MONTANA
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DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED RULEMAKING

MAR NOTICE NO. 2025-524.1

Summary

Amendment of ARM 37.40.1402, 37.40.1406, 37.40.1415 and repeal of ARM 37.40.1436 and 37.40.1438 pertaining to community supports and supported living services

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Hearing Date and Time

Friday, August 15, 2025, at 10:00 a.m.

Virtual Hearing Information

Join Zoom Meeting : https://mt-gov.zoom.us/j/87586705062?pwd=Ys9kglH17eAKrsVuWVzqm7cXA5hpyD.1

Meeting ID: 875 8670 5062 and Password: 929042

Dial by Telephone +1 646 558 8656

Meeting ID: 875 8670 5062 and Password: 929042

Find your local number: https://mt-gov.zoom.us/u/kbXHcC9dl1

Comments

Comments may be submitted using the contact information below. Comments must be received by Friday, August 22, 2025, at 5:00 p.m.

Accommodations

The agency 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. Requests must be made by Friday, August 1, 2025, at 5:00 p.m.

Contact

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Rulemaking Actions

AMEND

The rules proposed to be amended are as follows, stricken matter interlined, new matter underlined:

37.40.1402 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSON: DEFINITIONS

(1) "Adult residential care" means a residential habilitation option for consumers residing in an adult foster home, group home, or 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 through the program to a consumer.

~~(3) "Community supports" means services that are inclusive of personal assistant services (Attendant PAS and Socialization/Supervision PAS), homemaker, chore, transportation, and respite type services.~~

~~(4)~~(3) "Community transitions services" means nonrecurring set-up expenses for individuals 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.

~~(5)~~(4) "Consultative clinical and therapeutic services" means services that assist unpaid and/or paid caregivers in carrying out individual service plans and are necessary to improve the individual's independence and inclusion in the community.

~~(6)~~(5) "Consumer-directed goods and services" means services, supports, supplies, or goods not otherwise provided through this waiver or the Medicaid state plan.

~~(7)~~(6) "Family training and support" means a service that provides training to families and others who work or play with a child with a disability.

~~(8)~~(7) "Financial management services" means services provided by an individual called a financial manager who provides finance, employer, payroll, and related functions for the consumer or personal representative.

~~(9)~~(8) "Habilitation" means the provision of intervention services designed for assisting a consumer to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully at home and in the community.

~~(10)~~(9) "Health and wellness" means services that assist consumers in acquiring, retaining, and improving self-help, socialization, and adaptive skills to reside successfully in the community.

~~(11)~~(10) "Homemaker chore" means services provided for individuals who are unable to manage their own home or when the consumer, normally responsible for homemaking, is absent.

~~(12)~~(11) "Independence advisor services" means services that provide an array of consumer-directed support activities to ensure the ability of consumers to direct their care successfully.

~~(13)~~(12) "Nonmedical transportation" means the provision to a consumer of transportation through common carrier or private vehicle for access to social or other nonmedical activities.

~~(14)~~(13) "Pain and symptom management" means a service that allows the provision of traditional and nontraditional methods of pain management.

~~(15)~~(14) "Participant direction" means an option available to individuals who elect to direct their own care and that participants, or their representatives, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available support.

~~(16)~~(15) "Personal assistant services" (PAS) is defined at 53-6-145, MCA and includes attendant PAS and socialization/supervision PAS.

~~(17)~~(16) "Post-acute rehabilitation services" means the provision of therapeutic intervention to a consumer with a brain injury or other related disability in a residential or nonresidential setting.

~~(18)~~(17) "Respite care" means the provision of supportive care to a consumer to relieve those unpaid persons normally caring for the consumer from that responsibility.

~~(19)~~(18) "Senior companion" means services directed at providing companionship and assistance.

~~(20)~~(19) "Serious occurrence" means a significant event which affects the health, welfare, and safety of an individual served in home and community-based services. The department has established a system of reporting and monitoring serious incidents that involve consumers served by the program in order to identify, manage, and mitigate overall risk to the individual.

~~(21)~~(20) "Service plans" means a written plan of supports and interventions based on an assessment of the status and needs of a consumer.

~~(22)~~(21) "Specialized child care for medically fragile children" means the provision of day care, respite care, and other direct and supportive care to a consumer under 18 years of age who is medically fragile and who, due to medical and other needs, cannot be served through traditional child care settings.

~~(23)~~(22) "Specially trained attendant care" means an option under personal assistance that is the provision of supportive services to a consumer residing in their own residence.

~~(24) "Supported living" means the provision of supportive services to a recipient residing in an individual residence or in a group living situation. It is a comprehensive service designed to support a person with brain injury or other severe disability.~~

Authorizing statute(s): 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-402, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-111, 53-6-402, MCA

37.40.1406 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SERVICES

(1) The services available through the program are limited to those specified in this rule.

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

(a) the recipient'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 recipient's needs;

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

(d) the recipient'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; or

(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, can no longer 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; and

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

(5) The department may make program services for persons with intensive needs available to a recipient whom it determines, based on past medical history and current medical diagnosis, would otherwise require on a long-term basis the level of care of an inpatient hospital or a rehabilitation service setting.

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

(a) adult day health;

(b) adult residential care;

(c) case management services;

~~(d) community supports services;~~

~~(e)~~(d) community transition services;

~~(f)~~(e) consultative clinical and therapeutic services;

~~(g)~~(f) consumer-directed goods and services;

~~(h)~~(g) day habilitation;

~~(i)~~(h) dietetic services;

~~(j)~~(i) environmental accessibility adaptations;

~~(k)~~(j) family training and support;

~~(l)~~(k) financial management;

~~(m)~~(l) habilitation;

~~(n)~~(m) health and wellness;

~~(o)~~(n) homemaker chore services;

~~(p)~~(o) homemaker;

~~(q)~~(p) independence advisor;

~~(r)~~(q) nonmedical transportation;

~~(s)~~(r) nursing;

~~(t)~~(s) nutrition services;

~~(u)~~(t) occupational therapy;

~~(v)~~(u) pain and symptom management;

~~(w)~~(v) personal assistance;

~~(x)~~(w) personal emergency response systems;

~~(y)~~(x) physical therapy;

~~(z)~~(y) post-acute rehabilitation services;

~~(aa)~~(z) respiratory therapy;

~~(bb)~~(aa) respite care;

~~(cc)~~(bb) senior companion services;

~~(dd)~~(cc) speech pathology and audiology;

~~(ee)~~(dd) specially trained attendants;

~~(ff)~~(ee) specialized child care for medically fragile children;

~~(gg)~~(ff) specialized medical equipment and supplies; and

~~(hh) supported living; and~~

~~(ii)~~(gg) vehicle modifications.

(7) 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.

(8) The program is considered the payor of last resort. A service available through the program is not available to any extent that a service of another program is otherwise available to a recipient to meet the recipient's need for that service.

Authorizing statute(s): 53-2-201, 53-6-101, 53-6-113, 53-6-402, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-402, MCA

37.40.1415 HOME AND COMMUNITY BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: REIMBURSEMENT

(1) Services available through the program are reimbursed as specified in this rule.

(2) The following services are reimbursed as provided in (3):

(a) adult day health;

(b) adult residential care;

(c) case management services;

~~(d) community supports services;~~

~~(e)~~(d) community transition services;

~~(f)~~(e) consultative clinical and therapeutic services;

~~(g)~~(f) consumer-directed goods and services;

~~(h)~~(g) dietetic services;

~~(i)~~(h) environmental accessibility adaptations;

~~(j)~~(i) family training and support;

~~(k)~~(j) financial management;

~~(l)~~(k) habilitation;

~~(m)~~(l) health and wellness;

~~(n)~~(m) homemaker chore services;

~~(o)~~(n) homemaker;

~~(p)~~(o) independence advisor;

~~(q)~~(p) nonmedical transportation;

~~(r)~~(q) nursing;

~~(s)~~(r) nutrition services;

~~(t)~~(s) pain and symptom management;

~~(u)~~(t) personal emergency response systems;

~~(v)~~(u) post-acute rehabilitation services;

~~(w)~~(v) respite care;

~~(x)~~(w) senior companion services;

~~(y)~~(x) specialized child care for medically fragile children; and

~~(z) supported living; and~~

~~(aa)~~(y) vehicle modifications.

(3) The services specified in (2) are, except as otherwise provided in (4), reimbursed at the lower of the following:

(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 as a service of the general Medicaid program.

(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 37.40.1302;

(b) outpatient occupational therapy as provided at ARM 37.86.610;

(c) outpatient physical therapy as provided at ARM 37.86.610;

(d) speech therapy as provided at ARM 37.86.610; and

(e) audiology as provided at ARM 37.86.705.

(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) Specialized medical equipment and supplies are reimbursed as follows:

(a) equipment and supplies which are reimbursable under ARM 37.86.1801, 37.86.1802, 37.86.1806, and 37.86.1807 shall be reimbursed as provided in ARM 37.86.1807;

(b) equipment and supplies which are not reimbursable under ARM 37.86.1801, 37.86.1802, 37.86.1806, and 37.86.1807 shall be reimbursed at the lower of the following:

(i) the provider's usual and customary charge for the item; or

(ii) the negotiated rate up to the department's maximum allowable fee.

(9) Reimbursement is not available for the provision of a service to a person that may be reimbursed through another program.

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

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

(12) Payment for the following services may be made to legally responsible individuals, if all program criteria in ARM 37.40.1407 are met:

(a) personal assistance;

(b) homemaker;

(c) specially trained attendant;

(d) specialized child care for medically fragile children;

(e) private duty nursing;

(f) transportation;

(g) respite;

~~(h) community supports;~~

~~(i)~~(h) consumer-directed goods and services;

~~(j)~~(i) homemaker chore;

~~(k)~~(j) pain and symptom management;

~~(l)~~(k) vehicle modifications; and

~~(m)~~(l) environmental accessibility adaptations.

(13) When the Legislature funds a direct care wage initiative, waiver providers targeted by the initiative must report to the department, for a determined time period, actual hourly wage and benefit rates paid for all direct care workers or the lump sum payment amounts for all direct care workers that will receive the benefit of the increased funds. The reported data shall be used by the department for the purpose of tracking distribution of direct care wage funds to designated workers.

(a) The department will pay targeted waiver providers that submit an approved request to the department a lump sum payment in addition to the Medicaid reimbursement rate to be used only for wage and benefit increases or lump sum payments for direct care workers.

(b) To receive the direct care workers' lump sum payment, a targeted provider shall submit for approval a request form to the department stating how the direct care workers' lump sum payment will be spent to comply with all department requirements. The provider shall submit all of the information required on the form in order to continue to receive subsequent lump sum payment amounts.

(c) If these funds will be distributed in the form of a wage increase to direct care workers the form for wage and benefit increases will request information including, but not limited to:

(i) the number of category of each direct care worker that will receive the benefit of the increased funds;

(ii) the actual per hour rate of pay before benefits and before the direct care wage increase has been implemented for each worker that will receive the benefit of the increased funds;

(iii) the projected per hour rate of pay with benefits after the direct wage increase has been implemented;

(iv) the number of staff receiving a wage or benefit increase by category of worker, effective date of implementation of the increase in wage and benefit; and

(v) the number of projected hours to be worked in the budget period.

(d) If these funds will be used for the purpose of providing lump sum payments (i.e., bonus, stipend, or other payment types) to direct care workers the form will request information including, but not limited to:

(i) the number of category of each direct care worker that will receive the benefit of the increased funds;

(ii) the type and actual amount of lump sum payment to be provided for each worker that will receive the benefit of the lump sum funding;

(iii) the breakdown of the lump sum payment by the amount that represents benefits and the direct payment to workers by category of worker; and

(iv) the effective date of implementation of the lump sum benefit.

(e) A provider that does not submit a qualifying request for use of the funds distributed under (2), or does not include all of the information requested by the department, within the time established by the department, or a provider that does not wish to participate in this additional funding amount shall not be entitled to their share of the funds available for wage and benefit increases or lump sum payments for direct care workers.

(14) A provider that receives funds under this rule must maintain appropriate records documenting the expenditure of the funds. This documentation must be maintained and made available to authorize governmental entities and their agents to the same extent as other required records and documentation under applicable Medicaid record requirements, including but not limited to the provisions of ARM 37.40.345, 37.40.346, and 37.85.414.

Authorizing statute(s): 53-2-201, 53-6-113, 53-6-402, MCA

Implementing statute(s): 53-6-101, 53-6-111, 53-6-113, 53-6-402, MCA

REPEAL

The rules proposed to be repealed are as follows:

37.40.1436 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COMMUNITY SUPPORTS SERVICES, REQUIREMENTS

Authorizing statute(s): 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-402, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-111, 53-6-402, MCA

37.40.1438 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SUPPORTED LIVING, REQUIREMENTS

Authorizing statute(s): 53-2-201, 53-6-113, 53-6-402, MCA

Implementing statute(s): 53-6-402, MCA

General Reasonable Necessity Statement

The Department of Public Health and Human Services (department) is proposing the amendment and repeal of the above-stated rules to implement changes required by the Centers for Medicare & Medicaid Services (CMS) to Montana's 1915(c) Home and Community Based Montana Medicaid Big Sky Waiver (BSW). During the submission of the BSW renewal, CMS determined that community support and supported living are bundled services that do not comply with 42 CFR 441.301(b)(4). Under this federal requirement, furnished waiver services are required to be separately defined and multiple services that are generally considered to be separate services may not be consolidated under a single service definition.

As required by CMS, these bundled services are no longer available under the BSW. Removal of these bundled services from administrative rule is necessary to ensure the department's rules governing BSW services align with federal requirements and the BSW renewal effective July 1, 2024.

The department has a transition plan in place that includes working with Case Management Teams (CMTs) to assist with the transition of members from community supports and supported living services to identical BSW and state plan stand-alone services. CMTs will ensure that members will be transitioned to these identical stand-alone services without interruption to service delivery to meet member needs as reflected in member service plans. CMTs will also provide member referrals to community resources and State Plan services as needed. CMTs will notify all members who are receiving community supports and supported living services of the transition from bundled services to stand-alone BSW services and will utilize person centered planning processes to smoothly transition members. This transition plan is outlined on pages 13 through 15 of the approved 1915(c) Home and Community-Based Services Waiver and is electronically accessible at: https://www.dphhs.mt.gov/assets/hcbs/1915cHomeandCommunityBasedServicesWaiver.pdf.

ARM 37.40.1402

Consistent with the current BSW, the department proposes to remove the definitions of "community supports" and "supported living."

ARM 37.40.1406
The department proposes to remove community supports services and supported living from the list of services that may be provided through the BSW program since such services are no longer available as bundled services under the program.

ARM 37.40.1415
The department proposes to remove community supports services and supported living from the list of services that are reimbursed or for which payment may be made to legally responsible individuals because the program no longer covers such services as bundled services.

ARM 37.40.1436
The department proposes to repeal this rule, which established the requirements for the reimbursement of community supports services because such services are no longer covered as bundled services under the BSW program.

ARM 37.40.1438
The department proposes to repeal this rule, which established the requirements for the reimbursement of supported living services because such services are no longer covered as bundled services under the BSW program.

Fiscal Impact

Removal of Supported Living Services
Four members are currently receiving services through the supported living bundled service. The supported living bundled service had an administrative cost of $414,884 in state fiscal year (SFY) 2024. Supported Living services will be transitioned to BSW standalone services with a projected administrative cost of $312,229 in SFY 2025. The proposed removal of this bundled service will result in a projected cost savings of approximately $102,000.

Removal of Community Support Services
Currently, 24 members are receiving community support bundled services consisting of personal assistance and, homemaker chore. The community support bundled service had an administrative cost of $323,625 in SFY 2025.

BSW personal assistance services had an administrative cost of $959,678 in SFY 2025. BSW personal assistance services include personal care services, personal emergency response systems, and medical escort. These services will be transitioned to the Community First Choice program. Federal participation under CFC is 6% higher than the standard Federal Medical Assistance Percentage (FMAP). FMAP in SFY 2025 is 62.37% for traditional Medicaid and 68.37% for CFC FMAP. Transition from BSW to CFC is estimated to result in a cost savings of $57,581.

The proposed removal of the community support bundles services is projected to result in a cost savings of $912,777 to the BSW program.

Interested Persons

The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by the department. 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 emailed, mailed or otherwise delivered to the contact person above.

Bill Sponsor Notification

The bill sponsor contact requirements do not apply.

Small Business Impact

Pursuant to 2-4-111, MCA, the class of small businesses probably affected by the proposed rules are those providing community supports, supported living, independent advisor, or fiscal management services. The department does not believe the proposed rules will have a probable significant and direct effect on the small businesses given that individuals receiving community supports and supported living services will be transitioned to standalone services that small businesses can provide. Additionally, small businesses that provide independent advisor or fiscal management services can continue to provide those services to self-direct members who transition to the standalone services.

Medicaid Performance-Based Statement

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.

Rule Reviewer

Robert Lishman

Approval

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