



AN ACT PROVIDING FOR PEDIATRIC COMPLEX CARE ASSISTANT SERVICES UNDER THE MEDICAID PROGRAM; ESTABLISHING LICENSURE REQUIREMENTS FOR CARE ASSISTANTS; ALLOWING MEDICAID COVERAGE OF CARE ASSISTANT SERVICES; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 37-1-401, 53-6-101, AND 53-6-402, MCA; AND PROVIDING AN EFFECTIVE DATE AND A TERMINATION DATE.

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

Section 1. Pediatric complex care assistant -- qualifications -- scope of practice. (1) An individual may not practice as a pediatric complex care assistant unless licensed under Title 37, chapter 1, and this chapter.

(2) An applicant for licensure must have:

(a) completed a training program approved by the department and received a valid certificate from the training program; and

(b) passed a hands-on examination approved by the department that demonstrates the applicant's competence.

(3) The training program approved by the department must include medication administration, airway clearance therapies, tracheostomy care, and enteral care and therapy for an individual under 21 years of age.

(4) A pediatric complex care assistant may provide services only to an individual under 21 years of age for whom the care assistant is a parent, guardian, other family member, or kinship care or foster care provider. The services must be:

(a) ordered by a physician and consistent with the individual's plan of care; and

(b) limited to:

- (i) duties considered by the department to be equivalent to those of a certified nursing assistant;
- (ii) medication administration;
- (iii) tracheostomy care and enteral care and therapy;
- (iv) airway clearance therapies; and
- (iv) other services as allowed by the department by rule.

Section 2. Rulemaking. The department shall adopt rules to carry out the purposes of [section 1], including but not limited to:

- (1) training and testing requirements for pediatric complex care assistants;
- (2) application fees; and
- (3) pediatric complex care assistant scope of practice.

Section 3. Section 37-1-401, MCA, is amended to read:

"37-1-401. Uniform regulation for licensing programs without boards -- definitions. As used in this part, the following definitions apply:

- (1) "Complaint" means a written allegation filed with the department that, if true, warrants an injunction, disciplinary action against a licensee, or denial of an application submitted by a license applicant.
- (2) "Department" means the department of labor and industry provided for in 2-15-1701.
- (3) "Investigation" means the inquiry, analysis, audit, or other pursuit of information by the department, with respect to a complaint or other information before the department, that is carried out for the purpose of determining:
 - (a) whether a person has violated a provision of law justifying discipline against the person;
 - (b) the status of compliance with a stipulation or order of the department;
 - (c) whether a license should be granted, denied, or conditionally issued; or
 - (d) whether the department should seek an injunction.
- (4) "License" means permission in the form of a license, permit, endorsement, certificate, recognition, or registration granted by the state of Montana to engage in a business activity or practice at a specific level in a profession or occupation governed by:

(a) Title 37, chapter 2, [sections 1 and 2];

(b) _____ Title 37, chapter 35, 72, or 73; or

~~(b)(c)~~ Title 50, chapter 39, 74, or 76.

(5) "Profession" or "occupation" means a profession or occupation regulated by the department

under the provisions of:

(a) Title 37, chapter 2, [sections 1 and 2];

(b) _____ Title 37, chapter 35, 49, 72, or 73; or

~~(b)(c)~~ Title 50, chapter 39, 74, or 76."

Section 4. Section 53-6-101, MCA, is amended to read:

"53-6-101. Montana medicaid program -- authorization of services. (1) There is a Montana medicaid program established for the purpose of providing necessary medical services to eligible persons who have need for medical assistance. The Montana medicaid program is a joint federal-state program administered under this chapter and in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq. The department shall administer the Montana medicaid program.

(2) The department and the legislature shall consider the following funding principles when considering changes in medicaid policy that either increase or reduce services:

(a) protecting those persons who are most vulnerable and most in need, as defined by a combination of economic, social, and medical circumstances;

(b) giving preference to the elimination or restoration of an entire medicaid program or service, rather than sacrifice or augment the quality of care for several programs or services through dilution of funding; and

(c) giving priority to services that employ the science of prevention to reduce disability and illness, services that treat life-threatening conditions, and services that support independent or assisted living, including pain management, to reduce the need for acute inpatient or residential care.

(3) Medical assistance provided by the Montana medicaid program includes the following services:

(a) inpatient hospital services;

(b) outpatient hospital services;

- (c) other laboratory and x-ray services, including minimum mammography examination as defined in 33-22-132;
 - (d) skilled nursing services in long-term care facilities;
 - (e) physicians' services;
 - (f) nurse specialist services;
 - (g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age, in accordance with federal regulations and subsection (10)(b);
 - (h) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;
 - (i) targeted case management services, as authorized in 42 U.S.C. 1396n(g), for high-risk pregnant women;
 - (j) services that are provided by physician assistants within the scope of their practice and that are otherwise directly reimbursed as allowed under department rule to an existing provider;
 - (k) health services provided under a physician's orders by a public health department;
 - (l) federally qualified health center services, as defined in 42 U.S.C. 1396d(l)(2);
 - (m) routine patient costs for qualified individuals enrolled in an approved clinical trial for cancer as provided in 33-22-153;
 - (n) for children 18 years of age and younger, habilitative services as defined in 53-4-1103; and
 - (o) services provided by a person certified in accordance with 37-2-318 to provide services in accordance with the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.
- (4) Medical assistance provided by the Montana medicaid program may, as provided by department rule, also include the following services:
- (a) medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;
 - (b) home health care services, including services provided by pediatric complex care assistants licensed pursuant to [section 1];
 - (c) private-duty nursing services;
 - (d) dental services;

- (e) physical therapy services;
 - (f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 10;
 - (g) clinical social worker services;
 - (h) prescribed drugs, dentures, and prosthetic devices;
 - (i) prescribed eyeglasses;
 - (j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;
 - (k) inpatient psychiatric hospital services for persons under 21 years of age;
 - (l) services of professional counselors licensed under Title 37, chapter 23;
 - (m) hospice care, as defined in 42 U.S.C. 1396d(o);
 - (n) case management services, as provided in 42 U.S.C. 1396d(a) and 1396n(g), including targeted case management services for the mentally ill;
 - (o) services of psychologists licensed under Title 37, chapter 17;
 - (p) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C. 1396d(h), in a residential treatment facility, as defined in 50-5-101, that is licensed in accordance with 50-5-201;
 - (q) services of behavioral health peer support specialists certified under Title 37, chapter 38, provided to adults 18 years of age and older with a diagnosis of a mental disorder, as defined in 53-21-102; and
 - (r) any additional medical service or aid allowable under or provided by the federal Social Security Act.
- (5) Services for persons qualifying for medicaid under the medically needy category of assistance, as described in 53-6-131, may be more limited in amount, scope, and duration than services provided to others qualifying for assistance under the Montana medicaid program. The department is not required to provide all of the services listed in subsections (3) and (4) to persons qualifying for medicaid under the medically needy category of assistance.
- (6) In accordance with federal law or waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department may implement limited medicaid benefits, to be known as basic medicaid, for adult recipients who are eligible because they are receiving cash assistance, as defined in 53-4-201, as the specified caretaker relative of a dependent child and for all adult recipients of

medical assistance only who are covered under a group related to a program providing cash assistance, as defined in 53-4-201. Basic medicaid benefits consist of all mandatory services listed in subsection (3) but may include those optional services listed in subsections (4)(a) through (4)(r) that the department in its discretion specifies by rule. The department, in exercising its discretion, may consider the amount of funds appropriated by the legislature, whether approval has been received, as provided in 53-1-612, and whether the provision of a particular service is commonly covered by private health insurance plans. However, a recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage.

(7) The department may implement, as provided for in Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, a program under medicaid for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

(8) (a) The department may set rates for medical and other services provided to recipients of medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

(b) The department shall strive to close gaps in services provided to individuals suffering from mental illness and co-occurring disorders by doing the following:

(i) simplifying administrative rules, payment methods, and contracting processes for providing services to individuals of different ages, diagnoses, and treatments. Any adjustments to payments must be cost-neutral for the biennium beginning July 1, 2017.

(ii) publishing a report on an annual basis that describes the process that a mental health center or chemical dependency facility, as those terms are defined in 50-5-101, must utilize in order to receive payment from Montana medicaid for services provided to individuals of different ages, diagnoses, and treatments.

(9) The services provided under this part may be only those that are medically necessary and that are the most efficient and cost-effective.

(10) (a) The amount, scope, and duration of services provided under this part must be determined by the department in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended.

(b) The department shall, with reasonable promptness, provide access to all medically necessary services prescribed under the early and periodic screening, diagnosis, and treatment benefit, including access

to prescription drugs and durable medical equipment for which the department has not negotiated a rebate.

(11) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

(12) (a) Prior to enacting changes to provider rates, medicaid waivers, or the medicaid state plan, the department of public health and human services shall report this information to the following committees:

(i) the children, families, health, and human services interim committee;

(ii) the legislative finance committee; and

(iii) the health and human services budget committee.

(b) In its report to the committees, the department shall provide an explanation for the proposed changes and an estimated budget impact to the department over the next 4 fiscal years.

(13) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program after taking into consideration the funding principles set forth in subsection (2). (Subsection (3)(o) terminates September 30, 2023--sec. 7, Ch. 412, L. 2019.)"

Section 5. 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 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) services provided by a licensed pediatric complex care assistant as authorized under [sections

1 and 2]:

~~(d)~~(e) personal care services;

~~(e)~~(f) adult day health services;

~~(f)~~(g) habilitation services;

~~(g)~~(h) respite care services; and

~~(h)~~(i) 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, including rules for substantive changes to approved waiver provisions as required under 53-6-413. The rules may include but are not limited to the following:

- (i) the populations or subsets of populations, as provided in subsection (7), to be served in each program;
- (ii) limits on enrollment;
- (iii) limits on per capita expenditures;

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

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

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

(vii) provider requirements and reimbursement;

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

(ix) utilization measures;

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

(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.

(c) Reimbursement rates for pediatric complex care assistants licensed pursuant to [section 1] must reflect the special skills needed to meet the health care needs of the individuals receiving the services and must be comparable to the reimbursement rate for home health aide services.

(14) The department shall establish by rule the procedures for moving a person from a waiting list for services provided through a medicaid home and community-based services waiver into the waiver services, including the process and priorities to be used in making determinations related to the waiting list. The department may not modify the policies established in rule by adopting supplemental policies or procedures not subject to the administrative rulemaking process.

(15) 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.

(16) 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 6. Codification instruction. [Sections 1 and 2] are intended to be codified as a new part in Title 37, chapter 2, and the provisions of Title 37, chapter 2, apply to [sections 1 and 2].

Section 7. Coordination instruction. If both House Bill No. 152 and [this act] are passed and approved, and House Bill No. 152 contains one or more sections giving the department of labor and industry authority to adopt rules for professional and occupational licensing programs, then [section 2 of this act] is void.

Section 8. Coordination instruction. If both House Bill No. 152 and [this act] are passed and approved and House Bill No. 152 repeals 37-1-401, then [section 3 of this act], amending 37-1-401, is void.

Section 9. Effective date. [This act] is effective July 1, 2023.

Section 10. Termination. [This act] terminates June 30, 2031.

- END -

I hereby certify that the within bill,
HB 449, originated in the House.

Chief Clerk of the House

Speaker of the House

Signed this _____ day
of _____, 2023.

President of the Senate

Signed this _____ day
of _____, 2023.

HOUSE BILL NO. 449

INTRODUCED BY A. BUCKLEY, E. BUTTREY, D. SALOMON, T. WELCH, D. HARVEY, D. BEDEY, G.

NIKOLAKAKOS

AN ACT PROVIDING FOR PEDIATRIC COMPLEX CARE ASSISTANT SERVICES UNDER THE MEDICAID PROGRAM; ESTABLISHING LICENSURE REQUIREMENTS FOR CARE ASSISTANTS; ALLOWING MEDICAID COVERAGE OF CARE ASSISTANT SERVICES; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 37-1-401, 53-6-101, AND 53-6-402, MCA; AND PROVIDING AN EFFECTIVE DATE AND A TERMINATION DATE.