AN ACT GENERALLY REVISING MEDICAID LAWS RELATED TO DIRECT PRIMARY CARE; ALLOWING FOR COVERAGE OF DIRECT PRIMARY CARE CONTRACTS UNDER THE MONTANA MEDICAID PROGRAM; PROHIBITING THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES FROM REQUIRING A MEDICAID ENROLLEE TO PARTICIPATE IN A PRIMARY CARE CASE MANAGEMENT SERVICE IF THE ENROLLEE ENTERS INTO A DIRECT PRIMARY CARE CONTRACT; PROVIDING A DEFINITION OF DIRECT PRIMARY CARE CONTRACT; PROVIDING AN APPROPRIATION; AMENDING SECTIONS 53-6-101, 53-6-116, AND 53-6-124, MCA; AND PROVIDING AN EFFECTIVE DATE.

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

Section 1. Section 53-6-101, MCA, is amended to read:

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

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

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

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

(c) giving priority to services that employ the science of prevention to reduce disability and illness,

services that treat life-threatening conditions, and services that support independent or assisted living, including pain management, to reduce the need for acute inpatient or residential care.

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

(a) inpatient hospital services;

(b) outpatient hospital services;

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

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

(e) physicians' services;

(f) nurse specialist services;

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

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

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

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

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

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

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

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

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

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

(q) planned home births for women with a low risk of adverse birth outcomes, as established by the appropriate licensing board, that are attended by certified nurse-midwives licensed under Title 37, chapter

8, or direct-entry midwives licensed under Title 37, chapter 27. Coverage under this section includes prenatal care and postpartum care.

(4) Medical assistance provided by the Montana medicaid program may, as provided by department rule, also include the following services:

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

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

(c) private-duty nursing services;

(d) dental services;

(e) physical therapy services;

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

(g) clinical social worker services;

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

(i) prescribed eyeglasses;

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

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

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

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

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

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

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

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

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

(s) direct patient care agreements, as provided for in 50-4-107; and

~~(s)~~(t) 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)~~ (4)(t) 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 2. Section 53-6-116, MCA, is amended to read:

"**53-6-116. Medicaid managed care -- capitated health care.** (1) The department of public health and human services, in its discretion, may develop managed care and capitated health care systems for medicaid recipients.

(2) The department may contract with one or more persons for the management of comprehensive physical health services and the management of comprehensive mental health services for medicaid recipients. The department may contract for the provision of these services by means of a fixed monetary or capitated amount for each recipient.

(3) A managed care system is a program organized to serve the medical needs of medicaid recipients in an efficient and cost-effective manner by managing the receipt of medical services for a geographical or otherwise defined population of recipients through appropriate health care professionals.

(4) The provision of medicaid services through managed care and capitated health care systems is not subject to the limitations provided in 53-6-104. The managed care or capitated health care system that is provided to a defined population of recipients may be based on one or more of the medical assistance services provided for in 53-6-101.

(5) The proposed systems, referred to in subsection (1), must be submitted to the legislative finance committee. The legislative finance committee shall review the proposed systems at its next regularly scheduled meeting and shall provide any comments concerning the proposed systems to the department. The department shall provide a copy of any reports made to the legislative finance committee concerning the proposed systems to the legislature in accordance with 5-11-210.

(6) A managed care or capitated health care system, except for a primary care case management service, that requires for implementation a waiver from the centers for medicare and medicaid is subject to the provisions of Title 53, chapter 6, part 7.

(7) The department may not require an enrollee to participate in a primary care case management service if the enrollee enters into a direct patient care agreement pursuant to 50-4-107."

Section 3. Section 53-6-124, MCA, is amended to read:

"**53-6-124. Definitions.** As used in 53-6-101, 53-6-116, 53-6-125, 53-6-127, and this section, the following definitions apply:

(1) "Conversion factor" means the dollar value that is multiplied by the appropriate relative value unit to calculate a price for a service provided by a physician.

(2) "Department" means the department of public health and human services.

(3) "Direct patient care agreement" means an agreement for health care services as provided for in 50-4-107.

~~(3)~~(4) "Medicaid" means the Montana medical assistance program established under Title 53, chapter 6.

~~(4)~~(5) "Physician" has the meaning provided in 37-3-102.

~~(5)~~(6) "Policy adjuster" means a factor by which the fee determined under 53-6-125 is multiplied to increase the fee paid by medicaid for certain categories of services.

~~(6)~~(7) "Relative value unit" means a numerical value assigned in the resource-based relative value scale to each procedure code used to bill for services provided by a physician.

~~(7)~~(8) "Resource-based relative value scale" means the medicare resource-based relative value scale contained in the physician's medicare fee schedule adopted by the centers for medicare and medicaid services of the U.S. department of health and human services."

Section 4. Appropriation. There is appropriated $5,000 from the general fund to the department of public health and human services for the biennium beginning July 1, 2025, for the purposes of implementing [this act].

Section 5. Effective date. [This act] is effective July 1, 2025.

- END -

I hereby certify that the within bill,

HB 953, originated in the House.

_____

Chief Clerk of the House

_____

Speaker of the House

Signed this _____day

of_____, 2025.

_____

President of the Senate

Signed this _____day
of_____, 2025.

HOUSE BILL NO. 953

INTRODUCED BY E. BUTTREY

AN ACT GENERALLY REVISING MEDICAID LAWS RELATED TO DIRECT PRIMARY CARE; ALLOWING FOR COVERAGE OF DIRECT PRIMARY CARE CONTRACTS UNDER THE MONTANA MEDICAID PROGRAM; PROHIBITING THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES FROM REQUIRING A MEDICAID ENROLLEE TO PARTICIPATE IN A PRIMARY CARE CASE MANAGEMENT SERVICE IF THE ENROLLEE ENTERS INTO A DIRECT PRIMARY CARE CONTRACT; PROVIDING A DEFINITION OF DIRECT PRIMARY CARE CONTRACT; PROVIDING AN APPROPRIATION; AMENDING SECTIONS 53-6-101, 53-6-116, AND 53-6-124, MCA; AND PROVIDING AN EFFECTIVE DATE.