SENATE BILL NO. 366

INTRODUCED BY M. CAFERRO

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING THE CHILDREN'S HEALTH INSURANCE PROGRAM TO COVER TREATMENT OF AUTISM SPECTRUM DISORDER; AMENDING SECTION 53-4-1005, MCA; AND PROVIDING AN EFFECTIVE DATE AND A CONTINGENT TERMINATION DATE."

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

NEW SECTION. **Section 1. Coverage of autism spectrum disorder.** (1) The program must provide coverage of treatment as specified in this section for a child who is diagnosed with autism spectrum disorder as defined by the department by rule and in compliance with the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

(2) Coverage must include:

(a) habilitative and rehabilitative care that is prescribed, provided, or ordered by a licensed physician or licensed psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;

(b) medications prescribed by a physician licensed under Title 37, chapter 3;

(c) psychiatric or psychological care; and

(d) therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.

(3) (a) Habilitative and rehabilitative care includes medically necessary interactive therapies derived from evidence-based research, including applied behavior analysis.

(b) Applied behavior analysis services covered under this section must be designed and overseen by an individual who is certified by the behavior analyst certification board as a board-certified behavior analyst or board-certified behavior analyst-doctoral.

(4) Special deductibles, coinsurance, copayment, or other limitations that are not applicable to other medical care covered under the program may not be imposed on the coverage for autism spectrum disorder provided for in this section.

(5) (a) When treatment is expected to require continued services, the program may request that the treating physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is medically necessary. The treatment plan must be based on evidence-based screening criteria.

(b) The program may ask that the treatment plan be updated every 6 months.

(6) As used in this section, "medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician or psychologist licensed in this state and that will or is reasonably expected to:

(a) prevent the onset of an illness, condition, injury, or disability;

(b) reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability; or

(c) assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

Section 2. Section 53-4-1005, MCA, is amended to read:

"53-4-1005. (Temporary) Benefits provided. (1) Benefits provided to participants in the program may include but are not limited to:

(a) inpatient and outpatient hospital services;

(b) physician and advanced practice registered nurse services;

(c) laboratory and x-ray services;

(d) well-child and well-baby services;

(e) immunizations;

(f) clinic services;

(g) dental services;

(h) prescription drugs;

(i) mental health and substance abuse treatment services;

(j) treatment of autism spectrum disorder as provided in [section 1];

~~(j)~~(k) hearing and vision exams; and

~~(k)~~(l) eyeglasses.

(2) The program must comply with the provisions of 33-22-153.

(3) The department shall adopt rules, pursuant to its authority under 53-4-1009, allowing it to cover significant dental needs beyond those covered in the basic plan. Expenditures under this subsection may not exceed $100,000 in state funds, plus any matched federal funds, each fiscal year.

(4) The department is specifically prohibited from providing payment for birth control contraceptives under this program.

(5) The department shall notify enrollees of any restrictions on access to health care providers, of any restrictions on the availability of services by out-of-state providers, and of the methodology for an out-of-state provider to be an eligible provider. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999; sec. 3, Ch. 169, L. 2007; sec. 10, Ch. 97, L. 2013.)"

NEW SECTION. **Section 3. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 53, chapter 4, part 10, and the provisions of Title 53, chapter 4, part 10, apply to [section 1].

NEW SECTION. **Section 4. Effective date.** [This act] is effective July 1, 2015.

NEW SECTION. **Section 5. Contingent termination.** (1) (a) [Section 1] terminates on the date that the director of the department of public health and human services certifies to the governor that the federal government has terminated the program or that federal funding for the program has been discontinued.

(b) The governor shall transmit a copy of the certification to the code commissioner.

(c) Any excess funds remaining upon the termination of the program must be transferred to the general fund.

(2) [Section 2] terminates on occurrence of the contingency contained in section 15, Chapter 571, Laws of 1999.

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