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Children, Families, Health, and Human Services Interim Committee

61th Montana Legislature

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TO: Committee members
FROM: Lisa Mecklenberg Jackson, Staff Attorney
RE: DPHHS Administrative Rule Activity
DATE: January 15, 2010

The Department of Public Health and Human Services has filed the following rule notices with the Secretary of State's Office for publication in the Montana Administrative Register (MAR): *(Notices in their entirety are available online at: http://www.dphhs.mt.gov/legalresources/)*

Notices of Proposed Rules:

I.

MAR 2010 Issue No. 1 (January 14, 2010), MAR 37-498, NOTICE OF PROPOSED AMENDMENT -- the department has filed a NOTICE OF AMENDMENT regarding the proposed amendment of three rules pertaining to administrative review of fair hearing decisions. No public hearing is contemplated. The comment period runs until February 11, 2010. The Child and Family Services Division (CFSD) of the department proposes to amend ARM 37.47.610(6) to allow a means by which fair hearing decisions may be reviewed administratively before becoming final agency decisions. Currently, these decisions may only be reviewed by appealing to district court. CFSD believes this proposed change will allow parties who may not have the means or desire to go to district court to potentially preempt the necessity of doing so by asking the director to consider the proposed decision, the exceptions filed, briefs and oral argument, and the record of the hearing before allowing the proposed decision to become final. The proposed administrative review process is already being used by other divisions in the department and, accordingly, adoption of this proposed change would make CFSD's review process consistent with that being used elsewhere in the department.

TECHNICAL NOTE: The proposed rules were reviewed by committee legal staff and no technical problems were noted.

II.

MAR 2009 Issue No. 24 (December 24, 2009), MAR 37-497, NOTICE OF PROPOSED AMENDMENT -- the department has filed a NOTICE OF AMENDMENT regarding the proposed amendment of one rule pertaining to components of quality assessment activities. No public hearing is contemplated. The comment period runs until January 21, 2010. The Managed Care Plan Network Adequacy and Quality Assurance Act (Title 33, chapter 36, MCA), established standards for health carriers offering managed care plans and for the implementation of quality assurance standards in administrative rules. ARM 7.108.501 et. seq., were adopted in 2001 to establish mechanisms for the department to evaluate quality assurance activities of

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health carriers providing managed care plans in Montana. ARM 37.108.507 requires health carriers to report their quality assessment activities to the department using health effectiveness data and information set (HEDIS) measures, nationally utilized measures that are updated annually. Since the HEDIS standards change somewhat each year, the rule must also be updated annually to reflect the current year's measures and to ensure that national comparisons are possible, since the other states will also be using the same updated measures. This rule proposal changes the date of reference for the HEDIS measures from 2009 to 2010.

TECHNICAL NOTE: The proposed rules were reviewed by committee legal staff and no technical problems were noted.

III.

MAR 2009 Issue No. 24 (December 24, 2009), MAR 37-496, NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, AMENDMENT, AND REPEAL -- the department has filed a NOTICE OF PUBLIC HEARING regarding the proposed adoption of three new rules, the amendment of seven rules, and the repeal of one rule pertaining to emergency medical services (EMS). A hearing was held January 13, 2010 in the DPHHS Auditorium, 111 N. Sanders, Helena, Montana. The comment period runs until January 21, 2010. The proposed changes are necessary to implement changes made during the 2009 Legislature (HB 93--sponsors Representative Sands, and Senators Laible and Juneau have been notified), to clarify issues raised in a 2008 legislative performance audit and to modify various rules that were outdated and confusing. The three proposed new rules clarify the personnel necessary for a service licensed as an intermediate level service, a "new" level of service, which must be able to reasonably provide an intermediate level of care 24 hours a day, seven days a week.* The department is proposing a new definition for "service medical director" in ARM 37.104.101 which matches the definition in HB 93 and clarifies that a service medical director must meet requirements for being an EMT medical director under rules promulgated by the Board of Medical Examiners. Similarly, ARM 37.104.218(2) is necessary to reference a new definition for offline medical direction that was adopted in HB 93. ARM 24.156.2771 outlines how out-of-state EMTs may be authorized to provide either basic or advanced life support during emergencies. Most of the proposed rule repeals relate to information that is no longer needed after the department began converting EMS service licensing records to an electronic system over the last several months.

TECHNICAL NOTE: The proposed rules were reviewed by committee legal staff and no technical problems were noted. Rules relating to another 2009 CFHHS-sponsored EMS bill (HB 85) are being drafted by the Department of Transportation and a draft copy was sent to bill sponsors Representative Sands and Senator Laible. These rules provide for a grant program for emergency medical service providers for emergency response vehicles or equipment and require MDT to administer the grant program including the establishment of criteria for the grant and the weighing of those criteria, reasons for not awarding the grant, providing an appeal process, and establishing the reporting requirements for the grant program.

*For committee clarification, I asked Jim DeTienne, EMS and Trauma Systems, DPHHS, to explain the differences between basic, intermediate, and advanced life support services in terms of duties and personnel required: A Basic Life Support service is defined under 37.104.101(10) and it is a service that uses EMT-Basics (ambulance) or EMT-

First Responders (quick response units). They provide basic life support services; nothing advanced or invasive. An Intermediate Life Support service (defined under the proposed rules) is an EMS service that has enough EMT-Intermediates to reasonably assure that an EMT-I will be available on all calls, 24/7. An Advanced Life Support service, defined under 37.104.101(2), is an EMS service that has enough EMT-Paramedics to reasonably assure that a paramedic will be available on all calls, 24/7. Advanced life support is defined under 37.104.101(1) and references any provider who provides advanced life support services: 1) an EMT-Basic with ALS endorsements; 2) an EMT-Intermediate; or 3) an EMT-Paramedic. For services which have staff that are licensed and authorized to provide advanced life support services, but do not have enough staff to assure provision of those ALS services 24/7, we allow a service to be licensed at a Basic Life Support level, but be authorized to provide limited advanced life support. This licensing strategy is used by many volunteer services who have limited personnel to provide ALS and cannot assure that someone with those skills will always be available. Hence, those services are licensed at Basic Life Support but given an authorization to provide ALS when personnel are available.

IV.

MAR 2009 Issue No. 21 (November 12, 2009), MAR Notice 37-495, NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION AND AMENDMENT -- the department has filed a NOTICE OF PUBLIC HEARING regarding the proposed adoption of one new rule and the amendment of three rules pertaining to Medicaid physician administered drug reimbursement and pharmacy outpatient drug reimbursement. A hearing was held December 2, 2009 in the DPHHS Auditorium, 111 N. Sanders, Helena, Montana. The comment period ran until December 10, 2009. Outpatient drugs and physician administered drugs are covered under Montana Medicaid. The reimbursement price Montana Medicaid pays pharmacies for outpatient drugs has two components, the cost of acquiring the drug from a manufacturer and a dispensing fee. The cost of acquiring the drug is estimated based on three possible methods, the state maximum allowable cost, estimated acquisition cost, and usual and customary charges. New Rule I describes how the department would apply these three methods to calculate the price Montana Medicaid will pay pharmacies for outpatient drugs. The proposed amendment to ARM 37.86.1105 is to consistently use the term "state maximum allowable cost." By implementing a state maximum allowable cost (SMAC) method in the pricing structure the state could save $1.1 million in general fund while ensuring a fair price for medications dispensed at retail pharmacies. The proposed amendment to ARM 37.86.105 states Montana Medicaid current practices for setting reimbursement for physician administered drugs (PADs), which generally mirror the Medicare average sales price methods. This proposed amendment impacts approximately 5,000 providers. The estimated fiscal impact of this change is a decrease of $7,828 in federal expenditures and $2,320 of state expenditures. The department intends the proposed rule changes to be applied effective January 1, 2010.

TECHNICAL NOTE: The proposed rules were reviewed by committee legal staff and no technical problems were noted.

Notices of Adopted Rules:

V.

MAR 2009 Issue No. 24 (December 24, 2009), MAR Notice 37-494, NOTICE OF AMENDMENT -- a public hearing was held December 3, 2009 regarding the proposed amendment of two rules pertaining to Medicaid eligibility. No comments were received. To qualify for the Montana Medicaid program, an individual must meet the eligibility requirements

ser forth in ARM Title 37, Chapter 82. ARM 37.82.101 adopts and incorporates by reference the Medicaid policy manuals. By incorporating these manuals into the administrative rules, the department gives interested parties and the public notice and an opportunity to comment on policies governing Medicaid eligibility. Changes were made to the manuals regarding penalty periods for asset transfers made by nursing home and home and community-based waiver applicants, and eligibility requirements for certain households to receive Family Transitional Medicaid for up to 12 months. Additionally, in ARM 37.82.701(1)(e) the income limit for receipt of Medicaid under the pregnancy coverage group is being changed from 133% to 150% of the federal poverty guidelines. The department has been using the higher income limit since 2007 when the Legislature approved additional Medicaid funds so that women with incomes up to 150% of poverty could receive Medicaid, but the rule was never amended to reflect the new income level. It is estimated an additional 248 women will receive Medicaid during the biennium as a result of raising the income limit from 133% to 150% of FPL as well as an estimated 199 infants who will receive child-newborn coverage due to the increased income limit for pregnant women. The rule changes were effective January 1, 2010.

VI.

MAR 2009 Issue No. 24 (December 24, 2009), MAR Notice 37-493, NOTICE OF AMENDMENT -- a public hearing was held December 2, 2009 regarding the proposed amendment of three rules pertaining to Medicaid reimbursement for psychiatric residential treatment facility (PRTF) services. Eleven responses were received. The rule changes were an attempt to provide clear direction on PRTF discharge planning requirements and reimbursement for medical and ancillary services when they are provided "in and by" in-state and out-of-state PRTFs. The department made these changes to its PRTF rules and Medicaid state plan (SPA) to conform to a federal appeals board decision and directives from CMS which state that federal financial participation (FFP) is not available for medical services provided outside a PRTF, to youth residing in the PRTF. The rule changes identify services that may be provided "in and by" the PRTF. Services provided "outside" the PRTF, for youth in the PRTF, would be limited to emergency services reimbursed at the prevailing Montana Medicaid rate. The department's PRTF SPA would not be approved without these rule changes. PRTFs will be monitored more closely by the department to assure discharge planning is occurring as appropriate under federal regulations and national accreditation standards. There are three in-state and approx. 18 out-of-state PRTFs currently enrolled in Montana Medicaid. Approx. 431 youth were served in a PRTF (in-state and out-of-state) in SFY 2009.The rule amendments were effective January 1, 2010.

VII.

MAR 2009 Issue No. 24 (December 24, 2009), MAR Notice 37-492, NOTICE OF ADOPTION -- a public hearing was held December 3, 2009 with regard to the proposed amendment of five rules pertaining to Medicaid reimbursement for audiology services, hearing aids, and durable medical equipment (DME). No comments were received. These amendments are necessary to conform Montana Medicaid reimbursement rules for those items reimbursed by Medicare to Medicare standards and to adopt the Medicaid fee reimbursement methodology. The department adopted the U.S. Department of Health's CMS Durable Medical Equipment Reimbursement Center Region D Medicare Fee Schedule to simplify billing for providers so now Medicare and

Medicaid fees would be the same. Rental of hearing aids and references to invoice printing were deleted. The amendments adopt Medicare criteria for approval of Medicare covered durable medical equipment (equipment medically necessary to treat a health problem or physical condition in a patient's home, school, residence, etc.), prosthetics, orthotics, and supplies. The department will make its own determinations for prosthetic devices, durable medical equipment, and medical supplies not covered by Medicare. The amendments were effective January 1, 2010.

VIII.

MAR 2009 Issue No. 23 (December 10, 2009), MAR Notice 37-490, NOTICE OF AMENDMENT -- a public hearing was held November 18, 2009 regarding the proposed amendment of two rules pertaining to Temporary Assistance for Needy Families (TANF). No comments were received. The proposed amendments to ARM 37.78.102 are necessary to incorporate into the Administrative Rules of Montana the revised versions of the federal TANF policy manual and to reflect the increase in the TANF payment standards from 33 of the 2007 Federal Poverty Guidelines to 33% of the 2009 Federal Poverty Guidelines. The increase was approved in the 2009 Legislative session under HB 2. The department estimates this change could positively affect a monthly average of 3,302 TANF households. This rule was also updated to reflect the increase in the TANF eligibility standards from 30% of the 2002 Federal Poverty Guidelines to 30% of the 2009 Federal Poverty Guidelines. This increase was authorized under HB 645, 2009. The department estimates this change could result in a monthly average of 70 additional households being eligible for TANF cash assistance. The rule changes were effective January 1, 2010.

IX.

MAR 2009 Issue No. 23 (December 10, 2009), MAR Notice 37-489, NOTICE OF AMENDMENT -- a public hearing was held November 5, 2009 regarding the proposed amendment of one rule pertaining to basic Medicaid services for able-bodied adults. No comments were received. These rule amendments facilitate the provision of basic Medicaid services to one additional population, referred to as "MHSP waiver." "MHSP waiver" individuals are otherwise uninsured individuals qualified for the state-only Mental Health Services Plan (MHSP) program, who have schizophrenia or bipolar disorder, who are at least 18 years of age, and who are residents of Montana with incomes at or below 150% of FPL. Montana has been operating a basic Medicaid waiver program since 1996. Recently Montana submitted, and CMS anticipates approval of, a basic Medicaid extension amendment that would allow continued coverage for 7,704 able-bodied adults, with incomes at or below 33% of FPL as described in the current basic Medicaid waiver, without change. One additional population, the "MHSP waiver" population, could be covered with the extension (an additional 400 individuals in 2010 and up to 800 additional individuals in 2011 and beyond if Medicaid spending remains neutral). With the waiver expansion, the "MHSP waiver" population would receive the same basic Medicaid benefits, would be subject to the same restrictions, and would pay the same cost share as currently eligible able-bodied adults. The department expects to use accumulated federal savings from the existing basic Medicaid waiver to provide federal funding for the addition of the "MHSP waiver" expanded population to the basic Medicaid waiver. State funding would

come from the state-only MHSP Program. Total state and federal costs for a three-year extension, February 2009 through January 2012, for continuing the able-bodied adults population and adding one new expansion population of 400 individuals, is estimated at $101,006,485. The proposed rules changes were effective January 1, 2010.

X.

MAR 2009 Issue No. 23 (December 10, 2009), MAR Notice 37-488, NOTICE OF AMENDMENT -- a public hearing was held November 5, 2009 regarding the proposed amendment of four rules pertaining to the Pharmacy Access Prescription Drug Benefit Program (Big Sky Rx Program). No comments were received. These amendments were made to the rules pertaining to the Pharmacy Access Prescription Drug Benefit Program (Big Sky Rx Program) to coincide with changes in the federal program Social Security Extra Help and were updated to match the federal monthly benefit benchmark. In-kind support as counted income was removed to coincide with the federal program requirements. The proposed amendments assist the Big Sky Rx Program in evaluating income level to determine if applicants should apply for the federal program Social Security Extra Help. The monthly maximum benefit increased from $33.19 to $37.55 to match the new federal monthly benefit benchmark. This will help Big Sky Rx enrollees pay their monthly Medicare Part D premiums which in turn allows them more money to pay their other monthly expenses. The amendments were effective January 1, 2010.

XI.

MAR 2009 Issue No. 23 (December 10, 2009), MAR Notice 37-486, NOTICE OF ADOPTION AND AMENDMENT -- a public hearing was held October 15, 2009 regarding the proposed adoption of three new rules and the amendment of 16 rules pertaining to home and community based services (HCBS) for youth with serious emotional disturbance (SED). Two comments were received. One expressed concern with the low rate of reimbursement for wraparound facilitation services. The department agreed and adopted a rate of $14.50 for a 15 minute unit, the same rate paid for family support specialist services. The other comment asked that the mental health professional supervision requirement for family support specialists be eliminated as not all agencies hiring family support specialists have licensed mental health professionals on staff. The department agreed and that requirement was taken out of new Rule I. The new rules and amendments, pertaining to Medicaid childrens' mental health waiver services authorized under section 1915(c) of the Social Security Act: add Missoula and Ravalli Counties as areas where home and community based services (HCBS) for youth with serious emotional disturbance (SED) are available as of August 1, 2009 (funding comes from a federal grant); increase the maximum age for participation in the program to 18; add family support specialist services, wraparound facilitation, and caregiver peer-to-peer support specialist services to the spectrum of HCBS for youth with SED; and increase the spending limit for customized goods and services (from $200 to $1,000 annually). Since October 1, 2007 the department has operated a program, authorized by CMS, of Medicaid funded HCBS for youth who have SED. The department expects no increase or decrease in the cost of benefits for recipients of HCBS waiver services and no overall change in reimbursement levels for providers. There are at least three mental health centers plus numerous mental health providers in Missoula and Ravalli Counties eligible to provide HCBS mental health waiver services and approximately 35 to 50 youth may

be eligible for those services. The rule amendments will be applied retroactively to August 1, 2009.

XII.

MAR 2010 Issue No. 1 (January 1, 2010), MAR Notice 37-471, NOTICE OF ADOPTION, AMENDMENT, AND REPEAL -- public hearings were held June 3, 2009 and August 7, 2009 regarding the proposed adoption of 168 new rules, the amendment of 12 rules, and the repealing of 43 rules pertaining to swimming pools, spas, and other water features. 272 comments were received. The department repealed its existing swimming pool rules because they were outdated and no longer reflected industry standards. Most of the previous rules were adopted in 1985. Since 1985, the industry has begun to develop numerous new water features at water parks and in individual swimming pools available for public use, including such features as water slides, lazy rivers, and wave pools. Additionally, new designs, construction materials, disinfectants, circulation systems, etc. have been developed. The new rules update current industry standards and address new features to ensure that public health and safety concerns are addressed in the design, construction, and operation of swimming pools, spas, and other water features. The department also repealed old rules which addressed swimming areas in natural bodies of water. Because the Legislature created new statutes addressing recreational uses of water, the department no longer regulates natural recreational waters. All licensed pools, spas, or other water features will need to meet the operation requirements of the proposed rules upon their adoption, with the exception that currently licensed operations will have until December 31, 2011, for operators(s) to meet new certification requirements.

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