MONTANA
ADMINISTRATIVE
REGISTER

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED RULEMAKING

MAR NOTICE NO. 2025-53.1

Summary

Amendment of ARM 37.85.206 and adoption of NEW RULES 1 through 3 pertaining to Pediatric Complex Care Assistant Services

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Hearing Date and Time

Friday, July 18, 2025, at 9:00 a.m.

Virtual Hearing Information

Join Zoom Meeting

https://mt-gov.zoom.us/j/82258062357?pwd=Gb1lFeyzMbatbFHxCIu7lHPaEbw8kp.1

Meeting ID: 822 5806 2357 and Password: 266550

Dial by Telephone +1 646 558 8656

Meeting ID: 822 5806 2357 and Password: 266550

Find your local number: https://mt-gov.zoom.us/u/kcLIY806R6

Comments

Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may be submitted using the contact information below. Comments must be received by Friday, July 25, 2025, at 5:00 p.m.

Accommodations

The agency will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. Requests must be made by Thursday, July 3, 2025, at 5:00 p.m.

Contact

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Rulemaking Actions

AMEND

The rule proposed to be amended is as follows, stricken matter interlined, new matter underlined:

37.85.206 SERVICES PROVIDED

(1) Except as otherwise provided in this rule, the following medical or remedial care and services are available to all persons who are eligible for Medicaid benefits under this chapter, including deceased persons, categorically related, who would have been eligible had death not prevented them from applying.

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) non-hospital laboratory and x-ray services;

(d) nursing facility services;

(e) early and periodic screening, diagnosis, and treatment services;

(f) physician's services;

(g) podiatry services;

(h) outpatient physical therapy services;

(i) speech therapy, audiology, and hearing aid services;

(j) outpatient occupational therapy services;

(k) home health care services;

(l) personal care services in a member's home;

(m) home dialysis services;

(n) private duty nursing services;

(o) clinic services;

(p) dental services;

(q) outpatient drugs;

(r) durable medical equipment, prosthetic devices, and medical supplies;

(s) eyeglasses and optometric services;

(t) transportation and per diem;

(u) ambulance services;

(v) specialized nonemergency transportation;

(w) family planning services;

(x) home and community services;

(y) mid-level practitioner services;

(z) hospice services;

(aa) licensed psychologist services;

(bb) licensed clinical social worker services;

(cc) licensed professional counselor services;

(dd) inpatient psychiatric services;

(ee) mental health center services;

(ff) case management services;

(gg) institutions for mental diseases for persons ~~age~~aged 65 and over;

(hh) payment of premiums, co-insurance, deductibles, and other cost sharing obligations under an individual or group health plan in accordance with the provisions of ARM 37.82.424;

(ii) diabetes and cardiovascular disease prevention services;

(jj) habilitative services; ~~and~~

(kk) rehabilitative services~~.~~; and

(ll) pediatric complex care assistant services.

(2) Only those medical or remedial care and services also covered by Medicare are available to a person who is eligible for Medicaid benefits as a qualified Medicare beneficiary under ARM 37.83.201 and 37.83.202.

(3) State plan Medicaid benefits are available for members who are Medicaid-covered through the Waiver for Additional Services and Populations (WASP) Medicaid 1115 Waiver as approved by the Centers for Medicare and Medicaid Services (CMS).

(a) A person may receive coverage through the WASP Medicaid 1115 Waiver if the person is 18 or older, has severe disabling mental illnesses (SDMI), would qualify for or be enrolled in the state-financed mental health services plan (MHSP) or the WASP Medicaid 1115 Waiver but is otherwise ineligible for Medicaid benefits, and either:

(i) the person's income is 0 to 138% of the federal poverty level and the person is eligible for or is enrolled in Medicare; or

(ii) the person's income is 139 to 150% of the federal poverty level whether Medicare- eligible or not.

(b) A person determined categorically eligible for Medicaid as aged, blind, or disabled (ABD) in accordance with ARM 37.82.901 through 37.82.903 is not subject to the annual $1,125 dental treatment limit. The monies expended for treatment costs exceeding the limit are covered through the WASP Medicaid 1115 Waiver.

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

Implementing statute(s): 53-2-201, 53-6-101, 53-6-103, 53-6-111, 53-6-113, 53-6-131, 53-6-141, MCA

ADOPT

The rules proposed to be adopted are as follows:

NEW RULE 1 PEDIATRIC COMPLEX CARE ASSISTANT SERVICES, REQUIREMENTS

(1) To qualify for Pediatric Complex Care Assistant (PCCA) services, an individual must be a Medicaid member under 21 years of age.

(2) PCCA services must be provided in accordance with the requirements of 37-2-603, MCA. The services are limited to those provided for under the statute and in ARM 24.160.501.

(3) PCCA services must not replace Private Duty Nursing Services or supplant other services the member is receiving, but a member may receive PCCA services, Personal Care Assistant services, and/or Private Duty Nursing services under a person-centered care plan.

(4) PCCA services may only be provided by licensed pediatric complex care assistants employed by a Medicaid-enrolled PCCA provider agency and selected by the member or their authorized representative.

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

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

NEW RULE 2 PEDIATRIC COMPLEX CARE ASSISTANT SERVICES, PROVIDER REQUIREMENTS AND ENROLLMENT

(1) Pediatric Complex Care Assistant (PCCA) service provider agencies must be enrolled Medicaid providers.

(2) PCCA service provider agencies must be a business entity formed or registered to do business under Montana law.

(3) PCCA services must be prior-authorized by the department or the department's designee.

(4) PCCA service provider agencies must provide documentation to the department verifying the PCCA’s certification training and current licensure.

(5) PCCA service provider agencies must use an electronic visit verification (EVV) system to electronically document the delivery of services and submit claims.

(a) In accordance with 42 U.S.C. 1396b(l), the EVV system must capture the following data elements:

(i) the type of service performed;

(ii) the member receiving the service;

(iii) the date of the service;

(iv) the location of the service delivery;

(v) the individual providing the service; and

(vi) the time the service begins and ends.

(b) The use of EVV is required for all members utilizing PCCA services, including members for whom services are provided by a live-in caregiver.

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

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

NEW RULE 3 PEDIATRIC COMPLEX CARE ASSISTANT SERVICES, REIMBURSEMENT

(1) Pediatric Complex Care Assistant (PCCA) services may not exceed 24 hours, or 96 units, in a single day for an individual.

(2) The rate for PCCA services is the lesser of:

(a) $10.78 per 15-minute unit of service, which equates to $43.12 per hour of service provided; or

(b) the provider's usual and customary charge.

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

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

General Reasonable Necessity Statement

The Department of Public Health and Human Services (department) is proposing to adopt NEW RULES 1 through 3 and to amend ARM 37.85.206 to implement House Bill (HB) 449 that passed and was enacted into law during Montana's 68th Legislative Session. HB 449 establishes Pediatric Complex Care Assistant (PCCA) services and authorizes the services to be provided through the Montana Medicaid program to members under the age of 21 who have complex medical needs. These rules are necessary to establish PCCA service requirements and the rate for reimbursement in accordance with HB 449 and Medicaid State Plan Amendment #24-0016 that was approved by the Centers for Medicare & Medicaid Services (CMS) on September 9, 2024.

PCCA services are designed to:

1. improve access to specialized care for eligible Medicaid members, particularly in rural and underserved areas of Montana;

2. provide families with the resources to deliver medically necessary services at home to eligible members; and

3. provide clarity regarding PCCA service requirements, provider enrollment standards, and rate reimbursement.

NEW RULE 1

The department is proposing this rule to set forth the eligibility criteria for PCCA services and the scope of allowable services in accordance with 37-2-603, MCA, ARM 24.160.501, and Montana's approved Medicaid state plan.

NEW RULE 2

This rule establishes requirements for PCCA service provider agencies. As part of this rule, the department is proposing to require the use of an Electronic Visit Verification (EVV) system for all PCCA caregivers. Federal law mandates that states require EVV use for Medicaid-funded personal care services and home health care services for in-home visits by a provider. 42 U.S.C. § 1396b(l). EVV is a technology that automates the gathering of service information by capturing time, attendance, and care plan information entered by a home care worker at the point of care. Under current CMS guidance, federal EVV requirements do not apply if the individual receiving services lives with the caregiver providing the service because CMS does not consider such services to constitute an "in-home visit." However, CMS encourages states to provide appropriate oversight to services provided by live-in caregivers and states may choose to implement EVV to such services, particularly when using discrete units of reimbursement.[1] Under New Rule 3, PCCA services are to be paid in discrete units of reimbursement of 15-minute increments.

To control fraud, waste, and abuse, the department is proposing for EVV requirements to apply to services provided to all members utilizing PCCA services, including members for whom services are provided by a live-in caregiver. EVV combats fraud, waste, and abuse in several different ways. First, EVV provides for accurate timekeeping of services by automatically recording the exact time a caregiver clocks in and out, which prevents errors in time entry and billing for more time than is actually worked in providing services. Second, EVV provides for location verification at the time of services, to confirm a caregiver's location at the time of reported services. Third, EVV facilitates data analysis to proactively allow provider agencies and the department to identify patterns of potential abuse and other concerns, such as excessively long shifts or inconsistent care delivery. Fourth, EVV reduces administrative burden for

[1] CMS Informational Bulletin, FAQ #1 (Aug. 9, 2019), https://www.medicaid.gov/federal-policy-guidance/downloads/cib080819-2.pdf

provider agencies by allowing for automatic timekeeping, reducing the need for manual paperwork and the potential for errors in billing.

NEW RULE 3

The department is proposing this rule to establish the Medicaid reimbursement rate for PCCA services. The proposed rate of $10.78 per 15-minute increment of service is based primarily on direction provided in HB 449 for the PCCA rate to be comparable to the reimbursement rate for home health services. The current Medicaid rate for home health services is $42.49 per visit. The department added a 1.5% inflationary factor to this rate to reach an hourly amount of $43.13. This amount of $42.13 was divided into four and rounded to the nearest cent to set the PCCA reimbursement rate at $10.78 per 15-minute unit of service.

ARM 37.85.206

The department is proposing to amend this rule to add PCCA services to the list of enumerated Medicaid services available to eligible members. The department is also proposing to amend this rule to correct a grammatical error in (1)(gg).

Fiscal Impact

Based upon past claims data for Medicaid Private Duty Nursing (PDN) services, the department estimates that 20 individuals will use PCCA services, with an average utilization rate of 30 hours per week per individual (1,560 hours annually). The rate for PCCA services equates to $43.12 per hour. The total estimated fiscal impact is $1,345,344 per year (20 members x 1560 hours x $43.12 = $1,345,344 per year).

There is potential for some of these costs to be offset as the department anticipates the availability of PCCA services will result in a reduction in the utilization of PDN services. However, until PCCA services are implemented, the extent of the reduction in utilization of PDN services is unknown and the anticipated cost savings cannot be quantified.

Funds impacted are the federal Medicaid fund source (03583) and general fund source (01100).

Interested Persons

The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by the department. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be emailed, mailed or otherwise delivered to the contact person above.

Bill Sponsor Notification

The bill sponsor contact requirements apply and have been fulfilled. The primary bill sponsor of HB 449 from the 2023 Legislative Session was notified by mail and electronic mail on April 14, 2025.

Small Business Impact

The class of small businesses probably affected by the proposed rules are those seeking to serve as a provider agency for Pediatric Complex Care Assistant (PCCA) services. The probable significant and direct effects of these proposed rules on these small businesses is that the rules create the framework and establish a process for the small businesses to enroll and serve as PCCA provider agencies.

Medicaid Performance-Based Statement

Section 53-6-196, MCA, requires that the department, when adopting by rule proposed changes in the delivery of services funded with Medicaid monies, make a determination of whether the principal reasons and rationale for the rule can be assessed by performance-based measures and, if the requirement is applicable, the method of such measurement. The statute provides that the requirement is not applicable if the rule is for the implementation of rate increases or of federal law.

The department has determined that the proposed program changes presented in this notice are not appropriate for performance-based measurement and therefore are not subject to the performance-based measures requirement of 53-6-196, MCA.

Rule Reviewer

Robert Lishman

Approval

Charles T. Brereton, Director

Department of Public Health and Human Services