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

In the matter of the adoption of New Rules I through XV, the amendment of ARM 37.90.401, 37.90.402, 37.90.403, 37.90.406, 37.90.408, 37.90.410, 37.90.412, 37.90.413, 37.90.415, 37.90.416, 37.90.417, 37.90.420, 37.90.425, 37.90.430, 37.90.431, 37.90.438, 37.90.447, 37.90.448, 37.90.449, and 37.90.450, and the repeal of ARM 37.90.428, 37.90.429, 37.90.432, 37.90.436, 37.90.437, 37.90.440, 37.90.441, 37.90.442, 37.90.445, 37.90.446, 37.90.460, and 37.90.461, pertaining to Home and Community Based Services for Adults with Severe and Disabling Mental Illness	))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, AMENDMENT, AND REPEAL

TO: All Concerned Persons

1. On June 5, 2020, at 9:30 a.m., the Department of Public Health and Human Services will hold a public hearing via remote conferencing to consider the proposed adoption, amendment, and repeal of the above-stated rules. Because there currently exists a state of emergency in Montana due to the public health crisis caused by the coronavirus, there will be no in-person hearing. Interested parties may access the remote conferencing platform in the following ways:

(a) Join Zoom Meeting https://mt-gov.zoom.us/j/97954506622?pwd=ZEhxdFVZSW5EREVEd1poeFdGY1c2dz09, meeting ID: 979 5450 6622, password: 649201;

(b) Dial by telephone +1 406 444 9999 or +1 646 558 8656, meeting ID: 979 5450 6622, password: 649201, find your local number: https://mt-gov.zoom.us/u/ajQrLXmNG; or

(c) Join by Skype for Business https://mt-gov.zoom.us/skype/97954506622.

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 28, 2020, to advise us of the nature of the accommodation that you need. Please contact Heidi Clark, 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 dphhslegal@mt.gov.

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

NEW RULE I HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: SEVERE AND DISABLING MENTAL ILLNESS CRITERIA (1) A member has a severe and disabling mental illness if the member:

(a) has been involuntarily committed to the Montana State Hospital or the Montana Mental Health Nursing Care Center for at least 30 consecutive days in the previous 12 months; or

(b) is 18 years of age or older and:

(i) has a minimum of two areas of high-level impairment as measured by a score of three or higher on the Severe and Disabling Mental Illness, Home and Community Based Waiver, Evaluation and Level of Impairment form; and

(ii) is diagnosed with one of the following diagnoses, excluding mild or not otherwise specified:

(A) Schizophrenia, paranoid type;
(B) Schizophrenia, disorganized type;
(C) Schizophrenia, catatonic type;
(D) Schizophrenia, undifferentiated type;
(E) Schizophrenia, residual type;
(F) Delusional disorder;
(G) Schizoaffective disorder;
(H) Schizoaffective disorder, depressive type;
(I) Bipolar I disorder, manic, moderate;
(J) Bipolar I disorder, manic, severe without psychotic features;
(K) Bipolar I disorder, manic, severe with psychotic features;
(L) Bipolar I disorder, depressed, moderate;
(M) Bipolar I disorder, depressed, severe without psychotic features;
(N) Bipolar I disorder, depressed, severe with psychotic features;
(O) Bipolar I disorder, mixed, moderate;
(P) Bipolar I disorder, mixed, severe without psychotic features;
(Q) Bipolar I disorder, severe with psychotic features;
(R) Major depressive disorder, single, moderate;
(S) Major depressive disorder, single, severe without psychotic features;
(T) Major depressive disorder, single, severe with psychotic features;
(U) Major depressive disorder, recurrent, moderate;
(V) Major depressive disorder, recurrent, severe without psychotic features;
(W) Major depressive disorder, recurrent, severe with psychotic features;
(X) Post traumatic stress disorder, acute;
(Y) Post traumatic stress disorder, chronic;
(Z) Panic disorder with agoraphobia;
(AA) Panic disorder without agoraphobia;
(AB) Borderline personality disorder;
(AC) Dissociative amnesia disorder;
(AD) Dissociative fugue disorder;
(AE) Dissociative stupor disorder; and

(AF) Dissociative identity disorder.

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: ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (1) Environmental accessibility adaptations are modifications to a member's home that are necessary to increase accessibility, independence, and prevent the need for a higher level of care.

(2) The member's need for the adaptation must be documented by an individual with the appropriate licensure, certification, or experience with home modification to document the member's need for the adaptation to increase accessibility, independence, and prevent the need for a higher level of care.

(3) The provision of environmental accessibility adaptations may include the provision of consultation regarding the appropriateness of the equipment or supplies.

(4) The waiver program does not cover:

(a) additions to the square footage of the home;

(b) services that are for comfort or convenience;

(c) services that are not a direct and specific benefit for the member; and

(d) services that are for maintenance, repair, or building code compliance that is the responsibility of the homeowner.

(5) Environmental accessibility adaptations must:

(a) ensure the health, welfare, and safety of the member in their home; and

(b) allow the member to function with greater independence in their home.

(6) Environmental accessibility adaptations must be provided in accordance with applicable state and local building codes by individuals licensed through the Montana Department of Labor and Industry to do home modifications.

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

NEW RULE III 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.

(2) Services may be directed by:

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

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

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

(3) The person directing the services must:

(a) be 18 years of age or older;

(b) successfully complete required training for self-direction; and

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

(4) The case management teams must:

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

(b) assist the member to develop an emergency backup plan, identifying and mitigating risks or potential risks, and monitor the health and safety of the member.

(5) Members must:

(a) be capable of making choices about activities of daily living, understand the impact of their choices, and assume responsibility for those choices;

(b) be capable of managing all tasks related to service delivery including recruiting, hiring, scheduling, training, directing, and dismissal of attendants; and

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

(6) The provider agency must:

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

(b) assist with recruiting, interviewing, hiring, training, managing, paying, and dismissing workers; and

(c) monitor health and welfare of the member.

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

(a) the 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 member; and

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

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

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

NEW RULE IV HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: RESIDENTIAL HABILITATION, ASSISTED LIVING (1) Residential habilitation, assisted living, provides 24-hour services and supports designed to ensure the health, safety, and welfare of a member and assist the member acquiring and improving behaviors necessary to live and participate in the community.

(2) Assisted living facilities must be licensed in accordance with ARM Title 37, chapter 106, subchapter 28.

(3) Assisted living includes the following service components:

(a) personal care;

(b) social and recreational activities;

(c) medication management and oversite;

(d) medical escort;

(e) non-medical transportation;

(f) meals; and

(g) 24-hour onsite awake staff.

(4) A provider of adult residential care must report serious occurrences, as defined in ARM 37.90.403, to the department.

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

NEW RULE V HOME AND COMMUNITY BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: RESIDENTIAL HABILITATION, INTENSIVE MENTAL HEALTH GROUP HOME (1) Residential habilitation, intensive mental health group home, provides 24-hour care designed to ensure the health, safety, and welfare of a member and provide supervision for the member to live and participate in the community.

(2) Intensive mental health group homes must be licensed in accordance with ARM Title 37, chapter 106, subchapter 19.

(3) Only the Montana State Hospital, the Montana Mental Health Nursing Care Center, or the Addictive and Mental Disorders Division may refer a member for intensive mental health group home services under the waiver program.

(4) An intensive mental health group home must:

(a) be a licensed mental health center with a group home endorsement;

(b) be approved by the Addictive and Mental Disorders Division; and

(c) be knowledgeable about commitment and recommitment processes, as well as the process for use of involuntary medications.

(5) Intensive mental health group homes consist of the following staff:

(a) a program supervisor, .5 FTE, who provides clinical supervision as described in the member's Person-Centered Recovery Plan;

(b) a residential manager, 1.0 FTE; and

(c) 24 hour onsite awake staff with at least a 1:3 staffing ratio for at least 16 hours per day during awake hours and at least one staff for eight hours during sleeping hours, as determined by the provider.

(6) The member must:

(a) have a history of repeated unsuccessful placements in less intensive community-based programs;

(b) have at least one full year combined of institutionalization within the past three years; and

(c) exhibit an inability to perform activities of daily living in an appropriate manner due to the member's Severe and Disabling Mental Illness (SDMI) diagnosis.

(7) Intensive mental health group homes must offer the following service components:

(a) assistance with activities of daily living and instrumental activities of daily living, as needed;

(b) medication management, administration, and oversite;

(c) medical escort;

(d) crisis stabilization services as needed by the member;

(e) close supervision and support of daily living activities;

(f) access to community involvement;

(g) care coordination;

(h) discharge planning; and

(i) transportation and supervision, if appropriate, to suitable community resources.

(8) A provider of adult residential care must report serious occurrences, as defined in ARM 37.90.403, to the department.

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

NEW RULE VI HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: RESIDENTIAL HABILITATION, MENTAL HEALTH GROUP HOME (1) Residential habilitation, mental health group home, provides 24 hours of available services and supports designed to ensure health, safety, and welfare of a member and assist the member in the acquisition and improvement of behaviors necessary to live and participate in the community.

(2) A mental health group home must be a licensed mental health center with a group home endorsement.

(3) Mental health group homes consist of the following staff:

(a) a program supervisor, .5 FTE, who provides clinical supervision as determined in the member's Person-Centered Recovery Plan;

(b) a residential manager, 1.0 FTE; and

(c) 24-hour onsite awake staff with a minimum 1:4 staffing ratio for at least 16 hours per day during awake hours and at least one staff for eight hours during sleeping hours, as determined by the provider.

(4) The member must have:

(a) a history of repeated unsuccessful placements in less intensive rehabilitative community-based programs;

(b) impaired interpersonal or social functioning;

(c) impaired occupational functioning;

(d) impaired judgment;

(e) poor impulse control; or

(f) a lack of family or other community or social supports.

(5) The member must exhibit:

(a) an inability to perform activities of daily living in an appropriate manner due to the member's SDMI diagnosis; and

(b) symptoms related to the SDMI severe enough that a less intensive level of service would be insufficient to support the member in an independent living environment and requires a structured treatment environment to be successfully treated in a less restrictive setting.

(6) Mental health group homes must offer the following service components:

(a) assistance with activities of daily living and instrumental activities of daily living as needed;

(b) medication management, administration, and oversite as needed;

(c) medical escort;

(d) crisis stabilization services as needed by the member;

(e) supervision and support of daily living activities;

(f) assistance with medications, including administration of medications as necessary;

(g) skills building in areas of community reintegration and independent living;

(h) care coordination;

(i) discharge planning for transition to a less restrictive setting; and

(j) transportation and supervision, if appropriate, to suitable community resources.

(7) A provider of adult residential care must report serious occurrences, as defined in ARM 37.90.403, to the department.

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

NEW RULE VII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: RESIDENTIAL HABILITATION, ADULT GROUP HOME (1) Residential habilitation, adult group home, provides 24-hour available services and supports designed to ensure health, safety, and welfare of a member and assist the member in the acquisition and improvement of behaviors necessary to live and participate in the community.

(2) An adult group home must be provided in the setting as defined in ARM Title 37, chapter 88, subchapter 9.

(3) Placement in an adult group home must be supported by the member's level of impairment and strengths assessment found in the Person-Centered Recovery Plan.

(4) Adult group home is a bundled service that includes:

(a) personal care;

(b) homemaker services;

(c) social activities;

(d) recreational activities;

(e) medication management and oversite;

(f) medical escort;

(g) nonmedical transportation; and

(h) 24-hour onsite awake staff to meet the needs of the members and provide supervision for safety and security.

(5) Members in an adult group home may not receive the following services under the Home and Community Based Services, Adults with Severe and Disabling Mental Illness Waiver Program:

(a) personal assistance;

(b) homemaker chore;

(c) respite care;

(d) environmental accessibility adaptations; or

(e) meals.

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

NEW RULE VIII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: RESIDENTIAL HABILITATION, FOSTER CARE (1) Residential habilitation, foster care, provides 24-hour services and supports designed to ensure the health, safety, and welfare of

a member and assist the member in acquiring and improving behaviors necessary to live and participate in the community.

(2) Residential habilitation, foster care, must be licensed in accordance with ARM Title 37, chapter 106, subchapter 20.

(3) Residential habilitation, foster care, includes the following components:

(a) personal care;

(b) social activities;

(c) recreational activities;

(d) medication management and oversite;

(e) medical escort;

(f) nonmedical transportation;

(g) meals; and

(h) 24-hour on-site supervision to meet the needs of the member for safety and security.

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

NEW RULE IX 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 available in the waiver and state plan are insufficient in meeting the needs of the member due to challenging behaviors and assistance is required to improve or restore function in activities of daily living (ADL), instrumental activities of daily living (IADL), or social and adaptive skills.

(2) Behavioral intervention assistant service is provided by entities that are licensed and insured to deliver personal care services.

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

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

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

NEW RULE X HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: HOMEMAKER CHORE

(1) Homemaker chore services are extensive cleaning beyond the scope of general household cleaning under Community First Choice/Personal Assistance Service (CFC/PAS) state plan and is needed to return a residence to a sanitary and safe environment.

(2) Homemaker chore may be provided by:

(a) entities that provide deep cleaning, yard, trash removal, and moving services;

(b) home health providers; and

(c) CFC/PAS providers.

(3) Homemaker chore is provided when neither the member nor other community resources are available to provide the service.

(4) Moving expenses must be prior authorized by the department.

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

NEW RULE XI HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: PAYEE (1) A payee is an individual or organization that accepts monetary or benefit payments on behalf of a member and expends the funds to pay for the current and future needs of the member.

(2) Payee services may be provided by public agencies, nonprofit organizations, banks, or fiscal management agencies that are licensed and insured.

(3) A payee must:

(a) determine the needs of the member and use the money or benefits to meet those needs;

(b) save any money left after meeting the member's current needs in an interest-bearing account or savings bonds for the member's future needs;

(c) provide all records of how payments are spent or saved to the member upon request; and

(d) complete reports accounting for the use of the member's money or benefits.

(4) Payee services are duplicative of representative, organizational, or individual payee services appointed by the Social Security Administration.

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

NEW RULE XII HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: CONSULTATIVE CLINICAL AND THERAPEUTIC SERVICES (1) Consultative clinical and therapeutic services provide comprehensive expertise, training, and technical assistance to improve the ability of providers and caregivers to carry out therapeutic interventions and reduce challenges that may be interfering with a member's daily functioning, independence, and quality of life.

(2) Consultative clinical and therapeutic services include:

(a) a clinical/functional evaluation;

(b) implementation of positive behavioral supports as part of the member's Person-Centered Recovery Plan (PCRP);

(c) training and technical assistance for the member's paid and non-paid caregivers to implement the positive behavioral supports; and

(d) monitoring the member's response to the positive behavioral supports and updating the PCRP if necessary.

(3) Consultative clinical and therapeutic services must meet a documented behavioral need that cannot be addressed through other waiver or state plan services.

(4) Consultative clinical and therapeutic services may be provided by a:

(a) psychiatrist;

(b) psychologist;

(c) neuropsychiatrist;

(d) licensed clinical professional counselor; or

(e) licensed clinical social worker.

(5) Training must be aimed at assisting the provider and caregiver in meeting the needs of the member and must include instruction to implement the positive behavioral supports outlined in the member's PCRP.

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

NEW RULE XIII 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 a member's overall health and well-being and addresses the obstacles that impede a member's progress towards self-sufficiency, improved health, and well-being.

(2) Life coach services may be provided by:

(a) independent living centers;

(b) home health agencies; and

(c) other entities approved by the department.

(3) Life coaches must have at least eight hours of specialized behavioral health training annually approved by the department.

(4) A member must have a SDoH assessment with identified needs and established goals in their Person-Centered Recovery Plan.

(5) Life coach services must include at least one of the following social determinants of health:

(a) economic stability;

(b) neighborhood and physical environment;

(c) education;

(d) regular and consistent access to healthy foods, education on nutrition, and overall health impacts;

(e) access to needed healthcare; and

(f) community and social context.

(6) Life coach services may not duplicate services provided under behavioral intervention assistant or payee services.

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

NEW RULE XIV HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: SUPPORTED EMPLOYMENT (1) Supported employment services assist members to prepare for,

find, and keep competitive jobs that exist in the open labor market, pay at least minimum wage, and are in a variety of integrated work settings.

(2) Supported employment services are provided by public or private employment agencies, Independent Living Centers, organizations that provide support for individuals with disabilities, Mental Health Centers, or a self-employed individual with at least:

(a) an associate degree in vocational rehabilitation, career development, or disability services;

(b) an Individual Placement Services (IPS) certification; or

(c) two years of experience in vocational rehabilitation, career development, or disability services and receive an IPS certification within six months of hire.

(3) A supported employment provider must have at least eight hours of specialized behavioral health training annually approved by the department.

(4) Supported employment services are for members who have previously been unable to succeed in competitive employment due to significant disabilities or challenging behaviors and need intensive, ongoing job supports to maintain long-term employment.

(5) The need for supported employment must be documented in the member's Person-Centered Recovery Plan and individualized to meet the identified need.

(6) Supported employment may:

(a) continue for as long as the member wants and needs support; and

(b) be provided in conjunction with other employment services.

(7) Supported employment may be provided only in a competitive employment setting.

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

NEW RULE XV HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: MEALS (1) Meal service is the provision of hot or cold meals to a member up to twice daily.

(2) Meals may be provided by:

(a) a non-profit entity or public agency that provides congregate or home-delivered meals on a regular basis to individuals who are unable to gain access to meals due to age or disability;

(b) entities that provide home-delivered meals that are transported from a preparation site to the member's residence; or

(c) meal preparation entities.

(3) Members must need special assistance to ensure adequate nutrition due to:

(a) special nutritional needs; or

(b) the member's inability to gain access to proper nutrition due to a disability.

(4) The provider must follow the rules that govern the provision of meal services at ARM 37.41.306 through 37.41.315.

(5) If meals are provided during the provision of another service, the total combined meals provided to the member may not exceed two meals per day.

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

4. The rules as proposed to be amended provide as follows, new matter underlined, deleted matter interlined:

37.90.401 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: FEDERAL AUTHORIZATION AND STATE ADMINISTRATION (1) The department has established ~~a~~ the Severe and Disabling Mental Illness, Home and Community Based Services waiver program ~~of Medicaid funded home and community-based services for persons~~ for members who have severe and disabling mental illness, as defined in ~~ARM 37.89.103~~ [NEW RULE I], and who would otherwise have to reside in and receive Medicaid reimbursed care in a nursing facility ~~or a hospital~~. ~~Upon formal approval, the department will initiate the program in accordance with the conditions of approval governing federal and state authorities and these rules.~~

(2) The department, in accordance with ~~the~~ state and federal statutes, ~~and the~~ administrative rules, ~~generally governing the provision of Medicaid funded home and community-based services, any~~ federal-state agreements ~~specifically~~ governing the provision of the Medicaid funded home and community-based services ~~to be~~ delivered under this program, and within the available funding appropriated for the program, may determine within in its discretion:

(a) the types of services ~~to be~~ available through the program;

(b) remains the same.

(c) the ~~categories of persons~~ target population to be served through the program;

(d) the total number of ~~persons~~ members who may receive services through the program;

(e) ~~the total number of persons who may receive services through the program by category of eligibility, geographical area, or specific case management team~~ delivery approach; and

(f) eligibility of ~~individual persons~~ members for the program.

(3) remains the same.

(4) ~~The state has received federal approval to waive statewide coverage in the provision of program services. Program services may only be delivered to persons in the following service areas for which federal approval of coverage has been received:~~ The Severe and Disabling Mental Illness, Home and Community Based Services waiver program is referred to throughout this subchapter as "the SDMI HCBS waiver program" or "the waiver program."

~~(a) Yellowstone County Region, inclusive of the counties of Yellowstone, Big Horn, Carbon, Stillwater, and Sweet Grass;~~

~~(b) Cascade County Region, inclusive of the counties of Cascade, Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, Toole, and Phillips;~~

~~(c) Butte-Silver Bow County Region, inclusive of the counties of Butte-Silver Bow, Beaverhead, Deer Lodge, Granite, Powell, and Jefferson;~~

~~(d) Missoula County;~~

~~(e) Lewis and Clark County; and~~

~~(f) Flathead County Region, inclusive of the counties of Flathead, Lake, Sanders, and Lincoln.~~

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

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: ~~limited to those specified in this rule.~~

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

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

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

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

(e) consultative clinical and therapeutic services, as defined in [NEW RULE XII];

(f) environmental accessibility adaptations, as defined in [NEW RULE I];

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

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

(i) life coach, as defined in [NEW RULE XIII];

(j) meals, as defined in ARM 37.90.446;

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

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

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

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

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

(p) payee, as defined in ARM 37.90.440;

(q) residential habilitation, as defined in ARM 37.90.428, 37.90.429, 37.90.432, 37.90.460, and 37.90.461;

(r) respite care, as defined in ARM 37.90.438;

(s) specialized medical equipment and supplies, as defined in ARM 37.90.449; and

(t) supported employment, as defined in ARM 37.90.445.

~~(2) The department may determine the particular services of the program to make available to a person based on, but not limited to, the following criteria:~~

~~(a) the person's need for a service generally and specifically;~~

~~(b) the availability of a specific service through the program and any ancillary service necessary to meet the person's needs;~~

~~(c) the availability otherwise of alternative public and private resources and services to meet the person's need for the service;~~

~~(d) the person's risk of significant harm or of death if not in receipt of the service;~~

~~(e) the likelihood of placement into a more restrictive setting if not in receipt of the service; and~~

~~(f) the financial costs for and other impacts on the program arising out of the delivery of the service to the person.~~

~~(3) A person enrolled in the program may be denied a particular service available through the program that the person desires to receive or is currently receiving.~~

~~(4) Bases for denying a service to a person include, but are not limited to:~~

~~(a) the person requires more supervision than the service can provide;~~

~~(b) the person's needs, inclusive of health, cannot be effectively or appropriately met by the service;~~

~~(c) access to the service, even with reasonable accommodation, is precluded by the person's health or other circumstances;~~

~~(d) a necessary ancillary service is no longer available; or~~

~~(e) the financial costs for and other impacts on the program arising out of the delivery of the service to the person.~~

~~(5) The following services, as defined in these rules, may be provided through the program:~~

~~(a) case management services;~~

~~(b) homemaking;~~

~~(c) personal assistance;~~

~~(d) adult day health;~~

~~(e) habilitation;~~

~~(f) respite care;~~

~~(g) personal emergency response systems;~~

~~(h) nutrition services;~~

~~(i) nonmedical transportation;~~

~~(j) outpatient occupational therapy;~~

~~(k) nursing;~~

~~(l) psycho-social consultation;~~

~~(m) dietetic services;~~

~~(n) adult residential care;~~

~~(o) specially trained attendant care;~~

~~(p) substance use related disorder services;~~

~~(q) specialized medical equipment and supplies;~~

~~(r) supported living;~~

~~(s) illness management and recovery services;~~

~~(t) Wellness Recovery Action Plan (WRAP) services;~~

~~(u) community transition services;~~

~~(v) health and wellness; and~~

~~(w) pain and management.~~

~~(6) Monies available through the program may not be expended on the following:~~

~~(a) room and board;~~

~~(b) special education and related services as defined at 20 USC 1401(16) and (17); and~~

~~(c) vocational rehabilitation.~~

~~(7) The program is considered the payor of last resort. A program service is not available to a person if that type of service is otherwise available to the person from another source.~~

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) "Adult residential care" means a residential habilitation option for persons residing in an adult foster home, group home, or an assisted living facility.~~

~~(2) "Case management" means a service that provides the planning for, arranging for, implementation of, and monitoring of the delivery of services available to an person through the program.~~

~~(3) "Community transitions services" means nonrecurring set-up expenses for persons who are transitioning from an institutional or other provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.~~

~~(4) "Habilitation" means intervention services designed to assist a person to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully at home and in the community.~~

~~(5) "Health and wellness" means services that assist persons in acquiring, retaining, and improving self-help, socialization, and adaptive skills to reside successfully in the community.~~

~~(6) "Homemaker chore" means services provided for persons who are unable to manage their own homes, or when the person normally responsible for homemaking is absent.~~

~~(7) "Illness management and recovery (IMR)" means an evidence-based program to provide services consisting of personalized strategies for managing mental illness and achieving personal goals.~~

~~(8) "Nonmedical transportation" means transportation through common carrier or private vehicle for access to social or other nonmedical activities.~~

~~(9) "Pain and symptom management" means a service of traditional and nontraditional methods of pain management.~~

~~(10) "Personal assistant services (PAS)" is defined at 53-6-145, MCA and includes attendant PAS and socialization/supervision PAS.~~

~~(11) "Plan of care" means a written plan of supports and interventions to guide the provision of services based on an assessment of the status and needs of a consumer.~~

~~(12) "Respite care" means the provision of supportive care to a consumer to relieve those unpaid persons normally caring for the consumer.~~

(1) "Activities of daily living" means basic personal everyday activities.

(2) "Community First Choice (CFC) and Personal Assistance Service (PAS) Programs are programs designed to provide long term supportive care in a home setting.

(3) "Institutionalization" means placement in a nursing facility, a mental health nursing facility, or a state mental health hospital.

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

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

(6) "Level of impairment assessment" 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) "Mental health professional" means as defined in 53-21-102, MCA.

(9) "Quality improvement organization" means a group of health quality experts organized to improve the quality of care delivered to members.

~~(13)~~(10) "Serious occurrence" means a significant event which affects the health, welfare, and safety of a ~~person~~ member served in home and community-based services. The department has established a system of reporting and monitoring ~~serious~~ critical and non-critical incidents that involve ~~persons~~ members served by the program in order to identify, manage, and mitigate overall risk to the ~~person~~ member. For information pertaining to reporting a serious occurrence, see the SDMI HCBS Policy #305, located at: https://dphhs.mt.gov/amdd/HCBSPolicyManual.

~~(14)~~(11) "Severe and disabling mental illness" is defined in ~~ARM 37.86.3503~~ [NEW RULE I].

~~(15) "Specially trained attendant care" means an option under personal assistance that is the provision of supportive services to a person residing in their own residence.~~

~~(16) "Substance use related disorder services" means provision of counseling to a person with a substance use related disorder by a licensed addiction counselor or appropriate licensed professional.~~

~~(17) "Supported living" means the provision of comprehensive supportive services to a person residing in an individual residence or in a group living situation.~~

~~(18) "Wellness, recovery and action plan (WRAP)" means an individualized plan developed by a person to manage their mental illness. This is a tool to guide persons through the process of identifying and understanding their personal wellness resources.~~

AUTH: 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) ~~Services of the program~~ The waiver program services may only be provided by ~~or through~~ a provider that:

(a) is enrolled ~~with the department~~ as a Montana Medicaid provider; ~~or, if not an enrolled Medicaid provider, is under contract with a Medicaid provider that the department is contracting with for home and community-based case management services and that the department has authorized to reimburse non-Medicaid providers;~~

~~(b) meets all the requirements necessary for the receipt of Medicaid monies;~~

~~(c) has been determined by the department to be qualified to provide services to adults with severe disabling mental illness;~~

~~(d) is a legal entity;~~

~~(e) is appropriately insured as determined by the department; and~~

~~(f)~~ (b) meets all facility, ~~and other~~ licensing, and insurance requirements applicable to the services offered, the service settings provided, and the professionals employed~~.~~; and

(c) meets the criteria as a qualified provider authorized to deliver the service as specified in 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) ~~A recipient's immediate family members may not provide services to the recipient as a reimbursed provider or as an employee of a reimbursed provider. Immediate family members include a spouse or legal guardian.~~ 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) community transition;

(b) environmental accessibility adaptations;

(c) health and wellness;

(d) homemaker chore;

(e) meals; and

(f) specialized medical equipment and supplies.

(3) ~~A provider may also provide support to other family members in the recipient's household during hours of program reimbursed service if approved by the case management team.~~ A provider must document the completion of required training in the personnel file of the staff or in the provider's staff training files which includes:

(a) title of the training;

(b) the date of the training;

(c) name and title of the trainer;

(d) type or topic of the training;

(e) the agenda of the training;

(f) the hours of the training; and

(g) the signature and date of the staff who received the training.

(4) Providers must ensure that direct care staff are trained and capable of providing waiver program services.

AUTH: 53-2-201, 53-6-402, MCA
IMP: ~~53-2-401,~~ 53-6-402, MCA

37.90.408 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: REIMBURSEMENT (1) The department adopts and incorporates by reference the Medicaid Home and Community-Based Services for Adults ~~With~~ with Severe and Disabling Mental Illness ~~Fee Schedule~~ fee schedule. ~~The provider reimbursement rate for a covered service for Home and Community-Based Services for Adults with Severe Disabling Mental Illness, unless provided otherwise in this rule, is stated in the department's fee~~

~~schedule as provided in ARM 37.85.105(5)(b).~~ Unless otherwise provided for in rule, the provider reimbursement rate for waiver program services is stated in the department's fee schedule as provided in ARM 37.85.105(5)(b). These fees are calculated based on:

(a) and (b) remain the same.

(2) ~~The following services are reimbursed as provided in (3)~~ Medicaid reimbursement for the SDMI HCBS waiver program will be the lesser of:

(a) ~~homemaking;~~ the provider's usual and customary charge for the service; or

(b) ~~adult day health;~~ the rate established in the department's Medicaid fee schedule adopted and incorporated into ARM 37.85.105(5)(b).

~~(c) habilitation;~~
~~(d) personal emergency response systems;~~
~~(e) nutrition;~~
~~(f) psycho-social consultation;~~
~~(g) nursing;~~
~~(h) dietetic services;~~
~~(i) specially trained attendant care;~~
~~(j) substance use related disorder services;~~
~~(k) supported living;~~
~~(l) adult residential care;~~
~~(m) respite care not provided by a nursing facility;~~
~~(n) nonmedical transportation;~~
~~(o) specialized medical equipment and supplies;~~
~~(p) illness management and recovery services;~~
~~(q) Wellness Recovery Action Plan (WRAP);~~
~~(r) community transition service;~~
~~(s) health and wellness; and~~
~~(t) pain and symptom management.~~

(3) ~~The services specified in (2) are, except as otherwise provided in (4), reimbursed at the lower of the following:~~ The SDMI HCBS waiver program is the payor of last resort and will not reimburse a service that otherwise is or should be paid by another source.

~~(a) the provider's usual and customary charge for the service; or~~

~~(b) the rate negotiated with the provider by the case management team up to the department's maximum allowable fee.~~

(4) ~~The services specified in (2) are reimbursed as provided in (3) except that reimbursement for components of those services that are incorporated by specific cross reference from the general Medicaid program may only be reimbursed in accordance with the reimbursement methodology applicable to the component service of the general Medicaid program.~~ The SDMI HCBS waiver program will not reimburse for services provided to individuals of a member's household or family.

~~(5) The following services are reimbursed in accordance with the referenced provisions governing reimbursement of those services through the general Medicaid program:~~

~~(a) personal assistance as provided at ARM 37.40.1105; and~~

~~(b) outpatient occupational therapy as provided at ARM 37.86.610.~~

~~(6) Case management services are reimbursed, as established by contractual terms, on either a per diem or hourly rate.~~

~~(7) Respite care services provided by a nursing facility are reimbursed at the rate established for the facility in accordance with ARM Title 37, chapter 40, subchapter 3.~~

~~(8) Reimbursement will not be paid for a service that is otherwise available from another source.~~

~~(9) No copayment is imposed on services provided through the program but persons are responsible for copayment on other services reimbursed with Medicaid monies.~~

~~(10) Reimbursement is not available for the provision of services to other members of a person's household or family unless specifically provided for in these rules.~~

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 ~~(1) The department may consider for eligibility in and may enroll in the program persons who the department determines qualify for enrollment in accordance with the criteria in ARM 37.90.410.~~

~~(2) In order to be considered by the department for eligibility in the program, a person must be determined to qualify for enrollment in accordance with the criteria in this rule.~~

~~(3)~~ (1) A ~~person~~ member is ~~qualified~~ eligible ~~to be considered~~ for enrollment in the program if the ~~person~~ member meets the following criteria:

(a) is at least 18 years of age ~~and, if under the age of 65, has been determined to be disabled according to the Social Security Administration~~;

(b) remains 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 ~~in accordance with the preadmission screening provided for in ARM 37.40.202, 37.40.205, and 37.40.206~~;

~~(d) does not currently reside in a hospital or a nursing facility;~~

~~(e) has needs that can be met through the program;~~

~~(f)~~ (d) meets the severe and disabling mental illness ~~definition~~ criteria at ~~ARM 37.89.103~~ [NEW RULE I]; 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.

~~(g) resides in one of the following service areas for which federal approval of coverage has been received:~~

~~(i) Yellowstone County Region, inclusive of the counties of Yellowstone, Big Horn, Carbon, Stillwater, and Sweet Grass;~~

~~(ii) Cascade County Region, inclusive of the counties of Cascade, Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, Toole, and Phillips;~~

~~(iii) Butte-Silver Bow County Region, inclusive of the counties of Butte-Silver Bow, Beaverhead, Deer Lodge, Granite, Powell, and Jefferson;~~

~~(iv) Missoula County;~~

~~(v) Lewis and Clark County; and~~

~~(vi) Flathead County Region, inclusive of the counties of Flathead, Lake, Sanders, and Lincoln.~~

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

(a) offers the member an available opening for program services if one is available; or

(b) places the member on the wait list for an available opening.

(3) A member is placed on the wait list in the service areas the member selects.

(4) ~~The department may consider for an available opening for program services a person who, as determined by the department:~~ The case management team must use the member's combined LOC and LOI score to determine the member's score for placement on the wait list.

~~(a) meets the criteria of ARM 37.90.410;~~

~~(b) is actively seeking services;~~

~~(c) is in need of the services available;~~

~~(d) is likely to benefit from the available services; and~~

~~(e) has a projected total cost of plan of care that is within the limits specified in ARM 37.90.413.~~

(5) ~~The department offers an available opening for program services to the applicant, as determined by the department, who is:~~ If more than one member has the same combined wait list score, then each member is placed on the wait list based upon the member's wait list score as determined in (4), and thereafter on a first-come, first-served basis.

~~(a) most in need of the available services;~~

~~(b) most likely to benefit from the available services; and~~

~~(c) whose projected total cost plan of care is within the applicable limits specified in ARM 37.90.413.~~

~~(6) Factors to be considered in the determination of whether a person is:~~

~~(a) in need of the available program services;~~

~~(b) likely to benefit from those services; and~~

~~(c) which person is most likely to benefit from the available services include, but are not limited to, the following:~~

~~(i) medical condition;~~

~~(ii) degree of independent mobility;~~

~~(iii) ability to be alone for extended periods of time;~~

~~(iv) presence of problems with judgment;~~

~~(v) presence of a cognitive impairment;~~

~~(vi) prior enrollment in the program;~~

~~(vii) current institutionalization or risk of institutionalization;~~

~~(viii) risk of physical or mental deterioration or death;~~

~~(ix) willingness to live alone;~~

~~(x) adequacy of housing;~~
~~(xi) need for adaptive aids;~~
~~(xii) need for 24-hour supervision;~~
~~(xiii) need of person's caregiver for relief;~~
~~(xiv) appropriateness for the person, given the person's current needs and risks, of services available through the program;~~
~~(xv) status of current services being purchased otherwise for the person; and~~
~~(xvi) status of support from family, friends, and community.~~

~~(7)~~ (6) A ~~person~~ member may be removed from the SDMI HCBS waiver program ~~by the department. Bases for removal from the program include, but are not limited to~~ for the following reasons:

(a) a determination by ~~the case management team~~ a mental health professional that the member no longer meets the eligibility criteria ~~the services, as provided for in the plan of care, are no longer appropriate or effective in relation to the person's needs~~;

(b) ~~the failure of the person to use the services as provided for in the plan of care~~ the member does not select and actively participate in at least two services in the waiver program within 45 calendar days from the date the member agrees to and signs the PCRP;

(c) ~~the behaviors of the person place the person, the person's caregivers, or others at serious risk of harm or substantially impede the delivery of services as provided for in the plan of care~~ the department determines that the member has failed to utilize or attempted to utilize at least two waiver services, in over 90 days, with repeated attempts documented by the case management team to engage the member; and

~~(d) the health of the person is deteriorating or in some other manner placing the person at serious risk of harm;~~

~~(e) a determination by the case management team that the service providers necessary for the delivery of services to the person, as provided for in the plan of care, are unavailable;~~

~~(f) a determination that the total cost of the person's plan of care is not within the limits specified at ARM 37.90.413;~~

~~(g)~~ (d) the ~~person~~ member no longer requires the level of care of a nursing facility as determined ~~in accordance with the preadmission screening provided for in ARM 37.40.202, 37.40.205, and 37.40.206;~~ by the Quality Improvement Organization under contract with the department.

~~(h) the person no longer resides in one of the counties specified in ARM 37.90.410.~~

(7) Eligibility for consideration for the waiver program does not entitle an individual 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: ~~PLANS OF CARE~~ PERSON-CENTERED RECOVERY PLAN (1) ~~A plan of care is a written plan of supports and~~

~~interventions, inclusive of personal recovery oriented goals to guide the provision of services, based on an assessment of the status and needs of a recipient. The plan of care describes the needs of the recipient and the services available through the program and otherwise that are to be made available to the recipient in order to maintain the recipient at home and in the community.~~ 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.

(2) ~~The~~ All services ~~that a recipient may receive through the program and the amount, scope, and duration of those services~~ must be specifically authorized in writing ~~through an individual plan of care for the person~~ in the member's PCRP.

(3) ~~The plan of care is initially developed upon the person's entry into the program. The plan must be reviewed and, if necessary, revised at intervals of at least six months beginning with the date of the initial plan of care.~~ Each PCRP must be developed, reviewed, and revised by the case management team. The case management team must:

(a) initiate the development of the PCRP upon the member's enrollment into the SDMI HCBS waiver program;

(b) have monthly telephone contact with the member;

(c) 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 any changes to the information listed in (5)(a) through (j); and

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

(4) ~~Each plan of care is developed, reviewed, and revised by the case management team.~~ The case management team must develop the PCRP in consultation with:

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

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

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

(5) ~~The case management team, in developing the plan of care, consults with the recipient or the recipient's legal representative, with treating and other appropriate health care professionals, and others who have knowledge of the recipient's needs.~~ The PCRP must include:

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

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

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

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

(e) all other services the member requires including Montana Medicaid state plan services and community-based services and supports; 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 member's functional needs outlined in the Severe and Disabling Mental Illness, Home and Community Based Services, Evaluation and Level of Impairment form;

(g) a crisis plan;

(h) physicians' orders;

(i) a discharge plan;

(j) the projected annual cost of SDMI Home and Community-Based Services (HCBS) waiver program services provided;

(k) the signature of the member or the 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.

~~(6) Each plan of care must include the following:~~

~~(a) diagnosis, symptoms, complaints, and complications indicating the need for services;~~

~~(b) a description of the recipient's functional level;~~

~~(c) objectives;~~

~~(d) any orders for:~~

~~(i) medication;~~

~~(ii) treatments;~~

~~(iii) restorative and rehabilitative services;~~

~~(iv) activities;~~

~~(v) therapies;~~

~~(vi) social services;~~

~~(vii) diet; and~~

~~(viii) other special procedures recommended for the health and safety of the recipient to meet the objectives of the plan of care;~~

~~(e) the specific program and other services to be provided, the frequency of the services, and the type of provider to provide them;~~

~~(f) the projected annualized costs of each program service; and~~

~~(g) names and signatures of all persons who have participated in developing the plan of care (including the recipient, unless the recipient's inability to participate is documented) which will verify participation, agreement with the plan of care, and acknowledgement of the confidential nature of the information presented and discussed.~~

~~(7) Inclusion of the need for and the identification of nonprogram services in the plan of care does not financially obligate the department to fund those services or to assure their delivery and quality.~~

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

~~(9) Plan of care approval is based on:~~

~~(a) completeness of plan;~~

~~(b) consistency of plan with the needs of the person; and~~

~~(c) feasibility of service provision, including cost-effectiveness of plan as provided for in ARM 37.90.413; and~~

~~(d) the conformance of the plan with ARM 37.90.401, 37.90.402, 37.90.406, 37.90.408, 37.90.410, 37.90.412, 37.90.413, 37.90.420, and 37.90.425.~~

~~(10)~~ (7) ~~In accordance with ARM 37.85.414, the~~ The case management team must ~~keep the plans of care on file and all records must be retained for a period of at least six years and three months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later~~ retain all of the member's records in accordance with ARM 37.85.414.

AUTH: 53-2-201, 53-6-402, MCA
IMP: ~~53-2-401,~~ 53-6-402, MCA

37.90.413 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: COST OF ~~PLAN OF CARE~~ PERSON-CENTERED RECOVERY PLAN (1) In order to maintain the program cost within the appropriated ~~monies~~ federal and state funds, ~~of the financial limitations imposed under federal authorities, the cost of~~ plans ~~of care for recipients~~ the cost of a member's Person-Centered Recovery Plan (PCRP) may be limited by the department ~~collectively and individually~~.

(2) The total annual cost of services for each ~~recipient~~ member, except as ~~provided in (3)~~ approved by the department, may not exceed a maximum amount set by the department ~~based on the number of recipients and the amount of monies available to the program as authorized in appropriation by the legislature~~.

(3) ~~The total cost of services provided under a plan of care to a recipient may exceed the maximum amount set by the department if authorized by the department based on the department's determination that one or more of the following circumstances is applicable:~~ The department may limit the services members receive under the waiver program based upon the appropriation of funding by the legislature.

~~(a) the excess service need is short term and only a one time purchase is necessary;~~

~~(b) the excess service need is intensive services of 90 days or less which are necessary to:~~

~~(i) resolve a crisis situation which threatens the health and safety of the recipient;~~

~~(ii) stabilize the recipient following hospitalization or acute medical episode; or~~

~~(iii) prevent institutionalization during the absence of the normal caregiver;~~

~~(c) the excess service need is adult residential services; or~~

~~(d) the recipient has long term needs that result in the maximum amount being exceeded in minor amounts at various times.~~

(4) The cost of services ~~to be provided under a plan of care is~~ in the PCRP must be determined prior to implementation of the ~~proposed plan of care~~ PCRP and may be revised as necessary ~~after implementation~~ by the department or the department's designee.

~~(5) The cost determination for the services provided under a plan of care may be made at any time that there is a significant revision in the plan of care.~~

AUTH: 53-2-201, 53-6-402, MCA
IMP: ~~53-2-401,~~ 53-6-402, MCA

37.90.415 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: COMMUNITY TRANSITION SERVICES ~~REQUIREMENTS~~ (1) Community transition services ~~means~~ are nonrecurring set-up expenses for ~~persons~~ members who are transitioning from an institutional ~~or other provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses~~ setting into a community living setting or a private residence and are necessary to coordinate and purchase to establish a basic household.

(2) The department may approve community transition services on a case-by-case basis from other settings in circumstances that address a member's health or safety.

(3) The case management team must complete a needs assessment prior to implementation of the service.

(4) The needs assessment must demonstrate community transition services are required to:

(a) address a health or safety concern; and

(b) discharge from or avert institutionalization.

(2) remains the same but is renumbered (5).

(a) remains the same.

(b) essential household ~~furnishings~~ items ~~required, including furniture, window coverings, food preparation items, and bed/bath linens~~;

(c) moving expenses incurred directly from the moving, transport, provision, or assembly of household furnishings for the residence;

(d) customary setup fees or deposits for utility or service access, including telephone landline or cell phone, electricity, heating, and water; ~~and~~

(e) ~~activities to assess need for, arrange for, or procure resources~~ services necessary for a member's health and safety; and

(f) fees associated with obtaining legal or identification documents necessary for housing applications.

(3) and (4) remain the same but are renumbered (6) and (7).

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

37.90.416 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: PAIN AND SYMPTOM MANAGEMENT ~~REQUIREMENTS~~ (1) Pain and symptom management is defined as a service that ~~allows the provision of~~ provides traditional and nontraditional methods of pain reduction ~~and/~~or management.

(2) ~~Treatments are limited to~~ Allowable non-traditional or mind-body therapies include:

(a) through (d) remain the same.

(e) ~~mind-body therapies such as~~ hypnosis ~~and biofeedback~~;

(f) biofeedback; and

~~(f)~~ (g) pain mitigation counseling/coaching.~~;~~

~~(g) chiropractic therapy; and~~

~~(h) nursing services by a nurse specializing in pain and symptom management.~~

(3) Allowable traditional therapies include:

(a) chiropractic therapy; and

(b) nursing services by a nurse specializing in pain and symptom management.

(4) The service must be prescribed by a licensed health care professional.

(5) The service must be documented in the member's Person-Centered Recovery Plan and:

(a) address the member's chronic or acute symptoms, complaints, or complications indicating the need for services;

(b) include the number of authorized sessions; and

(c) document the expected outcomes of the provision of the service.

(6) Services must be provided by a person licensed or certified to provide the service.

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

37.90.417 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: HEALTH AND WELLNESS ~~REQUIREMENTS~~ (1) Health and wellness ~~is defined as~~ services are services that assist ~~consumers~~ a member in acquiring, retaining, and improving self-help, socialization, and adaptive skills to reside successfully in the community.

(2) The ~~service includes~~ services include ~~adaptive health, wellness, and therapeutic recreational services such as~~:

~~(a) hydrotherapy;~~

(a) classes on weight loss, smoking cessation, and healthy lifestyles;

~~(b) living well with a disability; and~~

(b) health club memberships and exercise classes;

~~(c) access to fitness and exercise facilities.~~

(c) art, music, and dance classes;

(d) costs associated for participating in adaptive sports and recreational activities;

(e) classes on managing disabilities; and

(f) hippotherapy.

(3) The service must be prescribed by a licensed health care professional.

(4) The service must be documented in the member's Person-Centered Recovery Plan and:

(a) address the member's symptoms, complaints, or complications indicating the need for services;

(b) include the number of authorized sessions; and

(c) document the expected outcomes of the provision of the service.

(5) Services may be provided in a setting appropriate to the provision of the service.

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

IMP: 53-6-402, MCA

37.90.420 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: NOTICE AND FAIR HEARING (1) The department provides written notice to ~~an applicant for and recipient of services~~ a member when a determination is made by the department concerning:

(a) ~~financial~~ Medicaid eligibility;

(b) ~~level of care~~ eligibility for the SDMI HCSB waiver program; and

(c) ~~feasibility, including cost-effectiveness of services to the recipient; and~~ changes to a member's Person-Centered Recovery Plan (PCRP).

~~(d) termination of recipient's eligibility for the program.~~

(2) The department provides a ~~recipient of services~~ member with notice ten working days before termination of services due to a determination of ineligibility.

(3) ~~A person aggrieved by any adverse final determinations as listed in (1)(a) through (d) or any adverse determinations regarding services in the plan of care may request a~~ Requirements for administrative review and fair hearings ~~as~~ are provided for in ~~ARM 37.5.304, 37.5.307, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, and 37.5.337~~ ARM Title 37, chapter 5, subchapter 3.

~~(4) Fair hearings will be conducted as provided for in ARM 37.5.304, 37.5.307, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, and 37.5.337.~~

AUTH: 53-2-201, 53-6-402, MCA
IMP: ~~53-2-401,~~ 53-6-402, MCA

37.90.425 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: CASE MANAGEMENT~~,~~ ~~REQUIREMENTS~~ (1) Case management means case management as defined at the Code of Federal Regulations (CFR) at 42 CFR 440.169(d)(e). ~~is the planning for, arranging for, implementation of, and monitoring of the delivery of services available through the program to a person.~~

~~(2) Case management services include:~~

~~(a) developing a plan of care for a person;~~

~~(b) monitoring and managing a plan of care for a person;~~

~~(c) establishing relationships and contracting with service providers and community resources;~~

~~(d) maximizing a person's efficient use of services and community resources such as family members, church members, and friends;~~

~~(e) facilitating interaction among people working with a person;~~

~~(f) prior authorizing the provision of all services; and~~

~~(g) managing expenditures.~~

(2) Case management services offered under the Severe and Disabling Mental Illness, Home and Community Based waiver program are provided through a selective contract for conflict free case management under the authority of a 1915(b)(4) waiver authorized under Section 1915(b) of the Social Security Act.

(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 ~~persons~~ 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 licensed social worker with two consecutive years' experience providing case management services to adults with severe and disabling mental illness.

~~(4) The case management team must:~~

~~(a) be a legal entity contractually retained by the department to provide Medicaid funded home and community case management services to persons who are elderly or who have physical disabilities;~~

~~(b) function as directed by the department;~~

~~(c) assure that services provided to recipients are of appropriate quality and cost effective;~~

~~(d) provide case management services to no more than the number of persons specified by the department;~~

~~(e) manage expenditures within the allocated monies; and~~

~~(f) meet the department's reporting requirements.~~

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

37.90.430 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: ADULT DAY HEALTH~~;~~ ~~REQUIREMENTS~~ (1) Adult day health ~~is the provision of services to meet the health, social, and habilitation needs of a recipient in settings outside the recipient's place of residence~~ is a supervised daytime program that offers health and social services for adults with severe and disabling mental illness to ensure optimal functioning of the member and enrichment activities through engaging social community but who do not require the intervention or services of a registered nurse or licensed rehabilitative therapist onsite.

(2) An entity providing adult day health services must be licensed as an adult day care center as provided at ARM 37.106.301, et seq.

(3) Adult day health services are furnished in an outpatient setting that does not include overnight residential services.

(4) Adult day health includes the following service components:

(a) meals as described in ARM 37.106.2616;

(b) health, nutritional, recreational, and social habilitation; and

(c) transportation between the member's place of residence and the adult day health center.

AUTH: 53-2-201, 53-6-402, MCA
IMP: ~~53-2-401,~~ 53-6-402, MCA

37.90.431 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: PERSONAL ASSISTANCE SERVICE~~, REQUIREMENTS~~ (1) Personal assistance service (PAS) is the provision of ~~an array of personal care and other services to a recipient for the~~

~~purpose of meeting personal needs in the home and the community~~ long term service and supports in a member's home and in the community tailored to each member's needs and living situation.

(2) ~~Personal assistance services include the provision of the following services~~ PAS may be provided by:

(a) ~~personal care services as specified at ARM 37.40.1101(1) through (5) and 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, and 37.40.1308~~ a home health agency provider;

(b) ~~homemaking services as specified at ARM 37.90.436~~ a community first choice/personal assistance service (CFC/PAS) provider; or

(c) ~~supervision for health and safety reasons; and~~ a member self-directing the service, as described in [NEW RULE III].

~~(d) nonmedical transportation as specified at ARM 37.90.450.~~

(3) ~~Personal assistance services do not include any skilled services that require professional medical training except as allowed in ARM 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, and 37.40.1308.~~ PAS may be provided only when the services available in CFC/PAS are insufficient to meet the following needs of the member:

(a) the member has a documented physical need that requires hours in addition to the 42 bi-weekly hours available under CFC/PAS; or

(b) the member requires services outside of their residence that cannot be provided by CFC/PAS.

(4) ~~The requirements for the delivery of personal care services specified at ARM 37.40.1101, 37.40.1102, 37.40.1105, 37.40.1106, 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, 37.40.1308, and 37.40.1315 govern the provision of personal assistance services.~~ PAS may not be provided in a residential habilitation.

(5) PAS includes the following service components:

(a) activities of daily living;

(b) instrumental activities of daily living; and

(c) non-medical transportation.

AUTH: 53-2-201, 53-6-402, MCA
IMP: ~~53-2-401,~~ 53-6-402, MCA

37.90.438 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: RESPITE CARE~~, REQUIREMENTS~~ (1) Respite care is ~~the provision of supportive care to a recipient so as to relieve those unpaid persons normally caring for the recipient from that responsibility~~ planned or emergency care provided to a member with need for support and supervision in order to provide temporary relief to the unpaid caregiver of the member.

(2) Respite care services may be provided ~~only on a short term basis, such as part of a day, weekends, or vacation periods.~~ in:

(a) a member's place of residence;

(b) an alternative private residence; or

(c) a residential habilitation setting or a nursing facility.

(3) Respite care ~~services may be provided only on a short term basis, such as part of a day, weekends, or vacation periods.~~ is provided for members who:

(a) in the absence of respite care, would require institutional level of care;

(b) are unable to care for themselves; and

(c) have an unpaid caregiver as the member's primary caregiver.

(4) A person providing respite care services must be:

(a) physically and mentally qualified to provide this service to the ~~recipient~~ member; ~~and~~

(b) aware of emergency assistance systems and CPR-certified; and

(c) able to follow the positive behavioral supports that are in place.

(5) A person who provides respite care services to a ~~recipient~~ member may be required by the case management team to have the following when the ~~recipient's~~ member's needs so warrant:

(a) knowledge of the physical and mental conditions of the ~~recipient~~ member;

(b) knowledge of common medications and related conditions of the ~~recipient~~ member; and

(c) ~~capability~~ ability to administer basic first aid.

AUTH: 53-2-201, 53-6-402, MCA
IMP: ~~53-2-401,~~ 53-6-402, MCA

37.90.447 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: PRIVATE DUTY NURSING~~, REQUIREMENTS~~ (1) ~~Nursing is the provision of individual and continuous nursing care.~~ Private duty nursing are medically necessary nursing services delivered to a member in their place of residence.

(2) Private duty nursing may be provided by:

(a) a licensed registered nurse (RN); or

(b) a licensed practical nurse (LPN) under the supervision of a RN, physician, dentist, osteopath, or podiatrist authorized by the state of Montana to prescribe medication.

(3) Private duty nurses may be employed by a home health care provider or self-employed.

(4) Private duty nursing may be provided when Home Health Agency services under state plan, defined in ARM 37.40.701, are not appropriate or available.

(5) Private duty nursing must be prescribed by an appropriately licensed medical professional.

(6) Private duty nurses must comply with the Montana Nurse Practice Act.

AUTH: 53-2-201, 53-6-402, MCA
IMP: ~~53-2-401,~~ 53-6-402, MCA

37.90.448 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: PERSONAL EMERGENCY RESPONSE SYSTEMS~~, REQUIREMENTS~~ (1) A personal emergency response system (PERS) is an electronic device ~~or mechanical system~~ used to ~~summon~~

secure assistance in an emergency situation to allow a member to gain greater independence.

(2) A ~~personal emergency response system~~ PERS must be connected to ~~a local~~ an emergency response unit with the capacity to activate emergency ~~medical~~ personnel.

(3) remains the same.

AUTH: 53-2-201, 53-6-402, MCA
IMP: ~~53-2-401,~~ 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~~, REQUIREMENTS~~ (1) Specialized medical equipment and supplies is the provision of items of medical equipment and supplies to a ~~recipient~~ member for the purpose of maintaining and improving the ~~recipient's~~ member's ability to reside at home and to function in the community.

~~(2) The provision of medical equipment and supplies services may include:~~

~~(a) the provision of consultation regarding the appropriateness of the equipment or supplies; and~~

~~(b) the provision of supplies and care necessary to maintain a service animal.~~

~~(3)~~ (2) Specialized medical equipment and supplies must:

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

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

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

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

~~(4) Any particular item of medical equipment or supplies, except for an item or supply necessary to maintain a service animal, is limited to a one time purchase unless otherwise authorized by the department in writing.~~

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

~~(6)~~ (4) A service animal is an animal trained to undertake particular tasks on behalf of a ~~recipient~~ member that the ~~recipient~~ member cannot perform and that are necessary to meet the ~~recipient's~~ member's needs for accessibility, independence, health, or safety.

(7) remains the same but is renumbered (5).

~~(8)~~ (6) Supplies necessary for the performance of a service animal ~~may include, but are not limited to, leashes, harness, backpack, and mobility cart when the supplies are specifically related to the performance of the service animal~~ to meet the specific needs of the ~~recipient~~ member are allowable expenses. Supplies do not include food to maintain the service animals.

~~(9)~~ (7) Care necessary to the health and maintenance of a service animal ~~may~~ include~~, but is not limited to,~~ veterinarian care, transportation for veterinarian

care, license, registration, and where the ~~recipient~~ member or ~~recipient's~~ member's primary care giver is unable to perform it, grooming.

(10) and (11) remain the same but are renumbered (8) and (9).

AUTH: 53-2-201, 53-6-402, MCA
IMP: ~~53-2-401,~~ 53-6-402, MCA

37.90.450 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS: NONMEDICAL TRANSPORTATION~~, REQUIREMENTS~~ (1) Nonmedical transportation is the provision to a ~~recipient~~ member of transportation through common carrier or private vehicle for access to social or other nonmedical activities.

(2) remains the same.

(3) Nonmedical transportation may be provided by accessible transportation providers, cabs, personal care provider agencies, and Life Coaches. Nonmedical transportation providers must ~~provide~~ show proof of:

(a) a valid Montana driver's license; and

(b) adequate automobile insurance~~; and~~.

~~(c) assurance of vehicle compliance with all applicable federal, state, and local laws and regulations.~~

(4) Nonmedical transportation services must be:

(a) provided by the most cost-effective mode~~.~~; and

(b) provided only after all volunteer, state plan, or other publicly funded transportation programs have been exhausted or determined inappropriate.

(5) Nonmedical transportation services are available only for the transport of ~~recipients~~ members to and from activities ~~that are included in the individual plan of care~~ identified in the member's Person-Centered Recovery Plan.

AUTH: 53-2-201, 53-6-402, MCA
IMP: ~~53-2-401,~~ 53-6-402, MCA

5. The department proposes to repeal the following rules:

37.90.428 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ADULT RESIDENTIAL CARE REQUIREMENTS

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

37.90.429 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SUPPORTED LIVING, REQUIREMENTS

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

37.90.432 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: HABILITATION, REQUIREMENTS

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

37.90.436 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SPECIALLY TRAINED ATTENDANT CARE, REQUIREMENTS

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

37.90.437 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: HOMEMAKING REQUIREMENTS

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

37.90.440 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: OUTPATIENT OCCUPATIONAL THERAPY, REQUIREMENTS

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

37.90.441 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PSYCHO-SOCIAL CONSULTATION, REQUIREMENTS

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

37.90.442 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SUBSTANCE-RELATED DISORDERS SERVICES, REQUIREMENTS

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

37.90.445 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: DIETETIC SERVICES, REQUIREMENTS

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

37.90.446 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NUTRITION, REQUIREMENTS

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

37.90.460 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ILLNESS MANAGEMENT AND RECOVERY SERVICES, REQUIREMENTS

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

37.90.461 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: WELLNESS RECOVERY ACTION PLAN (WRAP) SERVICES, REQUIREMENTS

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

6. STATEMENT OF REASONABLE NECESSITY

The Department of Public Health and Human Services (department) is proposing to amend ARM 37.90.401, 37.90.402, 37.90.403, 37.90.406, 37.90.408, 37.90.410, 37.90.412, 37.90.413, 37.90.415, 37.90.416, 37.90.417, 37.90.420, 37.90.425, 37.90.430, 37.90.431, 37.90.438, 37.90.447, 37.90.448, 37.90.449, and 37.90.450. The department proposes to adopt New Rules I through XV and repeal ARM 37.90.428, 37.90.429, 37.90.432, 37.90.436, 37.90.437, 37.90.440, 37.90.441, 37.90.442, 37.90.445, 37.90.446, 37.90.460 and 37.90.461.

The following summary explains the programmatic changes and the reasonable necessity for the proposed rulemaking.

Home and Community Based Services for Adults with Severe and Disabling Mental Illness

The department has submitted a request to the Centers for Medicare and Medicaid Services (CMS) to renew the Montana Medicaid Severe and Disabling Mental Illness (SDMI) 1915(c) Home and Community Based Services (HCBS) Waiver and concurrent 1915(b)(4) SDMI Waiver, for an effective date of July 1, 2020. The waiver renewal will be for five years, to June 30, 2025. As part of the waiver renewal request to CMS, the department is proposing changes to the waiver program, and the following rule amendments implement the changes:

a. The SDMI definition has been updated to reflect current terminology. This does not reflect a change in eligibility for the waiver.

b. DPHHS is proposing to increase the unduplicated members served by the waiver from 357 per year to 600 members in year one, 650 members in year two, and 750 members in years three through five.
c. The SDMI determination form has been replaced with the Severe and Disabling Mental Illness, Home and Community Services Waiver, Evaluation and Level of Impairment form.
d. A member's placement on the waitlist will be determined by their combined scores from the level of care assessment and level of impairment evaluation. There will no longer be an additional assessment to determine a member's placement on the waitlist.
e. There is a proposed reserve capacity in the waiver for individuals discharging from the Montana State Hospital, the Montana Mental Health Nursing Care Center, and individuals accessing Money Follows the Person.
f. Services have been removed, added, and amended to better serve the behavioral needs and symptomology of members with severe and disabling mental illness and to alleviate duplicative services. Pre-vocational services are removed due to both underutilization and an inherent duplication with support employment. Residential habilitation has been expanded to add two new levels of group home services: mental health group home and intensive mental health group home. Specially trained attendant has been replaced with behavioral intervention assistant to better serve the behavioral needs of this population.
g. Additional oversight has been added for incident management. The definition for serious occurrences has been updated and classified under critical and non-critical. This also includes generating monthly reports to monitor serious occurrences and a monthly utilization report for emergency room visits.
h. Changes were made to provide further details regarding the overall waiver administration, oversight, and operations.

The reasonable necessity for proposing the above rule changes is to enact the changes made in the Medicaid Severe and Disabling Mental Illness (SDMI) 1915(c) Home and Community Based Services (HCBS) Waiver renewal. The proposed changes increase access for adults with a SDMI to receive long term services and supports individualized to their needs in the community and who might otherwise require services in an institution. In addition, it furthers the department's ability to meet the needs of adults with a SDMI through the provision of more services of specialty providers statewide.

The department is proposing to repeal rules for services that are no longer authorized or that have been restructured in the SDMI HCBS waiver, specifically ARM 37.90.428, 37.90.429, 37.90.432, 37.90.436, 37.90.437, 37.90.440, 37.90.441, 37.90.442, 37.90.445, 37.90.446, 37.90.460, and 37.90.461. This is necessary to align administrative rules with the services that will be authorized in the waiver effective July 1, 2020.

Fiscal Impact

The department is proposing to increase the unduplicated members served by the waiver from 351 per year to 600 in year one and 650 in year two. This has a fiscal impact of $84,500 in state fiscal year (SFY) 2021 and $101,800 in SFY2022.

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: Heidi Clark, 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 dphhslegal@mt.gov, and must be received no later than 5:00 p.m., June 12, 2020.

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 or may be made by completing a request form at any rules hearing held by the department.

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

11. With regard to the requirements of 2-4-111, MCA, the department has determined that the adoption, amendment, and repeal of the above-referenced rules will significantly and directly impact small businesses.

12. 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/ Sheila Hogan
Sheila Hogan, Director
Public Health and Human Services

Certified to the Secretary of State May 5, 2020.