

1 \_\_\_\_\_ BILL NO. \_\_\_\_\_

2 INTRODUCED BY \_\_\_\_\_  
3 (Primary Sponsor)

4 A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING HEALTH CARE INSURANCE LAWS;  
5 PROVIDING FOR PAY EQUITY FOR TELEMEDICINE SERVICES PROVIDED BY CERTAIN HEALTH CARE  
6 PROVIDERS; EXTENDING TELEMEDICINE COVERAGE AND PARITY REQUIREMENTS TO PUBLIC  
7 EMPLOYEE BENEFIT PLANS, STUDENT HEALTH PLANS, AND MEDICAID; AMENDING SECTIONS 2-18-  
8 704, 20-25-1403, 33-31-111, 33-35-306, AND 53-6-101, MCA; AND PROVIDING A DELAYED EFFECTIVE  
9 DATE."

10  
11 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

12  
13 NEW SECTION. **Section 1. Coverage requirements for telemedicine by certain providers.** (1)

14 Each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or  
15 health care services agreement that covers health care services must cover services provided by means of  
16 telemedicine as defined in 37-3-102 by a person licensed under Title 37, chapter 3 or 20, in accordance with  
17 both 33-22-138 and this section if the services are otherwise covered by the policy, certificate, contract, or  
18 agreement.

19 (2) (a) A health insurance issuer shall reimburse a provider who is delivering services by means of  
20 telemedicine on the same basis and to the same extent, including at least the same rate, that is allowed for  
21 comparable services delivered through in-person practice treatment, consultation, or contact if:

- 22 (i) the provider adheres to the same standards of care required for in-person medical care;
- 23 (ii) the services are medically and clinically appropriate for the covered condition;
- 24 (iii) a valid patient-provider relationship exists;
- 25 (iv) the patient has the opportunity to access care in person if desired; and
- 26 (v) the provider is in possession of the patient's medical history before providing care and coordinates
- 27 care with providers who are already treating the patient.

28 (b) Except as provided in subsection (2)(c), a valid patient-provider relationship may be established

1 for the purposes of telemedicine in any of the following ways:

2 (i) an in-person medical interview and physical examination when the standard of care requires an in-  
3 person encounter;

4 (ii) consultation with another health care provider who has a documented relationship with the patient  
5 and who agrees to participate in or supervise the patient's care; or

6 (iii) through telemedicine, including through interactive audio-video technology, if the standard of care  
7 does not require an in-person encounter.

8 (c) A patient-provider relationship may not be established using an audio-only communication.

9 (3) This section does not apply to a health care service that is not otherwise covered by the policy,  
10 certificate, contract, or agreement.

11

12 **Section 2.** Section 2-18-704, MCA, is amended to read:

13 **"2-18-704. Mandatory provisions.** (1) An insurance contract or plan issued under this part must  
14 contain provisions that permit:

15 (a) the member of a group who retires from active service under the appropriate retirement provisions  
16 of a defined benefit plan provided by law or, in the case of the defined contribution plan provided in Title 19,  
17 chapter 3, part 21, a member with at least 5 years of service and who is at least age 50 while in covered  
18 employment to remain a member of the group until the member becomes eligible for medicare under the  
19 federal Health Insurance for the Aged Act, 42 U.S.C. 1395, unless the member is a participant in another group  
20 plan with substantially the same or greater benefits at an equivalent cost or unless the member is employed  
21 and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or  
22 greater benefits at an equivalent cost;

23 (b) the surviving spouse of a member to remain a member of the group as long as the spouse is  
24 eligible for retirement benefits accrued by the deceased member as provided by law unless the spouse is  
25 eligible for medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible  
26 for equivalent insurance coverage as provided in subsection (1)(a);

27 (c) the surviving children of a member to remain members of the group as long as they are eligible for  
28 retirement benefits accrued by the deceased member as provided by law unless they have equivalent coverage

1 as provided in subsection (1)(a) or are eligible for insurance coverage by virtue of the employment of a  
2 surviving parent or legal guardian.

3 (2) An insurance contract or plan issued under this part must contain the provisions of subsection (1)  
4 for remaining a member of the group and also must permit:

5 (a) the spouse of a retired member the same rights as a surviving spouse under subsection (1)(b);

6 (b) the spouse of a retiring member to convert a group policy as provided in 33-22-508; and

7 (c) continued membership in the group by anyone eligible under the provisions of this section,  
8 notwithstanding the person's eligibility for medicare under the federal Health Insurance for the Aged Act.

9 (3) (a) A state insurance contract or plan must contain provisions that permit a legislator to remain a  
10 member of the state's group plan until the legislator becomes eligible for medicare under the federal Health  
11 Insurance for the Aged Act if the legislator:

12 (i) terminates service in the legislature and is a vested member of a state retirement system provided  
13 by law; and

14 (ii) notifies the department of administration in writing within 90 days of the end of the legislator's  
15 legislative term.

16 (b) A former legislator may not remain a member of the group plan under the provisions of subsection  
17 (3)(a) if the person:

18 (i) is a member of a plan with substantially the same or greater benefits at an equivalent cost; or

19 (ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with  
20 substantially the same or greater benefits at an equivalent cost.

21 (c) A legislator who remains a member of the group under the provisions of subsection (3)(a) and  
22 subsequently terminates membership may not rejoin the group plan unless the person again serves as a  
23 legislator.

24 (4) (a) A state insurance contract or plan must contain provisions that permit continued membership  
25 in the state's group plan by a member of the judges' retirement system who leaves judicial office but continues  
26 to be an inactive vested member of the judges' retirement system as provided by 19-5-301. The judge shall  
27 notify the department of administration in writing within 90 days of the end of the judge's judicial service of the  
28 judge's choice to continue membership in the group plan.

1 (b) A former judge may not remain a member of the group plan under the provisions of this  
2 subsection (4) if the person:

3 (i) is a member of a plan with substantially the same or greater benefits at an equivalent cost;

4 (ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with  
5 substantially the same or greater benefits at an equivalent cost; or

6 (iii) becomes eligible for medicare under the federal Health Insurance for the Aged Act.

7 (c) A judge who remains a member of the group under the provisions of this subsection (4) and  
8 subsequently terminates membership may not rejoin the group plan unless the person again serves in a  
9 position covered by the state's group plan.

10 (5) A person electing to remain a member of the group under subsection (1), (2), (3), or (4) shall pay  
11 the full premium for coverage and for that of the person's covered dependents.

12 (6) An insurance contract or plan issued under this part that provides for the dispensing of  
13 prescription drugs by an out-of-state mail service pharmacy, as defined in 37-7-702:

14 (a) must permit any member of a group to obtain prescription drugs from a pharmacy located in  
15 Montana that is willing to match the price charged to the group or plan and to meet all terms and conditions,  
16 including the same professional requirements that are met by the mail service pharmacy for a drug, without  
17 financial penalty to the member; and

18 (b) may only be with an out-of-state mail service pharmacy that is registered with the board under  
19 Title 37, chapter 7, part 7, and that is registered in this state as a foreign corporation.

20 (7) An insurance contract or plan issued under this part must include coverage for:

21 (a) treatment of inborn errors of metabolism, as provided for in 33-22-131; and

22 (b) therapies for Down syndrome, as provided in 33-22-139.

23 (8) (a) An insurance contract or plan issued under this part that provides coverage for an individual in  
24 a member's family must provide coverage for well-child care for children from the moment of birth through 7  
25 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in  
26 force in the contract or plan.

27 (b) Coverage for well-child care under subsection (8)(a) must include:

28 (i) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory

1 tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and  
2 treatment services program provided for in 53-6-101; and

3 (ii) routine immunizations according to the schedule for immunization recommended by the  
4 immunization practice advisory committee of the U.S. department of health and human services.

5 (c) Minimum benefits may be limited to one visit payable to one provider for all of the services  
6 provided at each visit as provided for in this subsection (8).

7 (d) For purposes of this subsection (8):

8 (i) "developmental assessment" and "anticipatory guidance" mean the services described in the  
9 Guidelines for Health Supervision II, published by the American academy of pediatrics; and

10 (ii) "well-child care" means the services described in subsection (8)(b) and delivered by a physician or  
11 a health care professional supervised by a physician.

12 (9) Upon renewal, an insurance contract or plan issued under this part under which coverage of a  
13 dependent terminates at a specified age must continue to provide coverage for any dependent, as defined in  
14 the insurance contract or plan, until the dependent reaches 26 years of age. For insurance contracts or plans  
15 issued under this part, the premium charged for the additional coverage of a dependent, as defined in the  
16 insurance contract or plan, may be required to be paid by the insured and not by the employer.

17 (10) Prior to issuance of an insurance contract or plan under this part, written informational materials  
18 describing the contract's or plan's cancer screening coverages must be provided to a prospective group or plan  
19 member.

20 (11) The state employee group benefit plans and the Montana university system group benefits plans  
21 must provide coverage for hospital inpatient care for a period of time as is determined by the attending  
22 physician and, in the case of a health maintenance organization, the primary care physician, in consultation  
23 with the patient to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection  
24 for the treatment of breast cancer.

25 (12) (a) The state employee group benefit plans and the Montana university system group benefits  
26 plans must provide coverage for outpatient self-management training and education for the treatment of  
27 diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes.

28 (b) Coverage must include a \$250 benefit for a person each year for medically necessary and

1 prescribed outpatient self-management training and education for the treatment of diabetes.

2 (c) The state employee group benefit plans and the Montana university system group benefits plans  
3 must provide coverage for diabetic equipment and supplies that at a minimum includes insulin, syringes,  
4 injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips,  
5 visual reading and urine test strips, one insulin pump for each warranty period, accessories to insulin pumps,  
6 one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United  
7 States food and drug administration, and glucagon emergency kits.

8 (d) Nothing in subsection (12)(a), (12)(b), or (12)(c) prohibits the state or the Montana university  
9 group benefit plans from providing a greater benefit or an alternative benefit of substantially equal value, in  
10 which case subsection (12)(a), (12)(b), or (12)(c), as appropriate, does not apply.

11 (e) Annual copayment and deductible provisions are subject to the same terms and conditions  
12 applicable to all other covered benefits within a given policy.

13 (f) This subsection (12) does not apply to disability income, hospital indemnity, medicare supplement,  
14 accident-only, vision, dental, specific disease, or long-term care policies offered by the state or the Montana  
15 university system as benefits to employees, retirees, and their dependents.

16 (13) (a) The state employee group benefit plans and the Montana university system group benefits  
17 plans that provide coverage to the spouse or dependents of a peace officer as defined in 45-2-101, a game  
18 warden as defined in 19-8-101, a firefighter as defined in 19-13-104, or a volunteer firefighter as defined in 19-  
19 17-102 shall renew the coverage of the spouse or dependents if the peace officer, game warden, firefighter, or  
20 volunteer firefighter dies within the course and scope of employment. Except as provided in subsection (13)(b),  
21 the continuation of the coverage is at the option of the spouse or dependents. Renewals of coverage under this  
22 section must provide for the same level of benefits as is available to other members of the group. Premiums  
23 charged to a spouse or dependent under this section must be the same as premiums charged to other similarly  
24 situated members of the group. Dependent special enrollment must be allowed under the terms of the  
25 insurance contract or plan. The provisions of this subsection (13)(a) are applicable to a spouse or dependent  
26 who is insured under a COBRA continuation provision.

27 (b) The state employee group benefit plans and the Montana university system group benefits plans  
28 subject to the provisions of subsection (13)(a) may discontinue or not renew the coverage of a spouse or

1 dependent only if:

2 (i) the spouse or dependent has failed to pay premiums or contributions in accordance with the terms  
3 of the state employee group benefit plans and the Montana university system group benefits plans or if the  
4 plans have not received timely premium payments;

5 (ii) the spouse or dependent has performed an act or practice that constitutes fraud or has made an  
6 intentional misrepresentation of a material fact under the terms of the coverage; or

7 (iii) the state employee group benefit plans and the Montana university system group benefits plans  
8 are ceasing to offer coverage in accordance with applicable state law.

9 (14) The state employee group benefit plans and the Montana university system group benefits plans  
10 must comply with the provisions of 33-22-153.

11 (15) The state employee group benefit plans and the Montana university system group benefits plans  
12 must provide coverage and reimbursement for telemedicine services as provided in 33-22-138 and [section 1].

13 ~~(15)~~(16) An insurance contract or plan issued under this part and a group benefits plan issued by the  
14 Montana university system must provide mental health coverage that meets the provisions of Title 33, chapter  
15 22, part 7. (See compiler's comments for contingent termination of certain text.)"

16

17 **Section 3.** Section 20-25-1403, MCA, is amended to read:

18 **"20-25-1403. Authorization to establish self-insured health plan for students -- requirements --**  
19 **exemption.** (1) The commissioner may establish a self-insured student health plan for enrolled students of the  
20 system and their dependents, including students of a community college district. In developing a self-insured  
21 student health plan, the commissioner shall:

22 (a) maintain the plan on an actuarially sound basis;

23 (b) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the  
24 plan; and

25 (c) deposit all reserve funds, contributions and payments, interest earnings, and premiums paid to the  
26 plan. The deposits must be expended for claims under the plan and for the costs of administering the plan,  
27 including but not limited to the costs of hiring staff, consultants, actuaries, and auditors, purchasing necessary  
28 reinsurance, and repaying debts.

1 (2) Prior to the implementation of a self-insured student health plan, the commissioner shall consult  
2 with affected parties, including but not limited to the board of regents and representatives of enrolled students  
3 of the system.

4 (3) A self-insured student health plan developed under this part is not responsible for and may not  
5 cover any services or pay any expenses for which payment has been made or is due under an automobile,  
6 premises, or other private or public medical payment coverage plan or provision or under a workers'  
7 compensation plan or program, except when the other payor is required by federal law to be a payor of last  
8 resort. The term "services" includes but is not limited to all medical services, procedures, supplies, medications,  
9 or other items or services provided to treat an injury or medical condition sustained by a member of the plan.

10 (4) The provisions of 20-25-1315 through 20-25-1320 apply to any self-insured student health plan  
11 developed under this part.

12 (5) (a) The Except as provided in subsection (5)(b), the provisions of Title 33 do not apply to the  
13 commissioner when exercising the duties provided for in this part.

14 (b) A self-insured student health plan established under this part must include coverage and  
15 reimbursement for telemedicine services as provided in 33-22-138 and [section 1]."

16

17 **Section 4.** Section 33-31-111, MCA, is amended to read:

18 **"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise  
19 provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance  
20 organization authorized to transact business under this chapter. This provision does not apply to an insurer or  
21 health service corporation licensed and regulated pursuant to the insurance or health service corporation laws  
22 of this state except with respect to its health maintenance organization activities authorized and regulated  
23 pursuant to this chapter.

24 (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or  
25 its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

26 (3) A health maintenance organization authorized under this chapter is not practicing medicine and is  
27 exempt from Title 37, chapter 3, relating to the practice of medicine.

28 (4) This chapter does not exempt a health maintenance organization from the applicable certificate of



1 need requirements under Title 50, chapter 5, parts 1 and 3.

2 (5) This section does not exempt a health maintenance organization from the prohibition of pecuniary  
3 interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704.  
4 A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701  
5 through 33-3-704.

6 (6) This section does not exempt a health maintenance organization from:

7 (a) prohibitions against interference with certain communications as provided under Title 33, chapter  
8 1, part 8;

9 (b) the provisions of Title 33, chapter 22, parts 7 and 19;

10 (c) the requirements of 33-22-134 and 33-22-135;

11 (d) network adequacy and quality assurance requirements provided under chapter 36; or

12 (e) the requirements of Title 33, chapter 18, part 9.

13 (7) Title 33, chapter 1, parts 6, 12, and 13, 33-2-1114, 33-2-1211, 33-2-1212, Title 33, chapter 2,  
14 parts 13, 19, and 23, 33-3-401, 33-3-422, 33-3-431, Title 33, chapter 3, part 6, Title 33, chapter 10, Title 33,  
15 chapter 12, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136,  
16 33-22-137, 33-22-138, 33-22-139, 33-22-141, 33-22-142, section 1, 33-22-152, 33-22-153, 33-22-156 through  
17 33-22-159, 33-22-180, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-  
18 524, 33-22-526, and Title 33, chapter 32, apply to health maintenance organizations."

19

20 **Section 5.** Section 33-35-306, MCA, is amended to read:

21 **"33-35-306. Application of insurance code to arrangements.** (1) In addition to this chapter, self-  
22 funded multiple employer welfare arrangements are subject to the following provisions:

23 (a) 33-1-111;

24 (b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare  
25 arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

26 (c) Title 33, chapter 1, part 7;

27 (d) Title 33, chapter 2, part 23;

28 (e) 33-3-308;

- 1 (f) Title 33, chapter 7;
- 2 (g) Title 33, chapter 18, except 33-18-242;
- 3 (h) Title 33, chapter 19;
- 4 (i) 33-22-107, 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-139, 33-22-141, 33-22-142,
- 5 section 1], 33-22-152, and 33-22-153; and
- 6 (j) 33-22-512, 33-22-515, 33-22-525, and 33-22-526.

7 (2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded  
8 multiple employer welfare arrangement that has been issued a certificate of authority that has not been  
9 revoked."

10

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

12 **"53-6-101. Montana medicaid program -- authorization of services.** (1) There is a Montana  
13 medicaid program established for the purpose of providing necessary medical services to eligible persons who  
14 have need for medical assistance. The Montana medicaid program is a joint federal-state program administered  
15 under this chapter and in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq. The  
16 department shall administer the Montana medicaid program.

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

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

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

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

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

27 (a) inpatient hospital services;

28 (b) outpatient hospital services;

- 1 (c) other laboratory and x-ray services, including minimum mammography examination as defined in
- 2 33-22-132;
- 3 (d) skilled nursing services in long-term care facilities;
- 4 (e) physicians' services;
- 5 (f) nurse specialist services;
- 6 (g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age,
- 7 in accordance with federal regulations and subsection ~~(40)(b)~~ (11)(b);
- 8 (h) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided
- 9 in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;
- 10 (i) targeted case management services, as authorized in 42 U.S.C. 1396n(g), for high-risk pregnant
- 11 women;
- 12 (j) services that are provided by physician assistants within the scope of their practice and that are
- 13 otherwise directly reimbursed as allowed under department rule to an existing provider;
- 14 (k) health services provided under a physician's orders by a public health department;
- 15 (l) federally qualified health center services, as defined in 42 U.S.C. 1396d(l)(2);
- 16 (m) routine patient costs for qualified individuals enrolled in an approved clinical trial for cancer as
- 17 provided in 33-22-153;
- 18 (n) for children 18 years of age and younger, habilitative services as defined in 53-4-1103; and
- 19 (o) services provided by a person certified in accordance with 37-2-318 to provide services in
- 20 accordance with the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.
- 21 (4) Medical assistance provided by the Montana medicaid program may, as provided by department
- 22 rule, also include the following services:
- 23 (a) medical care or any other type of remedial care recognized under state law, furnished by licensed
- 24 practitioners within the scope of their practice as defined by state law;
- 25 (b) home health care services;
- 26 (c) private-duty nursing services;
- 27 (d) dental services;
- 28 (e) physical therapy services;

- 1 (f) mental health center services administered and funded under a state mental health program
- 2 authorized under Title 53, chapter 21, part 10;
- 3 (g) clinical social worker services;
- 4 (h) prescribed drugs, dentures, and prosthetic devices;
- 5 (i) prescribed eyeglasses;
- 6 (j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;
- 7 (k) inpatient psychiatric hospital services for persons under 21 years of age;
- 8 (l) services of professional counselors licensed under Title 37, chapter 23;
- 9 (m) hospice care, as defined in 42 U.S.C. 1396d(o);
- 10 (n) case management services, as provided in 42 U.S.C. 1396d(a) and 1396n(g), including targeted
- 11 case management services for the mentally ill;
- 12 (o) services of psychologists licensed under Title 37, chapter 17;
- 13 (p) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C.
- 14 1396d(h), in a residential treatment facility, as defined in 50-5-101, that is licensed in accordance with 50-5-201;
- 15 (q) services of behavioral health peer support specialists certified under Title 37, chapter 38, provided
- 16 to adults 18 years of age and older with a diagnosis of a mental disorder, as defined in 53-21-102; and
- 17 (r) any additional medical service or aid allowable under or provided by the federal Social Security
- 18 Act.

19 (5) The department shall reimburse a service provided by means of telemedicine as defined in 37-3-  
 20 102 at the same rate as it reimburses the service when provided in an in-person setting if the service:

- 21 (a) is provided by a person licensed pursuant Title 37, chapter 3 or 20; and
- 22 (b) meets the criteria in [section 1(2)].

23 ~~(5)(6)~~ Services for persons qualifying for medicaid under the medically needy category of assistance,  
 24 as described in 53-6-131, may be more limited in amount, scope, and duration than services provided to others  
 25 qualifying for assistance under the Montana medicaid program. The department is not required to provide all of  
 26 the services listed in subsections (3) and (4) to persons qualifying for medicaid under the medically needy  
 27 category of assistance.

28 ~~(6)(7)~~ In accordance with federal law or waivers of federal law that are granted by the secretary of the

1 U.S. department of health and human services, the department may implement limited medicaid benefits, to be  
 2 known as basic medicaid, for adult recipients who are eligible because they are receiving cash assistance, as  
 3 defined in 53-4-201, as the specified caretaker relative of a dependent child and for all adult recipients of  
 4 medical assistance only who are covered under a group related to a program providing cash assistance, as  
 5 defined in 53-4-201. Basic medicaid benefits consist of all mandatory services listed in subsection (3) but may  
 6 include those optional services listed in subsections (4)(a) through (4)(r) that the department in its discretion  
 7 specifies by rule. The department, in exercising its discretion, may consider the amount of funds appropriated  
 8 by the legislature, whether approval has been received, as provided in 53-1-612, and whether the provision of a  
 9 particular service is commonly covered by private health insurance plans. However, a recipient who is  
 10 pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq., or  
 11 is less than 21 years of age is entitled to full medicaid coverage.

12 ~~(7)~~(8) The department may implement, as provided for in Title XIX of the Social Security Act, 42  
 13 U.S.C. 1396, et seq., as may be amended, a program under medicaid for payment of medicare premiums,  
 14 deductibles, and coinsurance for persons not otherwise eligible for medicaid.

15 ~~(8)~~(9) (a) The department may set rates for medical and other services provided to recipients of  
 16 medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

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

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

22 (ii) publishing a report on an annual basis that describes the process that a mental health center or  
 23 chemical dependency facility, as those terms are defined in 50-5-101, must utilize in order to receive payment  
 24 from Montana medicaid for services provided to individuals of different ages, diagnoses, and treatments.

25 ~~(9)~~(10) The services provided under this part may be only those that are medically necessary and that  
 26 are the most efficient and cost-effective.

27 ~~(10)~~(11) (a) The amount, scope, and duration of services provided under this part must be determined  
 28 by the department in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be

1 amended.

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

5 ~~(11)~~(12) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

6 ~~(12)~~(13) If available funds are not sufficient to provide medical assistance for all eligible persons, the  
7 department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical  
8 services made available under the Montana medicaid program after taking into consideration the funding  
9 principles set forth in subsection (2). (Subsection (3)(o) terminates September 30, 2023--sec. 7, Ch. 412, L.  
10 2019.)"

11

12 NEW SECTION. Section 7. Codification instruction. [Section 1] is intended to be codified as an  
13 integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 1].

14

15 COORDINATION SECTION. Section 8. Coordination instruction. If both House Bill No. 43 and  
16 [this act] are passed and approved and both bills contain a section amending 20-25-1403(5), then the  
17 amendments to 20-25-2403(5) are void and 20-25-1403(5) must be amended to read as follows:

18 "(5) The (a) Except as provided in subsection (5)(b), the provisions of Title 33 do not apply to the  
19 commissioner when exercising the duties provided in this part.

20 (b) A self-insured student health plan established under this part must include coverage for telehealth  
21 as provided in 33-22-138 and coverage and reimbursement for telemedicine as provided in [section 1]."

22

23 NEW SECTION. Section 9. Effective date. [This act] is effective January 1, 2022.

24

- END -