BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of ARM 37.27.905, 37.85.104, 37.85.105, 37.85.106, 37.85.406, 37.86.105, 37.86.205, 37.86.506, 37.86.1006, 37.86.1807, 37.86.2002, 37.86.2102, 37.86.2803, 37.86.2918, 37.86.3001, 37.86.3025, 37.86.3902, 37.86.3906, 37.87.903, 37.87.1226, 37.87.1401, 37.88.206, 37.88.306, 37.88.606, and repeal of ARM 37.86.3031, 37.86.3033, 37.86.3035, 37.86.3037, pertaining to Medicaid rate, service, and benefit changes	)	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT AND REPEAL

TO: All Concerned Persons

1. On February 1, 2018, at 1:00 p.m., the Department of Public Health and Human Services will hold a public hearing in the auditorium of the Department of Public Health and Human Services Building, 111 North Sanders, Helena, Montana, to consider the proposed amendment and repeal of the above-stated rules.

Participation in the hearing is also available via Webex teleconferencing by registering as an attendee prior to the hearing at the following internet address: https://hhsmt.webex.com/hhsmt/onstage/g.php?MTID=e4cc5e6fbbf7773a5c95c4df753320b6e.

2. The Department of Public Health and Human Services 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. If you require an accommodation, contact the Department of Public Health and Human Services no later than 5:00 p.m. on January 22, 2018, to advise us of the nature of the accommodation that you need. Please contact Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; telephone (406) 444-4094; fax (406) 444-9744; or e-mail dphhslegal@mt.gov.

3. The rules as proposed to be amended provide as follows, new matter underlined, deleted matter interlined:

<u>37.27.905 MEDICAID SUBSTANCE USE DISORDER SERVICES: REIMBURSEMENT</u> (1) through (3) remain the same.

<u>(4) The allowable non-Medicaid substance use disorder procedure billing codes and department fee schedules are available at the department's website</u>

located at http://medicaidprovider.mt.gov/ and incorporated by reference at ARM 37.85.104.

(5) The allowable Medicaid substance use disorder reimbursement rate for case management services for members with substance use disorder is stated in the department's fee schedule provided in ARM 37.85.106.

AUTH: 53-6-113, 53-24-204, 53-24-208, 53-24-209, MCA
IMP: 53-6-101, 53-24-204, 53-24-208, 53-24-209, MCA

37.85.104 EFFECTIVE DATES OF PROVIDER FEE SCHEDULES FOR MONTANA NON-MEDICAID SERVICES (1) The department adopts and incorporates by reference the fee schedule for the following programs within the Addictive and Mental Disorders Division and Developmental Services Division on the dates stated:

(a) and (b) remain the same.

(c) Youth respite care services, as provided in ARM 37.87.2203, is effective ~~January 1, 2018~~ March 1, 2018.

(d) Substance use disorder services provider reimbursement, as provided in ARM ~~37.27.908~~ 37.27.905, is effective ~~January 1, 2018~~ March 1, 2018.

(2) remains the same.

AUTH: 53-2-201, 53-6-101, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, MCA

37.85.105 EFFECTIVE DATES, CONVERSION FACTORS, POLICY ADJUSTERS, AND COST-TO-CHARGE RATIOS OF MONTANA MEDICAID PROVIDER FEE SCHEDULES (1) remains the same.

(2) The department adopts and incorporates by reference, the resource-based relative value scale (RBRVS) reimbursement methodology for specific providers as described in ARM 37.85.212 on the date stated.

(a) remains the same.

(b) Fee schedules are effective ~~January 1, 2018~~ March 1, 2018. The conversion factor for physician services is $36.53. The conversion factor for allied services is $24.29. The conversion factor for mental health services is $24.07. The conversion factor for anesthesia services is $28.87.

(c) through (j) remain the same.

(3) The department adopts and incorporates by reference, the fee schedule for the following programs within the Health Resources Division, on the date stated.

(a) The inpatient hospital services fee schedule and inpatient hospital base fee schedule rates including:

(i) the APR-DRG fee schedule for inpatient hospitals as provided in ARM 37.86.2907, effective ~~January 1, 2018~~ March 1, 2018; and

(ii) the Montana Medicaid APR-DRG relative weight values, average national length of stay (ALOS), outlier thresholds, and APR grouper version 34 are contained in the APR-DRG Table of Weights and Thresholds effective ~~January 1, 2018~~ March 1, 2018. The department adopts and incorporates by reference the APR-DRG Table of Weights and Thresholds effective ~~January 1, 2018~~ March 1, 2018.

(b) The outpatient hospital services fee schedules including:

(i) the Outpatient Prospective Payment System (OPPS) fee schedule as published by the Centers for Medicare and Medicaid Services (CMS) in ~~81 Federal Register 219, page 79562~~ 82 Federal Register 217, effective ~~January 1, 2017~~ January 1, 2018, and reviewed annually by CMS as required in 42 CFR 419.5 (2016) as updated by the department;

(ii) the conversion factor for outpatient services on or after ~~January 1, 2018~~ March 1, 2018 is ~~$54.95~~ $49.46;

(iii) and (c) remain the same.

(d) The Relative Values for Dentists, as provided in ARM 37.86.1004, reference published in 2017 resulting in a dental conversion factor of $32.77 and fee schedule is effective ~~January 1, 2018~~ March 1, 2018.

(e) The dental services covered procedures, the Dental and Denturist Program Provider Manual, as provided in ARM 37.86.1006, is effective ~~July 1, 2016~~ March 1, 2018.

(f) through (j) remain the same.

(k) Montana Medicaid adopts and incorporates by reference the Region D Supplier Manual, effective January 1, 2018, which outlines the Medicare coverage criteria for Medicare covered durable medical equipment, local coverage determinations (LCDs), and national coverage determinations (NCDs) as provided in ARM 37.86.1802, effective January 1, 2018. The prosthetic devices, durable medical equipment, and medical supplies fee schedule, as provided in ARM 37.86.1807, is effective ~~January 1, 2018~~ March 1, 2018.

(l) through (u) remain the same.

(v) The Targeted Case Management for Children and Youth with Special Health Care Needs fee schedule, as provided in ARM 37.86.3910, is effective ~~January 1, 2018~~ March 1, 2018.

(w) through (4) remain the same.

(5) The department adopts and incorporates by reference, the fee schedule for the following programs within the Addictive and Mental Disorders Division on the date stated:

(a) and (b) remain the same.

(c) Substance use disorder services reimbursement, as provided in ARM ~~37.27.908~~ 37.27.905, is effective ~~January 1, 2018~~ March 1, 2018.

(6) The department adopts and incorporates by reference, the fee schedule for the following programs within the Developmental Services Division, on the date stated: Mental health services for youth, as provided in ARM 37.87.901 in the Medicaid Youth Mental Health Services Fee Schedule, is effective ~~January 1, 2018~~ March 1, 2018.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-402, MCA

37.85.106 MEDICAID BEHAVIORAL HEALTH TARGETED CASE MANAGEMENT FEE SCHEDULE (1) remains the same.

(2) The Department of Public Health and Human Services (department) adopts and incorporates by reference the Medicaid Behavioral Health Targeted

Case Management Fee Schedule effective January 1, 2018, for the following programs within the Developmental Services Division (DSD) and the Addictive and Mental Disorders Division (AMDD):

(a) remains the same.

(b) Targeted Case Management Services for Substance Use Disorders (SUD), as provided in ARM ~~37.86.4010~~ 37.27.905; and

(c) and (3) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-402, MCA

37.85.406 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT (1) through (20) remain the same.

(21) ~~The method of determining payment rates for provider based entities will be the same as for other professional and facility providers except as otherwise provided in ARM 37.86.3031 and 37.86.3037.~~ Montana Medicaid does not reimburse for the facility component of a Provider Based entity service.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131, 53-6-149, MCA

37.86.105 PHYSICIAN SERVICES, REIMBURSEMENT/GENERAL REQUIREMENTS AND MODIFIERS (1) through (7) remain the same.

~~(8) Reimbursement and claim completion instructions for Medicaid designated provider based entities are found in ARM 37.86.3031, 37.86.3033, 37.86.3035, and 37.86.3037.~~

(9) through (12) remain the same, but are renumbered (8) through (11).

AUTH: 53-6-101, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, MCA

37.86.205 MID-LEVEL PRACTITIONER SERVICES, REQUIREMENTS AND REIMBURSEMENT (1) through (7) remain the same.

~~(8) Reimbursement and claim completion instructions for Medicaid designated provider based entities are found in ARM 37.86.3031 and 37.86.3037.~~

(9) through (11) remain the same, but are renumbered (8) through (10).

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, MCA

37.86.506 PODIATRY SERVICES, REIMBURSEMENT (1) remains the same.

~~(2) Reimbursement and claim completion instructions for Medicaid designated provider based entities are found in ARM 37.86.3031 and 37.86.3037.~~

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-111, 53-6-131, 53-6-141, MCA

37.86.1006 DENTAL SERVICES, COVERED PROCEDURES (1) through (4) remain the same.

(5) Covered services for adults age 21 and over include:

(a) and (b) remain the same.

(c) basic restorative services ~~including prefabricated crowns~~; and

(d) extractions~~; and~~ .

~~(e) porcelain fused to base metal crowns with prior authorization, limited to two per person per year, total. For second molars base metal crowns only.~~

(6) remains the same.

~~(7) Full maxillary and full mandibular dentures are a Medicaid covered service. Coverage is limited to one set of dentures every ten years. Only one lifetime exception to the ten-year time period is allowed per person if one of the following exceptions is authorized by the department:~~

~~(a) The dentures are no longer serviceable and cannot be relined or rebased.~~

~~(b) The dentures are lost, stolen, or damaged beyond repair.~~

~~(8) Maxillary partial dentures and mandibular partial dentures are a Medicaid covered service. Coverage is limited to one set of partial dentures every five years. Only one lifetime exception to the five-year limit is allowed per person if one of the following exceptions is authorized by the department:~~

~~(a) The partial dentures are no longer serviceable and cannot be relined or rebased.~~

~~(b) The partial dentures are lost, stolen, or damaged beyond repair.~~

~~(9) The limits on coverage of denture replacement may be exceeded when the department determines that the existing dentures are causing the person serious physical health problems.~~

~~(a) The dentist or denturist must indicate "replacement dentures" on the request for prior authorization of replacement dentures and document the medical necessity for the replacement.~~

~~(10) Coverage of all denture services is subject to the following requirements and limitations:~~

~~(a) A denturist may provide initial immediate full prosthesis and initial immediate partial prosthesis only when prescribed in writing by a dentist. The prescription must be signed and dated within 90 days and must be maintained in the patient file.~~

~~(b) Requests for full prosthesis must show the approximate date of the most recent extractions, and/or the age and type of the present prosthesis.~~

(11) remains the same, but is renumbered (7).

~~(12)~~ (8) Full band ~~orthodontia~~ comprehensive orthodontic or interceptive orthodontic treatment for persons ~~21~~ 20 and younger who have ~~malocclusion caused by traumatic injury or needed as part of treatment for a medical condition with orthodontic implications are covered in the department's Dental and Denturist Program Provider Manual.~~ one of the following handicapping conditions, indicated with an 'X' on the HLD score sheet:

(a) cleft palate;

(b) deep impinging overbite;

(c) anterior impaction; or

(d) who score a 30 or higher without a handicapping condition (as listed above) on the Handicapping Labio-Lingual Form (HLD Index).

~~(13)~~ (9) Unless otherwise provided by these rules, interceptive orthodontia is limited to children 12 years of age or younger with one or more of the following conditions:

(a) posterior unilateral crossbite ~~with shift~~;

(b) bilateral crossbite;

(b) remains the same, but is renumbered (c).

~~(14)~~ (10) All ~~full band~~ orthodontia treatment plans ~~for cleft lip/palate, congenital anomalies, cases related to malocclusion caused by traumatic injury and cases related to interceptive orthodontia~~ must receive prior authorization from the department's designated peer reviewer to determine individual eligibility for such orthodontia services.

(15) through (17) remain the same, but are renumbered (11) through (13).

~~(18)~~ (14) ~~Porcelain/ceramic crowns, noble metal crowns, and bridges~~ All crowns and bridges are not covered benefits of the Medicaid program for individuals age 21 and over.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, MCA

37.86.1807 PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES, FEE SCHEDULE (1) and (2) remain the same.

(3) The department's DMEPOS Fee Schedule for items other than those billed under generic or miscellaneous codes as described in (1) will include fees set and maintained according to the following methodology:

(a) remains the same.

(b) 100% of the Medicaid allowable fee established by the department if there is no Medicare region D allowable fee established; or

~~(b)~~ (c) Except as provided in (4), for all items for which no Medicare or Medicaid allowable fee is available, the department's fee schedule amount will be 72.8% of the provider's usual and customary charge.

(i) For purposes of (3)~~(b)~~(c) and (4), the amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers.

(A) through (4) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

37.86.2002 OPTOMETRIC SERVICES, REQUIREMENTS (1) and (2) remain the same.

(3) A Medicaid member under 21 years of age is limited to one eye examination for determination of refractive state per 365-day period. A Medicaid member 21 years of age or older is limited to one eye examination for determination of refractive state per 730-day period unless one of the following circumstances exist:

(a) and (b) remain the same.

AUTH: 53-6-113, MCA
IMP: 53-6-101, 53-6-141, MCA

37.86.2102 EYEGLASSES, SERVICES, REQUIREMENTS AND RESTRICTIONS (1) through (3) remain the same.

~~(4) A member is limited to one pair of eyeglasses per 365-day period unless additional pairs are necessary due to any of the following circumstances:~~

(4) A member under 21 years of age is limited to one pair of eyeglasses per 365-day period and a member 21 years of age or older is limited to one pair of eyeglasses every 730-day period.

(5) A member may receive additional lenses in the following circumstances:

(a) through (f) remain the same.

(g) a minimum of a 3 degree change in axis of any cylinder greater than 3.00 diopters; or

(h) any 1 prism diopter or more change in lateral prism~~; or~~.

~~(i) the inability of the member to wear bifocals because of a diagnosed medical condition.~~

~~(5) In the circumstances described in (4)(a) through (i), the member may be allowed two pairs of single vision eyeglasses every 365-day period.~~

(6) and (7) remain the same.

(8) If a member is unable to wear bifocals because of a diagnosed medical condition and a provider requests an exception:

(a) a member under 21 years of age may be allowed two pairs of single vision eyeglasses every 365-day period; and

(b) a member 21 years of age and older may be allowed two pairs of single vision eyeglasses every 730-day period.

~~(8)~~ (9) Contact lenses may be provided only if medically necessary.

(a) The limits stated in ~~(4)~~ (5) and ~~(5)~~ (6) apply to contacts.

(b) remains the same.

AUTH: 53-6-113, MCA
IMP: 53-6-101, 53-6-141, MCA

37.86.2803 ALL HOSPITAL REIMBURSEMENT, COST REPORTING

(1) remains the same.

(2) All hospitals reimbursed under ARM 37.86.2806, 37.86.2905, 37.86.2907, 37.86.2912, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, 37.86.2928, 37.86.2943, 37.86.2947, 37.86.3005, 37.86.3006, 37.86.3007, 37.86.3009, 37.86.3014, 37.86.3016, 37.86.3018, 37.86.3020, 37.86.3022, 37.86.3025, ~~37.86.3037,~~ or 37.86.3109 must submit, as provided in (3), an annual Medicare cost report in which costs have been allocated to the Medicaid program as they relate to charges. The facility shall maintain appropriate accounting records which will enable the facility to fully complete the cost report.

(3) All hospitals reimbursed under ARM 37.86.2806, 37.86.2905, 37.86.2907, 37.86.2912, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925,

37.86.2928, 37.86.2943, 37.86.2947, 37.86.3005, 37.86.3006, 37.86.3007, 37.86.3009, 37.86.3014, 37.86.3016, 37.86.3018, 37.86.3020, 37.86.3022, 37.86.3025, ~~37.86.3037,~~ or 37.86.3109 must file the cost report with the Montana Medicare intermediary and the department on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

(a) remains the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-149, MCA

37.86.2918 INPATIENT HOSPITAL READMISSIONS, PARTIAL ELIGIBILITY, OUTPATIENT BUNDLING, AND TRANSFERS FOR PROSPECTIVE PAYMENT SYSTEM (PPS) FACILITIES (1) and (2) remain the same.

(3) Outpatient hospital services, including ~~provider-based entity hospital outpatient services,~~ emergency room services~~,~~ and diagnostics services (including clinical diagnostic laboratory tests) that are provided by an entity owned or operated by the hospital and occur the day of or the day before the inpatient hospital admission are deemed to be inpatient services and must be bundled into the inpatient claim.

(4) remains the same.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3001 OUTPATIENT HOSPITAL SERVICES, DEFINITIONS

(1) through (19) remain the same.

(20) "Provider-based entity" means a provider that is either created by, or acquired by, a main provider for purposes of furnishing health care services under the name, ownership, and administrative and financial control of the main provider as in 42 CFR 413.65. ~~Both professional and facility (hospital outpatient department) providers are included together under this definition. For purposes of provider-based entity billing, a professional is a physician, podiatrist, mid-level, licensed clinical social worker, licensed professional counselor, or a licensed psychologist.~~

(21) through (23) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3025 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT FOR SERVICES NOT PAID UNDER THE AMBULATORY PAYMENT CLASSIFICATION SYSTEM (1) through (3) remain the same.

(4) Professional services~~, except as in ARM 37.86.3031 and 37.86.3037,~~ must bill separately on a professional billing form according to applicable rules governing billing for professional services.

(5) and (6) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3902 TARGETED CASE MANAGEMENT SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS, ELIGIBILITY (1) A child is eligible for targeted case management services for children and youth with special health care needs if the child meets all of the following:

(a) ~~the child~~ is receiving Medicaid or is presumptively eligible for Medicaid;

(b) ~~the child:~~

~~(i)~~ is birth through 18 years of age;

~~(ii) is diagnosed with special health care needs or at risk for chronic physical, developmental, behavioral, or emotional conditions; and~~

~~(iii) requires health and related services of a type or amount beyond that required by children of the same age; or~~

~~(c) the child is born to a woman who received targeted case management services as a high risk pregnant woman.~~

(c) has one or more of the following physical health conditions that is expected to last at least 12 months:

(i) is infected with the human immunodeficiency virus (HIV), as determined by a positive HIV antibody or antigen test, or who has a diagnosis of HIV disease or AIDS;

(ii) has been diagnosed with a congenital heart condition;

(iii) has been diagnosed with a neurological disorder or brain injury;

(iv) has been diagnosed with a condition that requires use of a ventilator;

(v) has been diagnosed with a condition that causes paraplegia or quadriplegia; or

(vi) has been diagnosed with another chronic physical health condition that causes difficulty performing activities of daily living; and

(d) is at high risk for medical compromise due to one of the following:

(i) failure to take advantage of necessary health care services;

(ii) noncompliance with their prescribed medication regime;

(iii) an inability to coordinate multiple medical, social, and other services; or

(iv) a lack of community support system to assist in appropriate follow-up care at home.

(2) and (3) remain the same.

AUTH: 53-6-113, MCA
IMP: 53-6-101, MCA

37.86.3906 TARGETED CASE MANAGEMENT SERVICES FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS, PROVIDER REQUIREMENTS (1) and (2) remain the same.

(3) A targeted case management provider must use an interdisciplinary team that includes members from the professions of nursing~~,~~ and social work~~, and nutrition~~.

(a) The professional requirements are the following:

(i) and (A) remain the same.

(B) a certified nurse practitioner; and

(ii) through (B) remain the same.

(C) bachelor's in social work (BSW) with two years' experience in community social services or public health~~; and~~.

~~(iii) nutrition services must be provided by a registered dietitian who is licensed as a nutritionist in Montana and has one-year experience in public health or maternal-child health.~~

(b) through (8) remain the same.

AUTH: 53-6-113, MCA
IMP: 53-6-101, MCA

37.87.903 MEDICAID MENTAL HEALTH SERVICES FOR YOUTH, AUTHORIZATION REQUIREMENTS (1) and (2) remain the same.

(3) Youth are not required to have a serious emotional disturbance to receive the following outpatient therapy services:

(a) the first ~~24~~ 10 sessions of individual, family, or both outpatient therapies per state fiscal year. Group outpatient therapy is not included in the ~~24~~ 10-session limit; and

(b) remains the same.

(4) through (6) remain the same.

(7) In addition to the requirements contained in rule, the department has developed and published a provider manual entitled Children's Mental Health Bureau, Medicaid Services Provider Manual (Manual), dated ~~August 6, 2016~~ March 1, 2018, for the purpose of implementing requirements for utilization management. The department adopts and incorporates by reference the Children's Mental Health Bureau, Medicaid Services Provider Manual, dated ~~August 6, 2016~~ March 1, 2018. A copy of the manual may be obtained from the department by a request in writing to the Department of Public Health and Human Services, Developmental Services Division, Children's Mental Health Bureau, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210 or at http://dphhs.mt.gov/dsd/CMB/Manuals.aspx.

(8) and (9) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, MCA

37.87.1226 OUT-OF-STATE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES, REIMBURSEMENT (1) Reimbursement for the out-of-state Psychiatric Residential Treatment Facility (PRTF) is established in the department's Medicaid fee schedule, as adopted in ARM 37.85.105. The maximum daily rate paid to an out-of-state PRTF facility is equal to 133% of the in-state PRTF rate. The in-state PRTF rate is published in the Medicaid Mental Health Youth Under 18 Fee Schedule referenced at ARM 37.85.105.

(2) through (4) remain the same.

AUTH: 53-6-101, MCA

IMP: 53-6-113, MCA

37.87.1401 HOME SUPPORT SERVICES AND THERAPEUTIC FOSTER CARE, SERVICES REIMBURSEMENT (1) and (2) remain the same.

(3) HSS and TFC providers are reimbursed a daily ~~or patient day~~ rate. ~~Patient day means a whole 24-hour period that a youth is present and receiving HSS or TFC services. Even though a youth may not be present for a whole 24-hour period, the day of admission is a patient day. The day of discharge is not a patient day.~~ To receive the daily rate, the provider must have contact as described in ARM 37.87.1410(6). The department will not reimburse the daily rate for any telephone contacts that exceed the number of face-to-face contacts reimbursed for in a four-week period. Reimbursement is limited to one contact per day.

(4) remains the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, MCA

37.88.206 LICENSED CLINICAL SOCIAL WORK SERVICES, REIMBURSEMENT (1) and (2) remain the same.

~~(3) Reimbursement and claim completion instructions for Medicaid designated provider based entities are found in ARM 37.86.3031 and 37.86.3037.~~

AUTH: 53-2-201, 53-6-113, 53-21-703, MCA
IMP: 53-1-601, 53-1-602, 53-1-603, 53-6-101, 53-6-113, 53-21-202, 53-21-701, 53-21-702, MCA

37.88.306 LICENSED PROFESSIONAL COUNSELOR SERVICES, REIMBURSEMENT (1) and (2) remain the same.

~~(3) Reimbursement and claim completion instructions for Medicaid designated provider based entities are found in ARM 37.86.3031 and 37.86.3037.~~

AUTH: 53-2-201, 53-6-113, 53-21-703, MCA
IMP: 53-1-601, 53-1-602, 53-1-603, 53-6-101, 53-6-113, 53-21-201, 53-21-202, 53-21-701, 53-21-702, MCA

37.88.606 LICENSED PSYCHOLOGIST SERVICES, REIMBURSEMENT

(1) and (2) remain the same.

~~(3) Reimbursement and claim completion instructions for Medicaid designated provider based entities are found in ARM 37.86.3031 and 37.86.3037.~~

AUTH: 53-2-201, 53-6-113, 53-21-703, MCA
IMP: 53-1-601, 53-1-602, 53-1-603, 53-6-101, 53-6-113, 53-21-202, 53-21-701, 53-21-702, MCA

4. The department proposes to repeal the following rules:

37.86.3031 PROVIDER BASED ENTITY SERVICES, GENERAL Found on page 37-20525 of the Administrative Rules of Montana.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, MCA

37.86.3033 PROVIDER-BASED ENTITY SERVICES, RECIPIENT ACCESS AND NOTIFICATION Found on page 37-20526 of the Administrative Rules of Montana.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, MCA

37.86.3035 PROVIDER BASED ENTITY SERVICES, COMPLIANCE, AND PENALTIES Found on page 37-20527 of the Administrative Rules of Montana.

AUTH: 53-6-101, 53-6-113, MCA
IMP: 53-6-101, MCA

37.86.3037 PROVIDER-BASED ENTITY SERVICES, REIMBURSEMENT Found on page 37-20528 of the Administrative Rules of Montana.

AUTH: 53-6-101, 53-6-113, MCA
IMP: 53-6-101, MCA

5. STATEMENT OF REASONABLE NECESSITY

The Department of Public Health and Human Services (department) administers the Montana Medicaid and non-Medicaid programs to provide health care to Montana's qualified low income, elderly and disabled residents. Medicaid is a public assistance program paid for with state and federal funds appropriated to pay health care providers for the covered medical services they deliver to Medicaid members. Non-Medicaid programs are funded primarily with state funds or grants. The legislature delegates authority to the department to set the reimbursement rates Montana pays providers for covered services.

In November of 2017, the governor called a special session to address the variances in revenue and high fire season expenditures. The governor and the legislature worked together to reach a compromise to bring the budget into balance. That compromise included a number of proposed spending reductions and a reduction to the DPHHS budget of $49 million general fund dollars.

Medicaid rates and services are stated in administrative rule. The rule amendments in this notice of proposed rulemaking are to implement the necessary spending reductions. The rule amendments in this notice of proposed rulemaking are proposed to implement the mandatory spending reductions under 17-7-140, MCA. The proposed rule amendments include program eliminations and reductions in

rates and services. In proposing the rates of reimbursement in this rule notice, the department primarily considered the availability of appropriated funds, as provided in 53-6-113(3), MCA. In considering service reductions proposed in this rule notice, the department considered the factors set forth in 53-6-101, MCA as follows:

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.

These rules apply to services for all people and eligibility categories for Montana Medicaid, including the Montana Medicaid Health and Economic Livelihood Partnership (HELP) Program that serves the Medicaid Expansion population.

The following summaries describe in detail the proposed rule amendments to be made:

ARM 37.27.905(4) and (5)

The department proposes to add (4) and (5) to refer to ARM 37.85.104, which is the non-Medicaid substance use disorder reimbursement rates, and ARM 37.85.106, which is the Medicaid substance use disorder reimbursement rates, for targeted case management. When this rule was promulgated as New Rule IV in MAR Notice No. 37-736, the department forgot to include cross-references to those rules.

ARM 37.85.104(1)(c)

Although the department proposes no changes to youth respite care services, the date for this fee schedule must be amended to March 1, 2018, because the department is proposing changes in other parts of that fee schedule and the date will be changed. See below, at ARM 37.85.105(6).

ARM 37.85.104(1)(d)

The Addictive and Mental Disorders Division (AMDD) proposes to change the citation to the rule referred to in this subsection to accurately cite the correct rule, ARM 37.27.905. Also, AMDD proposes to update the Substance Use Disorder Non-Medicaid Fee Schedule. The fee schedule will be effective March 1, 2018. The reason for updating the fee schedule is to change reimbursement methodology from the Healthcare Common Procedure Coding System (HCPC) to the national standard

Current Procedural Terminology (CPT) codes. The change from HCPC codes to CPT codes will align service requirements and reimbursement methodology for substance use disorder treatment providers with other behavioral health professionals, including mental health professionals. The change affects three codes: assessment, individual therapy, and group therapy.

In addition, the rule referred to in this subsection has been corrected to refer to ARM 37.27.905. This change corrects a reference to a rule that was repealed in MAR Notice No. 37-736.

ARM 37.85.105(2)(b)

The department proposes to update the physician fee schedule to eliminate reimbursement for the provider based facility component billed under revenue code 510. The change is intended to reimburse provider based entities in the same manner as other professional service providers, none of whom receive reimbursement for a facility component.

ARM 37.85.105(3)(a)

The department proposes to update fee schedules referenced here to decrease the base rates for general hospitals. This reduction does not apply to the base rates for Center of Excellence hospitals to ensure members have continued access to services that are not available in Montana.

ARM 37.85.105(3)(b)

The department proposes to update the reference from 81 Federal Register 219, effective January 1, 2017, to 82 Federal Register 217, effective January 1, 2018. This change is necessary to reflect the latest available Federal Register from the Centers for Medicare and Medicaid Services (CMS). This adoption allows providers to submit claims using the most recent codes and fees available; otherwise, the provider may need to bill Medicaid using different codes than other major payers, such as Medicare, resulting in administrative inefficiencies. In addition, the department is proposing a reduction of the outpatient conversion factor that is used for outpatient services.

ARM 37.85.105(3)(d) and (e)

The department proposes to update the fee schedules for dental services to reduce or eliminate coverage of high cost, extensive dental procedures, and dentures for adults. The department will continue to provide preventive and diagnostic dental services, along with a basic restorative package. These changes result in a required update to the effective date of the fee schedule to March 1, 2018. The department proposes to update the Dental and Denturist Program Provider Manual, to reflect changes outlined in ARM 37.86.1006.

ARM 37.85.105(3)(k)

The department proposes to adopt a new fee schedule, effective March 1, 2018, which implements a reduction in the reimbursement rate for incontinence supplies. A full explanation of the proposed reduction in incontinence supplies reimbursement can be found later in this notice, in the explanation for ARM 37.86.1807.

ARM 37.85.105(3)(v)

The department proposes to adopt a new fee schedule, effective March 1, 2018, which reduces the reimbursement rate of Targeted Case Management for Children and Youth with Special Health Care Needs. The proposed reimbursement rate will match the reimbursement rate for Targeted Case Management for High Risk Pregnant Women.

ARM 37.85.105(5)(c)

The department proposes to change the citation to the rule referred to in this subsection to accurately cite the correct rule, ARM 37.27.905. The change corrects a citation to the wrong rule, which was repealed in MAR Notice No. 37-736. Also, the department proposes to revise the substance use disorder Medicaid Provider Fee Schedule to reflect the change from HCPC to CPT reimbursement codes, which will be effective March 1, 2018. See explanation above for ARM 37.85.104(1)(d).

ARM 37.85.105(6)

The department proposes to adopt an updated Youth Mental Health Services Fee Schedule, which is amended to impose a cap on the daily rate for out-of-state psychiatric residential treatment facilities (PRTFs) at 133% of the in-state PRTF rate. This limit is necessary because some out-of-state providers have a usual and customary charge that is considerably higher than other out-of-state providers and higher than the daily rate paid to in-state PRTF facilities. The department can better control costs by imposing a cap on the out-of-state PRTF rate. Also, the department proposes to lower the number of outpatient psychotherapy sessions that a youth who does not have a severe emotional disturbance (SED) may receive, without prior authorization, from 24 to 10 sessions. After the tenth outpatient session, a youth must meet SED criteria for additional outpatient sessions to be deemed medically necessary. The department proposes to update the fee schedule date from January 1, 2018, to March 1, 2018.

ARM 37.85.106(2)(b)

The department proposes to correct this rule citation to ARM 37.27.905, which was promulgated in MAR Notice No. 37-736, and which correctly refers to the TCM fee schedule for Medicaid members with a substance use disorder. The current citation is incorrect.

ARM 37.85.406(21)

As explained above in ARM 37.85.105(2)(b), the department proposes to eliminate the allowance for reimbursement of facility charges for provider based entity services, and striking this language will effectuate that change for provider based reimbursement. This change is intended to reimburse provider based entities in the same manner as other professional service providers, none of whom receive reimbursement for a facility component. For clarity, the rule will explicitly state that Montana Medicaid does not reimburse for the facility component of provider based entity services.

ARM 37.86.105(8), 37.86.205(8), 37.86.506(2)

Because the department intends to eliminate the allowance for facility charges for provider based entities (see explanation above and at ARM 37.85.105(2)(b)), the department proposes to remove language that directs providers to provider based reimbursement and billing practices.

ARM 37.86.1006

The department proposes to reduce dental coverage of high cost, extensive dental procedures and dentures for the adult Medicaid population. The department would continue to provide preventive and diagnostic dental services along with a basic restorative package to prevent a cost shift to higher levels of care.

The medical necessity criteria for members under the age of 21 to receive comprehensive orthodontia benefits is being redefined. Program eligibility is defined by the numeric results of the Handicapping Labio-Lingual Deviation (HLD) scoring index and would change from 25 to 30. Those members who present with one of the three handicapping conditions, indicated with an 'X' will remain eligible. Those members 12 and younger who present with a crossbite; unilateral, bilateral, or anterior, will qualify for interceptive orthodontia services.

ARM 37.86.1807

The department proposes to add a new subsection to reflect that when Medicare does not establish an allowable fee, the department will pay durable medical equipment (DME) items at 100% of the fee that is established by the department.

The department has determined that it is currently overpaying for incontinence supplies. In a comparison of Montana's average reimbursement to the average reimbursement rate of 15 other states that have a set fee schedule rate, Montana's overall reimbursement rate is higher than all states except Indiana. Idaho and Wyoming both use a specific fee-for-service rate for the same services as Montana, and those states reimburse at an average rate of 25.68% less than Montana.

From this comparison, it was determined that Montana Medicaid should change to a set rate fee schedule for incontinence supplies and to use an average of the Idaho and Wyoming fee schedules, as these states are very similar in their rural nature to Montana. These new fees will be included in the March 1, 2018 fee schedule.

ARM 37.86.2002

The department proposes change the optometric services benefit to limit Medicaid members who are 21 years of age or older to one eye exam every two years. Currently, members may receive an eye exam once per year. The change will not affect Medicaid members under the age of 21, who will continue to be eligible for an eye exam once per year.

ARM 37.86.2102

The department proposes to change the eyeglasses benefit to limit Medicaid members who are 21 years of age or older to one pair of eyeglasses every two years unless any one of the stated conditions is present. Currently, members may receive one pair of eyeglasses every year. The change would not affect Medicaid members under the age of 21, who will continue to be eligible for one pair of eyeglasses every year. Although the proposal contemplates limiting new eyeglasses for members age 21 and older, the change would allow them to receive replacement lenses in certain specified circumstances. Section (8) has been reworded for clarity.

ARM 37.86.2803(2) and (3)

The department proposes to remove references to ARM 37.86.3037 because it is proposed to be repealed in this rule notice.

ARM 37.86.2918(3)

With the elimination of facility component reimbursement, the department proposes to remove the reference to provider based clinics within the language that explains what is considered bundled in an inpatient claim.

ARM 37.86.3001(20)

The department is proposing to update the definition of provider based clinics to remove the explanation of professional services. With the elimination of facility component reimbursement, provider based entities are reimbursed in the same manner as any other provider billing professional services, based on their enrolled provider type and services billed.

ARM 37.86.3025(4)

The department is proposing to remove reference to ARM 37.86.3031 and 37.86.3037 because they are proposed to be repealed in this rule notice.

ARM 37.86.3902 and 37.86.3906

The department proposes to limit Targeted Case Management for Children and Youth with Special Health Care Needs by establishing specific criteria to receive the service, including having one of six specified physical health conditions and demonstrating high risk for medical compromise. Under the proposed language, in order to qualify for TCM, a child must receive Medicaid or is presumptively eligible for Medicaid, is age 18 or under, has one or more of the conditions set forth in ARM 37.86.3902(1)(c), and is high risk for medical compromise due to one of the following conditions in ARM 37.86.3902(1)(d). This change is intended to reduce expenditures in this service by targeting its availability to high risk children and youth with specific conditions. The department also proposes to remove the requirement of a dietician as part of the case management team.

ARM 37.87.903

The department proposes to amend the Children's Mental Health Bureau Medicaid Services Provider Manual and update the effective date from August 6, 2016, to March 1, 2018, to reflect the following changes. First, the department proposes to reduce the number of outpatient psychotherapy sessions that youth who do not have a severe emotional disturbance (SED) may receive without prior authorization, from 24 to 10 sessions. After the tenth outpatient session, a youth must meet SED criteria for additional outpatient sessions to be deemed medically necessary. The department proposes to update the fee schedule date from January 1, 2018, to March 1, 2018. Second, the department proposes to decrease the review interval for prior authorization for Therapeutic Group Home (TGH) placement by reducing the initial stay period to 120 days. Third, in order to manage costs and avoid paying for services not medically necessary, the department proposes to add utilization review for genetics testing for youth prescribed medications for a mental health diagnosis. All of these changes are intended to contain costs.

ARM 37.87.1226

As explained above for ARM 37.85.105(6), the department proposes to impose a cap on the daily rate for out-of-state PRTFs at 133% of the in-state PRTF rate. This limit is necessary because some out-of-state providers have a usual and customary charge that is considerably higher than other out-of-state providers and higher than the daily rate paid to in-state PRTF facilities. The department can better control costs by imposing a cap on the out-of-state PRTF rate.

ARM 37.87.1401

The department proposes to restructure Medicaid Home Support Services (HSS) and Therapeutic Foster Care (TFC) to allow reimbursement of the daily rate only on

days a service was delivered. Currently HSS/TFC providers can bill a daily rate even if no contact was made with the family within the 24-hour period so long as they conduct the minimum number of contacts required by ARM 37.87.1410(6). This change will permit HSS/TFC reimbursement only on days in which a contact actually occurs.

ARM 37.88.206(3), 37.88.306(3), 37.88.606(3)

The department is proposing to remove language that directs providers to provider based reimbursement and billing practices to reflect the elimination of reimbursement for facility charges for provider based entities.

ARM 37.86.3031, 37.86.3033, 37.86.3035, 37.86.3037

As previously explained above in ARM 37.85.105(2)(b), with the elimination of reimbursement for facility charges for provider based entities, these rules are being repealed as they are not necessary when provider based entities are no longer reimbursed differently than other professional service providers.

Fiscal Impact

The following tables display the provider groups affected, the number of providers by type, and the fiscal impact for SFY 2018 and SFY 2019 for the proposed amendments.

ARM 37.85.105

Provider Type	SFY2018 State Funds Impact	SFY2018 Federal Funds Impact	SFY2018 All Funds Impact	Enrolled Provider Count
Outpatient Hospital	($1,074,330)	($1,972,897)	($3,047,227)	315
Inpatient Hospital	($752,444)	($1,426,027)	($2,178,471)	376
Dental	($778,839)	($1,476,050)	($2,254,889)	584
Denturist	($250,251)	($474,275)	($724,526)	19
Targeted Case Management – Children and Youth with Special Health Care Needs	($59,632)	($113,014)	($172,646)	15
Durable Medical Equipment	($125,839)	($238,489)	($364,328)	443

Provider Type	SFY2019 State Funds Impact	SFY2019 Federal Funds Impact	SFY2019 All Funds Impact	Enrolled Provider Count
Outpatient Hospital	($1,745,309)	($3,212,947)	($4,958,256)	315
Inpatient Hospital	($1,313,550)	($2,489,432)	($3,802,982)	376
Dental	($1,557,677)	($2,952,099)	($4,509,776)	584
Denturist	($500,502)	($948,549)	($1,449,051)	19
Targeted Case Management – Children and Youth with Special Health Care Needs	($138,457)	($262,403)	($400,860)	15
Durable Medical Equipment	($251,678)	($476,979)	($728,657)	443

ARM 37.85.406; 37.86.105; 37.86.205; 37.86.2918; 37.86.3001; 37.86.4401; 37.86.4412; 37.88.206; 37.88.306; 37.88.606; 37.86.3025; and 37.86.2803; 37.86.3031; 37.86.3033; 37.86.3035; and 37.86.3037

Provider Type	SFY2018 State Funds Impact	SFY2018 Federal Funds Impact	SFY2018 All Funds Impact	Enrolled Provider count
Hospital – outpatient	($679,210)	($1,287,234)	($1,966,444)	11
Critical Access Hospital	($53,492)	($101,378)	(154,870)	10

Provider Type	SFY2019 State Funds Impact	SFY2019 Federal Funds Impact	SFY2019 All Funds Impact	Enrolled Provider count
Hospital – outpatient	($1,358,419)	($2,574,468)	($3,932,887)	11
Critical Access Hospital	($106,985)	($202,757)	($309,742)	10

ARM 37.86.2002 and 37.86.2102

Provider Type	SFY2018 State Funds Impact	SFY2018 Federal Funds Impact	SFY2018 All Funds Impact	Enrolled Provider count
Optometrists	($81,867)	($155,154)	($237,021)	228

Provider Type	SFY2019 State Funds Impact	SFY2019 Federal Funds Impact	SFY2019 All Funds Impact	Enrolled Provider count
Optometrists	($163,734)	($310,308)	($474,042)	228

ARM 37.85.104 and 37.85.105

The following table reflects the proposal to update three SUD treatment procedure codes and the reimbursement of these codes to align with like services and requirements performed by other behavioral health professionals. Two procedure codes changes will result in a decrease in reimbursement to providers. One procedure code change will result in an increase in reimbursement to providers. The changes are reflected below:

Old Code /New Code	SUD schedule 1/1/2018	RBRVS 1/1/2018	Change	# billed per year (CY2016)	Total Change
H0001 /90791 Assessment	$ 282.50	$89.71	(-$192.79)	803	(-$154,810.37)
H0004 /90837 Individual	$ 16.99 /15 min	$87.06 / 1 hour	+ $19.01	25,920* (6933.25)	$132,425.08
H2035 /90853 Group	$24.27 /1 hour	$17.55 /event	(-$30.99) Based on 2 hour group	58,242* (22,957)	(-$711,437.43)
Total					(-$733,822.73)

*The number in parentheses is the converted units for the CPT Codes

ARM 37.85.105(6), 37.87.903, 37.87.1226, 37.87.1401

The cap on rates for out-of-state Psychiatric Residential Treatment Facility (PRTF) will impact about 15 children per month in four out-of-state PRTFs. The department's cost savings associated with out-of-state PRTF's are calculated below:

Out of State PRTF	FY2018	FY 2019
State Funds	(55,864)	(223,457)
Federal Funds	(112,886)	(451,543)
Total Funds	(168,750)	(675,000)

The department's cost savings for changes to outpatient limits for youth without SED are calculated below:

Out-Patient	FY2018	FY 2019
State Funds	(10,272)	(41,091)

Federal Funds	(29,077)	(83,909)
Total Funds	(39,349)	(125,000)

The department's cost savings for changes to genetic testing are calculated below:

Genetics Testing	FY2018	FY 2019
State Funds	(97,145)	(194,290)
Federal Funds	(209,892)	(419,784)
Total Funds	(307,037)	(614,074)

Decreasing the prior authorization review interval for TGH will impact medium/high acuity children needing group home services. Number of kids receiving group home care in state fiscal year (SFY) 2017 was 688. There are 11 in-state and two out-of-state youth group home providers.

Cost savings for TGH are calculated below:

Therapeutic Group Home	FY2018	FY 2019
State Funds	(24,623)	(49,246)
Federal Funds	(49,752)	(99,504)
Total Funds	(74,375)	(148,750)

Restructuring Home Support Services (HSS) and Therapeutic Foster Care (TFC) will impact about 1,596 youth in a state fiscal year. There are 13 mental health centers that provide HSS.

Cost savings for HSS and TFC are calculated below:

Category	FY2018	FY 2019
State Funds	(46,762)	(187,049)
Federal Funds	(93,638)	(561,600)
Total Funds	(140,400)	(748,649)

6. The department intends the proposed rule amendments to be applied effective March 1, 2018.

7. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; fax (406) 444-9744; or e-mail dphhslegal@mt.gov, and must be received no later than 5:00 p.m., February 9, 2018.

8. The Office of Legal Affairs, Department of Public Health and Human Services, has been designated to preside over and conduct this hearing.

9. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. 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 mailed or delivered to the contact person in 7 above or may be made by completing a request form at any rules hearing held by the department.

10. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

11. Pursuant to 2-4-111, MCA, the department has determined that the amendment and repeal of the above-stated rules may significantly and directly impact small businesses.

12. 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 rates 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.

/s/ Brenda K. Elias	/s/ Sheila Hogan
Brenda K. Elias, Attorney	Sheila Hogan, Director
Rule Reviewer	Public Health and Human Services

Certified to the Secretary of State January 2, 2018.