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

In the matter of the amendment of ARM 37.97.102, 37.97.106, 37.97.126, 37.97.127, 37.97.132, 37.97.142, 37.97.148, 37.97.903, 37.97.905, 37.97.906, and 37.97.907 pertaining to youth care facility requirements	)	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On June 11, 2021, the Department of Public Health and Human Services published MAR Notice No. 37-946 pertaining to the public hearing on the proposed amendment of the above-stated rules at page 700 of the 2021 Montana Administrative Register, Issue Number 11.

2. The department has amended the following rules as proposed: ARM 37.97.106, 37.97.126, 37.97.132, 37.97.142, and 37.97.905.

3. The department has amended the following rules as proposed, but with the following changes from the original proposal, new matter underlined, deleted matter interlined:

37.97.102 YOUTH CARE FACILITY (YCF): DEFINITIONS The following definitions apply to all YCF licensing rules:

(1) through (3) remain as proposed.

(4) "Clinical assessment" means an assessment with a DSM diagnosis and a social history completed by the mental health professional. Clinical assessments include the following information:

(a) and (b) remain as proposed.

(c) substance use history;

(d) through (8) remain as proposed.

(9) "Family" means the youth, the youth's biological, adoptive, or foster family ~~members~~, including siblings, grandparents, ~~or~~ godparents, and fictive kin, which refers to someone who, though unrelated by birth or marriage, has such a close emotional relationship with the youth that they may be considered part of the family.

(10) through (17) remain as proposed.

(18) "Program manager" means an employee of a therapeutic group home provider who is responsible for the overall management and supervision of the program ~~and trains and supervises direct care staff~~. A program manager must have a bachelor's degree in human services, or the experience and education, equivalent to a bachelor's degree. Human services experience equivalent to a bachelor's degree for a nondegree program manager is six years. Each year of post-secondary

education in human services for a nondegree program manager equals one year of experience.

(19) through (33) remain as proposed.

AUTH: 52-2-111, 52-2-603, 52-2-622, MCA
IMP: 52-2-113, 52-2-603, 52-2-622, 53-2-201, MCA

37.97.127 YOUTH CARE FACILITY (YCF): CASE RECORDS (1) A YCF shall maintain a written or electronic case record for each youth which shall include administrative, treatment, and educational data from the time of admission until the time the youth is discharged from the YCF. A youth's case record must include but is not limited to the following:

(a) remains as proposed.

(b) the name, address, and telephone number of the parent(s) or guardian of the youth;

(i) therapeutic group homes must maintain contact information on all known family ~~members~~ and document outreach efforts;

(c) through (q) remain as proposed.

(2) In addition to the requirements in (1), therapeutic group homes must maintain ~~an updated copy of the youth's clinical assessment.~~:

(a) an updated copy of the youth's clinical assessment;

(b) a list and contact information of all known family, as provided by the entity placing the youth, and family known to the TGH through their work with the youth; and

(c) documentation of all outreach efforts to identified family, to build a positive network to support the wellbeing of the youth. Documentation must include:

(i) a minimum of two attempts to contact all identified family;

(ii) results of each contact; and

(iii) how the TGH will support and facilitate regular contact with identified family as outlined in the youth's treatment plan.

AUTH: 52-2-111, 52-2-603, 52-2-622, MCA
IMP: 52-2-113, 52-2-603, 52-2-622, MCA

37.97.148 YOUTH CARE FACILITY (YCF): CASE PLAN (1) ~~Each~~ Except for therapeutic group homes, each YCF must develop a case plan for each youth in care. A case plan is a specific plan for providing care, treatment, and services of any kind to a specific youth.

(2) through (5) remain as proposed.

(6) Therapeutic group homes must ~~also~~ meet the treatment plan requirements in ARM 37.97.907.

AUTH: 52-2-111, 52-2-603, 52-2-622, MCA
IMP: 52-2-113, 52-2-603, 52-2-622, MCA

37.97.903 THERAPEUTIC GROUP HOMES (TGH): STAFFING (1) through (8) remain as proposed.

(9) The mental health professional shall be responsible for the supervision and overall provision of treatment services to youth in the TGH. The mental health professional must not be counted in the direct care staff to youth ratio.

(9) and (10) remain as proposed but are renumbered (10) and (11).

AUTH: 52-2-111, 52-2-603, 52-2-622, MCA
IMP: 52-2-113, 52-2-603, 52-2-622, MCA

37.97.906 THERAPEUTIC GROUP HOMES (TGH): THERAPEUTIC SERVICE REQUIREMENTS (1) ~~The therapeutic services provided by the mental health professionals are "therapy," and services provided by the program manager or direct care staff are "therapeutic intervention" services.~~ The TGH must provide therapeutic services to all youth. Therapeutic services include therapy and therapeutic interventions. The purpose of therapeutic services is to:

(a) through (d) remain as proposed.

(2) Each youth must receive 75 minutes of therapy and 75 minutes of therapeutic intervention services per week (Sunday through Saturday). ~~Therapy includes individual and group or family therapy as clinically indicated based on the specific treatment needs of the youth. Therapy requirements include the following:~~

(3) Therapy requirements must be provided by the mental health professional and include the following:

(a) Individual therapy must be provided at least 50 minutes out of the required 75 minutes per week as outlined in the youth's treatment plan. ~~Individual therapy may be provided in two 25- minute sessions per week as clinically appropriate. The mental health professional must document specific reasons why a 50-minute therapy session cannot be provided.~~

(b) Family therapy must be provided to the youth and family members as defined in ARM 37.97.102(9) and provided as outlined in the youth's treatment plan. ~~If family therapy is not appropriate based on the particular situation of the youth, the mental health professional must document specific reasons why family therapy cannot be provided.~~

(c) If no identified family members as defined in ARM 37.97.102(9) are able to participate in family therapy, specific reasons why family therapy cannot be provided must be documented in the youth's treatment plan.

(d) If the youth is on a home visit or the family is unable to participate in therapy on-site, the mental health professional may provide therapy electronically via video conferencing or telehealth.

~~(3)~~ (4) In the event the mental health professional is unavailable due to vacation, illness, ~~or if the youth is on a home visit,~~ or other similar circumstance for more than 150 minutes in a 24-week period per youth, ~~alternative~~ arrangements for therapy must be made based on the program's policy and procedures.

(a) The TGH must document in the youth's case record why the mental health professional could not provide therapy ~~was not provided~~ and what ~~alternative~~ arrangements for therapy were made.

(b) The 24-week time period will be based on the youth's admission date.

(5) Therapeutic interventions may be provided by the mental health professional, program manager, or direct care staff as outlined in the youth's

treatment plan.
(4) and (5) remain as proposed but are renumbered (6) and (7).

AUTH: 52-2-111, 52-2-603, 52-2-622, MCA
IMP: 52-2-113, 52-2-603, 52-2-622, MCA

37.97.907 THERAPEUTIC GROUP HOMES (TGH): TREATMENT PLAN
(1) remains as proposed.
(2) The initial treatment plan must be developed within 10 business days of admission and include:
(a) names of treatment team members including ~~appropriate biological~~ the youth's family, relatives, and fictive kin of the youth, appropriate school personnel, placing agency representative, and other professionals as appropriate;
(b) through (f) remain as proposed.
(g) identifying how the TGH will facilitate participation of family ~~members~~ in the treatment of the youth, including siblings;
(h) through (4) remain as proposed.
(5) All direct care staff and treatment team members, including the mental health professional involved in the care of the youth, must read and sign off on the treatment plan within seven days of its development ~~or~~ and update.
(6) remains as proposed.

AUTH: 52-2-111, 52-2-603, 52-2-622, MCA
IMP: 52-2-113, 52-2-603, 52-2-622, MCA

4. The department has thoroughly considered the comments and testimony received. A summary of the comments received and the department's responses are as follows:

Comment #1: Numerous commenters stated the proposed rules do not incorporate all requirements of the Family First Prevention Services Act (FFPSA) and do not create a single overarching direction and oversight of all aspects of the FFPSA or of qualified residential treatment programs (QRTP).

Response #1: The department recognizes that many aspects of the FFPSA are not within the scope of this rulemaking. The purpose of these rule amendments is to incorporate QRTP requirements into the licensure requirements for therapeutic group homes in the implementation of portions of FFPSA. The proposed changes are designed to increase family involvement with a goal of reducing the amount of time a youth spends in the group setting and returning the youth to a family setting at the earliest possible time. The department will ensure FFPSA compliance through additional rule amendments proposed by other divisions and through contract provisions with vendors.

Comment #2: One commenter stated the term "mental health professional" (MHP) typically refers to a licensed individual and, in some instances, requires certification.

The commenter suggested the department continue using the term "lead clinical staff" rather than changing the title to MHP.

Response #2: The department agrees that the term MHP typically refers to a licensed individual. The existing rule required the lead clinical staff to be licensed and the proposed rule amendment continues to require the MHP to be licensed. The department has changed the term from lead clinical staff to MHP to remain consistent with standard terminology for licensed staff.

Comment #3: Two commenters requested amending ARM 37.97.132(3)(a) to permit providers to hire staff who are 18 years of age, rather than the current age requirement of 21 years of age.

Response #3: The purpose of the rule notice is to incorporate QRTP requirements into the licensure requirements for therapeutic group homes in compliance with FFPSA, and the proposed amendments do not address the age of facility staff. Therefore, this comment is outside the scope of this rulemaking.

Comment #4: A commenter stated the lack of room and board payments poses a financial hardship on providers and is a financial disincentive to providers to accept Montana children into services that are not placed and funded by foster care. The commenter asked if Montana intends to pay for room and board costs for all Montana kids.

Response #4: The purpose of the rule notice is to incorporate QRTP requirements into the licensure requirements for therapeutic group homes in compliance with FFSPA, and the proposed amendments do not address payment for room and board. Therefore, this comment is outside the scope of this rulemaking.

Comment #5: A commenter asked the department to explicitly allow the use of electronic record management systems.

Response #5: The department currently permits facilities to use electronic medical records. The department has amended the language in ARM 37.97.127 to make it consistent with the department's current practice of allowing electronic medical record systems.

Comment #6: Numerous commenters stated the proposed rules restrict the program manager and MHP from acting as direct care staff and prohibit them from being counted in the youth to staff ratio. The commenters stated that implementation of the rule would likely see a reduction in the number of youth that programs are able to serve and create undo financial hardship as on-call stipends and overtime would be added expenses.

Response #6: The proposed rules in fact increase the hours during which the program manager may provide direct care and be counted in the direct care ratio. The rulemaking proposed adding the timeframe of 6 a.m. to 8 a.m. or any other two-

hour timeframe prior to youth leaving for school during which the program manager may be counted in the direct care ratio. The current rule permitted counting the program manager for the direct care ratio only if up to two youths do not attend school and remain at the facility during school hours, and that provision remains unchanged. Therefore, the proposed amendments increase the time the program manager can act as direct care. The rulemaking did not propose any changes relating to counting the MHP as direct care staff.

Comment #7: A commenter requested clarification on a due date requirement on the discharge plan. The commenter stated that the proposed amendment states the discharge plan is to be completed at time of admission but is also part of the initial treatment plan and that the initial treatment plan is due 10 business days from admission in accordance with the treatment plan date.

Response #7: Discharge planning must begin at the time of admission for all youth, and providers must document discharge planning at that time. Additionally, the discharge plan must be included in the initial treatment plan and updated as appropriate. The commenter is correct that the initial treatment plan for therapeutic group homes is required to be completed within 10 business days from admission.

Comment #8: Numerous comments were received regarding the distinctions between the case plan and the treatment plan. Providers asked if TGHs are required to have a case plan as required in ARM 37.97.148 and a treatment plan as required in ARM 37.97.907. The commenters recommended amending the language and adding clear and concise language so that TGHs are not required to have both a case plan and a treatment plan.

Response #8: The department did not intend to require TGHs to have two plans. The department agrees that clarification is necessary and has amended ARM 37.97.148 to include an exception for TGHs from the requirements of the rule and to articulate that TGHs must meet the requirements in ARM 37.97.907.

Comment #9: A commenter recommends amending ARM 37.97.906 to allow MHP to provide therapeutic intervention services.

Response #9: The department agrees with this comment and has amended ARM 37.97.906(5) to permit the MHP to provide therapeutic interventions. The department's intent is to require the MHP to provide therapy and have more time to meet the clinical needs of the youth. The department understands that the licensure requirements for therapy are minimal. If additional clinical needs are not necessary, the MHP may have time to provide therapeutic interventions.

Comment #10: A commenter requested clarification on how providers document both alternative arrangements for therapy and missed therapy sessions.

Response #10: The department agrees with this comment and has amended ARM 37.97.906(5) to clarify documentation requirements and the limitation on the number

of missed therapy sessions permitted. The department intends for MHP to document in the youth's case record the reason for all missed therapy sessions. The department has clarified the circumstances under which a MHP may skip a scheduled therapy session and has established a limit on the number of times it can happen. If a MHP exceeds the limit, the provider must ensure the youth's clinical needs continue to be met and ensure the youth receives therapy as outlined in the program's policies and procedures.

Comment #11: A commenter requested amending language to allow individual therapy to be provided at least 75 minutes per week or in three weekly contacts as outlined in treatment plans for those struggling with duration-based therapy sessions. The commenter stated under current rule clinicians spend three plus hours per week providing therapy for each individual.

Response #11: The current and proposed rule, ARM 37.97.906, allows for the MHP to complete the required 75 minutes of therapy in three weekly sessions as requested by the commenter. The department has maintained the minimal requirements for therapy; however, the department has modified the language to allow flexibility to MHP by allowing the required minutes of individual therapy as clinically indicated.

Comment #12: Several comments were received requesting more flexibility in how therapy is provided and suggested not requiring a specific amount of minutes for individual therapy. A commenter asserted the language is overly restrictive and limits the ability of the MHP to determine appropriate treatment parameters. A commenter suggested some clients would benefit more from therapy in a group setting or a stronger focus on family therapy.

Response #12: See response #11.

Comment #13: Two commenters asked if telehealth is allowed for therapy services.

Response #13: Telehealth is allowed under certain circumstances. Based on this comment, the department has amended ARM 37.97.906(3)(d) to clarify the circumstances that warrant telehealth: if the youth is on a home visit or the family is unable to participate in therapy on-site. Telehealth is included in the all-inclusive daily rate paid by Medicaid and cannot be billed separately.

Comment #14: A commenter expressed concern about how the expanded definition of "family" will impact the clinical aspect of treatment. The commenter did not request changes to the proposed rule but rather asked the department, providers, and other affected parties to work together in implementing the definition.

Response #14: Each facility is responsible for ensuring they are appropriately implementing rules and regulations, including the definition of family. The facilities have policies and procedures in place that are reviewed and approved by the department to ensure compliance.

Comment #15: A commenter requested the department define "all known family members" and asked if a provider is required to contact all known family members that do not participate in treatment.

Response #15: In response to this comment, the department has amended ARM 37.97.127 to clarify the requirements for identifying and contacting all known family members. The rule articulates that the providers must maintain a list and contact information of family, which is defined in ARM 37.97.102 and has been amended to clarify the definition of family. The list of known family refers to information provided by the entity placing the youth at the TGH and family known to the TGH through its involvement with the youth.

Comment #16: Numerous commenters expressed concern about implementing the requirements of ARM 37.97.906(3) regarding "alternative arrangements for therapy" and asked if the rule permits therapy to be missed provided the reasons are documented. Also, the commenters asked if alternative therapy arrangements are made and delivered, why would this be considered therapy not being provided. A commenter asked for more precision and clarity in this language and provided examples.

Response #16: The department agrees with the commenters and has amended ARM 37.97.906(3) to clarify that of the required 75 minutes of therapy per week, the MHP must provide at least 50 minutes of individual therapy to the youth. Family therapy must be provided to the youth and family, and if there are no identified family available to participate in family therapy, the MHP must document the reasons for their unavailability in the treatment plan. Also, telehealth may be used for therapy if a youth is on a home visit or if family is unavailable to participate on-site.

Comment #17: A commenter stated that aftercare is only listed in rule for discharging and that it is unclear on the role the TGH plays in providing aftercare and what requirements apply to aftercare.

Response #17: This rulemaking does not address aftercare. See the response to Comment #1. The rulemaking also does not address what role, if any, the TGH plays in providing aftercare. The existing rules provide that discharge planning must begin at the time of admission for all youth, and providers must document discharge planning at that time. Additionally, the discharge plan must be included in the initial treatment plan and updated as appropriate.

Comment #18: A commenter expressed concern the amendments to the administrative rules are absent the regulatory structure needed to ensure that youth care facilities operate in a truly trauma-informed way. The commenter noted proposed rules do not specify what trauma-informed model for organizational change facilities should use. The commenter suggested a model should be adopted that can be trained upon and measured for fidelity, as is best practice.

Response #18: The department intends for providers to select the trauma-informed model that works best for their organization. Providers must submit the policies and procedures outlining the trauma-informed model selected and how the provider will implement the model. These policies will be reviewed and approved by the department prior to implementation to ensure programs are truly applying a trauma-informed model.

Comment #19: A commenter expressed concern that the proposed rule only requires trauma-informed training to be conducted once during employee orientation. The commenter suggested comprehensive training on trauma-informed care should be provided on at least an annual basis.

Response #19: The department agrees it would be beneficial for staff to receive annual trauma-informed training; however, this rulemaking does not mandate it. Staff are required to receive 20 hours of annual training to improve proficiency in their knowledge and skills. Providers have the discretion to include trauma-informed training in annual training.

Comment #20: A commenter stated youth care facilities should be required to demonstrate that they are implementing increasingly trauma-informed approaches with fidelity through continuous quality improvement efforts. The commenter suggested work could be done through administration or organization on trauma-readiness assessments.

Response #20: The department appreciates the comment and notes that youth care facilities are required to implement a quality assessment program for improving policies, procedures, and services. The department intends for the quality assessment program to ensure appropriate implementation of trauma-informed care. Please also see responses to comments #18 and #19.

Comment #21: A commenter stated FFPSA emphasizes the importance of assessing youth for appropriateness of care and asked if the department intended to reduce a facility's responsibility to provide clinical assessment prior to admission.

Response #21: This rulemaking does not impose a requirement on a facility to conduct a clinical assessment prior to admission to the facility. Providers will continue to be required to complete a clinical assessment within ten days of the youth's admission unless a clinical assessment has been completed within three months prior to placement and submitted to the provider. For youth who are Medicaid members, the facility must receive prior authorization for placement in a TGH.

Comment #22: A commenter asked if providers have a responsibility to be a member of the Child and Family Services Permanency Team.

Response #22: This rulemaking does not address the Child and Family Services Permanency Team. Please see response #1.

Comment #23: A commenter would like to know what a facility's responsibility is for meeting the FFPSA requirement for an independent qualified professional completing an assessment within 30 days of placement.

Response #23: Please see response #1. This provision of the FFPSA is not part of this rulemaking.

Comment #24: A commenter asked if the premise of the department is that aftercare can be appropriately or effectively separated from discharge planning. The commenter asked if so, does aftercare start after discharge and therefore is not part of the requirements to operate a therapeutic group home.

Response #24: The aftercare requirements of FFPSA are outside the scope of this rulemaking. Please see responses #1 and #17.

Comment #25: A commenter stated FFPSA has specific requirements for family engagement and involvement. The commenter asked for clarification about any standards the state requires in meeting those requirements.

Response #25: In response to this comment, the department has amended ARM 37.97.102 and 37.97.906 to clarify the definition of "family" and to require documentation of outreach efforts, as provided in FFPSA guidelines. The change also increases family involvement in treatment planning and discharge planning of the youth. In addition, the rule increases opportunity for family therapy via telehealth for the youth's home visits or when the family is unable to attend on-site.

Comment #26: A commenter applauded the expanded definition of "family."

Response #26: The department appreciates the comments and thanks the commenter.

Comment #27: A commenter asked if family members include fictive kin as required by FFPSA.

Response #27: In response to this comment, the department has amended the definition of "family" in ARM 37.97.102 to include the term "fictive kin," as used in the FFPSA. The definition now refers to fictive kin as someone who, though unrelated by birth or marriage, has such an emotional attachment to the youth that they are considered family.

Comment #28: A commenter stated the proposed rule incentivizes reduced staffing patterns, a significant reduction in clinical and management oversight, and supervision. The commenter is opposed to any rule that will diminish the quality of our care of the children in our homes, which would be the result of reduced oversight, supervision, and training.

Response #28: In response to this comment, the department has amended ARM 37.97.903 to include a provision that was originally proposed to be removed from the rule. Thus, the rule will continue to provide that the MHP shall be responsible for the supervision and overall provision of treatment services to youth in the TGH and that the MHP cannot be counted in the direct care staff to youth ratio.

Comment #29: A commenter asked if the department intentionally omitted the current roles and responsibilities of the MHP which currently include being involved in family outreach, supervision, training, treatment planning, and program oversight or any other capacity except signing off on treatment plans.

Response #29: See response #28.

Comment #30: A commenter requested specific rules and guidance outlining standards of a trauma-informed model. Without specific rules and guidance, providers will be left to their subjective discretion and cause unnecessary and undesired tension between licensing agency and providers.

Response #30: The department intends for providers to have the flexibility to implement the trauma-informed model that works for the populations they serve. We would recommend providers review the SAMHSA Guidance for Trauma Informed Approach: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Comment #31: A commenter stated that the proposed rule focuses on the nursing component and simultaneously reduces the reliance on what will now be called the MHP.

Response #31: Please see response #28. The nursing requirement does not diminish the role of the MHP.

Comment #32: A commenter asked if a MHP can be a board-certified behavioral analyst, a licensed addiction counselor, or a psychiatrist.

Response #32: The term MHP is defined in ARM 37.97.102 and does not include those designations.

Comment #33: A commenter asked about the requirements in ARM 37.97.102 for the clinical assessment and questioned the terminology used to refer to substance use.

Response #33: The department modified the rule to use updated terminology from "chemical dependency" to "substance use history." The department has clarified the language and has amended ARM 37.97.102 accordingly.

Comment #34: A commenter requested the department define the outreach efforts expected of TGHs.

Response #34: As noted in response #25, the department has amended the rules relating to family. In response to this comment, the department has amended ARM 37.97.127 to clarify the requirements for conducting and documenting outreach efforts. TGHs must facilitate outreach to identify family to build a positive network of support for the youth. The TGH must document a minimum of two attempts to contact family, the result of such contacts, and support and facilitate regular contact with identified family.

Comment #35: A commenter asked if the department intends to reduce the requirements for training and supervision of direct care staff. If so, please describe which training and oversight requirements will be reduced or in the alternative make clear that this part of service delivery will be an unfunded mandate.

Response #35: The department does not intend to reduce the requirements for training or supervision of direct care staff.

Comment #36: Several comments were received asserting the proposed rule permits facilities to have outpatient therapy only. The allowance of an off-site, contracted MHP to simply provide direct therapy services provides the opportunity for fiscal savings at the expense of quality care.

Response #36: The department partially agrees with the commenter and has modified the language in ARM 37.97.903 to require the MHP to be on-site. See response #28.

Comment #37: Several comments were received for requests to define what nursing services are required and how group homes are expected to document how nursing services are available.

Response #37: TGHs must have registered or licensed nursing and other clinical staff who provide care within the scope of their practice as defined by state law, consistent with the TGH's trauma-informed treatment model. Nursing must be available 24 hours a day, seven days a week, but coverage does not have to be on-site. Each facility must develop their own policy on nursing services.

Comment #38: A commenter stated the FFPSA requires registered or licensed nursing services and other licensed clinical staff on-site, consistent with the treatment model and available 24 hours, seven days a week. The commenter asked if TGHs will be expected to separately meet this requirement.

Response #38: Nursing services and licensed clinical services are separate requirements. Licensed clinical services are not required on-site or available 24 hours a day, seven days a week. See response #37.

Comment #39: Two commenters asked if their treatment model allowed for nursing services to be available less than 24 hours a day, seven days a week, would they still meet the requirements of the rule.

Response #39: The requirements of the rule will not be satisfied if the treatment model does not include the availability of nursing services 24 hours a day, seven days a week. See response #37.

Comment #40: A commenter asked if nursing services have to be available on-site.

Response #40: Nursing services must be available 24 hours a day, seven days a week, but coverage does not have to be on-site. See response #37.

Comment #41: A commenter asked what a trauma-informed treatment model is.

Response #41: See response #30.

Comment #42: A commenter asked if it would be adequate if they write a policy that states "we will immediately begin planning and intend to implement a trauma-informed model effective 2056."

Response #42: No, the trauma-informed treatment model must be implemented at the time of adoption of this rulemaking.

Comment #43: A commenter asked if the MHP is not available for family engagement and involvement in meeting FFPSA standards in this area, who at a QRTP does the department envision being responsible for these extended duties.

Response #43: The MHP is responsible for providing family therapy and the overall treatment services to the youth. See responses #18 and #30. The responsibility for additional family engagement and involvement will be determined by the provider's policy, the trauma-informed treatment model, and the youth's treatment plan.

Comment #44: A commenter asked for clarification on ARM 37.97.901(5), requiring the MHP to sign off on treatment plans. The current rule states the MHP can sign off after the initial plan is developed or following updates. The commenter asked if the department intends for MHP sign off to happen in both instances.

Response #44: The department believes the commenter is referencing ARM 37.97.907(5). The department intends to have the MHP sign off on the treatment plan after its development and following any update. In response to this comment, the department has amended the rule to require sign off on the treatment plan within seven days of its update.

Comment #45: Numerous commenters requested clarification on ARM 37.97.906(3). They stated the rule simultaneously requires that therapy arrangements must be made by the program but also suggests that therapy does not need to be required as long as the reason (such as vacation or illness) is documented.

Response #45: The department agrees with this comment and has amended ARM 37.97.906 as explained in responses #9 through #11.

Comment #46: A commenter stated the Child and Family Services Division's new affidavit titled "Qualified Individual's Therapeutic Needs Assessment" is not identified within this proposed rule. The commenter asks for clarification on the expectations of the group home in working and soliciting this affidavit.

Response #46: The CFSD affidavit is outside the scope of this rulemaking. Please see response #1.

Comment #47: A commenter asked if the plan as we have heard is only to offer this service to some of the children at the QRTP, what will be the rational basis of our discriminating behavior and what liability protections will the state offer QRTP providers.

Response #47: The proposed rule changes apply to all children in the TGH. Any additional services required of other divisions are outside the scope of this rulemaking.

Comment #48: A commenter stated there is a significant difference in categories of youth care facilities. According to the commenter, the proposed changes are very difficult for shelter care facilities. Shelter care takes youth in crisis situations, and providers do not have a role in determining discharge criteria. The commenter stated the vast majority of parents are not involved.

Response #48: The department acknowledges there is a significant difference between shelter care facilities and TGHs. Proposed rule changes for shelter care are minimal and encourage participation of family members and case workers. Shelter care placements are intended to be short term which increases the necessity for discharge planning to begin at admission. Shelter care facilities may not have a role in determining the discharge criteria for certain youth; however, that does not negate the shelter care facilities' responsibility to assist placing agencies and parents in the discharge process.

Comment #49: A commenter would like clarification on when accreditation requirements will take place. Many providers are currently going through the process and accreditation will not be completed until the beginning of the year.

Response #49: The department expects providers to have accreditation at the time of implementation of this rule. If providers are in the process of accreditation the department will take that into consideration.

Comment #50: A commenter questioned whether requirements of 53-6-196, MCA apply to this rule.

Response #50: Section 53-6-196, MCA does not apply to this rulemaking because these rules implement federal law or regulations.

Comment #51: A commenter stated the proposed rule changes cause a significant fiscal impact on programs.

Response #51: The department administered a grant program offering $10,000 to offset the cost of implementing the changes to providers who apply for the funding. Additional costs incurred will be determined on how the provider designs the program model.

5. These rule amendments are effective October 1, 2021.

/s/ Brenda K. Elias	/s/ Adam Meier
Brenda K. Elias	Adam Meier, Director
Rule Reviewer	Public Health and Human Services

Certified to the Secretary of State September 14, 2021.