HOUSE BILL NO. 230

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A BILL FOR AN ACT ENTITLED: “AN ACT GENERALLY REVISING LAWS RELATED TO MEDICAID; ELIMINATING WORK REQUIREMENTS AND PREMIUMS; PROVIDING FOR 12-MONTH CONTINUOUS ELIGIBILITY; IMPROVING CUSTOMER SERVICE FOR MEDICAID CLIENTS; ESTABLISHING A MEDICAID CLIENT ADVISORY BOARD; PROVIDING DIRECTION TO THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; REPEALING THE TERMINATION DATE OF THE MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP ACT; PROVIDING AN APPROPRIATION; AMENDING SECTIONS 39-12-103, 53-2-301, 53-6-160, 53-6-1302, 53-6-1303, 53-6-1305, 53-6-1313, 53-6-1315, AND 53-6-1325, MCA; REPEALING SECTIONS 15-30-2660, 53-6-1307, 53-6-1308, 53-6-1309, AND 53-6-1314, MCA; REPEALING SECTION 28, CHAPTER 368, LAWS OF 2015, SECTIONS 38 AND 48, CHAPTER 415, LAWS OF 2019, SECTION 17, CHAPTER 456, LAWS OF 2019, AND SECTIONS 3 AND 4, CHAPTER 318, LAWS OF 2021; AND PROVIDING AN EFFECTIVE DATE.”

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

NEW SECTION. **Section 1. Twelve-month continuous eligibility -- direction to department of public health and human services.** (1) The department shall apply for amendments to existing medicaid section 1115 waivers to authorize 12-month continuous eligibility of medicaid coverage for:

(a) parents and caretaker relatives, as allowed prior to the waiver amendment approved March 30,

2022; and

(b) adults eligible for medicaid pursuant to this part, as allowed prior to the waiver amendment approved December 21, 2021.

(2) The department shall submit amendments no later than September 30, 2025, to authorize 12-month continuous eligibility under:

(a) the waiver for additional services and populations, project number 11-W-00181/8, for parents and caretaker relatives initially determined eligible for medicaid in the eligibility groups described in sections 1931 and 1925 of the federal Social Security Act; and

(b) the health and economic livelihood partnership waiver, project number 11-W-00300/8, for the medicaid expansion population.

NEW SECTION. **Section 2. Improved customer service -- direction to department -- report to legislature.** (1) To streamline the Montana medicaid program application and renewal process, the department shall accept:

(a) applications, renewals, recertifications, and periodic reports online and by phone; and

(b) required document submissions electronically, including via upload from a mobile device.

(2) (a) The department shall use text messaging and e-mail to communicate with members and applicants who provide cell phone numbers and e-mail addresses.

(b) The department shall establish a system to notify members and applicants via text message and e-mail when verifications are due and when a renewal, recertification, or periodic report is due.

(3) (a) The department shall provide a phone hotline for members and applicants. The hotline may also be used for other public assistance benefits.

(b) The department shall provide an expected wait time and offer a callback option to each hotline caller.

(4) The department shall allow a member to submit an online or a printed renewal form during a 90-day reconsideration period if the member's coverage under the Montana medicaid program is terminated for procedural reasons.

(5) The department shall set a target ex parte renewal rate of no less than 60% of the total

Montana medicaid population by June 30, 2026. An ex parte renewal is a renewal conducted pursuant to 42 CFR 435.916(b)(1).

(6) (a) Client-facing technology implemented after [the effective date of this act] must have optimal functionality on cell phones, tablets, and computers.

(b) The department shall modify existing client-facing technology to ensure optimal functionality on cell phones, tablets, and computers by June 30, 2026.

(7) All written application notices and application or renewal forms must be:

(a) written in plain language consistent with requirements of 42 CFR 435.905(b) and 42 CFR 457.110(a); and

(b) translated into the state's five most commonly spoken languages.

(8) The department shall report on a quarterly basis to the children, families, health, and human services interim committee, in accordance with 5-11-210, on issues related to medicaid client service, including:

(a) the total number of applications and renewals;

(b) ex parte renewal success rates, including:

(i) total renewals and percentage by coverage group;

(ii) data sources used;

(iii) monthly compliance with federal requirements; and

(iv) steps the department is taking to reach the target set in subsection (5);

(c) the percentage of applications and percentage of renewals submitted online, in person, by mail, and by phone;

(d) the percentage of applications and percentage of renewals completed within 24 hours, 7 days, 30 days, 45 days, 60 days, and 90 days;

(e) hotline call volume at the state and county level, including wait times and answer rates; and

(f) the number of individuals whose medicaid-related mail is returned to the department as undeliverable, and percentage of those individuals whom the department contacted by other means.

(9) As used in this section, "procedural reasons" means the state or a medicaid member fails to complete a part of the renewal process, and loss of medicaid coverage for the member occurs.

NEW SECTION. **Section 3. Client advisory board -- duties -- membership.** (1) (a) There is a client advisory board, composed of individuals who are currently or have been enrolled as members in the Montana medicaid program and individuals with direct experience supporting Montana medicaid program members.

(b) The department shall establish a selection process to appoint members of the board and publish this information on the department's website.

(c) The board must be composed of at least seven members selected by the director of the Montana medicaid program and must include:

(i) at least three current or former Montana medicaid members;

(ii) at least two individuals who have direct experience supporting a family member, including a child or family member with a disability, with enrolling in the Montana medicaid program and navigating medicaid services; and

(iii) at least two individuals who serve as a paid or unpaid caregiver for a Montana medicaid program member.

(d) Board members must be selected for 2-year terms.

(e) At least two members of the client advisory board must be appointed to the state's medicaid advisory council, as required under 42 CFR 431.12.

(2) (a) The board shall meet at least quarterly to advise the department on the experience of Montana medicaid program members and effective medicaid program administration.

(b) The department shall solicit feedback from the board regarding:

(i) new services and changes to services;

(ii) care coordination;

(iii) quality of services;

(iv) eligibility, enrollment, and renewal processes;

(v) beneficiary and provider communications by the department;

(vi) cultural competency, language access, health equity, disparities, and biases in the Montana medicaid program;

(vii) access to services; and

(viii) other issues that impact the provision of medical care services in the Montana medicaid

program and health outcomes for medicaid members.

(3) (a) The department shall provide staff support to the board.

(b) The department shall establish a meeting schedule and format to maximize participation, including ensuring members of the board can participate remotely.

Section 4. Section 39-12-103, MCA, is amended to read:

"**39-12-103. ~~(Temporary)~~ Montana HELP Act workforce development -- participation -- providers -- allowable activities -- report.** (1) The department shall provide individuals receiving assistance for health care services pursuant to Title 53, chapter 6, part 13, with the option of taking part in a workforce development program to allow the participant to increase the participant's earning capacity and economic stability.

(2) The department shall:

(a) assist program participants with completion of an employment or reemployment assessment; and

(b) contract with one or more private nonprofit or for-profit entities to provide workforce development services. The services must emphasize training in high-demand occupations, particularly in the health care field and in short-term certification programs for entry-level cybersecurity analysts.

(3) Allowable workforce development services include:

(a) education and training; and

(b) supportive services that assist a program participant with the items or services necessary to participate in the workforce, including but not limited to supportive services involving clothing, transportation, and equipment needed to obtain or maintain employment.

(4) Entities contracting to provide workforce development services shall report quarterly to the department on the activities provided. At a minimum, the entities shall report on:

(a) the number of clients enrolled in program activities and co-enrolled in other workforce programs;

(b) the types of services provided;

(c) the number of clients who attained a credential or gained a measurable skill;

(d) the number of clients who exited the program;

(e) the number of clients who exited the program to employment;

(f) the number of clients who continued enrollment in the program;

(g) the amount and type of outreach the entity has done to recruit program participants; and

(h) the amount of money spent directly on participants.

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

(b) The department is not required to provide further services under this section after it has provided the notification provided for in subsection (5)(a).

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

(6) The department shall report the following information to the legislative finance committee and the children, families, health, and human services interim committee in accordance with 5-11-210:

(a) the activities undertaken to establish the employer grant program provided for in 39-12-106;

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

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

(7) 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.

(8) The department shall reduce fraud, waste, and abuse in determining and reviewing eligibility for unemployment insurance benefits by enhancing technology system support to provide knowledge-based authentication for verifying the identity and employment status of individuals seeking benefits, including the use of public records to confirm identity and to flag changes in demographics. ~~(Terminates June 30, 2025--secs. 38, 48, Ch. 415, L. 2019.)~~"

Section 5. Section 53-2-301, MCA, is amended to read:

"**53-2-301. Local offices of public assistance to be established by department.** (1) The department shall establish one or more local offices of public assistance in each county of the state. ~~If conditions warrant,~~ Subject to the conditions prescribed in subsection (2), two or more counties may be combined into one administrative unit and the department may use the same local office of public assistance and staff to administer public assistance in the combined counties.

(2) (a) In accordance with subsection (2)(b), the legislature directs the department to reopen ten offices of public assistance by June 30, 2026.

(b) When determining the locations of reopened offices, the department shall consider the following data:

(i) percentage of overall calls into the hotline from individuals residing by county;

(ii) the distance required for individuals in each county to reach an office that is open as of [the effective date of this act]; and

(iii) the percentage of individuals enrolled in the Montana medicaid program who are disenrolled at renewal for procedural reasons, as defined by [section 2], by county; and

(iv) the percentage of individuals who have an initial period of enrollment in medicaid, followed by a loss of coverage, and subsequent reenrollment."

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

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

~~(b) This section applies to the information provided by a program participant to claim an exemption from community engagement requirements under 53-6-1308 or to report community engagement activities under 53-6-1309.~~

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

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

(3) A person is considered to have known that a claim, statement, or representation related to the medicaid program was false if the person knew, or by virtue of the person's position, authority, or responsibility should have known, of the falsity of the claim, statement, or representation.

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

(a) had the authority or responsibility to:

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

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

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

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

(5) (a) There is an inference that a person who signs or submits a document to a medicaid agency

on behalf of or in the name of a provider is authorized by the provider to do so and is acting under the provider's direction.

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

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

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

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

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

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

(7) This section applies only for the purpose of civil liability under Title 53 and does not apply in a criminal proceeding. ~~(Subsection (1)(b) terminates June 30, 2025, on occurrence of contingency--sec. 48, Ch. 415, L. 2019.)~~"

Section 7. Section 53-6-1302, MCA, is amended to read:

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

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

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

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

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

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

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

(c) reduce health care costs;

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

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

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

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

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

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

(c) reducing preventable hospital readmissions; and

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

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

(5) The legislature further finds that:

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

(b) state policymakers have an interest in testing the effectiveness of wellness incentives in order to collect and analyze information about the correlation between wellness incentives and health status.

(6) The purposes of the act are to:

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

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

(7) The department of labor and industry and the department of public health and human services shall maximize the use of existing resources in administering the program. ~~(Terminates June 30, 2025--secs. 38, 48, Ch. 415, L. 2019.)~~"

Section 8. Section 53-6-1303, MCA, is amended to read:

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

~~(1) "Community engagement" means participation in the activities specified in 53-6-1308 as a means to improve a program participant's well-being and opportunities for self-sufficiency.~~

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

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

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

~~(5)~~(4) "Program participant" or "participant" means an individual enrolled in the Montana Health and Economic Livelihood Partnership Act program established in Title 39, chapter 12, and this part. ~~(Terminates June 30, 2025--secs. 38, 48, Ch. 415, L. 2019.)~~"

Section 9. Section 53-6-1305, MCA, is amended to read:

"**53-6-1305. ~~(Temporary)~~ Montana HELP Act program -- delivery of health care services -- third-party administrator -- rulemaking.** (1) The department may contract as provided in Title 18, chapter 4, with one or more third-party administrators to assist in administering the delivery of health care services to members eligible under 53-6-1304, including but not limited to:

(a) establishing networks of health care providers;

(b) paying claims submitted by health care providers;

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

~~(d)~~(c) coordinating care;

~~(e)~~(d) helping to administer the program; and

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

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

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

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

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

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

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

(4) The department may contract with a third-party administrator for the services allowed under

subsections (1)(a) through ~~(1)(f)~~ (1)(e) only upon receipt of a federal waiver allowing a third-party administrator to provide services in accordance with this part. ~~(Terminates June 30, 2025--secs. 38, 48, Ch. 415, L. 2019.)~~"

Section 10. Section 53-6-1313, MCA, is amended to read:

"**53-6-1313. ~~(Temporary)~~ 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 53-6-1304 is set below the levels established in 42 U.S.C. 1396d(y)(1) on the effective date of this section, the continuation of coverage under this part 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 53-6-1307 to pay the difference; or~~

~~(3) a combination of legislative action and premium increases as necessary to provide for the increased state match obligation~~. ~~(Terminates June 30, 2025--sec. 38, Ch. 415, L. 2019.)~~"

Section 11. Section 53-6-1315, MCA, is amended to read:

"**53-6-1315. ~~(Temporary)~~ Montana HELP Act special revenue account.** (1) There is a Montana HELP Act account in the state special revenue fund to the credit of the department.

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

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

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

~~(c)~~(b) the health service corporation fee provided for in 33-2-714~~; and~~

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

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

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

(b) grants made under the HELP Act employer grant program provided for in 39-12-106.

(4) Money from the account must be used for the benefits and administrative costs of providing health care services under this part before any general fund is expended on the costs. ~~(Terminates June 30,~~

~~2025, on occurrence of contingency--sec. 48, Ch. 415, L. 2019.)~~"

Section 12. Section 53-6-1325, MCA, is amended to read:

"**53-6-1325. ~~(Temporary)~~ Report to legislature.** (1) The department shall report the following information to the legislative finance committee and the children, families, health, and human services interim committee quarterly:

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

(b) demographic information on program participants;

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

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

~~(e)~~(d) the amount of money deposited in the Montana HELP Act special revenue account, by source of funding;

~~(f)~~(e) the level of participant engagement in wellness activities or incentives offered under this part;

~~(g) the number of participants who took part in community engagement activities, the number whose program participation was suspended for failure to take part in community engagement activities, and the number who were disenrolled from the program for failure to report a change in circumstances;~~

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

~~(i)~~(g) the total cost of providing services under this part, including related administrative costs.

(2) A compilation of reports received during the interim must be provided to the legislature in accordance with 5-11-210. ~~(Terminates June 30, 2025, on occurrence of contingency--sec. 48, Ch. 415, L. 2019.)~~"

NEW SECTION. **Section 13. Repealer.** The following sections of the Montana Code Annotated are repealed:

15-30-2660. (Temporary) Taxpayer integrity fees.

53-6-1307. (Temporary) Premiums -- collection of overdue premiums -- nonpayment as voluntary disenrollment -- reenrollment -- exemptions.

53-6-1308. (Temporary) Community engagement requirements -- countable activities -- exemptions -- self-attestation.

53-6-1309. (Temporary) Community engagement -- reporting -- suspension -- audit.

53-6-1314. (Temporary) Disenrollment for failure to report change in circumstances.

NEW SECTION. **Section 14. Repealer.** Section 28, Chapter 368, Laws of 2015, sections 38 and 48, Chapter 415, Laws of 2019, section 17, Chapter 456, Laws of 2019, and sections 3 and 4, Chapter 318, Laws of 2021, are repealed.

NEW SECTION. **Section 15. Appropriation.** There is appropriated $3 million from the general fund to the department of public health and human services in each year of the biennium beginning July 1, 2025, for the purposes of implementing 53-2-301.

NEW SECTION. **Section 16. Codification instruction.** (1) [Section 1] is intended to be codified as an integral part of Title 53, chapter 6, part 13, and the provisions of Title 53, chapter 6, part 13, apply to [section 1].

(2) [Sections 2 and 3] are intended to be codified as an integral part of Title 53, chapter 6, part 1, and the provisions of Title 53, chapter 6, part 1, apply to [sections 2 and 3].

NEW SECTION. **Section 17. Effective date.** [This act] is effective June 30, 2025.

- END -