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: June 23, 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. 10 (May 27, 2010), MAR 37-513, NOTICE OF NEGOTIATED RULEMAKING -- the department has filed a NOTICE OF NEGOTIATED RULEMAKING regarding the establishment of a negotiated rulemaking committee on guest ranch and outfitting and guide facilities. The committee will develop proposed rules regarding guest ranches and outfitting facilities. The proposed rules must take into consideration the size, type, location, and seasonal operations of the establishment and may include only rules to ensure the establishment has safe drinking water and an adequate water supply, an adequate and sanitary sewage system and refuse disposal system, and address food safety concerns, such as adequate storage, refrigeration, and food handling. Comments and applications for memberships on the committee will be accepted until June 28 with the committee being established no later than August 31. The committee will transmit the proposed rules to the department by December 2010.

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

II.

MAR 2010 Issue No. 10 (May 27, 2010), MAR 37-512, NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION -- the department has filed a NOTICE OF PUBLIC HEARING regarding the proposed adoption of six new rules pertaining to Medicaid for workers with disabilities. A hearing will be held June 24, 2010 in the DPHHS Auditorium, 111 N. Sanders, Helena, Montana. The comment period runs until June 25, 2010. The 2009 legislature enacted SB 119 (the sponsor was Senator Esp who was contacted under the bill sponsor requirements of 2-4-302, MCA) which authorizes the department to create a new Medicaid eligibility group known as Medicaid for Workers with Disabilities which has less stringent income and resource limits than are used to determine other Aged, Blind, and Disabled Medicaid levels. These rules provide for a coverage group for individuals with disabilities who are employed so that they can work without losing their Medicaid coverage due to their earnings from employment. SB 119

authorizes the department to provide coverage under this group to individuals whose net family income is less then 250% of FPL. The department chose this income limit, which is significantly higher than the maximum allowed for other Medicaid coverage groups, because disabled individuals who are working may have additional expenses related to their employment and should therefore be allowed to have more income without being penalized by the loss of their Medicaid coverage. Rule I defines "employed" broadly without imposing a minimum number of hours of employment or a minimum amount of earnings. Rule IV specifies that the department will use SSI rules to calculate net family income because these are the rules used to determine eligibility for other coverage groups serving the disabled population. Rule V sets the resource (asset) limit for this coverage group at $8,000 for an unmarried individual and $12,000 for a married couple. These limits are four times higher than the resource limits used in the SSI program. The purpose of having higher resource limits is to allow workers with disabilities to be benefitted by employment by being allowed to accumulate assets without being penalized. Rule V also specifies that funds in a retirement or pension fund or plan will not be counted in determining eligibility for this coverage group as it is not desirable to force individuals to spend money they will need for their basic support in their old age or retirement on medical expenses. Proposed New Rule VI contains the tables that will be used to determine the amount of the cost share fee each individual will pay. The payment table contains four income/payment brackets. The department chose these payment amounts after studying the amounts participants in similar programs in other states are required to pay. Medicaid for Workers with Disabilities will begin on July 1, 2010 if the necessary approvals are received from CMS. It is estimated that 43 individuals will participate in the program in the first three months with 254 participating from October 1, 2010 through September 30, 2011. It is estimated that the total spent for the program from July 1, 2010 through September 30, 2011 will be $282, 960 of which $92,641 will be general fund dollars and $190,319 will be federal dollars. The department intends to apply proposed new Rules I through VI retroactively to July 1, 2010.

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

III.

MAR 2010 Issue No. 9 (May 13, 2010), MAR 37-511, NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION -- the department has filed a NOTICE OF PUBLIC HEARING regarding the proposed adoption of ten new rules pertaining to permissive licensing of drop-in child care facilities. A hearing was held June 8, 2010 in the DPHHS Auditorium, 111 N. Sanders, Helena, Montana. The comment period runs until June 25, 2010. These rule proposals came about as a result of HB 324, 2001 (the sponsor was Rep. Jeff Mangan who was contacted under the bill sponsor requirements of 2-4-302, MCA) which amended the Montana Child Care Act to allow for the permissive licensing of child care centers that provide care to children on an irregular basis, otherwise known as "drop in day care" facilities. In developing these voluntary rules, HB 324 required the department to provide for exceptions regarding child-to-staff ratios and requirements for immunization which are present in the regulations that currently exist for other types of regulated child care programs. The proposed new rules provide the minimum requirements that the department deems as being necessary to protect the health and safety of

children placed in drop-in day care facilities. The rules call for a plan of operation which is necessary in order to be licensed by the department, require the facility to have sufficient space, require the taking of emergency and health history information, establish emergency safety requirements, and require meals and snacks, as well as documenting staff qualifications.

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

Notices of Adopted Rules:

IV.

MAR 2010 Issue No. 12 (June 24, 2010), MAR 37-510, NOTICE OF AMENDMENT -- a public hearing was held May 27, 2010 regarding the proposed amendment of five rules pertaining to the Medicaid Health Improvement Program. No comments or testimony were received. These rule amendments pertain to the Health Improvement Program that is currently called "the Disease Management Program." The Health Improvement Program is a Medicaid service for qualified Medicaid clients to coordinate health care and educate clients. The purpose of the program is to improve clients' health and reduce Montana Medicaid's health care costs by reducing unnecessary health care utilization. The rule amendments change the program name from "disease management" to "health improvement." This is a shift in program philosophy from a disease-state focus to improving patients' overall health. This includes offering preventive services and assisting patients with psychosocial issues that may be hindering their ability to address medical issues. These rule amendments also state the change of delivery system from disease management organizations to health centers which will bring the delivery of health improvement program services into the local community, rather than provision by an out-of-state vendor, which the department believes will be more effective. Adding the term Healthy Montana Kids Plus (HMK Plus) was a necessary change because of the expansion and renaming of Montana Medicaid for children ages 0 through 19. The amendments also change how clients will be identified as eligible for the Health Improvement Program. Medicaid will now encourage primary care providers to refer clients at risk of high utilization of medical services and will identify clients through an analysis of claims history who are at risk of high utilization of medical services. This change is necessary because of CMA requirements allowing Montana to operate this program as an enhanced primary care management program under the department's Passport to Health waiver.

V.

MAR 2010 Issue No. 12 (June 24, 2010), MAR 37-509, NOTICE OF AMENDMENT -- a public hearing was held May 20, 2010 regarding the proposed amendment of one rule pertaining to the resource based relative value scale (RBRVS). Four comments were received. ARM 37.85.212 implements Montana Medicaid's resource based relative value scale (RBRVS) reimbursement method for specified provider types. Montana Medicaid uses the RBRVS rate system to calculate the fee Montana Medicaid pays to 20 types of health care professionals. The department annually proposes to amend ARM 37.85.212 to adopt current relative value units (RVUs). An RVU is a numerical value assigned to each medical procedure which is based on physician work, practice expense and malpractice, and express the relative effort and expense expended to

provide one procedure compared with another. The fee paid for a procedure by a health plan is calculated by multiplying that procedure's RVU by the health plan's conversion factor. The conversion factor for licensed physicians is set by 53-6-124 through 53-6-127, MCA. Because of the general fund budget deficit, the department is proposing to set conversion factors and fees for Medicaid reimbursement for physicians for SFY 2011 at the SFY 2010 level. Three of the four comments received by the department regarding this rule proposal, including from CFHHS legal staff, disagree with the department's authority to set the physician's reimbursement rate at SFY 2010 levels. In 2007, the Montana Legislature enacted 53-6-125, MCA, pertaining to physician's reimbursement rates and provides that for fiscal year 2011, the 2010 percentage of the conversion factor (and accordingly, physician rate increases) will be increased by a minimum of 6%. The department's position is that 53-6-125, MCA, is not a statutory mandate to increase the rate the state pays physicians for services to Medicaid clients "without regard to the state's projected general fund budget deficits." In reaching this conclusion, the department reasons that 17-7-140, MCA, which gives the Governor limited authority to reduce certain expenditures during a projected general fund budget deficit, is a basis for not increasing the physician rate increase by a minimum of 6%. However, in the opinion of legislative services, there is nothing in 17-7-140, MCA, which explicitly or implicitly gives the executive branch the authority to change statutorily prescribed payments or duties. Such a practice would be seen as a violation of the separation of powers. Furthermore, the department's assertion that because physician provider rates are not listed in 17-7-140(2), MCA, as being exempt from a reduction in spending, it is therefore allowable to make cuts to those statutorily mandated rates doesn't hold much water either. Only six exemptions are listed in 17-7-140(2). Using the department's reasoning, hundreds of state statutes should be specifically exempted in order to be free from reductions by the executive branch. For example, the executive branch could choose to not enforce various criminal statues as there is no exemption for the highway patrol or the department of justice specifically listed in 17-7-140(2), MCA. I had asked the department to respond to my concerns prior to adopting the rule. They chose to respond in the rule adoption notice in which they continued to state they had the authority to make the cuts to physician reimbursement rates. If these rates were not statutorily mandated, I would agree. The department has broad authority under 53-6-101(8) and 53-6-113 (3), MCA, to set Medicaid provider reimbursement rates but they cannot ignore or change other statutes. That is the role of the legislature. The CFHHS Committee may wish to write a letter objecting to the rule adoption pursuant to 2-4-406, MCA, (no implementing authority for the rule) and require the department to respond to the objection.

VI.

MAR 2010 Issue No. 12 (June 24, 2010), MAR 37-508, NOTICE OF AMENDMENT -- a public hearing was held May 27, 2010 regarding the proposed amendment of six rules pertaining to the Healthy Montana Kids Plan. No comments or testimony were received. Changes in the administrative rules implementing HMK and HMK Plus are necessitated by federal changes to the CHIP program (CHIPRA) and also updates to Montana's HMK program. The department is adopting Medicaid's prospective payment system and rate for federally qualified health centers and rural health centers services for children enrolled in HMK. Changes to ARM 37.79.303 clarify that cochlear implants and associated components are not covered benefits. ARM 37.79.316 and 317 are being amended to comply with CHIPRA's requirements that separate state

child health plans that provide mental health benefits and substance use disorder benefits may not impose annual and lifetime dollar limits more restrictive than those applicable to medical and surgical benefits. The department intends the proposed rule changes to be effective July 1, 2010.

VII.

MAR 2010 Issue No. 12 (June 24, 2010), MAR 37-507, NOTICE OF AMENDMENT -- a public hearing was held May 20, 2010 regarding the proposed amendment of two rules pertaining to the home and community-based services for adults with severe disabling mental illness. No comments or testimony were received. The department is amending ARM 37.90.401 to reflect the federal authorization of the Home and Community-Based Services (HCBS) waiver for adults with severe and disabling mental illness (SDMI). The department is amending ARM 37.90.401 to add Jefferson County to the Butte-Silver Bow County region and to add a fourth region that includes Missoula County to the list of counties in which individuals can be eligible for HCBS for adults with SDMI. This waiver program has been successful in allowing persons with mental illness to live independently in their communities as an alternative to nursing home level of care. The expansion of the SDMI HCBS waiver service areas was approved by the 2009 Legislature.

VIII.

MAR 2010 Issue No. 12 (June 24, 2010), MAR 37-506, NOTICE OF AMENDMENT AND REPEAL -- a public hearing was held May 19, 2010 regarding the proposed amendment of 18 rules and the proposed repeal of two rules pertaining to Medicaid inpatient and outpatient hospital services. Nine comments were received. The majority of comments indicate concern from hospitals that Medicaid payments for services will be lowered. The department stated that it is not proposing an increase or decrease in base rates but is attempting to save money by not implementing provider rate increases appropriated for SFY 2011. The department further stated that it is of the opinion that hospitals will not need to recover unpaid costs due to the reduction in Medicaid payments because most unpaid costs will be paid through the distribution of the DSH (disproportionate share hospital) payment. Out-of-state facilities do not benefit from the DSH payment. The rule amendments update Montana's rules with federal rules and interface these rules with the amendment to Montana's Medicaid inpatient hospital state plan which has been approved by CMS. The rules establish two base rates for reimbursement of inpatient hospital facilities. The two rates include a Montana average base rate and an average base rate for hospitals meeting the criteria for Centers of Excellence. The department eliminated the separate base rate for in-state and out-of-state distinct part rehabilitation units and long-term care (LTC) facilities. The department also repealed language relating to qualified rate adjustment (QRA) payments as the department no longer incorporates QRA payments into the reimbursement methodology for inpatient hospitals. The department intends the rules to be effective July 1, 2010.

IX.

MAR 2010 Issue No. 12 (June 24, 2010), MAR 37-505, NOTICE OF AMENDMENT -- a public hearing was held May 20, 2010 regarding the proposed amendment of eight rules pertaining to Medicaid reimbursement for hearing aid services, outpatient drugs, home infusion therapy services, eyeglasses, early and periodic screening, diagnostic and treatment services,

comprehensive school and community treatment, transportation and per diem, specialized nonemergency medical transportation, and ambulance services. No comments or testimony were received. The amendments change the dates of fees schedules from July 1, 2009 to July 1, 2010 (rules effective July 1, 2010). The amendment to ARM 37.86.2207(9) changes the fee schedule date from October 2009 to October 2010 for school-based services (rule effective October 1, 2010). There are no rate changes and no changes, other than dates.

X.

MAR 2010 Issue No. 12 (June 24, 2010), MAR 37-504, NOTICE OF AMENDMENT -- a public hearing was held May 19, 2010 regarding the proposed amendment of two rules pertaining to Medicaid nursing facility reimbursement. The rule amendments are necessary to implement nursing facility reimbursement for SFY 2011.Twenty-two comments were received. The bulk of the comments objected to the department's plan to not distribute a legislatively appropriated 2% rate increase for SFY 2011. The department plans to stick to that plan in accordance with the Governor's 5% general fund reduction plan allowable under 17-7-403(3), MCA. The department states that Montana's nursing facilities will continue to receive increases from one-time direct care wage funding (HB 645) that is separate from the 2% provider rate increase funding and will continue to participate and benefit from the intergovernmental transfer program (use of local county matching funds) that provide supplemental payments in addition to Medicaid payment rate set through the reimbursement methodology during SFY 2011. In addition, the department believes there will be sufficient funding appropriated to fund both an increase in acuity and a modest rate adjustment. This will assure that no facility receives a rate decrease. Funding is available because of the significant decrease in patient days. The department intends the rules to be effective July 1, 2010.

XI.

MAR 2010 Issue No. 12 (June 24, 2010), MAR 37-503, NOTICE OF ADOPTION AND AMENDMENT -- a public hearing was held May 6, 2010 with regard to the proposed adoption of one new rule and the amendment of five rules pertaining to Medicaid reimbursement of children's mental health services. Fifteen comments were received. The department adopted a new rule incorporating the Medicaid and Mental Health Services Plan, Individuals Under 18 Years of Age Fee Schedule (fee schedule) and the Medicaid Mental Health and Mental Health Services Plan for Youth Services Excluded from Simultaneous Reimbursement (service matrix) as the department received requests from providers to organize the children's mental health Medicaid and Mental Health Services Plan rules into one section so they would be easier to find. The rule changes specify that moderate level therapeutic family care and permanency level therapeutic family care may not be reimbursed on the same day and specify that no other mental health service on the service matrix will be reimbursed on the same day as psychiatric residential treatment services with the exception of the day of admission and/or discharge. A requirement is being added that if the discharge plan does not evolve adequately during a youth's stay in a PRTF, continued authorization for PRTF will be denied. Clarification is being added to indicate permanency level therapeutic family care services will only be authorized in foster care homes and not authorized in biological or postadoption homes. The rules adopt specific language regarding authorization requirements including prior and continued authorizations in ARM

37.87.903. Both prior and continued authorizations are needed before a service is provided to a Medicaid recipient. The department is also proposing a rule that waives the authorization requirement for 10 business days because of a clinical reason or failure of the department's equipment. The rule changes will be effective July 1, 2010.

XII.

MAR 2010 Issue No. 12 (June 24, 2010), MAR 37-502, NOTICE OF AMENDMENT -- a public hearing was held May 6, 2010 with regard to the proposed amendment of two rules pertaining to Medicaid reimbursement for psychiatric residential treatment facility (PRTF) services. No comments or testimony were received. The amendments make it clear that out-of-state psychiatric residential treatment facilities (PRTFs) must be certified by the state in which the facility is located to participate in the Montana Medicaid program as required by CMS. The department is currently unable to authorize admissions to out-of-state PRTFs that are not currently certified. As a result, some youths eligible for Montana medicaid benefits might not receive needed mental health treatment or treatment might be delayed. It is anticipated that in-state PRTFs or other out-of-state enrolled and certified PRTFs will be able to serve youth previously referred to the noncertified PRTFs. The department also anticipates some of the noncertified out-of-state PRTFs to become certified in the near future. The department intends to apply these rules retroactively to February 1, 2010.

XIII.

MAR 2010 Issue No. 10 (May 27, 2010), MAR 37-500, NOTICE OF AMENDMENT AND REPEAL -- a public hearing was held April 14, 2010 with regard to the proposed amendment of two rules and the repeal of two rules pertaining to standards for providers of services funded through certain disability transitions programs. One comment was received. These rule changes pertain to the standards for providers of services for vocational rehabilitation, blind and low vision services, older blind, visual medical, extended employment services, or independent living services. ARM 37.30.1001 specifies the Disability Transitions Programs to which provider standards are applicable and contains express authority for the department to undertake quality assurance on and off site reviews and to take action that fosters the delivery of services to meet the consumer's needs. The amendments to ARM 37.30.1002 remove the required applicability to independent living services of the standards of the National Council on Disability which no longer provides standards for this purpose. Instead, the department is specifying that an independent living center may be enrolled by the department based upon its recognition and direct funding by the federal Department of Education, Rehabilitation Services Administration, as an independent living center that meets the pertinent federal standards governing independent living facilities. The rule change also allows for the department to enroll service programs approved as providers by another state or federal program, which will further the delivery of services originating with different programs. Amendments to Rule 37.30.1002 also allow the department to enroll service programs as limited enrollment providers which will broaden the opportunities for consumers to receive services in their own communities.

XIV.

MAR 2010 Issue No. 9 (May 13, 2010), MAR 37-499, NOTICE OF AMENDMENT -- in

February, the department gave notice regarding the proposed amendment of one rule pertaining to laboratory testing fees. No public hearing was held. ARM 37.12.401 provides information regarding the fees charged for biological and environmental tests performed by the Montana State Laboratory. The changes include a new version of the state laboratory fee list, which provides an average increase of 5% in the cost of lab services which is necessary to keep the fees charged for lab service in line with the actual current cost associated with providing that service. The fees will cover increased costs incurred by the lab since the last fee increase, including personnel costs, costs of supplies, and costs of new and replacement testing equipment.

XV.

MAR 2010 Issue No. 10 (May 27, 2010), MAR Notice 37-491, NOTICE OF ADOPTION -- a hearing was held November 23, 2009 with regard to the proposed adoption of six new rules pertaining to state matching fund grants to counties for crisis intervention, jail diversion, involuntary precommitment, short-term inpatient treatment costs, and contracts for crisis beds and emergency and court-ordered detention beds for persons with mental illness. These rules implement HB 130, 2009, which provides for state matching fund grants to counties for local crisis intervention, jail diversion, involuntary precommitment, and short-term inpatient treatment costs for individuals with mental illnesses. The department also adopted one new rule pertaining to state contracts with eligible providers for crisis beds and emergency or court-ordered detention beds for the mentally ill which was the result of HB 131, 2009.

Administrative Rule Timeline

May 9, 2009	HB 130, HB 131 become law.
October 19, 2009	The proposed administrative rules regarding HB 130, HB 131 (MAR Notice 37-491) filed with the Secretary of State.
November 23, 2009	Letter was sent to DPHHS asking for the department's response to ten comments from CFHHS which were the result of concerns raised by committee members at their November 16, 2009 meeting regarding the proposed rules.
December 17, 2009	Upon request, the department extended the comment period until this date.
January 13, 2010	Department's response to CFHHS received.
January 25, 2010	CFHHS meets and hears from department on rules. Committee seems satisfied.
May 27, 2010	Final administrative rules regarding HB 130, HB 131 adopted.

Added to Rule II: Funds will be distributed to counties via a contract with the department. Counties must submit invoices to the department for funds. The adopted rules clarify that the sliding scale will be based on calculation of historical county use of the state hospital versus total state use of the state hospital and county population versus total state population (eliminated the per 1,000 county resident language). The sliding scale will be in increments of 50-70% (not 65% as proposed) in equal 5% increments. Final rules clarify that the matching rate for grants will be based on the sliding scale formula with no county receiving a grant amount larger than the grant amount requested. Letters of intent will be used only to discover if counties

intend to submit applications that would, in total, exceed the funds available. The per capita language in Rule IV will not be used to allocate funds but rather to "set aside" funds within the fiscal year's appropriation until a completed grant application is received and approved by the department. Match rates are based upon population and commitments. Grant amounts must be based on available funding. The adopted rules stipulate that after the initial first year, grant applications that continue or expand activities implemented with a previous year's funding may be given priority over new applications if grant application requirements are met and the department determines the plan would promote appropriate use of the Montana State Hospital and would ultimately result in cost savings to the state. The rules reiterate the department's commitment to make grants to "each eligible county" as directed by HB 130, rather than to counties with models that are already working and state that the delay in rulemaking did not affect the availability of funds to county grant applicants. As of May 27, 2010, the department has signed a contract with Yellowstone County (and ten partner counties). Contracts with Missoula County, Lewis & Clark County (and three partner counties), and Ravalli County are pending.

OF NOTE:

As you may recall, at the end of May , in conjunction with federal health reform, the State Auditor and Commissioner of Insurance set forth a proposal for six new rules pertaining to the administration of a new high risk insurance pool, the Montana Affordable Care Plan (MACP). MACP is designed to provide immediate access to insurance for uninsured individuals with a preexisting condition and will be in effect until 2014. The funding for the MACP high risk pool will come from money awarded by contract or grant from the federal government and premiums paid by the covered individual in the MACP. The department received five comments from Blue Cross Blue Shield which it responded to in its rule adoption notice on June 24. The department expected the risk pool contract with Health and Human Services to be signed on June 25 and applications will start being accepted on July 1, 2010.

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