 27-2-205, MCA; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE.