AN ACT REVISING LAWS REGARDING THE AUTHORITY OF THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO ADOPT RULES RELATING TO THE PROVISION OF MEDICAID SERVICES TO CHILDREN IN FOSTER CARE; PROVIDING THAT THE DEPARTMENT MAY NOT ADOPT RULES THAT EXCLUDE OR RESTRICT FOSTER CHILDREN FROM ACCESSING MEDICAID SERVICES SOLELY BECAUSE THE CHILDREN ARE IN FOSTER CARE; AMENDING SECTIONS 53-2-215, 53-6-113, AND 53-6-402, MCA; DIRECTING THE AMENDMENT OF ARM 37.34.907, 37.40.1002, 37.40.1111, AND 37.86.5102; AND PROVIDING AN EFFECTIVE DATE.

WHEREAS, in providing Medicaid services, the Department of Public Health and Human Services is treating children with disabilities who are in foster care differently from children with disabilities who are not in foster care; and

WHEREAS, children in foster care are having to take additional steps to receive Medicaid services and, in some cases, Medicaid providers automatically are not providing services to children in foster care; and

WHEREAS, the Legislature intends to revise the Department's rulemaking authority relating to the provision of Medicaid services and to revise existing administrative rules relating to the provision of Medicaid services to provide that foster children may not be excluded or restricted from accessing Medicaid services solely because the children are in foster care.

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

Section 1. Section 53-2-215, MCA, is amended to read:

"53-2-215. Social Security Act section 1115 waiver. (1) The department may pursue approval from the U.S. department of health and human services for implementation in Montana of a health insurance flexibility and accountability demonstration initiative and other demonstration projects through section 1115 waivers.

(2) The department may implement a demonstration project upon approval of a section 1115 waiver by the U.S. department of health and human services. The department may:

(a) coordinate a demonstration project with a program approved through a section 1915 waiver; or

(b) terminate and subsume in a new section 1115 waiver an existing managed care or access program approved through a section 1915(b) waiver, an optional state plan medicaid service authorized under 53-6-101, an optional state plan eligibility group authorized under 53-6-131, or an existing program approved by a section 1115 waiver, inclusive of the demonstration program authorized by 53-4-202 and Title 53, chapter 4, part 6, that is administered by the department.

(3) The department may amend the existing section 1115 demonstration project authorized in 53-4-601 and 53-6-101 to expand the demonstration project to implement the purposes of this section.

(4) The department may initiate and administer section 1115 waivers to more efficiently apply available state general fund money, other available state and local public and private funding, and federal money to the development and maintenance of medicaid-funded programs of health services and of other public assistance services and to structure those programs or services for more efficient and effective delivery to specific populations.

(5) (a) In establishing programs or services in a demonstration project approved through a section 1115 waiver, the department shall administer the expenditures under each demonstration project within the state spending authority that is available for that demonstration project. The department may limit enrollments in each program within a demonstration project, reduce the per capita expenditures available to enrollees, and modify and reduce the types and amounts of services available through each program when the department determines that expenditures can be reasonably expected to exceed the available state spending authority.

(b) The department shall develop a contingency plan if there is a spending cap as a condition of the waiver and the spending cap is exceeded. The contingency plan must address the effects on new programs, services, or eligibility groups.

(6) The department may coordinate the state children's health insurance program authorized under Title 53, chapter 4, part 10, with a section 1115 waiver for the purpose of increasing the state funding match available under the waiver and expanding the number of participants in the state children's health insurance program.

(7) The department, subject to the terms and conditions of the section 1115 waiver:

(a) shall establish the eligibility groups based upon the funding principles stated in 53-6-101(2);

(b) may provide medicaid coverage for one or more optional medicaid eligibility groups;

(c) may provide medicaid coverage for one or more specific populations of persons who are not within

the federally authorized medicaid eligibility groups but who are within the requirements of subsection (8);

(d) may establish the service coverage, eligibility requirements, financial participation requirements, and other features for the administration and delivery of services to each section 1115 waiver eligibility group;

(e) shall set limits on the number of participants for each section 1115 waiver eligibility group;

(f) shall set limits on the total expenditures under each demonstration project; and

(g) shall set the limits on the total expenditures on the services to be provided to each section 1115 waiver eligibility group.

(8) The categories of persons that the department may consider for establishment as a section 1115 waiver eligibility group include but are not limited to:

(a) low-income parents of children who are eligible to participate in medicaid under 53-6-131 or in the state children's health insurance program authorized under Title 53, chapter 4, part 10;

(b) children who because of limits on enrollment may not be covered through the state children's health insurance program authorized under Title 53, chapter 4, part 10;

(c) children who are eligible to participate in the state children's health insurance program authorized under Title 53, chapter 4, part 10; and

(d) other specific groups of persons who are participants in programs or services funded solely or primarily through state general funds or who the department determines are in need of specific types of health care and related services, such as prescription drugs, reproductive health care, and mental health services, and are without adequate financial means to procure health insurance coverage of those needs.

(9) Children participating in a section 1115 waiver eligibility group or children who would be eligible to participate in the state children's health insurance program are subject to the eligibility criteria applicable under 53-4-1004, except as provided in subsection (10) of this section, for participation in the state children's health insurance program and must receive benefits as provided through the state children's health insurance program under 53-4-1005.

(10) (a) Except as provided in this subsection (10), the eligibility for the section 1115 waiver eligibility groups may not exceed 150% of the federal poverty level.

(b) The department may establish eligibility at greater than 150% but no more than 200% of the federal poverty level for any of the following groups established for purposes of a section 1115 waiver:

(i) participants in the state children's health insurance program;

(ii) participants in a group that may be covered under the state children's health insurance program;

(iii) participants in a family planning program;

(iv) participants in a group composed of persons previously served through a program funded with state general fund money and other nonmedicaid money; or

(v) participants in a group composed of persons with a significant need for particular services that are not readily available to that population through insurance products or because of personal financial limitations.

(c) In establishing the eligibility criteria based upon federal poverty levels, the department shall select levels to ensure that the resulting expenditures will remain within the available funding and will conform with the terms and conditions of approval by the U.S. department of health and human services.

(d) The department may adopt additional programmatic and financial eligibility criteria for a section 1115 waiver eligibility group in order to appropriately define the subject population, to limit use for fiscal and programmatic purposes, to prevent improper use, and to conform the administration of the program with the terms and conditions of the section 1115 waiver.

(e) Eligibility criteria applicable to a section 1115 waiver eligibility group need not conform to the criteria applicable to another section 1115 waiver eligibility group or to a medicaid eligibility group that is not encompassed within the demonstration project.

(11) (a) For each section 1115 waiver eligibility group, the department shall establish the program benefit or benefits to be available to the participants in the group.

(b) Program benefits may be in the form of:

(i) assistance in the payment of health insurance premiums for health care coverage through an employer or other existing group coverage available to the program enrollee;

(ii) assistance in the payment of health insurance premiums for health care coverage that meets a set of defined standards and limitations adopted by the department in consultation with the commissioner of insurance and obtained from participating private insurers or through self-insured pools;

(iii) premium purchase for insurance coverage on behalf of children who are 18 years of age or younger for the defined set of health care and related services adopted by the department for the state children's health insurance program authorized in Title 53, chapter 4, part 10; or

(iv) coverage of a defined set of health care and related services administered directly by the department on a fee-for-service basis.

(c) The department may limit the types of program benefits available to enrollees in a program. For programs in which the department provides for more than one type of program benefit, the department may require that enrollees, either as a whole or on an individual basis based on certain circumstances, use certain types of program benefits in lieu of using other types of program benefits.

(d) The department shall, as necessary to maintain expenditures for a program within the available funding for that program, set monetary limitations on the total benefit amounts available on a periodic basis for an enrollee through that program, whether that benefit is in the form of premium assistance, premium purchase, or a set of covered services.

(12) The benefits for a section 1115 waiver eligibility group may be in the form of a defined set of covered services consisting of one or more of the mandatory and optional medicaid state plan services specified in 53-6-101 or other health-care related services. The department may select the types of services that constitute a defined set of covered services for a section 1115 waiver eligibility group. The department may provide coverage of a service not specified in 53-6-101 if the department determines the service to be appropriate for the particular section 1115 waiver eligibility group. The department may define the nature, components, scope, amount, and duration of each covered service to be made available to a section 1115 waiver eligibility group. The nature, components, scope, amount, and duration of a covered service made available to a section 1115 waiver eligibility group need not conform to those aspects of that service as defined by the department for delivery as a covered service to another section 1115 waiver eligibility group or to a medicaid eligibility group that is not encompassed within a section 1115 waiver.

(13) The department may adopt financial participation requirements for enrollees in a section 1115 eligibility group to foster appropriate use among enrollees and to maintain the fiscal accountability of the program. The department may adopt financial participation requirements, including but not limited to copayments, payment of monthly or yearly enrollment fees, or deductibles. The requirements may vary among the section 1115 waiver eligibility groups. In adopting financial participation requirements for enrollees selecting coverage as provided in subsection (11)(b)(iv), the department may not adopt cost-sharing amounts that exceed the nominal deductible, coinsurance, copayment, or similar charges adopted by the department to apply to categorically or medically needy persons for a service pursuant to the state medicaid plan.

(14) (a) The department shall adopt rules as necessary for the implementation of a section 1115 waiver. Rules may include but are not limited to:

~~(a)~~(i) designation of programs and activities for implementation of a section 1115 waiver;

~~(b)~~(ii) features and benefit coverage of the programs;

~~(c)~~(iii) the nature, components, scope, amount, and duration of each program service;

~~(d)~~(iv) appropriate insurance products and coverage as benefits;

~~(e)~~(v) required enrollee eligibility information;

~~(f)~~(vi) enrollee eligibility categories, criteria, requirements, and related measures;

~~(g)~~(vii) limits upon enrollment;

~~(h)~~(viii) requirements and limitations for service costs and expenditures;

~~(i)~~(ix) measures to ensure the appropriateness and quality of services to be delivered;

~~(j)~~(x) provider requirements and reimbursement;

~~(k)~~(xi) financial participation requirements for enrollees;

~~(l)~~(xii) use measures; and

~~(m)~~(xiii) other appropriate provisions necessary for administration of a demonstration project and for implementation of the conditions placed upon approval of a section 1115 waiver by the U.S. department of health and human services.

(b) Unless required by federal law or regulation, the department may not adopt rules that exclude a child from medicaid services or require prior authorization for a child to access medicaid services if the child would be eligible for or able to access the services without prior authorization if the child was not in foster care.

(15) The department shall administer the programs and activities that are subject to a section 1115 waiver in accordance with the terms and conditions of approval by the U.S. department of health and human services. The department may modify aspects of established programs and activities administered by the department as may be necessary to implement a section 1115 waiver as provided in this section.

(16) The department may seek an initial duration and durational extensions for a section 1115 waiver as the department determines appropriate for demonstration and fiscal considerations.

(17) The department shall provide a report to the legislature, as provided in 5-11-210, on the conditions of approval and the status of implementation for each section 1115 waiver approved by the U.S. department of health and human services. For any proposed section 1115 waiver not approved by the U.S. department of health and human services, the department shall provide to the next legislative session a report on the basis for disapproval and an analysis of the fiscal costs and programmatic impacts of serving the persons within the

proposed section 1115 waiver eligibility groups through eligibility under one of the optional medicaid eligibility categories established in federal law and authorized by 53-6-131.

(18) The department shall present a section 1115 waiver proposal to the appropriate medicaid advisory council, which must include consumer advocates, prior to the submission of the proposal to the federal government.

(19) The department shall present a section 1115 waiver proposal to the house appropriations committee or, during the interim, the children, families, health, and human services interim committee for review and comment at a public hearing prior to the submission of the proposal to the federal government for formal approval and shall also present the section 1115 waiver after final approval from the federal government.

(20) (a) The department shall provide for a public comment period on the proposed section 1115 waiver at least 60 days before the submission of the section 1115 waiver application to the federal government for formal approval.

(b) The department shall give notice of the proposal by announcing the pending submittal, stating its general purpose, and informing the public that information on the proposal is available on the department's website.

(c) The department shall provide for public comment through electronic means or mail and shall provide for a public forum in at least one location at which members of the public can submit views on the proposal. The department shall consider comments received and make any appropriate changes to the waiver request before submitting it to the federal government.

(d) The department shall post on its website the waiver concept paper, formal correspondence regarding a waiver proposal, and the final approved waiver, including documents received from the center for medicare and medicaid services."

Section 2. Section 53-6-113, MCA, is amended to read:

"53-6-113. (Temporary) Department to adopt rules. (1) The department shall adopt appropriate rules necessary for the administration of the Montana medicaid program as provided for in this part and that may be required by federal laws and regulations governing state participation in medicaid under Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as amended.

(2) The department shall adopt rules that are necessary to further define for the purposes of this part the

services provided under 53-6-101 and to provide that services being used are medically necessary and that the services are the most efficient and cost-effective available. The rules may establish the amount, scope, and duration of services provided under the Montana medicaid program, including the items and components constituting the services.

(3) The department shall establish by rule the rates for reimbursement of services provided under this part. The department may in its discretion set rates of reimbursement that it determines necessary for the purposes of the program. In establishing rates of reimbursement, the department may consider but is not limited to considering:

(a) the availability of appropriated funds;

(b) the actual cost of services;

(c) the quality of services;

(d) the professional knowledge and skills necessary for the delivery of services; and

(e) the availability of services.

(4) The department shall specify by rule those professionals who may deliver or direct the delivery of particular services.

(5) The department may provide by rule for payment by a recipient of a portion of the reimbursements established by the department for services provided under this part.

(6) (a) The department may adopt rules consistent with this part to govern eligibility for the Montana medicaid program, including the medicaid program provided for in 53-6-195. Rules may include but are not limited to financial standards and criteria for income and resources, treatment of resources, nonfinancial criteria, family responsibilities, residency, application, termination, definition of terms, confidentiality of applicant and recipient information, and cooperation with the state agency administering the child support enforcement program under Title IV-D of the Social Security Act, 42 U.S.C. 651, et seq.

(b) The department may not apply financial criteria below $15,000 for resources other than income in determining the eligibility of a child under 19 years of age for poverty level-related children's medicaid coverage groups, as provided in 42 U.S.C. 1396a(l)(1)(B) through (l)(1)(D).

(c) The department may not apply financial criteria below $15,000 for an individual and $30,000 for a couple for resources other than income in determining the eligibility of individuals for the medicaid program for workers with disabilities provided for in 53-6-195.

(7) The department may adopt rules limiting eligibility based on criteria more restrictive than that provided in 53-6-131 if required by Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, or if funds appropriated are not sufficient to provide medical care for all eligible persons.

(8) The department may adopt rules necessary for the administration of medicaid managed care systems. Rules to be adopted may include but are not limited to rules concerning:

(a) participation in managed care;

(b) selection and qualifications for providers of managed care; and

(c) standards for the provision of managed care.

(9) Subject to subsection (6), the department shall establish by rule income limits for eligibility for extended medical assistance of persons receiving section 1931 medicaid benefits, as defined in 53-4-602, who lose eligibility because of increased income to the assistance unit, as that term is defined in the rules of the department, as provided in 53-6-134, and shall also establish by rule the length of time for which extended medical assistance will be provided. The department, in exercising its discretion to set income limits and duration of assistance, may consider the amount of funds appropriated by the legislature.

(10) The department may adopt rules for implementing and administering one or more patient-centered medical home programs. The rules may include but are not limited to provider qualifications, coverage groups, services coverage, measures to ensure the appropriateness and quality of services delivered, payment rates and fees, and utilization measures. In implementing and administering patient-centered medical home programs, the department shall use only health care providers that have been qualified by the commissioner and authorized to use the designation of a patient-centered medical home. The department shall use the standards adopted by the commissioner for patient-centered medical homes under 33-40-105, except for those standards relating to settling payment rates and fees and any standards that may conflict with federal medicaid requirements.

(11) Unless required by federal law or regulation, the department may not adopt rules that exclude a child from medicaid services or require prior authorization for a child to access medicaid services if the child would be eligible for or able to access the services without prior authorization if the child was not in foster care. (Terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)

53-6-113. (Effective January 1, 2018) Department to adopt rules. (1) The department shall adopt appropriate rules necessary for the administration of the Montana medicaid program as provided for in this part and that may be required by federal laws and regulations governing state participation in medicaid under Title

XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as amended.

(2) The department shall adopt rules that are necessary to further define for the purposes of this part the services provided under 53-6-101 and to provide that services being used are medically necessary and that the services are the most efficient and cost-effective available. The rules may establish the amount, scope, and duration of services provided under the Montana medicaid program, including the items and components constituting the services.

(3) The department shall establish by rule the rates for reimbursement of services provided under this part. The department may in its discretion set rates of reimbursement that it determines necessary for the purposes of the program. In establishing rates of reimbursement, the department may consider but is not limited to considering:

(a) the availability of appropriated funds;

(b) the actual cost of services;

(c) the quality of services;

(d) the professional knowledge and skills necessary for the delivery of services; and

(e) the availability of services.

(4) The department shall specify by rule those professionals who may deliver or direct the delivery of particular services.

(5) The department may provide by rule for payment by a recipient of a portion of the reimbursements established by the department for services provided under this part.

(6) (a) The department may adopt rules consistent with this part to govern eligibility for the Montana medicaid program, including the medicaid program provided for in 53-6-195. Rules may include but are not limited to financial standards and criteria for income and resources, treatment of resources, nonfinancial criteria, family responsibilities, residency, application, termination, definition of terms, confidentiality of applicant and recipient information, and cooperation with the state agency administering the child support enforcement program under Title IV-D of the Social Security Act, 42 U.S.C. 651, et seq.

(b) The department may not apply financial criteria below $15,000 for resources other than income in determining the eligibility of a child under 19 years of age for poverty level-related children's medicaid coverage groups, as provided in 42 U.S.C. 1396a(l)(1)(B) through (l)(1)(D).

(c) The department may not apply financial criteria below $15,000 for an individual and $30,000 for a

couple for resources other than income in determining the eligibility of individuals for the medicaid program for workers with disabilities provided for in 53-6-195.

(7) The department may adopt rules limiting eligibility based on criteria more restrictive than that provided in 53-6-131 if required by Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, or if funds appropriated are not sufficient to provide medical care for all eligible persons.

(8) The department may adopt rules necessary for the administration of medicaid managed care systems. Rules to be adopted may include but are not limited to rules concerning:

(a) participation in managed care;

(b) selection and qualifications for providers of managed care; and

(c) standards for the provision of managed care.

(9) Subject to subsection (6), the department shall establish by rule income limits for eligibility for extended medical assistance of persons receiving section 1931 medicaid benefits, as defined in 53-4-602, who lose eligibility because of increased income to the assistance unit, as that term is defined in the rules of the department, as provided in 53-6-134, and shall also establish by rule the length of time for which extended medical assistance will be provided. The department, in exercising its discretion to set income limits and duration of assistance, may consider the amount of funds appropriated by the legislature.

(10) Unless required by federal law or regulation, the department may not adopt rules that exclude a child from medicaid services or require prior authorization for a child to access medicaid services if the child would be eligible for or able to access the services without prior authorization if the child was not in foster care."

Section 3. Section 53-6-402, MCA, is amended to read:

"53-6-402. Medicaid-funded home and community-based services -- waivers -- funding limitations -- populations -- services -- providers -- long-term care preadmission screening -- powers and duties of department -- rulemaking authority. (1) The department may obtain waivers of federal medicaid law in accordance with section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n, and administer programs of home and community-based services funded with medicaid money for categories of persons with disabilities or persons who are elderly.

(2) The department may seek and obtain any necessary authorization provided under federal law to implement home and community-based services for seriously emotionally disturbed children pursuant to a waiver

of federal law as permitted by section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n(c). The home and community-based services system shall strive to incorporate the following components:

(a) flexibility in design of the system to attempt to meet individual needs;

(b) local involvement in development and administration;

(c) encouragement of culturally sensitive and appropriately trained mental health providers;

(d) accountability of recipients and providers; and

(e) development of a system consistent with the state policy as provided in 52-2-301.

(3) The department may, subject to the terms and conditions of a federal waiver of law, administer programs of home and community-based services to serve persons with disabilities or persons who are elderly who meet the level of care requirements for one of the categories of long-term care services that may be funded with medicaid money. Persons with disabilities include persons with physical disabilities, chronic mental illness, developmental disabilities, brain injury, or other characteristics and needs recognized as appropriate populations by the U.S. department of health and human services. Programs may serve combinations of populations and subsets of populations that are appropriate subjects for a particular program of services.

(4) The provision of services to a specific population through a home and community-based services program must be less costly in total medicaid funding than serving that population through the categories of long-term care facility services that the specific population would be eligible to receive otherwise.

(5) The department may initiate and operate a home and community-based services program to more efficiently apply available state general fund money, other available state and local public and private money, and federal money to the development and maintenance of medicaid-funded programs of health care and related services and to structure those programs for more efficient and effective delivery to specific populations.

(6) The department, in establishing programs of home and community-based services, shall administer the expenditures for each program within the available state spending authority that may be applied to that program. In establishing covered services for a home and community-based services program, the department shall establish those services in a manner to ensure that the resulting expenditures remain within the available funding for that program. To the extent permitted under federal law, the department may adopt financial participation requirements for enrollees in a home and community-based services program to foster appropriate utilization of services among enrollees and to maintain fiscal accountability of the program. The department may adopt financial participation requirements that may include but are not limited to copayments, payment of monthly

or yearly enrollment fees, or deductibles. The financial participation requirements adopted by the department may vary among the various home and community-based services programs. The department, as necessary, may further limit enrollment in programs, reduce the per capita expenditures available to enrollees, and modify and reduce the types and amounts of services available through a home and community-based services program when the department determines that expenditures for a program are reasonably expected to exceed the available spending authority.

(7) The department may consider the following populations or subsets of populations for home and community-based services programs:

(a) persons with developmental disabilities who need, on an ongoing or frequent basis, habilitative and other specialized and supportive developmental disabilities services to meet their needs of daily living and to maintain the persons in community-integrated residential and day or work situations;

(b) persons with developmental disabilities who are 18 years of age and older and who are in need of habilitative and other specialized and supportive developmental disabilities services necessary to maintain the persons in personal residential situations and in integrated work opportunities;

(c) persons 18 years of age and older with developmental disabilities and chronic mental illness who are in need of mental health services in addition to habilitative and other developmental disabilities services necessary to meet their needs of daily living, to treat the their mental illness, and to maintain the persons in community-integrated residential and day or work situations;

(d) children under 21 years of age who are seriously emotionally disturbed and in need of mental health and other specialized and supportive services to treat their mental illness and to maintain the children with their families or in other community-integrated residential situations;

(e) persons 18 years of age and older with brain injuries who are in need, on an ongoing or frequent basis, of habilitative and other specialized and supportive services to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations;

(f) persons 18 years of age and older with physical disabilities who are in need, on an ongoing or frequent basis, of specialized health services and personal assistance and other supportive services necessary to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations;

(g) persons with human immunodeficiency virus (HIV) infection who are in need of specialized health

services and intensive pharmaceutical therapeutic regimens for abatement and control of the HIV infection and related symptoms in order to maintain the persons in personal residential situations;

(h) persons with chronic mental illness who suffer from serious chemical dependency and who are in need of intensive mental health and chemical dependency services to maintain the persons in personal or other community-integrated residential situations;

(i) persons 65 years of age and older who are in need, on an ongoing or frequent basis, of health services, personal assistance, and other supportive services necessary to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations; or

(j) persons 18 years of age and older with chronic mental illness who are in need, on an ongoing or frequent basis, of specialized health services and other supportive services necessary to meet their needs of daily living and to maintain the persons in personal or other community-integrated residential situations.

(8) For each authorized program of home and community-based services, the department shall set limits on overall expenditures and enrollment and limit expenditures as necessary to conform with the requirements of section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n, and the conditions placed upon approval of a program authorized through a waiver of federal law by the U.S. department of health and human services.

(9) A home and community-based services program may include any of the following categories of services as determined by the department to be appropriate for the population or populations to be served and as approved by the U.S. department of health and human services:

(a) case management services;

(b) homemaker services;

(c) home health aide services;

(d) personal care services;

(e) adult day health services;

(f) habilitation services;

(g) respite care services; and

(h) other cost-effective services appropriate for maintaining the health and well-being of persons and to avoid institutionalization of persons.

(10) Subject to the approval of the U.S. department of health and human services, the department may establish appropriate programs of home and community-based services under this section in conjunction with

programs that have limited pools of providers or with managed care arrangements, as implemented through 53-6-116 and as authorized under section 1915 of Title XIX of the Social Security Act, 42 U.S.C. 1396n, or in conjunction with a health insurance flexibility and accountability demonstration initiative or other demonstration project as authorized under section 1115 of Title XI of the Social Security Act, 42 U.S.C. 1315.

(11) (a) The department may conduct long-term care preadmission screenings in accordance with section 1919 of Title XIX of the Social Security Act, 42 U.S.C. 1396r.

(b) Long-term care preadmission screenings are required for all persons seeking admission to a long-term care facility.

(c) A person determined through a long-term care preadmission screening to have an intellectual disability or a mental illness may not reside in a long-term care facility unless the person meets the long-term care level-of-care determination applicable to the type of facility and is determined to have a primary need for the care provided through the facility.

(d) The long-term care preadmission screenings must include a determination of whether the person needs specialized intellectual disability or mental health treatment while residing in the facility.

(12) The department may adopt rules necessary to implement the long-term care preadmission screening process as required by section 1919 of Title XIX of the Social Security Act, 42 U.S.C. 1396r. The rules must provide criteria, procedures, schedules, delegations of responsibilities, and other requirements necessary to implement long-term care preadmission screenings.

(13) (a) The department shall adopt rules necessary for the implementation of each program of home and community-based services. The rules may include but are not limited to the following:

~~(a)~~(i) the populations or subsets of populations, as provided in subsection (7), to be served in each program;

~~(b)~~(ii) limits on enrollment;

~~(c)~~(iii) limits on per capita expenditures;

~~(d)~~(iv) requirements and limitations for service costs and expenditures;

~~(e)~~(v) eligibility categories criteria, requirements, and related measures;

~~(f)~~(vi) designation and description of the types and features of the particular services provided for under subsection (9);

~~(g)~~(vii) provider requirements and reimbursement;

~~(h)~~(viii) financial participation requirements for enrollees as provided in subsection (6);

~~(i)~~(ix) utilization measures;

~~(j)~~(x) measures to ensure the appropriateness and quality of services to be delivered; and

~~(k)~~(xi) other appropriate provisions necessary to the administration of the program and the delivery of services in accordance with 42 U.S.C. 1396n and any conditions placed upon approval of a program by the U.S. department of health and human services.

(b) Unless required by federal law or regulation, the department may not adopt rules that exclude a child from home and community-based services or require prior authorization for a child to access home and community-based services if the child would be eligible for or able to access the home and community-based services without prior authorization if the child was not in foster care.

(14) The department shall adopt rules for the provision of the fraud prevention training required under 53-6-405, including but not limited to establishing the elements that must be contained in fraud prevention education materials and the models that may be used for the training.

(15) The department shall adopt rules to carry out the cost reporting provisions of 53-6-406, including but not limited to the costs that a provider is required to report to the department, the format of the report, and the deadline for filing the report."

Section 4. The Department of Public Health and Human Services shall amend ARM 37.34.907 to read:

"37.34.907 0208 MEDICAID HOME AND COMMUNITY-BASED SERVICES PROGRAM: SELECTION AND ENTRY

(1) A person may be placed on the statewide waiting list for consideration for selection and entry into the 0208 Medicaid Home and Community-Based (HCBS) Waiver Program if the person is found eligible for the Developmental Disabilities Program (DDP) service in accordance with ARM 37.34.906.

(2) The DDP will enter the person's name onto the waiting list in chronological order based upon the date the case manager receives a complete request for services.

(3) The selection for consideration of persons with the same waiting list date will be made through a random selection process by the department.

(4) The DDP designee must notify a person selected for entry into the 0208 HCBS Waiver Program and the person's case manager in writing within ten working days of selection.

(5) Within five working days from the date of the notification letter the department designee must present all waiver service options available to the person selected and document which providers the person requests to meet and submit to the providers:

(a) the provider service referral packet;

(b) the plan of care; and

(c) other documents, as requested.

(6) A provider must contact the department designee within ten working days from the date the provider service referral packet was submitted to the provider and either:

(a) offer to serve the person; or

(b) decline to offer services.

(7) The person must determine which provider(s) he or she will accept services from within five days following the offer(s).

(8) The case manager must:

(a) document the person's choice of provider(s);

(b) obtain the person's or the person's legal representative's signature; and

(c) maintain the documentation in the person's file.

(9) Upon acceptance of service(s), the person must begin service(s) within 45 working days from the date of the provider(s) offer to serve the person.

(10) The department may prioritize and select a person who has a life-threatening physical condition, is eligible for DDP services, and that without services would jeopardize their continued existence.

(11) The department reserves the right to select a person from the waiting list based upon emergency criteria if, except as provided in subsection (11)(b), all other service options have been reviewed and do not meet the person's health and safety needs. The emergency criteria are as follows:

(a) a finding of maltreatment is determined by ~~Child Protective Services or~~ Adult Protective Services;

(b) a finding of maltreatment is determined by Child Protective Services, in which case no other service options need to be reviewed;

~~(b)~~(c) death or inability of the person's primary caregiver to provide care and no alternative caregiver is available; or

~~(c)~~(d) lack of appropriate placement for the person due to loss of housing or imminent discharge from

the temporary placement or hospitalization.

(12) A person who is selected for entry into the 0208 HCBS Waiver Program and does not accept waiver services will be removed from the waiting list.

(13) If the person selected for entry into the 0208 HCBS Waiver Program cannot find a provider able or willing to provide services within 90 days from the date of the selection notification letter, the opening is forfeited.

(14) A person discharged from an ICF/IID located in the state of Montana who is eligible for home and community-based services in accordance with ARM 37.34.906 is not subject to the selection criteria and entry procedures otherwise stated in this rule. The department in its discretion may provide the person with a placement in the 0208 HCBS Waiver Program."

Section 5. The Department of Public Health and Human Services shall amend ARM 37.40.1002 to read:

"37.40.1002 AGENCY-BASED AND SELF-DIRECTED COMMUNITY FIRST CHOICE SERVICES: ELIGIBILITY, SERVICES PROVIDED, AND LIMITATIONS

(1) To qualify for Community First Choice Services (CFCS), a person must:

(a) be Medicaid eligible;

(b) meet the level of care criteria found at ARM 37.40.205(1); and

(c) demonstrate a medical and functional need for assistance with activities of daily living.

(2) CFCS includes assistance with the following activities:

(a) activities of daily living;

(b) instrumental activities of daily living;

(c) medical escort services;

(d) skill acquisition, maintenance, and enhancement; and

(e) personal emergency response systems.

(3) Instrumental activities of daily living are only authorized when the member demonstrates a medical and functional need to receive assistance with activities of daily living. Instrumental activities of daily living may not account for more than one-third of the total time allocated per two-week period for CFCS or a maximum of ten hours per two-week time period, whichever is less.

(4) Medical escort services are only authorized when the member has demonstrated a medical and functional need for CFCS. Medical escort services must be directly related to a member's medical and functional

need for assistance en route to, or at the Medicaid reimbursable medical service, and are available when a family member or caregiver is unable to accompany the member.

(5) Skill acquisition, maintenance, and enhancement services are only authorized when the member demonstrates a medical and functional need to receive assistance with activities of daily living. The service may be authorized if a member is expected to achieve full independence in skill acquisition within a 90-day time period. A skill acquisition letter of endorsement signed by a skill acquisition advocate is required prior to authorization of the service.

(6) Personal emergency response system services (PERS) are only authorized when the member demonstrates a medical and functional need to receive assistance with activities of daily living.

(7) CFCS, except for medical escort services, shopping, laundry, and community integration, will be provided in the member's home.

(8) CFCS may not typically be provided in group home settings unless prior authorized by the department. Group home settings include ~~licensed youth foster homes,~~ mental health group homes~~,~~ and adult intensive community home services. CFCS may be authorized when the person's medical needs are beyond the scope of services normally provided by programs funding services in the group setting. ~~For example, a person requiring additional assistance because of an acute medical episode or post-hospitalization period may receive CFCS in a youth foster home setting.~~

(9) CFCS is not available to the following:

(a) persons who reside in a hospital, hospitals providing long-term care, or a long-term care facility as defined in 50-5-101, MCA, and licensed under 50-5-201, MCA;

(b) persons who reside in assisted living or adult foster homes, as defined in 50-5-225, MCA, and licensed under 50-5-227, MCA;

(c) persons who live in homes which are not safely accessible by normal modes of transportation.

(10) CFCS may not include any skilled services that require professional medical training unless otherwise permitted under 37-8-103, MCA, or ARM 24.159.1616.

(11) CFCS do not include services which maintain an entire household. CFCS do not include:

(a) cleaning floors and furniture in areas that members do not use or occupy;

(b) laundering clothing or bedding that members do not use;

(c) supervision, respite care, babysitting, or visiting;

(d) maintenance of animals unless the animal is a certified service animal specifically trained to meet the health and safety needs of the member;

(e) home and outside maintenance; and

(f) meal preparation for other family members.

(12) CFCS provided by a member of the member's immediate family is not CFCS for the purposes of the Medicaid program, and is not eligible for reimbursement. Immediate family member includes the following:

(a) a spouse; and

(b) a natural, adoptive, or foster parent of a minor child.

(13) CFCS must be delivered by a CFCS personal care attendant employed by an enrolled Medicaid provider that has met the criteria established by the department for the delivery of CFCS as referenced in ARM 37.40.1017 and 37.40.1018.

(14) CFCS may not be provided to relieve a parent of child-caring or other legal responsibilities. CFCS for children with disabilities may be appropriate when the parent is unqualified or otherwise unable to provide services and the child is at risk of institutionalization unless the services are provided."

Section 6. The Department of Public Health and Human Services shall amend ARM 37.40.1111 to read:

"37.40.1111 AGENCY-BASED AND SELF-DIRECTED PERSONAL ASSISTANCE SERVICES: ELIGIBILITY, SERVICES PROVIDED, AND LIMITATIONS

(1) To qualify for Personal Assistance Services (PAS), a person must:

(a) be Medicaid eligible; and

(b) demonstrate a medical and functional need for assistance with activities of daily living.

(2) PAS include assistance with the following activities:

(a) activities of daily living;

(b) instrumental activities of daily living; and

(c) medical escort services.

(3) Instrumental activities of daily living are only authorized when the member demonstrates a medical and functional need to receive assistance with activities of daily living. Instrumental activities of daily living may not account for more than one-third of the total time allocated per two-week period for PAS or a maximum of six hours per two-week time period, whichever is less.

(4) Medical escort services are only authorized when the member has demonstrated a medical and functional need for PAS. Medical escort services must be directly related to a member's medical and functional need for assistance en route to, or at the Medicaid reimbursable medical service, and are available when a family member or caregiver is unable to accompany the member.

(5) PAS, except for medical escort services, shopping, and laundry, will be provided in the member's home.

(6) PAS may not typically be provided in group home settings unless prior authorized by the department. Group home settings include ~~licensed youth foster homes,~~ mental health group homes~~,~~ and adult intensive community home services. PAS may be authorized when the person's medical needs are beyond the scope of services normally provided by programs funding services in the group setting. ~~For example, a person requiring additional assistance because of an acute medical episode or post-hospitalization period may receive PAS in a youth foster home setting.~~

(7) PAS are not available to the following:

(a) persons who reside in a hospital, hospitals providing long-term care, or a long-term care facility as defined in 50-5-101, MCA, and licensed under 50-5-201, MCA;

(b) persons who reside in assisted living or adult foster homes, as defined in 50-5-225, MCA, and licensed under 50-5-227, MCA; or

(c) persons who live in homes which are not safely accessible by normal modes of transportation.

(8) PAS may not include any skilled services that require professional medical training unless otherwise permitted under 37-8-103, MCA, or ARM 24.159.1616.

(9) PAS do not include services which maintain an entire household. PAS do not include:

(a) cleaning floors and furniture in areas that members do not use or occupy;

(b) laundering clothing or bedding that members do not use;

(c) supervision, respite care, babysitting, or visiting;

(d) maintenance of animals unless the animal is a certified service animal specifically trained to meet the health and safety needs of the member;

(e) home and outside maintenance; and

(f) meal preparation for other family members.

(10) PAS provided by a member of the member's immediate family are not PAS for the purposes of the

Medicaid program, and are not eligible for reimbursement. Immediate family member includes the following:

(a) a spouse; and

(b) a natural, adoptive, or foster parent of a minor child.

(11) PAS must be delivered by a PAS personal care attendant employed by an enrolled Medicaid provider that has met the criteria established by the department for the delivery of PAS as referenced in ARM 37.40.1126 and 37.40.1127.

(12) PAS may not be provided to relieve a parent of child-caring or other legal responsibilities. PAS for children with disabilities may be appropriate when the parent is unqualified or otherwise unable to provide services and the child is at risk of institutionalization unless the services are provided."

Section 7. The Department of Public Health and Human Services shall amend ARM 37.86.5102 to read:

"37.86.5102 PASSPORT TO HEALTH PROGRAM: DEFINITIONS

(1) "Case management" means directing and overseeing the delivery of certain services to an enrollee.

(2) "Clinic" means a federally qualified health center, a rural health clinic, an Indian health service clinic on a reservation, or any other clinic as defined in ARM 37.86.1401 which can meet the requirements of ARM 37.86.5111.

(3) "Emergency service" means, as defined at ARM 37.82.102(11), inpatient and outpatient services that are necessary to treat an emergency medical condition.

(4) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

(5) "Enroll" means to choose a primary care provider.

(6) "Enrollee" means a Medicaid member participating in the program and who is enrolled with a primary care provider under the program.

(7) "Exempt" means a Medicaid member who is:

(a) eligible for managed care but able to establish that participating would be a hardship;

(b) enrolled in a health maintenance organization that provides case management services;

(c) unable to find a primary care provider willing to provide case management; or

(d) residing in a county in which there are not enough primary care providers to serve the Medicaid population required to participate in the program. The department has the discretion to determine hardship and to place time limits on all exemptions described in (a) through (d) on a case-by-case basis.

(8) "Ineligible" means a Medicaid member who is not eligible to participate in a managed care program, such as the Passport Program, but is eligible for regular Medicaid. The following categories of members are ineligible for the Passport Program:

(a) eligible for Medicaid with a spend down (medically needy);

(b) living in a nursing home or institutional setting;

(c) receiving Medicaid for less than three months;

(d) eligible for Medicare;

(e) eligible for Medicaid adoption assistance or guardianship;

~~(f) eligible for Medicaid foster care;~~

~~(g)~~(f) retroactive Medicaid eligibility;

~~(h)~~(g) receiving Medicaid home and community-based services for persons who are aged or disabled;

~~(i)~~(h) eligible for Plan First; and

~~(j)~~(i) receiving Medicaid under a presumptive eligibility program.

(9) "Medical care" means care provided to meet the medical and medically related needs of a person.

(10) "Participate" means compliance with the requirements of the program.

(11) "Passport to Health Program" or "the program" means the primary care case management (PCCM) program for Medicaid members.

(12) "Primary care" means medical care provided at a person's first point of contact with the health care system, except for emergencies. It includes treatment of illness and injury, health promotion and education, identification of persons at special risk, early detection of serious disease, promotion of preventive health care, and referral to specialists when appropriate.

(13) "Primary care case management" or "managed care" means promoting the access to, coordination of, quality of, and appropriate use of medical care, and containing the costs of medical care by having an enrollee

obtain certain medical care from and through a primary care provider.

(14) "Primary care provider" means a physician, clinic, or midlevel practitioner other than a certified registered nurse anesthetist that is responsible by agreement with the department for providing primary care case management to enrollees in the Passport to Health Program.

(15) "Referral" means the approval by the Passport enrollee's primary care provider for the delivery by another provider of a service(s) that requires Passport referral. Referral is the provision of the primary care provider's Passport referral number to the other provider. The primary care provider shall establish the parameters of the referral.

(16) "Team Care" means a program for members identified as excessive or inappropriate utilizers of the Medicaid program as set forth in ARM 37.86.5303."

Section 8. Implementation. The department shall implement [this act] within existing resources.

Section 9. Effective date. [This act] is effective July 1, 2017.

- END -

I hereby certify that the within bill,

SB 0233, originated in the Senate.

President of the Senate

Signed this _____ day

of _____, 2017.

Secretary of the Senate

Speaker of the House

Signed this _____ day

of _____, 2017.

SENATE BILL NO. 233

INTRODUCED BY M. CAFERRO

AN ACT REVISING LAWS REGARDING THE AUTHORITY OF THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO ADOPT RULES RELATING TO THE PROVISION OF MEDICAID SERVICES TO CHILDREN IN FOSTER CARE; PROVIDING THAT THE DEPARTMENT MAY NOT ADOPT RULES THAT EXCLUDE OR RESTRICT FOSTER CHILDREN FROM ACCESSING MEDICAID SERVICES SOLELY BECAUSE THE CHILDREN ARE IN FOSTER CARE; AMENDING SECTIONS 53-2-215, 53-6-113, AND 53-6-402, MCA; DIRECTING THE AMENDMENT OF ARM 37.34.907, 37.40.1002, 37.40.1111, AND 37.86.5102; AND PROVIDING AN EFFECTIVE DATE.