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

In the matter of the amendment of ARM 37.27.902, 37.85.104, 37.85.105, 37.85.106, and 37.88.101 pertaining to Medicaid rates, services, and benefit changes	)))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On May 24, 2019, the Department of Public Health and Human Services published MAR Notice No. 37-878 pertaining to the public hearing on the proposed amendment of the above-stated rules at page 618 of the 2019 Montana Administrative Register, Issue Number 10.

2. The department has amended the following rules as proposed: ARM 37.27.902, 37.85.104, 37.85.106, and 37.88.101.

3. The department has amended the following rule as proposed, but with the following changes from the original proposal, new matter underlined, deleted matter interlined:

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

(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 as proposed.

(b) Fee schedules are effective July 1, 2019. The conversion factor for physician services is ~~$36.46~~ $38.46. The conversion factor for allied services is $23.97. The conversion factor for mental health services is $23.36. The conversion factor for anesthesia services is $30.03.

(c) through (6) remain as proposed.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-125, 53-6-402, MCA

4. The department has thoroughly considered the comments and testimony received. A summary of the comments received and the department's responses are as follows:

COMMENT #1: Although several commenters expressed general support for rate increases, they stated that the proposed Medicaid reimbursement rates do not cover

the costs of providing care and they questioned the expenditure of state appropriations.

RESPONSE #1: The 2019 Legislature explicitly directed the department to adopt funding for provider rate increases in the amount of .91% in State Fiscal Year (SFY) 2020. (See pages B-2 and B-51 of the Legislative Fiscal Division's HB 2 narrative, found at: https://leg.mt.gov/content/Publications/fiscal/2021-Session/Section-B-Brown.pdf.)

The department's authority to establish rates is found in 53-6-113, MCA, which sets forth a non-exhaustive list of factors the department may consider in establishing Medicaid rates of provider reimbursement, including the availability of appropriated funds. In proposing and adopting provider rates for SFY 2020, the department's primary considerations were the availability of appropriated funds and the Legislature's explicit direction to fund provider rate increases of .91% in SFY 2020.

The department believes that the Medicaid rates are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services will be available to members across Montana.

As stated in the department's comments at the hearing, the department noted a clerical error on the physician conversion factor in ARM 37.85.105(2)(b). The physician conversion factor was incorrectly listed in the original rule notice. The department has corrected this error to reflect the accurate physician conversion factor of $38.46.

COMMENT #2: A commenter expressed support for the proposed conversion factors and provider rate of reimbursement for Optometric providers but opposed certain aspects of the proposed rule. The commenter stated the department is not following 37-10-104, MCA, in that optometrists are not reimbursed for services in the same manner as other ocular practitioners rendering similar services. The commenter concluded that as long as the department continued to discriminate among licensed ocular practitioners it will be in violation of Montana state law and the commenter must oppose the proposed rule.

RESPONSE #2: The department disagrees with the comment that the rate structure violates Montana law. The department must follow Montana law, and 53-6-125, MCA requires the department to reimburse physicians with doctor of medicine (MD) and doctor of osteopathy (DO) degrees using a conversion factor different from other healthcare professionals, including optometrists. However, the department uses the same resource-based relative value scale (RBRVS) methodology in determining reimbursement rates for ophthalmologists and optometrists, and thus they are reimbursed in the same manner. Prior to 2008, optometrists were reimbursed using the same conversion factor as physicians. In 2007, the Montana 60th Legislature passed Senate Bill (SB) 354, which defined and clarified the Medicaid reimbursement conversion factor for physicians. SB 354, which is codified in 53-6-124, MCA and 53-6-125, MCA defined "physician" as a person who holds an MD or

DO degree and who has a valid license to practice medicine or osteopathic medicine in Montana. It must be presumed that the Legislature in 2007 was aware of 37-10-104, MCA, cited by the commenter, because that statute has been in existence since 1959. Also, if the legislature in 2007 intended for the physician conversion factor to apply to optometrists, it would have included them in the definition of physician but did not.

COMMENT #3: A commenter expressed concern regarding the dental codes that are not on the Dental Hygienist Services fee schedule. The commenter suggested certain codes should be added to the Dental Hygienist Services fee schedule because they are within the scope of practice for Limited Access Permit (LAP) Dental Hygienists. Specifically, Current Dental Terminology (CDT) codes D0190, Pre-Diagnostic Service Screening, and D0919 Assessment of a patient treatment, in addition, to several other procedure codes. The commenter also asked how tele-dentistry might work within their scope of practice.

RESPONSE #3: The department concurs and will add the above-referenced codes to the dental hygienists services fee schedule. The Montana Medicaid program does not currently reimburse for tele-dentistry. The department will continue its collaborative work with impacted providers.

COMMENT #4: A commenter expressed general support for MAR Notice No. 37-878, but questioned the reimbursement for compounded medications. The commenter suggested the department consider a change in the reimbursement rate for compounded products stating they are often filled well below cost.

RESPONSE #4: The department set the current compounding rate on a past study. Based on the comment, department staff will work with the Montana Pharmacy Association and compounding pharmacies to update the study to determine if additional changes to the professional dispensing fee for compounding medications are appropriate.

COMMENT #5: The department received several comments expressing support of the provider rate increase.

RESPONSE #5: The department thanks the commenters for their support.

COMMENT #6: Multiple commenters stated that the reimbursement rate for peer support specialists is inadequate to fund staff and programs.

RESPONSE #6: The department believes the peer support rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist enough providers so that care and services are or will become available to members as this new service grows. The service was piloted in the last biennium at the current rate. The rate for Medicaid behavioral health peer support services was researched and compared with other states in Region 8 of the Substance Abuse and Mental Health

Services Administration (SAMHSA) and is slightly higher to account for the cost of providing care in this very frontier state.

COMMENT #7: Multiple commenters stated that the Targeted Case Management (TCM) rate cuts had a negative impact on organizations providing case management and behavioral health services and the clients they serve.

RESPONSE #7: In response to comments received and based on available legislative appropriation, the department will increase the TCM rate to $13.32, per 15 minute unit. In establishing this rate, the department considered the following factors: average hourly salary, fringe benefits, administrative and overhead costs, additional operating costs, program support, and mileage. The department will continue its collaborative work with providers to maintain a Medicaid benefit package designed to improve health and reduce costs.

COMMENT #8: Multiple commenters expressed concern that the rule change would disallow concurrent treatment of co-occurring diagnosis.

RESPONSE #8: Thank you for your support of integrated services. The department has revised the manual to eliminate confusion that was caused by proposed language.

The department encourages integrated services for members who have a co-occurring mental health and substance use disorder diagnosis. Integrated treatment of co-occurring diagnosis is a best practice and recommended by SAMHSA. We encourage services with bundled reimbursement to provide integrated care to address the full person.

The department is responding to comments that pointed out this error by clarifying what services can be billed as a bundle and what is included in the bundled rates. When applicable, the department is also indicating when services do not have to be billed in a bundle and may be billed separately. The department has removed the concurrent services section of each service level entirely because we believe it has caused unnecessary confusion.

COMMENT #9: Multiple commenters opposed the Medicaid requirement for member information (such as name, social security number, etc.) to be required for Medicaid reimbursement. Opposition was based on difficulty of gathering information and the need for outreach, engagement, and crisis services as part of the Peer Model.

RESPONSE #9: The 2019 Legislature made Peer Support services a required Medicaid covered service. Previously, providers were reimbursed from federal block grants and the requirement for obtaining member information and demographics was not as stringent as Medicaid requirements. Medicaid is governed by state and federal rules, regulations, and statutes. All providers seeking reimbursement from Montana Medicaid must follow Medicaid rules and regulations as a result of the 2019

legislation that moved funding for peer support to Medicaid. Medicaid billing requires name, date of birth, address, phone number, and Medicaid number, much like other kinds of insurance.

COMMENT #10: Multiple commenters opposed the medical necessity criteria of a Severe and Disabling Mental Illness (SDMI) diagnosis or a Substance Use Disorder (SUD) diagnosis for Peer Support services.

RESPONSE #10: As stated in the response to Comment #8, the 2019 Legislature made Peer Support services a required Medicaid covered service. Medicaid is governed by state and federal statutes and rules. The department cannot remove the requirement of a diagnosis, as that is a federal Medicaid requirement. The department cannot expand its coverage to diagnoses that are not mental health and/or substance use disorder related without an appropriation to do so.

COMMENT #11: One commenter voiced concern about transportation no longer being an allowable service of a peer support.

RESPONSE #11: A Certified Behavioral Health Peer Support Specialist (CBHPSS) can provide a variety of face-to-face services. However, transportation is not one of the core services defined by current best practices. The department encourages the provision of peer support services in the community setting. The rule does not prohibit a CBHPSS from coaching, supporting, and facilitating transportation to and from appointments that support a member through the process of change to improve their health and live a self-directed life. Transportation to medical services is a separate benefit under the Montana Medicaid program.

COMMENT #12: Multiple commenters advocated for Medicaid reimbursement of CBHPSS facilitated groups.

RESPONSE #12: The department appreciates the comments. Groups led by CBHPSS will not be eligible for Medicaid reimbursement at this time.

COMMENT #13: One commenter requested longer-term prior authorizations and longer time periods between continued stay reviews for 3.1 homes to support patient stability and security for better treatment outcomes.

RESPONSE #13: The department is not making any changes to its utilization review because it is out of the scope of the current rulemaking. However, we appreciate the comment and we will consider this comment for future rule changes.

COMMENT #14: One commenter asked if CBHPSS have to be enrolled as a rendering provider with Conduent in order to bill for services.

RESPONSE #14: Peer Support Specialists do not need to enroll as a rendering provider with Conduent in order to bill for services.

COMMENT #15: Two commenters asked whether or not SUD screening and evaluations are required, and whether a screening, brief intervention, and referral to treatment (SBIRT) is required prior to conducting an assessment.

RESPONSE #15: SBIRT is a primary care best practice but its use is not mandated. Medicaid asks that clinicians use best professional judgment in determining whether a screening is necessary prior to conducting an assessment.

COMMENT #16: One commenter asked whether or not SUD services will be billed under the same taxonomy currently used. This question is based on Healthcare Common Procedure (HCPCS) codes being used for bundled services and Current Procedural Terminology (CPT) codes for non-bundled services.

RESPONSE #16: The department does not fully understand the comment. Proposed changes to the SUD Medicaid and Non-Medicaid Fee Schedule are available to review and will always be available to review prior to implementation. HCPCS codes include fee-for-service, per diem, and bundled rates. CPT codes can be found on the Resource-Based Relative Value Scale (RBRVS) Proposed Fee Schedule, located at https://medicaidprovider.mt.gov/providertype#49243823-site-index.

COMMENT #17: Two commenters asked for clarification as to whether SUD providers can bill for school-based services and whether psychoeducation will still be an available service under the block grant.

RESPONSE #17: School-based services and psychoeducation will remain a billable service within the SUD block grant. Information pertaining to this service was removed from the proposed "AMDD Non-Medicaid Services Provider Manual for Substance Use Disorder" and will be included within the block grant contracts with the department.

COMMENT #18: One commenter asked whether all clients billed using the enhanced per diem rate for providing therapeutic mental health services must be seen by a dually licensed counselor.

RESPONSE #18: The department expects that therapeutic mental health services be provided by a mental health professional. That professional does not need to be dually licensed.

COMMENT #19: One commenter recommended that the department follow American Society of Addiction Medicine (ASAM) guidelines consistently and to allow 2.5 services to be offered in locations that meet the needs of the client rather than a facility that offers 3.7 level of care.

RESPONSE #19: ASAM 2.5 services have historically been provided in 3.7 facilities to allow for the direct access to psychiatric, medical, and laboratory services as stated in ASAM, and is located within the ASAM 3.7 licensing requirements.

However, the department appreciates this feedback and will amend the language in the manual to allow for the provision of ASAM 2.5 that complies with licensure rule and the program has direct access to psychiatric, medical, and laboratory services on site.

COMMENT #20: One commenter opposed the requirement that only licensed mental health professionals can provide Dialectical Behavioral Therapy (DBT) and requests that the department allow Licensed Addictions Counselors with DBT training to provide the service.

RESPONSE #20: This comment is outside the scope of this rulemaking as the requirement that a licensed mental health professional provide DBT was not changed during this rulemaking. However, we appreciate the comment, will research it, and will consider the comment for a future rulemaking.

COMMENT #21: One commenter stated there needs to be a definition of education requirements required to diagnose and treat substance abuse disorders as the rule appears to do away with A.A. degrees.

RESPONSE #21: The Board of Behavioral Health outlines the requirements and scope of education requirements for professions to diagnose and treat substance abuse disorders. This rule does not make any changes to those requirements.

COMMENT #22: One commenter stated that family therapy is separate, not bundled with individual and group therapy and asks if they should be separate core services.

RESPONSE #22: The department is not clear what bundled service the commenter is referring to. We agree that family, individual, and group therapy are different services. Therapy is one core component of ASAM 2.1 services.

COMMENT #23: One commenter asked if drug testing falls under one of the core services for Intensive Outpatient Services.

RESPONSE #23: Dip stick drug testing is a component of the bundled service rate for Intensive Outpatient services (IOP) but is not considered one of the core services that meets the service requirements of billing the IOP bundled rate. Urinalysis may be billed outside the bundle as clinically appropriate.

COMMENT #24: One commenter asked if only one assessment is billable a year, how that applies to mental health and substance use disorder assessments, and if they are both billed under the same code.

RESPONSE #24: The department asks the commenter to follow the CPT code parameters in determining how to bill assessments.

COMMENT #25: One commenter requested DPHHS/AMDD to initiate a 1115 waiver to allow a comprehensive array of behavioral health services for vulnerable populations and all Montanans.

RESPONSE #25: This comment is outside the scope of this rulemaking. The department will continue to work with providers and the appropriate authorities to implement innovative and required changes to the behavioral health and health care system to support the needs of vulnerable populations and all Montanans. An 1115 waiver may or may not be the appropriate federal authority under which the department chooses to apply.

COMMENT #26: Multiple commenters requested clarification regarding the ability to bill for services prior to completed assessments.

RESPONSE #26: If a service requirement includes a specific diagnosis, the billing provider must be able to show documentation that supports that diagnosis.

COMMENT #27: One commenter requested clarification on whether or not an individual in a detention center is eligible for Medicaid reimbursement.

RESPONSE #27: This comment is outside the scope of this rulemaking.

COMMENT #28: One commenter asked whether an assessment done by a previous provider in the past 12 months must also be obtained or whether the new provider could complete their own assessment instead.

RESPONSE #28: The department requests that the commenter follow clinical best practices. If a provider believes an assessment is medically necessary, he or she should conduct one.

COMMENT #29: One commenter stated that the AMDD Medicaid manual has a numbering error on page 56.

RESPONSE #29: The department will fix this error. The department notes that the proposed manual had a bolded statement under the Table of Contents that numbering would be updated upon adoption.

COMMENT #30: One commenter asked for a definition of crisis services.

RESPONSE #30: In response to this comment, the department added a definition of crisis services to the manual.

COMMENT #31: One commenter asked for a definition of care coordination.

RESPONSE #31: In response to this comment, the department added a definition of care coordination to the manual.

COMMENT #32: One commenter asked if the department tracks recidivism for SUD treatment facilities stating that there is a lack of accountability from providers regarding the quality of care being provided.

RESPONSE #32: The department intends to pilot the use of the DLA-20 for IOP services as a means for outcome measurement and monitoring. In addition, the department will be completing a longitudinal study of both IOP and Peer Support to review what services Medicaid members have received before, during, and after receiving those services. This will be the Montana Medicaid's first behavioral health outcome study that has been incorporated into rule. This outcome study and its rule will be reviewed, revised and possibly expanded in future rulemakings.

5. The department intends to apply these rule amendments retroactively to July 1, 2019. A retroactive application of the proposed rules does not result in a negative impact to any affected party.

/s/ Brenda K. Elias
Brenda K. Elias
Rule Reviewer

/s/ Sheila Hogan
Sheila Hogan, Director
Public Health and Human Services

Certified to the Secretary of State June 25, 2019.