HOUSE BILL NO. 771

INTRODUCED BY T. WINTER

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING THE "ENSURING ACCESS TO HIGH-QUALITY CARE FOR THE TREATMENT OF OPIOID USE DISORDER ACT"; REQUIRING INSURANCE AND MEDICAID COVERAGE OF MEDICATION-ASSISTED TREATMENT OF OPIOID USE DISORDER; ESTABLISHING REQUIREMENTS FOR FACILITIES TREATING OPIOID USE DISORDER; PROVIDING A PENALTY; AMENDING SECTIONS 33-22-502, 33-31-111, 33-35-306, 37-7-504, 50-5-103, 50-5-207, 53-6-101, AND 53-24-208, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Short title.** [Sections 1 through 6] may be cited as the "Ensuring Access to High-Quality Care for the Treatment of Opioid Use Disorder Act".

NEW SECTION. **Section 2. Purpose.** It is the purpose of [sections 1 through 6] to enhance efforts to prevent and comprehensively treat opioid use disorder by using medication-assisted treatment to reduce opioid-related misuse, overdose, and death.

NEW SECTION. **Section 3. Definitions.** As used in [sections 1 through 6], the following definitions apply:

(1) "Behavioral therapy" means medically necessary individual, family, or group therapy designed to help a patient engage in the treatment process, modify the patient's attitudes and behaviors related to substance use, and increase healthy life skills.

(2) "Drug product substitution" means dispensing a drug product other than the drug product originally prescribed for medication-assisted treatment of opioid use disorder.

(3) "Health care provider" or "provider" means an individual licensed under Title 37 to provide health care in the ordinary course of business or practice of a profession.

(4) "Health insurer" or "insurer" means an entity licensed under Title 33 offering health insurance coverage as defined in 33-22-140.

(5) "Medical necessity" or "medically necessary" means health care services that a health care provider exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, treating, curing, or relieving a health condition, illness, injury, or disease or its symptoms and that are:

(a) in accordance with generally accepted standards of practice;

(b) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and

(c) not primarily for the convenience of the patient or health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

(6) "Medication-assisted treatment" means the use of medically necessary pharmacologic therapy in combination with counseling and behavioral therapy for the treatment of opioid use disorder by a publicly or privately owned opioid treatment program or office-based medication-assisted treatment program.

(7) "Nonquantitative treatment limitation" means any limitation on the scope or duration of treatment that is not expressed numerically.

(8) "Opioid treatment program" means a program that is accredited by the federal substance abuse and mental health services administration and licensed to dispense methadone and other medications for the treatment of opioid use disorders.

(9) "Pharmacologic therapy" means a medically necessary prescribed course of treatment that includes methadone, buprenorphine, extended-release injectable buprenorphine, naltrexone, naloxone, or other medications that are approved by the U.S. food and drug administration or considered evidence-based for the treatment of opioid use disorder.

(10) "Prescriber" means a medical practitioner, as defined in 37-2-101, licensed under Title 37 to administer and prescribe medicine and drugs.

(11) (a) "Prior authorization" means the process by which a health insurer or other utilization review entity determines the medical necessity of otherwise covered health care services before the services are provided.

(b) The term includes a health insurer's or utilization review entity's requirement that an insured or health care provider notify the health insurer or utilization review entity prior to receiving or providing a health care service.

(12) "Quantitative treatment limitation" means numerical limits on the scope or duration of treatment, including annual, episode, and lifetime day and visit limits.

(13) "Step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a medical condition that are medically appropriate for a particular patient are authorized by a health insurer or an entity under contract to process and pay claims for prescription drugs.

(14) "Therapeutic class" means a group of similar drug products that have the same or similar mechanisms of action and are used to treat a specific condition.

(15) "Therapeutic equivalent drug" means:

(a) a product assigned an "A" code by the U.S. food and drug administration in the Approved Products with Therapeutic Equivalence Evaluations book; and

(b) animal drug products published in the U.S. food and drug administration's Approved Animal Drug Products list.

NEW SECTION. **Section 4. Health insurer coverage of medication-assisted treatment services -- prior authorization -- step therapy.** (1) Subject to subsection (5), a health insurer shall provide coverage of medication-assisted treatment for the treatment of opioid use disorder as required under this section.

(2) A formulary used by a health insurer must include all current and new formulations and medications approved by the U.S. food and drug administration for the treatment of opioid use disorder, including but not limited to:

(a) buprenorphine, including extended-release injectable buprenorphine;

(b) methadone;

(c) naloxone; and

(d) extended-release injectable naltrexone.

(3) A health insurer shall place at least one drug product from each medication-assisted treatment class listed under subsections (2)(a) through (2)(c) on the lowest cost-sharing tier of the formulary managed by the health insurer.

(4) Coverage for medication-assisted treatment under [sections 1 through 5] may not be subject to:

(a) annual or lifetime dollar limitations; or

(b) financial requirements and quantitative or nonquantitative treatment limitations that do not comply with the federal Mental Health Parity and Addiction Equity Act of 2008 and related federal regulations.

(5) A health insurer may not impose prior authorization or step therapy requirements for a prescription that:

(a) is used to treat opioid use disorder; and

(b) is for an oral therapy that contains methadone, buprenorphine, or naloxone.

NEW SECTION. **Section 5. Prescriber-authorized substitution of medication-assisted treatment drugs.** (1) A licensed prescriber may authorize a pharmacist to substitute a drug prescribed for medication-assisted treatment of an opioid use disorder with another drug in the same therapeutic class that would, in the opinion of the pharmacist, have a substantially equivalent therapeutic effect even though the substitute drug is not a therapeutic equivalent drug, if:

(a) the prescriber has clearly indicated that drug product substitution is permissible by indicating "therapeutic substitution allowed" or by making a similar designation;

(b) the drug product substitution is intended to ensure formulary compliance with the patient's health insurance plan or, in the case of a patient without insurance, to lower the cost to the patient while maintaining safety;

(c) the patient agrees to the drug product substitution, and the pharmacist clearly informs the patient of the differences in the drug products and specifies that the patient may refuse the substitution; and

(d) when a drug product substitution is made:

(i) the prescriber's directions are modified to allow for an equivalent amount of drug to be dispensed and prescribed; and

(ii) the pharmacist notifies the patient's original prescriber of the drug product substitution within 5 business days of dispensing the prescription.

(2) The substitution of a drug product by a registered pharmacist under the provisions of this section does not constitute the practice of medicine.

NEW SECTION. **Section 6. Opioid use disorder treatment facility requirements -- penalty -- appeal process.** (1) An entity providing treatment for or applying for licensure by the state to provide clinical treatment services for opioid use disorder shall:

(a) use criteria established by the American society of addiction medicine for:

(i) providing outcome-oriented and results-based care in the treatment of the disorder; and

(ii) placement, continued stay, and transfer or discharge of patients with opioid use disorder and co-occurring conditions;

(b) disclose the medication-assisted treatment services it provides;

(c) disclose which of its levels of care have been certified by an independent, national, or other organization that has competencies in the use of the applicable placement guidelines and level of care standards; and

(d) facilitate access to medication-assisted treatment if a patient meets clinically appropriate criteria for treating opioid use disorder through medication-assisted treatment.

(2) (a) An entity providing clinical treatment services for opioid use disorder that violates subsection (1)(d) is subject to citation by the department and an administrative civil penalty not to exceed $500 for each day the facility is in violation of the requirement.

(b) The department may, in its sole discretion, waive or reduce a penalty under this subsection (2) if the entity providing clinical treatment services for opioid use disorder timely corrects or cures the violation for which the penalty was imposed.

(c) Penalties collected under this section must be deposited in the general fund.

(3) (a) A citation or a penalty may be appealed to the department. An appeal must be submitted in writing and made within 30 days of the issuance of the citation or penalty.

(b) The appeal of a citation or a penalty is conducted as a contested case under Title 2, chapter 4.

Section 7. Section 33-22-502, MCA, is amended to read:

"33-22-502. Required provisions of group policies. Each group disability insurance policy delivered or issued for delivery in this state must contain in substance the following provisions:

(1) a provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person must be considered representations and not warranties and that a statement made for the purpose of effecting insurance may not avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the insured person or the insured person's beneficiary;

(2) a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member and to whom benefits are payable. If dependents are included in the coverage, only one certificate is required to be issued for each family unit.

(3) a provision that to the group originally insured may be added from time to time eligible new

employees or members or dependents, as the case may be, in accordance with the terms of the policy;

(4) a provision or the equivalent that reads:

"Conformity with Montana statutes. The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

(5) a provision that the policy complies with the requirements of [sections 1 through 5]."

Section 8. Section 33-31-111, MCA, is amended to read:

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

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

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

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

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

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

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

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

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

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

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

(7) Title 33, chapter 1, parts 12 and 13, 33-2-1114, 33-2-1211, 33-2-1212, Title 33, chapter 2, parts 13, 19, and 23, 33-3-401, 33-3-422, 33-3-431, Title 33, chapter 3, part 6, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-137, 33-22-138, 33-22-139, 33-22-141, 33-22-142, 33-22-152, 33-22-153, 33-22-156 through 33-22-159, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-524, 33-22-526, ~~and~~ Title 33, chapter 32, and [sections 1 through 5] apply to health maintenance organizations."

Section 9. Section 33-35-306, MCA, is amended to read:

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

(a) 33-1-111;

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

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

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

(e) 33-3-308;

(f) Title 33, chapter 7;

(g) Title 33, chapter 18, except 33-18-242;

(h) Title 33, chapter 19;

(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, 33-22-152, and 33-22-153; ~~and~~

(j) 33-22-512, 33-22-515, 33-22-525, and 33-22-526; and

(k) [sections 1 through 5].

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

Section 10. Section 37-7-504, MCA, is amended to read:

"37-7-504. General prohibition of drug product substitution. No person may substitute a drug product different from the one ordered or deviate in any manner from the requirements of an order or prescription,

except as provided in [section 5] and in this part."

Section 11. Section 50-5-103, MCA, is amended to read:

"50-5-103. Rules and standards -- accreditation. (1) The department shall adopt rules and minimum standards for implementation of parts 1 and 2.

(2) Any facility covered by this chapter shall comply with the state and federal requirements relating to construction, equipment, and fire and life safety.

(3) The department shall extend a reasonable time for compliance with rules for parts 1 and 2 upon adoption.

(4) (a) Any hospital located in this state that furnishes written evidence required by the department, including the recommendation for future compliance statements, to the department of its accreditation granted by an entity listed in subsection (4)(b) is eligible for licensure in the state for the accreditation period and may not be subjected to an inspection by the department for purposes of the licensing process.

(b) A hospital may provide evidence of its accreditation by:

(i) DNV healthcare, inc.;

(ii) the healthcare facilities accreditation program; or

(iii) the joint commission.

(c) The department may, in addition to its inspection authority in 50-5-116, inspect any licensed health care facility to answer specific complaints made in writing by any person against the facility when the complaints pertain to licensing requirements. Inspection by the department upon a specific complaint made in writing pertaining to licensing requirements is limited to the specific area or condition of the health care facility to which the complaint pertains.

(5) The department may consider as eligible for licensure during the accreditation period any health care facility located in this state, other than a hospital, that furnishes written evidence, including the recommendation for future compliance statements, of its accreditation by the joint commission. The department may inspect a health care facility considered eligible for licensure under this section to ensure compliance with state licensure standards.

(6) The department may consider as eligible for licensure during the accreditation period any rehabilitation facility that furnishes written evidence, including the recommendation for future compliance statements, of accreditation of its programs by the commission on accreditation of rehabilitation facilities. The

department may inspect a rehabilitation facility considered eligible for licensure under this section to ensure compliance with state licensure standards.

(7) The department may consider as eligible for licensure during the accreditation period any outpatient center for surgical services that furnishes written evidence, including the recommendation for future compliance statements, of accreditation of its programs by the accreditation association for ambulatory health care. The department may inspect an outpatient center for surgical services considered eligible for licensure under this section to ensure compliance with state licensure standards.

(8) The department may consider as eligible for licensure during the accreditation period any behavioral treatment program, chemical dependency treatment program, residential treatment facility, or mental health center that furnishes written evidence, including the recommendation for future compliance statements, of accreditation of its programs by the council on accreditation and that, if applicable, meets the requirements of [section 6]. The department may inspect a behavioral treatment program, chemical dependency treatment program, residential treatment facility, or mental health center considered eligible for licensure under this section to ensure compliance with state licensure standards."

Section 12. 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.

(i) The applicant plans to provide treatment for opioid use disorder and does not meet the requirements of [section 6].

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

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

(4) 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 13. 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; ~~and~~

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

(o) treatment for opioid use disorder that complies with the requirements of [sections 1 through 5].

(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;

(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 professional counselors licensed under Title 37, chapter 23;

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

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

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

(p) 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; and

(q) 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 financial assistance, as defined in 53-4-201, as the specified caretaker relative of a dependent child under the FAIM project and for all adult recipients of medical assistance only who are covered under a group related to a program providing financial 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)(q) 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) 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)."

Section 14. Section 53-24-208, MCA, is amended to read:

"53-24-208. Facility standards. (1) The department shall establish standards for approved treatment facilities that must be met for a treatment facility to be approved as a public or private treatment facility and fix the fees to be charged for the required inspections. The standards must be adopted by rule and may concern the health standards to be met and standards for the approval of treatment programs for patients.

(2) Facilities applying for approval shall demonstrate that a local need currently exists for proposed services.

(3) A facility offering treatment for opioid use disorder must meet the requirements of [section 6].

~~(3)~~(4) The department shall periodically inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

~~(4)~~(5) The department shall maintain a list of approved public and private treatment facilities.

~~(5)~~(6) Each approved public or private treatment facility shall, on request, file with the department data, statistics, schedules, and information that the department reasonably requires. An approved public or private treatment facility that without good cause fails to furnish any data, statistics, schedules, or information as requested or files fraudulent returns of the requested material must be removed from the list of approved treatment facilities.

~~(6)~~(7) The department, after holding a hearing in accordance with the Montana Administrative Procedure Act, may suspend, revoke, limit, or restrict an approval or refuse to grant an approval for failure to meet its standards.

~~(7)~~(8) A district court may restrain any violation of this section, review any denial, restriction, or revocation of approval, and grant other relief required to enforce its provisions.

~~(8)~~(9) Upon petition of the department and after a hearing held upon reasonable notice to the facility, a district court may issue a warrant to the department authorizing it to enter and inspect at reasonable times and examine the books and accounts of any approved public or private treatment facility that refuses to consent to inspection or examination by the department or that the department has reasonable cause to believe is operating in violation of this chapter.

~~(9)~~(10) If a rehabilitation facility otherwise meets the requirement in subsection (2), the department may consider as eligible for approval during the accreditation period any rehabilitation facility that furnishes written evidence, including the recommendation for future compliance statements, of accreditation of its programs by the commission on accreditation of rehabilitation facilities. The department shall inspect a facility considered eligible for approval under this section to ensure compliance with state approval standards."

NEW SECTION. **Section 15. Codification instruction.** (1) [Sections 1 through 5] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 through 5].

(2) [Section 6] is intended to be codified as an integral part of Title 53, chapter 24, and the requirements of Title 53, chapter 24, apply to [section 6].

NEW SECTION. **Section 16. Effective date.** [This act] is effective January 1, 2020.

- END -