SENATE BILL NO. 187

INTRODUCED BY J. WINDY BOY, T. CROWE, J. WEBER, A. GRIFFITH, M. DUNWELL, J. MORIGEAU, F. SMITH, M. CAFERRO, J. KARLEN, E. KERR-CARPENTER, C. POPE, C. FITZPATRICK

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING MEDICAID LAWS; ELIMINATING THE TERMINATION DATE FOR THE MEDICAID EXPANSION PROGRAM; PROVIDING FOR MEDICAID COVERAGE OF AUXILIARY PERSONNEL SERVICES AND TRADITIONAL HEALING SERVICES; AMENDING SECTIONS 53-6-101 AND 53-6-155, MCA; AMENDING SECTION 48, CHAPTER 415, LAWS OF 2019; REPEALING SECTION 28, CHAPTER 368, LAWS OF 2015, SECTION 38, CHAPTER 415, LAWS OF 2019, SECTION 17, CHAPTER 456, LAWS OF 2019, AND SECTIONS 3 AND 4, CHAPTER 318, LAWS OF 2021; AND PROVIDING EFFECTIVE DATES."

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

NEW SECTION. **Section 1. Directions to department of public health and human services.** (1) The department of public health and human services shall apply to the centers for medicare and medicaid services under the provisions of 53-2-215 to implement the requirements of [section 2(3)(p)].

(2) The department shall apply to the centers for medicare and medicaid services for a state plan amendment to implement the requirements of [section 2(3)(q)].

(3) The department shall comply with the requirements of 42 U.S.C. 1396a(a)(73) and 2-15-143 to seek advice from and engage in consultation with tribal and Indian health officials.

Section 2. 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) the following services provided by auxiliary personnel, as defined in 42 CFR 410.26:

(i) community health integration services to address unmet needs identified by a social determinants of health risk assessment; and

(ii) principal illness navigation for one or more serious conditions expected to last at least 3 months that put a patient at risk of hospitalization, nursing home placement, a sudden worsening of preexisting symptoms, physical or mental decline, or death;

(q) traditional healing services provided by a traditional healing provider in one of the following types of facilities:

(i) an Indian health service facility;

(ii) a tribal health program designated under the Indian Self-Determination and Education Assistance Act, Public Law 93-638;

(iii) an urban Indian organization, as defined in 25 U.S.C. 1603; or

(iv) a facility operated by a person who contracts with an urban Indian organization, described in subsection (3)(q)(iii);

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

~~(q)~~(s) 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 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 3. Section 53-6-155, MCA, is amended to read:

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

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

(2) "Applicant" means a person:

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

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

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

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

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

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

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

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

(9) "Medicaid agency" means any agency or entity of state, county, or local government that administers any part of the medicaid program, whether under direct statutory authority or under contract with an authorized agency of the state or federal government. The term includes but is not limited to the department, the department of corrections, local offices of public assistance, and other local and state agencies and their agents, contractors, and employees, when acting with respect to medicaid eligibility, claims processing or payment, utilization review, case management, provider certification, investigation, or other administration of

the medicaid program.

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

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

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

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

(14) (a) "Originating site provider" means an enrolled provider who is operating a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, et seq., and assisting an enrollee with the technology necessary for a telehealth visit.

(b) An originating site provider is not required to participate in the delivery of the health care service.

(15) "Recipient" means a person:

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

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

(16) (a) "Records" means medical, professional, business, or financial information and documents,

whether in written, electronic, magnetic, microfilm, or other form:

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

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

(iii) otherwise relating to or pertaining to a determination of eligibility for or entitlement to payment or reimbursement under the medicaid program.

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

(17) (a) "Telehealth" means the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance, including but not limited to the use of secure portal messaging, secure instant messaging, audiovisual communications, and audio-only communications.

(b) The term includes both clinical and nonclinical services.

(18) "Traditional healing provider" means an individual who provides traditional healing services in a manner that is recognized by an American Indian or Alaska Native tribe as being consistent with the tribe's traditional healing practices.

(19) "Traditional healing services" means a system of culturally appropriate healing methods for physical, mental, and emotional healing."

Section 4. Section 48, Chapter 415, Laws of 2019, is amended to read:

"**Section 48. Termination ~~-- contingency -- intent~~.** ~~(1) If a court of final disposition finds that the community engagement requirements provided for in [section 1] are invalid, [this act] terminates June 30, 2025.~~

~~(2) It is the intent of the legislature that if the contingency provided for in subsection (1) occurs, the legislature has an opportunity to consider issues of program integrity, reform, and cost-effectiveness to determine whether [this act] should continue.~~

~~(3)~~ [Sections 19 and 20] regarding supplemental transfers terminate June 30, 2021."

NEW SECTION. **Section 5. Repealer.** Section 28, Chapter 368, Laws of 2015, section 38, 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 6. Notification to tribal governments.** The secretary of state shall send a copy of [this act] to each federally recognized tribal government in Montana.

NEW SECTION. **Section 7. Effective dates -- contingency.** (1) Except as provided in subsection (2), [this act] is effective on passage and approval.

(2) [Sections 2 and 3] are effective when the director of the department of public health and human services certifies to the governor that the waivers and amendments required under [section 1] have been approved by the centers for medicare and medicaid services. The director shall make the certification within 10 days of being notified of the approval and shall submit a copy of the certification to the code commissioner.

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