AN ACT GENERALLY REVISING LAWS RELATED TO FACILITIES LICENSED BY THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; REVISING DEFINITIONS; PROVIDING A DEFINITION FOR SUBSTANCE USE DISORDER TREATMENT FACILITY; UPDATING LICENSURE REQUIREMENTS FOR COMMUNITY HOMES FOR PERSONS WITH SEVERE DISABILITIES AND FOR PERSONS WITH DEVELOPMENTAL DISABILITIES; AND AMENDING SECTIONS 7-34-2201, 33-36-103, 50-5-101, 50-5-201, 50-5-203, 50-5-204, 50-5-207, 50-5-226, 50-6-401, 50-20-901, 52-2-736, 52-2-806, 52-4-203, 53-6-101, 53-20-302, AND 53-20-305, MCA."

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

Section 1. Section 7-34-2201, MCA, is amended to read:

"**7-34-2201. Erection and management of county health care facilities -- definition -- provision of health care services.** (1) The board of county commissioners has jurisdiction and power, under the limitations and restrictions prescribed by law, to erect, furnish, equip, expand, improve, and maintain health care facilities and to provide health care services in those facilities as permitted by law.

(2) The board of county commissioners of a county that has or may acquire title to a site and building or buildings suitable for county health care purposes has jurisdiction and power, under the limitations and restrictions prescribed by law, to erect, furnish, equip, expand, improve, maintain, and operate the building or buildings for health care purposes as provided by this section.

(3) As used in parts 21 and 23 through 25 and this part, unless the context clearly requires otherwise, the term "health care facility" means a hospital, ~~a medical assistance facility,~~ a critical access hospital, a hospice, an end-stage renal dialysis facility, an outpatient center for surgical services, an outpatient center for primary care, a rehabilitation facility, a long-term care facility, or an adult day-care center, as defined in 50-5-101, a public health center, as defined in 7-34-2102, or any combination and related medical facilities,

including offices for physicians or other health care professionals providing outpatient, rehabilitative, emergency, nursing, or preventive care."

Section 2. Section 33-36-103, MCA, is amended to read:

"**33-36-103. Definitions.** As used in this chapter, the following definitions apply:

(1) "Closed plan" means a managed care plan that requires covered persons to use only participating providers under the terms of the managed care plan.

(2) "Combination plan" means an open plan with a closed component.

(3) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(4) "Covered person" means a policyholder, subscriber, or enrollee or other individual participating in a health benefit plan.

(5) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

(6) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(7) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, ~~medical assistance facility,~~ critical access hospital, or rural emergency hospital, as those terms are defined in 50-5-101, or other licensed inpatient center, an outpatient center for surgical services, a treatment center, a skilled nursing center, a residential treatment center, a diagnostic laboratory, a diagnostic imaging center, or a rehabilitation or other therapeutic health setting.

(8) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(9) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified pursuant to the laws of this state to perform specified health care services consistent with state law.

(10) "Health care provider" or "provider" means a health care professional or a facility.

(11) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(12) "Health carrier" means an entity subject to the insurance laws and rules of this state that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a disability insurer, health maintenance organization, or health service corporation or another entity providing a health benefit plan.

(13) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract between a health carrier and a provider or between a health carrier and a network.

(14) "Managed care plan" means a health benefit plan that either requires or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by a health carrier, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.

(15) "Medically necessary" means services, medicines, or supplies that are necessary and appropriate for the diagnosis or treatment of a covered person's illness, injury, or medical condition according to accepted standards of medical practice and that are not provided only as a convenience.

(16) "Network" means the group of participating providers that provides health care services to a managed care plan.

(17) "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

(18) "Participating provider" means a provider who, under a contract with a health carrier or with the health carrier's contractor, subcontractor, or intermediary, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

(19) "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and who may be required by the health carrier to initiate a referral for specialty care and to maintain supervision of health care services rendered to the covered person.

(20) "Quality assessment" means the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups, or populations.

(21) "Quality assurance" means quality assessment and quality improvement.

(22) "Quality improvement" means an effort to improve the processes and outcomes related to the provision of health care services within a health plan."

Section 3. Section 50-5-101, MCA, is amended to read:

"**50-5-101. Definitions.** As used in parts 1 through 3 of this chapter, unless the context clearly indicates otherwise, the following definitions apply:

(1) "Accreditation" means a designation of approval.

(2) "Activities of daily living" means tasks usually performed in the course of a normal day in a resident's life that include eating, walking, mobility, dressing, grooming, bathing, toileting, and transferring.

(3) "Adult day-care center" means a facility, freestanding or connected to another health care facility, that provides adults, on a regularly scheduled basis, with the care necessary to meet the needs of daily living but that does not provide overnight care.

(4) (a) "Adult foster care home" means a private home or other facility that offers, except as provided in 50-5-216, only light personal care or custodial care to four or fewer disabled adults or aged persons who are not related to the owner or manager of the home by blood, marriage, or adoption or who are not under the full guardianship of the owner or manager.

(b) As used in this subsection (4), the following definitions apply:

(i) "Aged person" means a person as defined by department rule as aged.

(ii) "Custodial care" means providing a sheltered, family-type setting for an aged person or disabled adult so as to provide for the person's basic needs of food and shelter and to ensure that a specific person is available to meet those basic needs.

(iii) "Disabled adult" means a person who is 18 years of age or older and who is defined by department rule as disabled.

(iv) (A) "Light personal care" means assisting the aged person or disabled adult in accomplishing such personal hygiene tasks as bathing, dressing, and hair grooming and supervision of ~~prescriptive~~ prescription medicine administration.

(B) The term does not include the administration of ~~prescriptive~~ prescription medications.

(5) "Affected person" means an applicant for a certificate of need, a long-term care facility located in the geographic area affected by the application, an agency that establishes rates for long-term care facilities, or a third-party payer who reimburses long-term care facilities in the area affected by the proposal.

(6) "Assisted living facility" means a congregate residential setting that provides or coordinates personal care, 24-hour supervision and assistance, both scheduled and unscheduled, and activities and health-related services.

(7) "Capital expenditure" means:

(a) an expenditure made by or on behalf of a long-term care facility that, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance; or

(b) a lease, donation, or comparable arrangement that would be a capital expenditure if money or any other property of value had changed hands.

(8) "Certificate of need" means a written authorization by the department for a person to proceed with a proposal subject to 50-5-301.

~~(9) "Chemical dependency facility" means a facility whose function is the treatment, rehabilitation, and prevention of the use of any chemical substance, including alcohol, that creates behavioral or health problems and endangers the health, interpersonal relationships, or economic function of an individual or the public health, welfare, or safety.~~

~~(10)~~ (9) "Clinical laboratory" means a facility for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.

~~(11)~~ (10) "Comparative review" means a joint review of two or more certificate of need

applications that are determined by the department to be competitive in that the granting of a certificate of need to one of the applicants would substantially prejudice the department's review of the other applications.

~~(12)~~ (11) "Congregate" means the provision of group services designed especially for elderly or disabled persons who require supportive services and housing.

~~(13)~~ (12) "Construction" means the physical erection of a new health care facility and any stage of the physical erection, including groundbreaking, or remodeling, replacement, or renovation of:

(a) an existing health care facility; or

(b) a long-term care facility as defined in 50-5-301.

~~(14)~~ (13) "Critical access hospital" means a facility that is located in a rural area, as defined in ~~42 U.S.C. 1395ww(d)(2)(D)~~ federal regulations adopted by the U.S. centers for medicare and medicaid services, and that has been designated by the department as a critical access hospital pursuant to 50-5-233.

~~(15)~~ (14) "Department" means the department of public health and human services provided for in 2-15-2201.

~~(16)~~ (15) "Eating disorder center" means a facility that specializes in the treatment of eating disorders.

~~(17)~~ (16) "End-stage renal dialysis facility" means a facility that specializes in the treatment of kidney diseases and includes freestanding hemodialysis units.

~~(18)~~ (17) "Federal acts" means federal statutes for the construction of health care facilities.

~~(19)~~ (18) "Governmental unit" means the state, a state agency, a county, municipality, or political subdivision of the state, or an agency of a political subdivision.

~~(20)~~ (19) (a) "Health care facility" or "facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term includes abortion clinics as defined in 50-20-901, ~~chemical dependency facilities,~~ critical access hospitals, eating disorder centers, end-stage renal dialysis facilities, home health agencies, home infusion therapy agencies, hospices, hospitals, infirmaries, long-term care facilities, intermediate care facilities for the developmentally disabled, ~~medical assistance facilities,~~ mental health centers, outpatient centers for primary care, outpatient centers for surgical services, rehabilitation facilities, residential care facilities,

residential treatment facilities, ~~and~~ rural emergency hospitals, and substance use disorder facilities.

(b) The term does not include offices of private physicians, dentists, or other physical or mental health care workers regulated under Title 37, including licensed addiction counselors.

~~(21)~~ (20) "Home health agency" means a public agency or private organization or subdivision of the agency or organization that is engaged in providing home health services to individuals in the places where they live. Home health services must include the services of a licensed registered nurse and at least one other therapeutic service and may include additional support services.

~~(22)~~ (21) "Home infusion therapy agency" means a health care facility that provides home infusion therapy services.

~~(23)~~ (22) "Home infusion therapy services" means the preparation, administration, or furnishing of parenteral medications or parenteral or enteral nutritional services to an individual in that individual's residence. The services include an educational component for the patient, the patient's caregiver, or the patient's family member.

~~(24)~~ (23) "Hospice" means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and the patient's family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component. The term includes:

(a) an inpatient hospice facility, which is a facility managed directly by a medicare-certified hospice that meets all medicare certification regulations for freestanding inpatient hospice facilities; and

(b) a residential hospice facility, which is a facility managed directly by a licensed hospice program that can house three or more hospice patients.

~~(25)~~ (24) (a) "Hospital" means a facility providing, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick individuals. Except as otherwise provided by law, services provided must include medical personnel available to provide emergency care onsite 24 hours a day and may include any other service allowed by state licensing authority. A hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week, and provides 24-hour nursing care by licensed registered nurses. The term includes:

(i) hospitals specializing in providing health services for psychiatric, developmentally disabled, and tubercular patients; and

(ii) specialty hospitals.

(b) The term does not include critical access hospitals or rural emergency hospitals.

(c) The emergency care requirement for a hospital that specializes in providing health services for psychiatric, developmentally disabled, or tubercular patients is satisfied if the emergency care is provided within the scope of the specialized services provided by the hospital and by providing 24-hour nursing care by licensed registered nurses.

~~(26)~~ (25) "Infirmary" means a facility located in a university, college, government institution, or industry for the treatment of the sick or injured, with the following subdefinitions:

(a) an "infirmary--A" provides outpatient and inpatient care;

(b) an "infirmary--B" provides outpatient care only.

~~(27)~~ (26) (a) "Intermediate care facility for the developmentally disabled" means a facility or part of a facility that provides intermediate developmental disability care for two or more persons.

(b) The term does not include community homes for persons with developmental disabilities that are licensed under 53-20-305 or community homes for persons with severe disabilities that are licensed under 52-4-203.

~~(28)~~ (27) "Intermediate developmental disability care" means the provision of intermediate nursing care services, health-related services, and social services for persons with a developmental disability, as defined in 53-20-102, or for persons with related problems.

~~(29)~~ (28) "Intermediate nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed nurse to patients not requiring 24-hour nursing care.

~~(30)~~ (29) "Licensed health care professional" means a licensed physician, physician assistant, advanced practice registered nurse, or registered nurse who is practicing within the scope of the license issued by the department of labor and industry.

~~(31)~~ (30) (a) "Long-term care facility" means a facility or part of a facility that provides skilled nursing care, residential care, intermediate nursing care, or intermediate developmental disability care to a total

of two or more individuals or that provides personal care.

(b) The term does not include community homes for persons with developmental disabilities licensed under 53-20-305; community homes for persons with severe disabilities, licensed under 52-4-203; youth care facilities, licensed under 52-2-622; hotels, motels, boardinghouses, roominghouses, or similar accommodations providing for transients, students, or individuals who do not require institutional health care; or correctional facilities operating under the authority of the department of corrections.

~~(32) "Medical assistance facility" means a facility that meets both of the following:~~

~~(a) provides inpatient care to ill or injured individuals before their transportation to a hospital or that provides inpatient medical care to individuals needing that care for a period of no longer than 96 hours unless a longer period is required because transfer to a hospital is precluded because of inclement weather or emergency conditions. The department or its designee may, upon request, waive the 96-hour restriction retroactively and on a case-by-case basis if the individual's attending physician, physician assistant, or nurse practitioner determines that the transfer is medically inappropriate and would jeopardize the health and safety of the individual.~~

~~(b) either is located in a county with fewer than six residents a square mile or is located more than 35 road miles from the nearest hospital.~~

~~(33)~~ (31) "Mental health center" means a facility providing services for the prevention or diagnosis of mental illness, the care and treatment of mentally ill patients, the rehabilitation of mentally ill individuals, or any combination of these services.

~~(34)~~ (32) "Nonprofit health care facility" means a health care facility owned or operated by one or more nonprofit corporations or associations.

~~(35)~~ (33) "Offer" means the representation by a health care facility that it can provide specific health services.

~~(36)~~ (34) (a) "Outdoor behavioral program" means a program that provides treatment, rehabilitation, and prevention for behavioral problems that endanger the health, interpersonal relationships, or educational functions of a youth and that:

(i) serves either adjudicated or nonadjudicated youth;

(ii) charges a fee for its services; and

(iii) provides all or part of its services in the outdoors.

(b) "Outdoor behavioral program" does not include recreational programs such as boy scouts, girl scouts, 4-H clubs, or other similar organizations.

~~(37)~~ (35) "Outpatient center for primary care" means a facility that provides, under the direction of a licensed physician, either diagnosis or treatment, or both, to ambulatory patients and that is not an outpatient center for surgical services.

~~(38)~~ (36) "Outpatient center for surgical services" means a clinic, infirmary, or other institution or organization that is specifically designed and operated to provide surgical services to patients not requiring hospitalization and that may include recovery care beds.

~~(39)~~ (37) "Patient" means an individual obtaining services, including skilled nursing care, from a health care facility.

~~(40)~~ (38) "Person" means an individual, firm, partnership, association, organization, agency, institution, corporation, trust, estate, or governmental unit, whether organized for profit or not.

~~(41)~~ (39) "Personal care" means the provision of services and care for residents who need some assistance in performing the activities of daily living.

~~(42)~~ (40) "Practitioner" means an individual licensed by the department of labor and industry who has assessment, admission, and prescription authority.

~~(43)~~ (41) "Recovery care bed" means, except as provided in 50-5-235, a bed occupied for less than 24 hours by a patient recovering from surgery or other treatment.

~~(44)~~ (42) "Rehabilitation facility" means a facility that is operated for the primary purpose of assisting in the rehabilitation of disabled individuals by providing comprehensive medical evaluations and services, psychological and social services, or vocational evaluation and training or any combination of these services and in which the major portion of the services is furnished within the facility.

~~(45)~~ (43) "Resident" means an individual who is in a long-term care facility or in a residential care facility.

~~(46)~~ (44) "Residential care facility" means an adult day-care center, an adult foster care home, an assisted living facility, or a retirement home.

~~(47)~~ (45) "Residential psychiatric care" means active psychiatric treatment provided in a

residential treatment facility to psychiatrically impaired individuals with persistent patterns of emotional, psychological, or behavioral dysfunction of such severity as to require 24-hour supervised care to adequately treat or remedy the individual's condition. Residential psychiatric care must be individualized and designed to achieve the patient's discharge to less restrictive levels of care at the earliest possible time.

~~(48)~~ (46) "Residential treatment facility" means a facility operated for the primary purpose of providing residential psychiatric care to individuals under 21 years of age.

~~(49)~~ (47) "Retirement home" means a building or buildings in which separate living accommodations are rented or leased to individuals who use those accommodations as their primary residence.

~~(50)~~ (48) "Rural emergency hospital" means a facility defined in 42 U.S.C. 1395x(kkk)(2) that is designated by the department as a rural emergency hospital in accordance with 50-5-234.

~~(51)~~ (49) "Skilled nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed registered nurse on a 24-hour basis.

~~(52)~~ (50) (a) "Specialty hospital" means a subclass of hospital that is exclusively engaged in the diagnosis, care, or treatment of one or more of the following categories:

(i) patients with a cardiac condition;

(ii) patients with an orthopedic condition;

(iii) patients undergoing a surgical procedure; or

(iv) patients treated for cancer-related diseases and receiving oncology services.

(b) For purposes of this subsection (52), a specialty hospital may provide other services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick individuals as otherwise provided by law if the care encompasses 35% or less of the hospital services.

(c) The term "specialty hospital" does not include:

(i) psychiatric hospitals;

(ii) rehabilitation hospitals;

(iii) children's hospitals;

(iv) long-term care hospitals; ~~or~~

(v) critical access hospitals; or

(vi) rural emergency hospitals.

~~(53)~~ (51) "State long-term care facilities plan" means the plan prepared by the department to project the need for long-term care facilities within Montana and approved by the governor and a statewide health coordinating council appointed by the director of the department.

(52) "Substance use disorder facility" means a facility whose function is the treatment, rehabilitation and prevention of the use of any chemical substance, including alcohol, that creates behavioral or health problems and endangers the physical or mental health, interpersonal relationships, or economic function of an individual or the public health, welfare, or safety.

~~(54)~~ (53) "Swing bed" means a bed approved pursuant to 42 U.S.C. 1395tt to be used to provide either acute care or extended skilled nursing care to a patient."

Section 4. Section 50-5-201, MCA, is amended to read:

"**50-5-201. License requirements.** (1) A facility or licensee considering construction of or alteration or addition to a health care facility shall submit plans and specifications to the department for preliminary inspection and approval prior to commencing construction.

(2) A person may not operate a health care facility unless the facility is licensed by the department. Licenses may be issued for a period of 1 to 3 years in duration. A license is valid only for the person and premises for which it was issued. A license may not be sold, assigned, or transferred.

(3) Upon discontinuance of the operation or upon transfer of ownership of a facility, the license must be returned to the department or destroyed by the owners.

(4) Licenses must be displayed in a conspicuous place near the admitting office of the facility."

Section 5. Section 50-5-203, MCA, is amended to read:

"**50-5-203. Application for license.** The procedure to apply for a license is as follows:

(1) At least ~~30~~ 45 days prior to the opening of a facility and after that no later than the expiration date of the license, application is ~~made~~ submitted to the department accompanied by the license fee.

(2) The application shall contain:

(a) the name and address of the applicant if an individual, the name and address of each member

if a firm, partnership, or association, or the name and address of each officer if a corporation;

(b) the location of the facility;

(c) the name of the person ~~or persons who will manage or supervise~~ who will act as administrator of the facility;

(d) the number and type of patients or residents for which care is provided;

(e) any information which the department may require pertaining to the number, experience, and training of employees;

(f) information on ownership, contract, or lease agreement if operated by a person other than the owner.

(3) Applications must include attestation or supporting documentation required by the department ~~pertaining to~~ indicating the applicant has read and understands the licensure requirements of ~~specialty hospitals using the procedures provided in parts 1 and 2 of this chapter. The attestation may be used as the basis for the issuance of a provisional or temporary license~~ the facility type that is the subject of the application."

Section 6. Section 50-5-204, MCA, is amended to read:

"**50-5-204. Issuance and renewal of licenses -- inspections.** (1) After receipt of a new application and notice that the facility is ready to be inspected, the department or its authorized agent shall conduct an initial inspection of the facility within 45 days.

(2) After receipt of an application for renewal of a license, the department or its authorized agent shall inspect the facility without prior notice to the operator or staff prior to the expiration of the current license.

(3) If the department determines that the facility meets minimum standards and the proposed or existing staff is qualified, the department shall issue a license for a period of 1 to 3 years in duration.

(4) If minimum standards are not met, the department may reduce a license to, or issue, a provisional license for less than 1 year if operation will not result in undue hazard to patients or residents or if the demand for accommodations offered is not met in the community.

~~(5) The minimum standards that home health agencies must meet in order to be licensed must be as outlined in 42 U.S.C. 1395x(o), as amended, and in rules implementing it that add minimum standards.~~

~~(6)~~ (5) The department may inspect a licensed health care facility whenever it considers it necessary. The entire premises of a licensed facility must be open to inspection, and access to all records must be granted at all reasonable times."

Section 7. Section 50-5-207, MCA, is amended to read:

"**50-5-207. Denial, suspension, or revocation of health care facility license -- provisional license.** (1) The department may deny, suspend, or revoke a health care facility license if any of the following circumstances exist:

(a) The facility fails to meet the minimum standards pertaining to it prescribed under 50-5-103.

(b) The staff is insufficient in number or unqualified by lack of training or experience.

(c) The applicant or any person managing it has been convicted of a felony and denial of a license on that basis is consistent with 37-1-203 or the applicant otherwise shows evidence of character traits inimical to the health and safety of patients or residents.

(d) The applicant does not have the financial ability to operate the facility in accordance with law or rules or standards adopted by the department.

(e) There is cruelty or indifference affecting the welfare of the patients or residents.

(f) There is misappropriation of the property or funds of a patient or resident.

(g) There is conversion of the property of a patient or resident without the patient's or resident's consent.

(h) Any provision of parts 1 through 3 is violated.

(2) The department may reduce a license to provisional status if:

(a) as a result of an inspection, it is determined that the facility has failed to comply with a provision of part 1 or 2 of this chapter or has failed to comply with a rule, license provision, or order adopted or issued pursuant to part 1 or 2~~.~~ ;

(b) a facility is unable to be surveyed due to lack of patients or residents;

(c) the facility is currently under review for accreditation and the review will not be complete prior to the expiration date of its current license; or

(d) the department requires additional time to complete the inspection review.

(3) A provisional license may be issued for a period of up to 1 year.

~~(3)~~ (4) The denial, suspension, or revocation of a health care facility license is not subject to the certificate of need requirements of part 3.

~~(4)~~ (5) The department may provide in its revocation order that the revocation is in effect for up to 2 years. If this provision is appealed, it must be affirmed or reversed by the court."

Section 8. Section 50-5-226, MCA, is amended to read:

"**50-5-226. Placement in assisted living facilities.** (1) An assisted living facility may provide personal-care services to a resident who is 18 years of age or older and in need of the personal care for which the facility is licensed under 50-5-227.

(2) An assisted living facility licensed as a category A facility under 50-5-227 may not admit or retain a category A resident unless each of the following conditions is met:

(a) The resident may not require physical or chemical restraint or confinement in locked quarters, but may consent to the use of safety devices pursuant to Title 50, chapter 5, part 12.

(b) The resident may not have a stage 3 or stage 4 pressure ulcer.

(c) The resident may not have a gastrostomy or jejunostomy tube.

(d) The resident may not require skilled nursing care or other skilled services on a continued basis except for the administration of medications consistent with applicable laws and regulations.

(e) The resident may not be a danger to self or others.

(f) The resident must be able to accomplish activities of daily living with supervision and assistance based on the following:

(i) the resident may not be consistently and totally dependent in four or more activities of daily living as a result of a cognitive or physical impairment; ~~and~~

(ii) the resident may not have a severe cognitive impairment that renders the resident incapable of expressing needs or making basic care decisions; and

(iii) the resident requires physical assistance with at least one activity of daily living.

(3) An assisted living facility licensed as a category B facility under 50-5-227 may not admit or retain a category B resident unless each of the following conditions is met:

(a) The resident may require skilled nursing care or other services for more than 30 days for an incident, for more than 120 days a year that may be provided or arranged for by either the facility or the resident, and as provided for in the facility agreement.

(b) The resident may be consistently and totally dependent in more than four activities of daily living.

(c) The resident may not require physical or chemical restraint or confinement in locked quarters, but may consent to the use of safety devices pursuant to Title 50, chapter 5, part 12.

(d) The resident may not be a danger to self or others.

(e) The resident must have a practitioner's written order for admission as a category B resident and written orders for care.

(f) The resident must have a signed health care assessment, renewed on a quarterly basis by a licensed health care professional who:

(i) actually visited the facility within the calendar quarter covered by the assessment;

(ii) has certified that the particular needs of the resident can be adequately met in the facility; and

(iii) has certified that there has been no significant change in health care status that would require another level of care.

(4) An assisted living facility licensed as a category C facility under 50-5-227 may not admit or retain a category C resident unless each of the following conditions is met:

(a) The resident has a severe cognitive impairment that renders the resident incapable of expressing needs or of making basic care decisions.

(b) The resident may be at risk for leaving the facility without regard for personal safety.

(c) Except as provided in subsection (4)(b), the resident may not be a danger to self or others.

(d) The resident may not require physical or chemical restraint or confinement in locked quarters, but may consent to the use of safety devices pursuant to Title 50, chapter 5, part 12.

(5) (a) An assisted living facility licensed as a category D facility under 50-5-227 may not admit or retain a category D resident unless each of the conditions in subsections (5)(b) and (5)(c) is met or a court has ordered diversion as provided in subsection (5)(d).

(b) The resident must be dependent on assistance for two or more activities of daily living and may

require skilled nursing care or other services that may be provided or arranged for by either the facility or the resident or provided for in the facility agreement.

(c) The resident must be assessed by a practitioner or adjudged by a court as having been or potentially being a danger to self or others. The practitioner shall submit both a health care assessment, renewed on a monthly basis, and a written order for care that:

(i) provides information on behavioral patterns under which the category D resident may pose a threat to others and may need to be kept separate from other category D residents or residents in other categories of assisted care;

(ii) lists the conditions under which the category D resident can be reasonably, temporarily restrained, using protective restraints, medications, or confinement to avoid harm to the resident or others;

(iii) includes a reason why a category D assisted living facility is more appropriate than other options for care and provides an assessment of the resident's needs and plan for care; and

(iv) indicates the timeframe over which the resident's health care status has remained the same or changed.

(d) A court may order a diversion from an involuntary commitment to Montana state hospital or from the Montana mental health nursing care center as provided in 53-21-127 or 53-21-199. A diversion ordered pursuant to 53-21-199 may be an involuntary commitment but must be treated as provided in 53-21-181.

(6) For category B, C, and D residents, the assisted living facility shall specify services that it will provide in the facility admission criteria.

(7) The department shall develop standardized forms and education and training materials to provide to the assisted living facilities and to the licensed health care professionals who are responsible for the signed ~~statements~~ health care assessments provided for in subsection (3)(f). The use of the standardized forms is voluntary.

(8) The department shall provide by rule:

(a) an application or placement procedure informing a prospective resident and, if applicable, the resident's practitioner of:

(i) physical and mental standards for residents of assisted living facilities;

(ii) requirements for placement in a facility with a higher standard of care if a resident's condition deteriorates; and

(iii) the services offered by the facility and services that a resident may receive from third-party providers while the resident lives at the facility;

(b) standards to be used by a facility and, if appropriate, by a screening agency to screen residents and prospective residents to ~~prevent residence by individuals referred to in subsections (3) through (5)~~ determine needed level of care and appropriateness of placement. An individual subject to 46-14-301 is not eligible to be placed in a category D assisted living facility.

(c) a method by which the results of any screening decision made pursuant to rules established under subsection (8)(b) may be appealed by the facility operator or by or on behalf of a resident or prospective resident;

(d) standards for operating a category A assisted living facility, including standards for the physical, structural, environmental, sanitary, infection control, dietary, social, staffing, and recordkeeping components of a facility and the storage and administration of over-the-counter and prescription medications;

(e) standards for operating a category B assisted living facility, which must include the standards for a category A assisted living facility and additional standards for assessment of residents, care planning, qualifications and training of staff, prevention and care of pressure sores, and incontinence care; and

(f) standards for operating a category C and a category D assisted living facility, which must include the standards for a category B assisted living facility and additional standards for resident assessment, the provision of specialty care to residents with cognitive impairments, and additional qualifications of and training for the administrator and direct-care staff. The standards for a category D assisted living facility must also include specific safety and restraint training."

Section 9. Section 50-6-401, MCA, is amended to read:

"**50-6-401. Definitions.** As used in this part, unless the context clearly requires otherwise, the following definitions apply:

(1) "Department" means the department of public health and human services provided for in Title 2, chapter 15, part 22.

(2) "Emergency medical service" means an emergency medical service as defined by 50-6-302.

(3) "Health care facility" or "facility" means a hospital~~,~~ or critical access hospital~~, or medical assistance facility~~ as defined in 50-5-101.

(4) "Hospital trauma register" means patient-specific trauma data that is maintained by a health care facility, in a format prescribed by department rule, and that has the primary purpose of facilitating peer review and quality improvement at the health care facility.

(5) "Quality improvement" means the process of defining trauma care system performance standards, collecting data against which the standards may be applied, using the data to determine compliance with the standards, and using the data and compliance information in a nonpunitive manner, including peer review, that will continuously improve performance and facilitate compliance with the standards.

(6) "State trauma register" means trauma data relating to a specific patient or health care facility that is maintained by the department in an electronic format and that has the primary purpose of facilitating peer review and quality improvement for a health care facility or a trauma care system.

(7) "Trauma" means a severe, abrupt injury to the human body that is caused by mechanical, environmental, thermal, or other physical force.

(8) "Trauma care committee" means the trauma care committee created in 2-15-2216.

(9) "Trauma care system" means a state or regional system for the prevention of trauma and the provision of optimal medical care to trauma victims that includes both provision of appropriate health care services and provision of emergency medical care, equipment, and personnel for effective and coordinated prehospital, hospital, interhospital, and rehabilitative care for trauma patients.

(10) "Trauma facility" means a health care facility designated by the department pursuant to 50-6-410 as providing a specialized program in trauma care with appropriately trained personnel, equipment, and other facility resources that are specifically organized to provide optimal care to a trauma patient at the facility.

(11) "Trauma region" means a geographic area, designated by department rule pursuant to 50-6-402, within which trauma services are coordinated and evaluated through a regional trauma care system."

Section 10. Section 50-20-901, MCA, is amended to read:

"**50-20-901. Definitions.** As used in this part, the following definitions apply:

(1) (a) "Abortion clinic" means a facility that:

(i) performs surgical abortion procedures; or

(ii) provides an abortion-inducing drug.

(b) The term does not include:

(i) a hospital as defined in 50-5-101;

(ii) a critical access hospital as defined in 50-5-101;

(iii) a rural emergency hospital as defined in 50-5-101;

~~(iii)~~ (iv) an outpatient center for surgical services as defined in 50-5-101; or

~~(iv)~~ (v) a facility that provides, prescribes, administers, or dispenses an abortion-inducing drug to fewer than five patients each year.

(2) (a) "Abortion-inducing drug" means a medicine, drug, or other substance provided with the intent of terminating the clinically diagnosable pregnancy of a woman.

(b) The term includes the off-label use of drugs known to have abortion-inducing properties that are prescribed specifically with the intent of causing an abortion.

(c) The term does not include the use of drugs that may be known to cause an abortion if the drugs are prescribed for a medical indication other than abortion.

(3) "Affiliate" means an organization that directly or indirectly:

(a) owns or controls another organization;

(b) is owned or controlled, in whole or in part, by another organization;

(c) is related by shareholdings or other means of control to another organization;

(d) is a parent or subsidiary of another organization; or

(e) is under common control with another organization.

(4) "Medical practitioner" means a person authorized under 50-20-109 to perform an abortion in this state."

Section 11. Section 52-2-736, MCA, is amended to read:

"**52-2-736. Prohibition against administering medicine without authorization -- provision for emergency -- definitions -- penalty.** (1) An employee, owner, household member, volunteer, or operator of a

day-care facility, as defined in 52-2-703, regardless of whether the facility is licensed or registered, may not purposely or knowingly administer any medicine, as defined in 37-7-101, to a child attending the day-care facility without written authorization. Written authorization must include the child's name, date or dates for which the authorization is applicable, dosage instructions, and signature of the child's parent or guardian.

(2) If an emergency medical condition arises and the parent or guardian of the child is unavailable, an employee, owner, or operator of a day-care facility may administer medicine to a child attending the day-care facility without the written authorization of a parent or guardian as provided in subsection (1) if:

(a) a medical practitioner provides a written authorization containing the child's name, date or dates for which the authorization is applicable, dosage instructions, and the medical practitioner's signature; or

(b) a medical practitioner, emergency services provider, or 9-1-1 responder verbally directs the employee, owner, or operator of the day-care facility attending the child to immediately administer a medicine to the child and the child is subsequently transported within a reasonable time by the child's parents, an owner, operator, or employee of the child-care facility, a health care provider, or an emergency services provider to a health care facility or a medical practitioner for followup care.

(3) A medicine administered to a child pursuant to subsection (1) or (2) may not be inappropriately administered.

(4) An employee, owner, or operator of a day-care facility who has administered medicine to a child in accordance with this section may not be prosecuted for causing bodily injury or severe bodily injury to a child.

(5) For the purposes of this section:

(a) "bodily injury" has the meaning provided in 45-2-101;

(b) "emergency medical condition" means circumstances in which a prudent lay person acting reasonably would believe that an emergency medical condition exists;

(c) "emergency services provider" has the meaning provided in 50-16-701;

(d) "health care facility" means a profit or nonprofit, public or private physician's office, hospital, critical access hospital, infirmary, clinic, outpatient center for primary care, or outpatient center for surgical services, ~~or medical assistance facility,~~ as any of those terms are defined in 50-5-101;

(e) "inappropriately administered" means to give medicine to a child that is not indicated, as to the

medicine's type, dosage, or frequency of use or the container instructions, if any, by the medical symptoms exhibited by the child;

(f) "knowingly" has the meaning provided in 45-2-101;

(g) "medical practitioner" has the meaning provided in 37-2-101;

(h) "9-1-1 responder" means a law enforcement dispatcher or other person answering a 9-1-1 telephone call, a person answering a telephone call made to a poison control center, or an emergency services provider;

(i) "purposely" has the meaning provided in 45-2-101; and

(j) "serious bodily injury" has the meaning provided in 45-2-101.

(4) (a) A person convicted of purposely or knowingly administering medicine without authorization resulting in bodily injury to a child shall be imprisoned in the county jail for a term not to exceed 6 months or be fined an amount not to exceed $500, or both.

(b) A person convicted of purposely or knowingly administering medicine without authorization resulting in serious bodily injury to a child or in the death of a child shall be imprisoned for a term not to exceed 20 years or be fined an amount not to exceed $50,000, or both."

Section 12. Section 52-2-806, MCA, is amended to read:

"**52-2-806. Provisional license.** The department may issue a provisional license for a period not to exceed ~~6 months~~ 1 year if it finds that a licensee or applicant does not meet all standards established by the department as long as the licensee or applicant is attempting to meet the minimum standards."

Section 13. Section 52-4-203, MCA, is amended to read:

"**52-4-203. Licensing.** (1) A person may not operate a community home for persons with severe disabilities, also called a facility, ~~must be~~ unless the facility is licensed ~~annually~~ by the department.

~~(2) The department may also issue temporary and provisional licenses.~~

(2) A community home for persons with severe disabilities must be inspected and licensed annually by the department of public health and human services.

(3) A license may not be sold, assigned, or transferred. Upon discontinuance of the operation or

upon transfer of ownership of a facility, the license must be returned to the department or destroyed by the owners.

(4) A facility shall display its license in a conspicuous place near its admitting office.

(5) If a facility is the subject of substantiated claims of abuse, neglect, or exploitation, or if a facility does not meet the minimum standards for operating a community home for people with severe disabilities, the department may reduce the facility's license to, or issue the facility, a provisional license for less than 1 year if operation or continued operation of the facility will not result in undue hazards to its residents.

(6) The department may inspect a licensed community home for people with severe disabilities whenever it considers necessary. The entire premises of a licensed facility must be open to inspection, and access to all records must be granted at all reasonable times."

Section 14. Section 53-6-101, MCA, is amended to read:

"**53-6-101. Montana medicaid program -- authorization of services.** (1) There is a Montana medicaid program established for the purpose of providing necessary medical services to eligible persons who have need for medical assistance. The Montana medicaid program is a joint federal-state program administered under this chapter and in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq. The department shall administer the Montana medicaid program.

(2) The department and the legislature shall consider the following funding principles when considering changes in medicaid policy that either increase or reduce services:

(a) protecting those persons who are most vulnerable and most in need, as defined by a combination of economic, social, and medical circumstances;

(b) giving preference to the elimination or restoration of an entire medicaid program or service, rather than sacrifice or augment the quality of care for several programs or services through dilution of funding; and

(c) giving priority to services that employ the science of prevention to reduce disability and illness, services that treat life-threatening conditions, and services that support independent or assisted living, including pain management, to reduce the need for acute inpatient or residential care.

(3) Medical assistance provided by the Montana medicaid program includes the following services:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) other laboratory and x-ray services, including minimum mammography examination as defined in 33-22-132;

(d) skilled nursing services in long-term care facilities;

(e) physicians' services;

(f) nurse specialist services;

(g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age, in accordance with federal regulations and subsection (10)(b);

(h) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;

(i) targeted case management services, as authorized in 42 U.S.C. 1396n(g), for high-risk pregnant women;

(j) services that are provided by physician assistants within the scope of their practice and that are otherwise directly reimbursed as allowed under department rule to an existing provider;

(k) health services provided under a physician's orders by a public health department;

(l) federally qualified health center services, as defined in 42 U.S.C. 1396d(l)(2);

(m) routine patient costs for qualified individuals enrolled in an approved clinical trial for cancer as provided in 33-22-153;

(n) for children 18 years of age and younger, habilitative services as defined in 53-4-1103;

(o) services provided by a person certified in accordance with 37-2-318 to provide services in accordance with the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.;

(p) fertility preservation services in accordance with 33-22-2103; and

(q) planned home births for women with a low risk of adverse birth outcomes, as established by the appropriate licensing board, that are attended by certified nurse-midwives licensed under Title 37, chapter 8, or direct-entry midwives licensed under Title 37, chapter 27. Coverage under this section includes prenatal care and postpartum care.

(4) Medical assistance provided by the Montana medicaid program may, as provided by

department rule, also include the following services:

(a) medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(b) home health care services[, including services provided by pediatric complex care assistants licensed pursuant to 37-2-603];

(c) private-duty nursing services;

(d) dental services;

(e) physical therapy services;

(f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 10;

(g) clinical social worker services;

(h) prescribed drugs, dentures, and prosthetic devices;

(i) prescribed eyeglasses;

(j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;

(k) inpatient psychiatric hospital services for persons under 21 years of age;

(l) services of clinical professional counselors licensed under Title 37, chapter 39;

(m) services of a marriage and family therapist licensed under Title 37, chapter 39;

(n) hospice care, as defined in 42 U.S.C. 1396d(o);

(o) case management services, as provided in 42 U.S.C. 1396d(a) and 1396n(g), including targeted case management services for the mentally ill;

(p) services of psychologists licensed under Title 37, chapter 17;

(q) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C. 1396d(h), in a residential treatment facility, as defined in 50-5-101, that is licensed in accordance with 50-5-201;

(r) services of behavioral health peer support specialists certified under Title 37, chapter 39, provided to adults 18 years of age and older with a diagnosis of a mental disorder, as defined in 53-21-102; and

(s) any additional medical service or aid allowable under or provided by the federal Social Security Act.

(5) Services for persons qualifying for medicaid under the medically needy category of assistance,

as described in 53-6-131, may be more limited in amount, scope, and duration than services provided to others qualifying for assistance under the Montana medicaid program. The department is not required to provide all of the services listed in subsections (3) and (4) to persons qualifying for medicaid under the medically needy category of assistance.

(6) In accordance with federal law or waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department may implement limited medicaid benefits, to be known as basic medicaid, for adult recipients who are eligible because they are receiving cash assistance, as defined in 53-4-201, as the specified caretaker relative of a dependent child and for all adult recipients of medical assistance only who are covered under a group related to a program providing cash assistance, as defined in 53-4-201. Basic medicaid benefits consist of all mandatory services listed in subsection (3) but may include those optional services listed in subsections (4)(a) through (4)(s) that the department in its discretion specifies by rule. The department, in exercising its discretion, may consider the amount of funds appropriated by the legislature, whether approval has been received, as provided in 53-1-612, and whether the provision of a particular service is commonly covered by private health insurance plans. However, 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.

(7) The department may implement, as provided for in Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, a program under medicaid for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

(8) (a) The department may set rates for medical and other services provided to recipients of medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

(b) The department shall strive to close gaps in services provided to individuals suffering from mental illness and co-occurring disorders by doing the following:

(i) simplifying administrative rules, payment methods, and contracting processes for providing services to individuals of different ages, diagnoses, and treatments. Any adjustments to payments must be cost-neutral for the biennium beginning July 1, 2017.

(ii) publishing a report on an annual basis that describes the process that a mental health center or ~~chemical dependency~~ substance use disorder facility, as those terms are defined in 50-5-101, must utilize in

order to receive payment from Montana medicaid for services provided to individuals of different ages, diagnoses, and treatments.

(9) The services provided under this part may be only those that are medically necessary and that are the most efficient and cost-effective.

(10) (a) The amount, scope, and duration of services provided under this part must be determined by the department in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended.

(b) The department shall, with reasonable promptness, provide access to all medically necessary services prescribed under the early and periodic screening, diagnosis, and treatment benefit, including access to prescription drugs and durable medical equipment for which the department has not negotiated a rebate.

(11) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

(12) (a) Prior to enacting changes to provider rates, medicaid waivers, or the medicaid state plan, the department shall report this information to the following committees:

(i) the children, families, health, and human services interim committee;

(ii) the legislative finance committee; and

(iii) the health and human services budget committee.

(b) In its report to the committees, the department shall provide an explanation for the proposed changes and an estimated budget impact to the department over the next 4 fiscal years.

(13) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program after taking into consideration the funding principles set forth in subsection (2). (Subsection (3)(o) terminates September 30, 2025--sec. 1, Ch. 298, L. 2023; bracketed language in subsection (4)(b) terminates June 30, 2031--sec. 10, Ch. 628, L. 2023.)"

Section 15. Section 53-20-302, MCA, is amended to read:

"**53-20-302. Definition of community home -- limitation on number of residents.** (1) A community home for persons with developmental disabilities is a family-oriented residence or home designed to provide facilities for two to ~~eight~~ six persons with developmental disabilities, established as an alternative to existing

state institutions. ~~The number of persons with developmental disabilities may not exceed eight in a community home, except that the department of public health and human services may grant written approval for more than eight but not more than twelve persons.~~

(2) The department may waive the limit on the number of residents prescribed in subsection (1) for a community home licensed and in operation prior to [the effective date of this act]."

Section 16. Section 53-20-305, MCA, is amended to read:

"**53-20-305. ~~Local control of community~~ Community homes -- departmental licensing, administration, operation, health and safety standards.** (1) ~~Community homes~~ A person may not operate a community home for persons with developmental disabilities, also referred to as a facility, ~~may be under local control, and the nonprofit corporations or associations operating community homes are authorized to establish homes and programs they believe in the best interest of their homes~~ unless the facility is licensed by the department.

(2) ~~(a)~~ A community home for persons with developmental disabilities must be inspected and licensed annually by the department of public health and human services.

~~(b) One temporary license may be issued for no longer than 60 days if there are unavoidable delays in the certification process.~~

(3) A license may not be sold, assigned, or transferred. Upon discontinuance of the operation or upon transfer of ownership of a facility, the license must be returned to the department or destroyed by the owners.

(4) A facility shall display its license in a conspicuous place near its admitting office.

(5) If a facility is the subject of substantiated claims of abuse, neglect, or exploitation, or if a facility does not meet the minimum standards for operating a community home for people with developmental disabilities, the department may reduce the facility's license to, or issue the facility, a provisional license for less than 1 year if operation or continued operation of the facility will not result in undue hazards to its residents.

(6) The department may inspect a licensed community home for people with severe disabilities whenever it considers necessary. The entire premises of a licensed facility must be open to inspection, and access to all records must be granted at all reasonable times.

~~(3)~~ (7) The department of public health and human services for the purpose of licensing shall adopt standards and rules concerning the administration, operation, health, and safety of community homes for persons with developmental disabilities."

- END -

I hereby certify that the within bill,

SB 516, originated in the Senate.

_____

Secretary of the Senate

_____

President of the Senate

Signed this _____day

of_____, 2025.

_____

Speaker of the House

Signed this _____day
of_____, 2025.

SENATE BILL NO. 516

INTRODUCED BY M. YAKAWICH

AN ACT GENERALLY REVISING LAWS RELATED TO FACILITIES LICENSED BY THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; REVISING DEFINITIONS; PROVIDING A DEFINITION FOR SUBSTANCE USE DISORDER TREATMENT FACILITY; UPDATING LICENSURE REQUIREMENTS FOR COMMUNITY HOMES FOR PERSONS WITH SEVERE DISABILITIES AND FOR PERSONS WITH DEVELOPMENTAL DISABILITIES; AND AMENDING SECTIONS 7-34-2201, 33-36-103, 50-5-101, 50-5-201, 50-5-203, 50-5-204, 50-5-207, 50-5-226, 50-6-401, 50-20-901, 52-2-736, 52-2-806, 52-4-203, 53-6-101, 53-20-302, AND 53-20-305, MCA."