BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 37.90.402, 37.90.403, 37.90.406, 37.90.408, 37.90.409, 37.90.410, 37.90.412, 37.90.425, 37.90.433, 37.90.434, 37.90.439, and 37.90.449 and the adoption of NEW RULES I and II pertaining to Mental Health Medicaid Funded 1115 and 1915 Waivers	)))))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT AND ADOPTION

TO: All Concerned Persons

1. On June 3, 2024, at 10:00 a.m., the Department of Public Health and Human Services will hold a public hearing via remote conferencing to consider the proposed amendment and adoption of the above-stated rules. Interested parties may access the remote conferencing platform in the following ways:

(a) Join Zoom Meeting at: https://mt-gov.zoom.us/j/89388521515?pwd=UWVJUnBnY1JNUmd0dWQzYkdFRmszZz09 meeting ID: 893 8852 1515, and password: 351760; or

(b) Dial by telephone: +1 646 558 8656, meeting ID: 893 8852 1515, and password: 351760. Find your local number: https://mt-gov.zoom.us/u/kbLvdVFxyQ.

2. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the Department of Public Health and Human Services no later than 5:00 p.m. on May 20, 2024, to advise us of the nature of the accommodation that you need. Please contact Bailey Yuhas, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; telephone (406) 444-4094; fax (406) 444-9744; or e-mail hhsadminrules@mt.gov.

3. The rules as proposed to be amended or adopted provides as follows, new matter underlined, deleted matter interlined:

37.90.402 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: ~~THE PROVISION OF~~ SERVICES (1) The services available through the waiver program are:

(a) adult day health, as ~~defined~~ described in ARM 37.90.430;

(b) behavioral intervention assistant, as ~~defined~~ described in ARM ~~37.90.436~~ 37.90.433;

(c) case management, as ~~defined~~ described in ARM 37.90.425;

(d) community transition services, as ~~defined~~ described in ARM 37.90.415;

(e) consultative clinical and therapeutic services, as ~~defined~~ described in ARM 37.90.418;

(f) environmental accessibility adaptations, as ~~defined~~ described in ARM ~~37.90.409~~ 37.90.414;

(g) health and wellness, as ~~defined~~ described in ARM 37.90.417;

(h) homemaker chore, as ~~defined~~ described in ARM ~~37.90.437~~ 37.90.419;

(i) life coach, as ~~defined~~ described in ARM 37.90.434;

(j) meals, as ~~defined~~ described in ARM ~~37.90.446~~ 37.90.426;

(k) non-medical transportation, as ~~defined~~ described in ARM 37.90.450;

(l) pain and symptom management, as ~~defined~~ described in ARM 37.90.416;

(m) personal assistance service, as ~~defined~~ described in ARM 37.90.431;

(n) personal emergency response system, as ~~defined~~ described in ARM 37.90.448;

(o) private duty nursing, as ~~defined~~ described in ARM 37.90.447;

(p) residential habilitation, as ~~defined~~ described in ARM ~~37.90.428, 37.90.429, 37.90.432, 37.90.460, and 37.90.461~~ 37.90.451, 37.90.452, 37.90.453, 37.90.454, and 37.90.455;

(q) respite care, as ~~defined~~ described in ARM 37.90.438;

(r) specialized medical equipment and supplies, as ~~defined~~ described in ARM 37.90.449; and

(s) supported employment, as ~~defined~~ described in ARM ~~37.90.445~~ 37.90.435.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

37.90.403 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: DEFINITIONS (1) "Activities of daily living" (ADL) means basic personal everyday activities.

(2) "Applicant" means an individual requesting services but not enrolled in the SDMI program.

~~(2)~~(3) "Community First Choice" ~~(CFC)~~ and "Personal Assistance Service" ~~(PAS)~~ Programs (CFC/PAS) are Medicaid state plan programs designed to provide long term supportive care in a home setting. These programs are distinct from the PAS waiver service described in ARM 37.90.431.

(4) "Critical incident" is an incident that is serious in nature and poses a risk to the health, safety, or welfare of an enrolled member or others. It is a serious occurrence that includes abuse, neglect, and exploitation, each of which are defined under 52-3-803, MCA.

(5) "Enrolled member" means an individual enrolled in the SDMI program and authorized to receive services under the SDMI program.

(3) remains the same but is renumbered (6).

~~(4)~~(7) "Instrumental activities of daily living" (IADL) means household tasks which are limited to cleaning the area used by the member.

~~(5)~~(8) "Level of care assessment" (LOC) means a functional assessment used to determine if an individual requires the level of care normally provided in a nursing facility.

~~(6)~~(9) "Level of impairment assessment" (LOI) means an assessment used to identify areas in which a member requires long term services and supports.

~~(7) "Member" means an individual who is Medicaid eligible.~~

~~(8)~~(10) "Mental health professional" ~~means as defined~~ has the meaning provided in 53-21-102, MCA.

(11) "Non-critical incidents" are minor in nature and do not pose a risk to the health, safety, or welfare of an enrolled member or others.

(12) "Person-centered recovery plan" (PCRP) is a written plan that identifies the supports and services that are necessary for the enrolled member to remain out of institutional level of care, allow the enrolled member to function at the enrolled member's maximum capacity, and enable the enrolled member to achieve personal goals toward recovery.

~~(9)~~(13) "Quality improvement organization" (QIO) means ~~a group of health quality experts organized to improve the quality of care delivered to members~~ the entity under contract with the department to complete agreed upon utilization review activities for Montana Medicaid services.

~~(10) "Serious occurrence" means a significant event which affects the health, welfare, and safety of a member served in home and community-based services. The department has established a system of reporting and monitoring critical and non-critical incidents that involve members served by the program in order to identify, manage, and mitigate overall risk to the member. For information pertaining to reporting a serious occurrence, see the SDMI HCBS Policy #305, located at: https://dphhs.mt.gov/amdd/HCBSPolicyManual.~~

~~(11)~~(14) ~~"Severe and disabling mental illness" is defined in ARM 37.90.409~~ "SDMI" is used in this subchapter to refer to severe and disabling mental illness, which is described in ARM 37.90.409.

(15) "SDMI HCBS waiver program" is used in this subchapter to refer to severe and disabling mental illness home and community-based services waiver services.

AUTH: 52-3-803, 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

37.90.406 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: PROVIDER REQUIREMENTS (1) The waiver program services may only be provided by a provider that:

(a) is enrolled as a Montana Medicaid provider except as provided in (2);

(b) remains the same.

(c) meets the criteria as a qualified provider authorized to deliver the service as specified in this subchapter. ~~the Provider Requirements Matrix for the SDMI HCBS waiver program. The department adopts and incorporates by reference the Provider Requirements Matrix for the SDMI HCBS waiver program, dated July 1, 2020, and located at: https://dphhs.mt.gov/amdd/HCBSPolicyManual.~~

(2) The department may authorize a ~~SDMI HCBS~~ contracted case management entity to issue pass-through payment for reimbursement of services rendered by a non-Medicaid provider for the following services:

(a) through (4) remain the same.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

37.90.408 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: REIMBURSEMENT

(1) through (3) remain the same.

(4) The SDMI HCBS waiver program will not reimburse for services provided to individuals of an enrolled member's household or family.

(5) All SDMI HCBS services, except for case management, must be prior authorized before delivery of services. Services that are delivered before prior authorization is received will not be approved and, if reimbursed, may be subject to repayment.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

37.90.409 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: SEVERE AND DISABLING MENTAL ILLNESS DIAGNOSIS CRITERIA (1) To ~~qualify for the SDMI HCBS waiver program~~ be found to have a qualifying SDMI diagnosis, ~~a member~~ an individual must:

(a) remains the same.

(b) have a minimum of three areas of high-level impairment indicated by a score of three or higher on the Behavioral Health and Developmental Disabilities (BHDD) Severe and Disabling Mental Illness, Home and Community-Based (HCBS) Waiver, Evaluation and Level of Impairment (LOI) form; and

(c) and (c)(i) remain the same.

(ii) diagnosed with one of the following diagnoses ~~in (2)~~, excluding mild or not otherwise specified~~.~~:

~~(2) The following qualify as a severe and disabling mental illness diagnosis:~~

~~(a)~~(A) Schizophrenia, paranoid type;

~~(b)~~(B) Schizophrenia, disorganized type;

~~(c)~~(C) Schizophrenia, catatonic type;

~~(d)~~(D) Schizophrenia, undifferentiated type;

~~(e)~~(E) Schizophrenia, residual type;

~~(f)~~(F) Delusional disorder;

~~(g)~~(G) Schizoaffective disorder;

~~(h)~~(H) Schizoaffective disorder, depressive type;

~~(i)~~(I) Bipolar I disorder, manic, moderate;

~~(j)~~(J) Bipolar I disorder, manic, severe without psychotic features;

~~(k)~~(K) Bipolar I disorder, manic, severe with psychotic features;

~~(l)~~(L) Bipolar I disorder, depressed, moderate;

~~(m)~~(M) Bipolar I disorder, depressed, severe without psychotic features;

~~(n)~~(N) Bipolar I disorder, depressed, severe with psychotic features;

~~(o)~~(O) Bipolar I disorder, mixed, moderate;

~~(p)~~(P) Bipolar I disorder, mixed, severe without psychotic features;
~~(q)~~(Q) Bipolar I disorder, severe with psychotic features;
~~(r)~~(R) Bipolar II disorder;
~~(s)~~(S) Major depressive disorder, single, moderate;
~~(t)~~(T) Major depressive disorder, single, severe without psychotic features;
~~(u)~~(U) Major depressive disorder, single, severe with psychotic features;
~~(v)~~(V) Major depressive disorder, recurrent, moderate;
~~(w)~~(W) Major depressive disorder, recurrent, severe without psychotic features;
~~(x)~~(X) Major depressive disorder, recurrent, severe with psychotic features;
~~(y)~~(Y) Post traumatic stress disorder, acute;
~~(z)~~(Z) Post traumatic stress disorder, chronic;
~~(aa)~~(AA) Generalized anxiety disorder; and
~~(ab)~~(AB) Borderline personality disorder.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

37.90.410 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: ~~ELIGIBILITY AND SELECTION~~ CONSIDERATION FOR PROGRAM ELIGIBILITY AND ENROLLMENT SELECTION (1) ~~A member~~ An applicant ~~is eligible~~ may be considered for enrollment in the program if the ~~member~~ applicant meets the following criteria:

(a) and (b) remain the same.

(c) requires the level of care (LOC) of a nursing facility ~~as determined by the Quality Improvement Organization under contract with the department~~;

(d) meets the ~~severe and disabling mental illness~~ criteria ~~at~~ in ARM 37.90.409; and

~~(e) meets the level of impairment criteria established in the waiver program Evaluation and Level of Impairment (LOI) form, as determined by a licensed mental health professional, by scoring a three or higher on at least two areas.~~

(e) meets the following additional criteria:

(i) the case management team determines that the applicant needs at least two SDMI HCBS waiver program services that can only be met through the SDMI HCBS waiver program. One of those services must be case management, and the SDMI HCBS waiver program service of meals cannot be counted as one of the two services; and

(ii) the case management team determines that the service providers necessary to deliver the services requested by the applicant are available at the time of enrollment.

(2) ~~Once a member~~ When an applicant is found eligible to receive waiver program services, the ~~member is referred to the appropriate case management team. The~~ case management team will:

(a) offer~~s~~ the ~~member~~ applicant an available opening for program services if ~~one~~ an opening is available; or

(b) places the ~~member~~ applicant on the wait list ~~for an available opening~~ if an opening for program services is not available.

(3) ~~A member~~ If an applicant is placed on the wait list in accordance with (2)(b), the applicant will be placed on the SDMI HCBS waiver program wait list in the service areas the ~~member~~ applicant selects.

(4) The case management team must use the ~~member's~~ applicant's combined LOC and LOI scores to determine the ~~member's~~ applicant's score for relative placement on the SDMI HCBS waiver program wait list.

(5) If more than one ~~member~~ applicant has the same combined wait list score, then each ~~member~~ applicant is placed on the SDMI HCBS waiver program wait list based upon the ~~member's~~ applicant's wait list score as determined in (4), and thereafter in the order in which the applicant is placed on the SDMI HCBS waiver program wait list ~~on a first-come, first-served basis~~.

(6) Placement on the SDMI HCBS waiver program wait list is not a guarantee an applicant will receive enrollment into the SDMI HCBS waiver program. Individuals qualified but not enrolled in another waiver program may be placed on the SDMI HCBS waiver program wait list. While on the SDMI HCBS waiver program wait list, the case management team will assist applicants in securing available non-waiver supports or services.

(7) The case management teams must review the SDMI HCBS waiver program wait list and update the SDMI HCBS waiver program wait list quarterly to ensure that individuals on the list continue to meet criteria for SDMI HCBS waiver program services. The review consists of verifying everyone's ongoing Medicaid eligibility, ongoing need for at least two SDMI HCBS waiver program services, and continued LOC and LOI criteria.

(8) An applicant must be removed from the wait list for the following reasons:

(a) the applicant's whereabouts are unknown, and the case management team has attempted to contact the applicant a minimum of twice per quarter for two consecutive quarters and no response has been received from the applicant;

(b) the case management team determines that the service providers necessary to deliver at least two SDMI HCBS waiver program services requested by the applicant are unavailable. The SDMI HCBS waiver program meals service does not count towards the two services;

(c) the applicant's needs cannot be met by the SDMI HCBS waiver program, as determined by the case management team;

(d) the applicant has reported he or she will not or cannot pay any Medicaid spend down;

(e) the applicant has moved out of state;

(f) the applicant requests to be removed from the wait list;

(g) the Office of Public Assistance has determined the applicant does not meet established financial and resource criteria; or

(h) the applicant's death is confirmed.

(9) An applicant must not remain on the wait list for more than six consecutive months. Exceptions may be made with prior approval from SDMI program staff.

~~(6)~~(10) The case management team must provide an enrolled member with written notice ten working days before termination of services due to a determination

of program ineligibility. An enrolled member may be removed from the SDMI HCBS waiver program for the following reasons:

(a) a determination by a mental health professional that the enrolled member no longer meets the ~~eligibility~~ SDMI diagnosis criteria set forth in ARM 37.90.409;

(b) the enrolled member ~~does not~~ fails to select ~~and~~ or does not actively participate in at least two services in the waiver program within ~~45~~ 30 calendar days from the date the enrolled member agrees to and signs the PCRP. The service of meals cannot be counted as one of the two services;

(c) the department determines that the enrolled member has failed to utilize or to ~~attempted~~ attempt to utilize at least two waiver services, in ~~over 90~~ 30 days, with repeated attempts documented by the case management team to engage the enrolled member; ~~and~~

(d) the enrolled member no longer requires the level of care of a nursing facility as determined by the ~~Quality Improvement Organization~~ QOI under contract with the department~~.~~;

(e) the case management team or program staff received written notification from the Office of Public Assistance confirming Medicaid ineligibility;

(f) insufficient SDMI HCBS waiver program funds;

(g) the enrolled member moved out of state;

(h) the enrolled member refuses to sign or participate in the completion of the PCRP or quarterly review;

(i) the enrolled member's behavior creates serious risk to the member, caregivers, or others, or substantially impedes the delivery of services as established in the PCRP;

(j) the enrolled member's death;

(k) the enrolled member's failure to use services as established in the PCRP;

(l) the enrolled member's needs cannot be met through the SDMI HCBS waiver program;

(m) the enrolled member's written request to withdraw from the program;

(n) the health of the enrolled member deteriorates or in some manner places the enrolled member at serious risk of harm;

(o) the enrolled member is admitted to a nursing facility or hospital for a stay exceeding 30 days;

(p) the service providers necessary for the delivery of services are unavailable; or

(q) the services are no longer appropriate or effective in relation to the enrolled member's needs as determined by the case management team.

~~(7)~~(11) Eligibility for consideration for the waiver program does not entitle an individual to ~~for~~ selection and entry into the program.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

37.90.412 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: PERSON-CENTERED RECOVERY PLAN (1) ~~A person-centered recovery Plan (PCRP) is a written plan that identifies the supports and services that are necessary for the member to~~

~~remain out of institutional level of care, allow the member to function at the member's maximum capacity, and achieve personal goals towards recovery.~~ The PCRP is developed by the enrolled member and the case management team to meet the enrolled member's identified needs as well as cost of identified services.

(2) All services must be specifically authorized in writing in the enrolled member's PCRP.

(3) Each PCRP must be developed, reviewed, and revised by the CIO case management team. The case management team must:

(a) ~~initiate the development of the~~ develop an initial PCRP upon the enrolled member's enrollment into the SDMI HCBS waiver program~~;~~ which is the date the enrolled member begins receiving services under the SDMI HCBS waiver program;

(b) ensure the initial PCRP includes all aspects of (5)(a) through (m) based on the LOC, LOI, and the information obtained by the case management team;

(c) initiate the strength assessment to determine the enrolled member's strengths, needs, preferences, goals, and desired outcomes, along with his/her health status and risk factors. The strength assessment must be initiated within 30 days of enrollment into the care management system;

(d) complete the strength assessment within three months of the enrolled member's enrollment into the program. Upon completion of the strength assessment, the PCRP is finalized;

~~(b)~~(e) have monthly telephone contact with the enrolled member consisting of monthly monitoring calls;

(f) conduct in-person reviews of the PCRP with the enrolled member every three months. Any issues with the PCRP and the delivery and implementation of services are to be discussed at this time. The review is conducted at the enrolled member's place of residence, place of service, or other appropriate setting, as determined by the enrolled member's needs. This is an opportunity for case management teams to monitor the health and welfare of the enrolled member and evaluate the delivery of services to the enrolled member. This review includes evaluating and assessing strategies for meeting the needs, preferences, and goals of the enrolled member. It also includes evaluating and obtaining information concerning the enrolled member's satisfaction with the services, the effectiveness of services being provided, changes in the enrolled member's function, and cost effectiveness of the services.

~~(c)~~(g) ~~review the PCRP quarterly with the member in the member's residence, place of service, or other appropriate setting, and~~ update the PCRP ~~if there are~~ to reflect any changes to the information listed in (5)(a) through (j); and

~~(d)~~(h) complete an annual review of the PCRP with the enrolled member and update the PCRP if there are any changes to the information listed in (5)(a) through (j).

(4) The case management team must develop the PCRP in consultation with:

(a) the enrolled member or the enrolled member's legal representative;

(b) the enrolled member's treating professional and other appropriate health care professionals; and

(c) others who have knowledge of the enrolled member's needs.

(5) The PCRP must include:

(a) the primary SDMI diagnosis and any other diagnosis of the enrolled member that are relevant to the services provided;

(b) the enrolled member's symptoms, complaints, and complications indicating the need for services;

(c) the enrolled member's strengths, areas of concern, goals, objectives, and required interventions;

(d) the ~~SMDI~~ SDMI ~~HCSB~~ HCBS waiver program services that will be provided;

(e) all other services the enrolled member requires including Montana Medicaid state plan services and community-based services and supports.~~; however~~ However, including non-program services in the PCRP does not obligate the department to pay for the non-program services or ensure their delivery or quality;

(f) a description of how each service addresses each of the enrolled member's functional needs outlined in the Severe and Disabling Mental Illness, Home and Community Based Services, Evaluation and Level of Impairment form;

(g) through (j) remain the same.

(k) the signature of the enrolled member or the enrolled member's legal representative which signifies the participation in and agreement of the PCRP; ~~and~~

(l) the names and signatures of all individuals who participated in the development of the PCRP which signifies the participation in and agreement of the PCRP.~~;~~ and

(m) the enrolled member's bill of rights that informs enrolled members they have the right to choose from the full range of services available in the waiver if appropriate and that services will be delivered by a qualified provider of the enrolled member's choice.

(6) remains the same.

(7) The case management team must retain all of the enrolled member's records in accordance with ARM 37.85.414.

(8) The PCRP must be approved by the department initially and then annually. The annual review must ensure compliance with this rule and federal guidance. If the initial PCRP is found to meet program criteria, the department must approve the PCRP within 30 days of enrollment into the care management system.

(9) The department reviews all initial and annual PCRP and at any time there is a change.

(10) The PCRP is subject to review by the department at any time.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

37.90.425 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: CASE MANAGEMENT

(1) Case management means case management as defined in ~~at~~ the Code of Federal Regulations (CFR) at 42 CFR 440.169(d)(e).

(2) remains the same.

(3) A case management team must consist of:

~~(a) a registered nurse or a licensed practical nurse, with experience on a case management team serving members through a program of home and~~

~~community-based services for the elderly and persons with physical disabilities, or severe and disabling mental illness; and~~

~~(b)~~(a) a ~~social worker~~ case manager with a bachelor's ~~degree~~ level education in the field of human services; and ~~and two consecutive years' experience providing case management services to adults with severe and disabling mental illness.~~

(b) a registered nurse, licensed practical nurse, licensed clinical social worker, or licensed clinical professional counselor to provide clinical supervision for every two case managers.

(4) Case management teams submit annual report cards to the SDMI HCBS waiver program staff as well as monthly utilization reports to ensure that quality assurance measures are met in accordance with performance measures.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

37.90.433 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: BEHAVIORAL INTERVENTION ASSISTANT (1) Behavioral Intervention Assistant service is provided when the ~~personal assistance services~~ PAS available in the waiver and CFC/PAS provided in the state plan are insufficient in meeting the needs of the enrolled member due to challenging behaviors and assistance is required to improve or restore function in ~~activities of daily living (~~ADL~~s~~), ~~instrumental activities of daily living (~~IADL~~s~~), or social and adaptive skills.

(2) Behavioral intervention assistant service is provided by entities that are licensed and insured to deliver personal care services. If an enrolled member chooses to self-direct their services as a co-employer, the enrolled member must use an agency providing personal assistance, behavioral intervention assistance, or life coach type services, with the goal of ensuring the enrolled member is successful with the self-direction experience.

(3) Behavioral intervention assistants must ~~have at least eight hours of specialized behavioral health training annually that is approved by the department.~~:

(a) have at least eight hours of mental health training within six months of hire and annually thereafter, in order to develop and maintain specialized skills to address the challenging behaviors of enrolled members;

(b) be at least 18 years of age;

(c) receive training, within 30 days of hire in:

(i) abuse reporting;

(ii) incident reporting;

(iii) client confidentiality; and

(iv) any specialty training required or needed to sufficiently address the entire needs of the enrolled member, to provide whole person care;

(d) possess the ability to complete the documentation requirements of the program; and

(e) possess a valid driver's license and proof of auto liability insurance if transporting the enrolled member.

(4) Behavioral intervention assistants provide instructive assistance, cueing to prompt, and supervision, to assist the enrolled member in completion of ADLs, IADLs, and community integration activities.

(5) Behavioral intervention assistant services may not be provided concurrently with personal assistance services or supported employment services.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

37.90.434 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: LIFE COACH (1) Life coach focuses on social determinants of health (SDoH) that impact an enrolled member's overall health and well-being, and addresses the obstacles that impede an enrolled member's progress towards self-sufficiency, improved health, and well-being.

(2) Life coach services may be provided by:

(a) remains the same.

(b) ~~home health agencies~~ personal care entities; ~~and~~

(c) other entities approved by the department~~.~~; or

(d) a member self-directing the service, as described in ARM 37.90.439.

(3) remains the same.

(4) All life coach providers must complete and submit the designated application to the department.

~~(4)~~(5) An enrolled member must have a SDoH assessment with identified needs and established goals in their ~~person-centered recovery Plan~~ PCRP.

(5) and (6) remain the same but are renumbered (6) and (7).

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

37.90.439 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: SELF-DIRECTED SERVICES (1) ~~Self-directed services may only be provided by an agency.~~ Enrolled members in the waiver program must be offered an opportunity to utilize self-directed services as a co-employer. Once an enrolled member's comprehensive assessment and PCRP process have been completed and needed waiver services are identified, the enrolled member may select the specific services they wish to self-direct from the list of services indicated in (10). The enrolled member may also receive some of the services in their PCRP through traditional supports and services from a provider agency, as long as no services are duplicated. The entities responsible for supporting self-direction include case managers, the QIO, and the provider agencies.

(2) Services may be directed by:

(a) an enrolled member who has the capacity to self-direct, as determined by the department or the department's designee;

(b) a legal representative of the enrolled member, including a parent, spouse, or legal guardian; or

(c) a nonlegal representative freely chosen by the enrolled member or ~~his/her~~ the enrolled member's legal representative.

(3) The person directing the services must:

(a) and (b) remain the same.

(c) if acting in the capacity of a representative, demonstrate understanding of the enrolled member's needs and preferences.

(4) If an enrolled member indicates an interest in the self-directed option, the case management team is responsible for referring the enrolled member to the QIO. The QIO must assign a health care professional to:

(a) conduct a capacity interview over the telephone; and

(b) certify that the enrolled member, legal representative, or nonlegal personal representative is capable of managing the tasks and understands the risks involved. An approved capacity determination is required to self-direct services.

~~(4)~~(5) The case management teams must:

~~(a) refer member to the department's designee for a functional capacity evaluation; and~~

~~(b)~~(a) assist the enrolled member to develop an emergency backup plan, identifying and mitigating risks or potential risks, and monitor the health and safety of the enrolled member. Agency-based PAS managed by provider agencies under agreement with Medicaid are not available to enrolled members who are participating in the self-directed program. The use of PAS managed by provider agencies is permissible only if the enrolled member's backup plan fails;

(b) educate enrolled members regarding self-directed opportunities;

(c) meet with enrolled members to detail the self-directed service options during the intake process, annual visit, as well as throughout their service plan year as indicated through assessed need;

(d) provide assistance for informed decision-making by enrolled members and their families/representatives about the election of self-direction with information and training on the roles, risks, and responsibilities assumed by those who choose self-direction;

(e) inform enrolled members they are able to assist with the development of formal/informal supports, plan development, as well as available resources for self-direction; and

(f) oversee the service delivery in the self-direct option.

~~(5)~~(6) ~~Members~~ The enrolled member, the enrolled member's legal representative, or the nonlegal personal representative must:

(a) and (b) remain the same.

(c) understand the shared responsibility between the enrolled member and the provider agency.

~~(6)~~(7) Enrolled members will be able to choose from several agencies providing personal assistance type services, ensuring members are successful with the self-direction experience. The provider agency must:

(a) advise, train, and support the enrolled member, as identified in the enrolled member's ~~Person-Centered Recovery Plan~~ PCRP;

(b) remains the same.

(c) assist with monitoring the ~~monitor~~ health and welfare of the enrolled member.

~~(7)~~(8) Self-directed services can be terminated when:

(a) the enrolled member chooses not to self-direct; or

(b) the case management team or the department identifies an instance where the self-directed option is not in the best interest of the enrolled member~~,~~; and a corrective action does not improve the situation.

~~(c) a corrective action does not improve the situation.~~

~~(8)~~(9) The enrolled member must be informed in writing of the plan to transfer to an agency-based service delivery.

(10) The following services may be self-directed as a co-employer:

(a) personal assistance services;

(b) behavioral intervention assistance; and

(c) life coach.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

37.90.449 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (1) Specialized medical equipment and supplies service is the provision of items of medical equipment and supplies to an enrolled member for the purpose of maintaining and improving the enrolled member's ability to reside at home and to function in the community.

(2) Specialized medical equipment and supplies must:

(a) be functionally necessary and relate specifically to the enrolled member's disability;

(b) substantively meet the enrolled member's needs for accessibility, independence, health, or safety;

(c) be likely to improve the enrolled member's functional ability or the ability of a caregiver or service provider to maintain the enrolled member in the enrolled member's home; and

(d) be the most cost-effective item that can meet the needs of the enrolled member.

(3) Specialized medical equipment and supplies service~~s do~~ does not include:

(a) and (b) remain the same.

(c) basic household furniture; ~~or~~

(d) educational items including computers, software, and books unless such items are purchased in conjunction with an environmental control unit~~.~~; or

(e) coverage for dentistry or dental-related procedures, services, equipment or supplies. This includes any 'D' procedure code definitions identified in the current American Medical Association's Common Procedural Terminology (CPT) manual or identified as dental pursuant to Medicare, the American Dental Association, and/or Montana Medicaid.

(4) ~~A service animal is an animal trained to undertake particular tasks on behalf of a member that the member cannot perform and that are necessary to meet the member's needs for accessibility, independence, health, or safety.~~ Specialized

medical equipment and supplies service includes service animals as defined in [NEW RULE II].

~~(5) A service animal does not include any of the following:~~

~~(a) pets, companion animals, and social therapy animals;~~

~~(b) guard dogs, rescue dogs, sled dogs, tracking dogs, or any other animal not specifically designated as a service animal; or~~

~~(c) wild, exotic, or any other animals not specifically supplied by a training program on the approved provider list.~~

~~(6) Supplies necessary for the performance of a service animal to meet the specific needs of the member are allowable expenses. Supplies do not include food to maintain the service animals.~~

~~(7) Care necessary to the health and maintenance of a service animal include veterinarian care, transportation for veterinarian care, license, registration, and where the member or member's primary care giver is unable to perform it, grooming.~~

(8) and (9) remain the same but are renumbered (5) and (6).

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

4. The rules proposed to be adopted provide as follows:

NEW RULE I HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: PROVISION OF SERVICES BY LEGALLY RESPONSIBLE INDIVIDUALS (1) A legally responsible individual (LRI) is an enrolled member's spouse or a court-appointed guardian for the enrolled member.

(2) The following services may be provided by a LRI:

(a) private duty nursing;

(b) personal assistance;

(c) non-medical transportation;

(d) respite; and

(e) behavioral intervention assistant.

(3) In order for a LRI to receive payment for services, it has to be demonstrated that services provided meet the following criteria:

(a) be a service/support identified in the approved SDMI HCBS waiver program application;

(b) be necessary to avoid institutionalization;

(c) be a service or support that is specified in the enrolled member's PCRP;

(d) be provided by a LRI who meets the provider qualifications and training standards specified in the waiver for that service;

(e) be paid at a rate that does not exceed what is allowed by the department for the payment of similar services; and

(f) be extraordinary care, as provided in (4).

(4) The CMT must assess the enrolled member's need for extraordinary care using the following criteria:

(a) the activity is one that exceeds the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the enrolled member and meet either (i) or (ii) as listed below:

(i) the enrolled member scores as severely or gravely impaired on the Behavioral Health and Developmental Disabilities (BHDD) Severe and Disabling Mental Illness (SDMI) Home and Community Based Services (HCBS) Waiver Evaluation and Level of Impairment (LOI) Form in Areas One, Two, or Seven; or

(ii) the enrolled member scores a 4 (total dependence) in the Activities of Daily Living/Instrumental Activities of Daily Living section on the Level of Care form.

(5) An enrolled member must be offered a choice of providers. If the enrolled member or the enrolled member's authorized representative chooses a relative or legal guardian as a care provider, the choice must be documented on the PCRP. In addition to case management, monitoring, and reporting activities required for all waiver services, the following requirements are applied when a relative or legal guardian is paid as a care provider:

(a) quarterly face-to-face reviews with the enrolled member of expenditures, and the enrolled member's health, safety, and welfare status;

(b) monthly reviews by the provider agency of hours billed for relative provided care;

(c) a relative or legal guardian who is an enrolled member's authorized representative may not also be paid to provide services; and

(d) an enrolled member's spouse employed by a personal care agency may not be reimbursed directly to provide personal care to the enrolled member.

(6) A relative or legal guardian may not provide more than 40 hours of paid time in a seven-day period.

(7) The CMT checks in with the LRI to see if there are concerns regarding the risk factors. A back-up plan is part of the PCRP plan that would provide relief to the caregiver in the event they are at risk.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

NEW RULE II HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES – SERVICE ANIMALS (1) A service animal is an animal trained to undertake a particular task or tasks on behalf of an enrolled member that the enrolled member cannot perform and that are necessary to meet the enrolled member's needs for accessibility, independence, health, or safety. A service animal is limited to a dog trained to perform a task or tasks directly related to the enrolled member's disability.

(2) The following requirements must be met prior to the department approving and paying for a service animal:

(a) the enrolled member must be evaluated by a physician to determine if the member would benefit from a service animal in maintaining and improving the enrolled member's ability to reside at home and to function in the community;

(b) the evaluating physician must provide a recommendation for a service animal for the enrolled member and must identify the work or task the service animal will perform for the enrolled member and whether and how the work or task relates to the enrolled member's SDMI;

(c) the work or task performed by the service animal must relate to the enrolled member's SDMI as defined in ARM 37.90.403; and

(d) the enrolled member's case management team must determine that a service animal is a practical means of meeting the enrolled member's need and that there exists no alternative method of meeting the enrolled member's need that is significantly less expensive than a service animal.

(3) A service animal does not include any of the following:

(a) pets, companion animals, emotional support animals, and therapy animals;

(b) guard dogs, rescue dogs, sled dogs, tracking dogs, or any other animal not specifically designated as a service animal; or

(c) wild, exotic, or any other animals not specifically designated as a service animal.

(4) The following expenses will be covered by the program:

(a) supplies necessary for the service animal to perform work or tasks for the enrolled member;

(b) veterinary care, transportation to veterinary care, licensing or registering of service animal, and grooming if the enrolled member or the enrolled member's primary care giver is unable to groom the service animal;

(c) training of service animal to undertake the particular tasks on behalf of an enrolled member as long as a qualified trainer has assessed the service animal and determined the animal to have the behavioral characteristics to successfully complete training.

(5) The program does not pay for food for the service animal.

(6) The department may require a consultation prior to the purchase of certain equipment and supplies.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-6-402, MCA

5. STATEMENT OF REASONABLE NECESSITY

The Department of Public Health and Human Services (department) is proposing to amend ARM 37.90.402, 37.90.403, 37.90.406, 37.90.408, 37.90.409, 37.90.410, 37.90.412, 37.90.425, 37.90.433, 37.90.434, 37.90.439, and 37.90.449, and is proposing to adopt NEW RULES I and II.

The 1915(c) Home and Community Based Severe and Disabling Mental Illness (SDMI) waiver offered several flexibilities during the COVID-19 public health emergency (PHE) through the Appendix K authority. With the expiration of the COVID-19 public health emergency, the department submitted to the Centers for Medicare & Medicaid Services (CMS) an application for amendment to its base

1915(c) waiver to make selected Appendix K flexibilities permanent. CMS has now approved these amendments to the 1915(c) waiver.

The changes are as follows:

- Add a self-direct service option to behavioral intervention assistant and life coach.
- Add conflict-free case management criteria to the base waiver.
- Update the SDMI waiver's case management team requirements.

This rulemaking is necessary to align the department's administrative rules with the base waiver and to reflect the changes made to the base waiver. The amendment to the 1915(c) waiver was effective October 1, 2023, so these rules are proposed to be effective retroactively to October 1, 2023.

ARM 37.90.402
This rule would be amended to update citations to administrative rules to ensure accuracy of this rule. The updated citations also reflect changes proposed within this rule notice.

ARM 37.90.403
This rule would be amended to reflect the correct hyperlink to the SDMI provider manual. It would also add definitions for "applicant," "critical incident," "enrolled member," and "non-critical incident." Defining these terms will provide clarity to these rules and avoid unnecessary repetition. The terms "member" and "serious occasion" would be replaced with "enrolled member" and "critical incident," respectively.

ARM 37.90.406
This rule would be amended to reflect the correct hyperlink to the SDMI provider manual.

ARM 37.90.408
This rule would be amended to clarify that waiver services would be prior authorized. The department would require prior authorization to ensure medical necessity for a waiver service.

ARM 37.90.409
This rule would be amended to indicate the qualifying diagnoses for the waiver service eligibility. It would remove language that suggests diagnosis guarantees enrollment in the waiver.

ARM 37.90.410
This rule would be amended to delineate the criteria for consideration for program eligibility and enrollment selection. The changes are proposed to ensure the criteria align with the waiver approved by CMS.

ARM 37.90.412
This rule would be amended to add person-centered recovery plan requirements to delineate the roles and responsibilities of both the case management team and the department. The changes are proposed to ensure the rule aligns with the waiver approved by CMS.

ARM 37.90.425
This rule would be amended to update the staffing requirements for case management teams.

ARM 37.90.433
This rule would be amended to add a self-direct option for behavioral intervention assistant services and to include requirements for staff delivering the service. Including the self-direct option for this service would promote personal choice for enrolled members.

ARM 37.90.434
This rule would be amended to add a self-direct option for life coach services. Including the self-direct option for this service would promote personal choice for enrolled members.

ARM 37.90.439
This rule would be amended to clarify self-directed services and align requirements with the approved waiver. This proposed change is in response to CMS's request that the department better define self-directed services and clarify the requirements around self-directed services.

ARM 37.90.449
This rule would be amended to clarify allowable specialized medical equipment and supplies. It would also remove service animal language, which instead would be found in NEW RULE II.

NEW RULE I
This rule would be added to describe requirements for the provision of waiver services by a legally responsible person and to permit that person to receive Medicaid reimbursement for providing the service.

NEW RULE II
This rule would be added to describe requirements for reimbursement related to service animals under the approved waiver. The new rule would provide explicit direction on how an enrolled member may qualify for a service animal and what costs would be covered by the waiver program. Using as a guide the Americans with Disabilities Act (ADA) and federal regulations that implement the ADA, the department proposes to limit service animals to dogs trained to perform a task directly related to an enrolled member's disability. The rule would not permit reimbursement for a service animal other than a dog trained to perform a task directly related to the enrolled member's disability.

Fiscal Impact

This proposed rulemaking does not have a fiscal impact.

6. The department intends these amendments and adoptions to be retroactively effective October 1, 2023.

7. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Bailey Yuhas, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; fax (406) 444-9744; or e-mail hhsadminrules@mt.gov, and must be received no later than 5:00 p.m., June 7, 2024.

8. The Office of Legal Affairs, Department of Public Health and Human Services, has been designated to preside over and conduct this hearing.

9. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to the contact person in 7 above.

10. An electronic copy of this notice is available on the department's web site at https://dphhs.mt.gov/LegalResources/administrativerules, or through the Secretary of State's web site at http://sosmt.gov/ARM/register.

11. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

12. With regard to the requirements of 2-4-111, MCA, the department has determined that the amendment of the above-referenced will not significantly and directly impact small businesses.

13. Section 53-6-196, MCA, requires that the department, when adopting by rule proposed changes in the delivery of services funded with Medicaid monies, make a determination of whether the principal reasons and rationale for the rule can be assessed by performance-based measures and, if the requirement is applicable, the method of such measurement. The statute provides that the requirement is not applicable if the rule is for the implementation of rate increases or of federal law.

The department has determined that the proposed program changes presented in this notice are not appropriate for performance-based measurement and therefore are not subject to the performance-based measures requirement of 53-6-196, MCA.

/s/ Brenda K. Elias
Brenda K. Elias
Rule Reviewer

/s/ Charles T. Brereton
Charles T. Brereton, Director
Department of Public Health and Human Services

Certified to the Secretary of State April 30, 2024.