

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

In the matter of the amendment of) NOTICE OF AMENDMENT
ARM 37.27.902, 37.85.104,)
37.85.105, 37.86.1006, and)
37.88.101 pertaining to Medicaid)
rates, services, and benefit changes)

TO: All Concerned Persons

1. On August 9, 2019, the Department of Public Health and Human Services published MAR Notice No. 37-888 pertaining to the public hearing on the proposed amendment of the above-stated rules at page 1156 of the 2019 Montana Administrative Register, Issue Number 15.

2. The department has amended the above-stated rules as proposed.

3. 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: The department received several comments in support of expanding the dental benefit to include Current Dental Terminology Code D2740, porcelain ceramic crown coverage, to adults. Some commenters recommended allowing D2740 for all teeth including 2nd molars. A commenter cited reasons such as material strength, durability, better biocompatibility than base metal and porcelain fused to base metal crowns, lower overhead cost, and better patient compliance.

RESPONSE #1: The department values the support from providers on the rule changes and will monitor utilization of this code and decide whether to allow coverage on all teeth for adults once a fiscal impact can be determined.

COMMENT #2: Some commenters stated porcelain ceramic crowns should not be covered for adults because they are costly and not medically necessary because they are cosmetic in nature.

RESPONSE #2: The department disagrees. Cost, reimbursement, and limits for porcelain crowns are the same as porcelain fused to metal crowns. The department does not consider them cosmetic for many of the same reasons noted in the comments of support for D2740. Additionally, ceramic crowns are now one of the most common treatment modalities used when a tooth requires a medically necessary full coverage restoration (i.e., large decay, tooth fracture, post-root canal treatment). Furthermore, a 2013 systematic review published in the Journal of Prosthetic Dentistry, found the clinical survival rate of all ceramic crowns to be between 92.7% to 100% and the survival rate of metal-ceramic crowns to be 70% to

100%. Finally, the department would like to add that this process is similar to composite restorations. When composite restorations were first introduced, they were primarily used when esthetics was a top concern. However, improvements in the materials and techniques, now make these restorations as equally durable as amalgam restorations.

COMMENT #3: A commenter requested clarification regarding page 1 of the proposed Substance Use Disorder Non-Medicaid provider fee schedule. The commenter asked if providers are capped at billing 8 units of group peer support per week or is each peer support specialist capped at billing 8 units per week or is each client billable for 8 group units per week.

RESPONSE #3: The department's intent is to allow up to 8 group units per week (2 hours) per client. The department will clarify this rate in the related fee schedules.

COMMENT #4: A commenter requested adolescents be included in SUD Certified Peer Support Services. The commenter stated that adolescents are at high risk of leaving treatment unplanned or refusing treatment, and the commenter's organization has found that Peer Support Services helps many adolescents to understand the benefits of treatment through relating to someone with real life experience with addiction.

RESPONSE #4: The 2019 Montana Legislative Session made Medicaid-reimbursed Peer Support Services for adults 18 years of age and older with a diagnosis of a mental disorder as defined in 53-21-102, MCA, a permissible service. The department was able to also fund Certified Peer Support Services for adults with a SUD. The legislature did not indicate intent to fund adolescent peer support services at this time.

COMMENT #5: A commenter requested to be reimbursed for peer support with both Medicaid and grant funds due to what the commenter referred to as a "shortfall" of funding through Medicaid only. The commenter stated the current language suggested that group peer should be referred to as SUD groups rather than peer support groups and billed accordingly.

RESPONSE #5: The amount of reimbursement for individual peer support under Medicaid will not change, so the department disagrees that there is a "shortfall" in reimbursement. Under Medicaid, the department cannot use federal block grant funding. The department, however, acknowledges that providers must follow Medicaid income guidelines and ensure that individuals qualify for Medicaid in order to provide the individual peer support benefit. With regard to group peer support services, the department will be piloting a program to reimburse for group peer support services. The department intends to pilot peer support groups led by Certified Peer Support Specialists using the Substance Abuse, Prevention, and Treatment block grant for the SUD population, as currently only individual peer support services are reimbursed through Medicaid.

COMMENT #6: A commenter requested clarification on intake and established MAT bundled rates regarding billing the bundled rate for clients already receiving bundled services. The commenter further asked if providers will be able to bill both the bundled rate for treatment and the bundled rate for MAT concurrently for an individual client.

RESPONSE #6: Per the July 1, 2019 rule amendment, the department removed the concurrent services section of each service level entirely because of the unnecessary confusion it caused for providers. For MAT provision, this rule clarifies what services components are billable for the provision of MAT. If the services are not duplicative and are both medically necessary, the services can be billed concurrently.

COMMENT #7: A commenter requested to change wording on proposed manual page 58, number 5, to: "Services must be based on a complete history and physical exam and assessment described above and documented in the member's ITP." The commenter also requested to remove "comprehensive physical" as it implicates a physical that is more intrusive than is required for MAT services.

RESPONSE #7: The department will remove the word "comprehensive" and will require providers to follow federal regulation regarding the provision of MAT services.

COMMENT #8: A commenter requested clarification on the time frame of services. The commenter recommends that physical or history and physical be completed within 12 months of initiating MAT services.

RESPONSE #8: The department did not outline specific timeframes in the manual. Providers are expected to follow the federal regulations in the provision of MAT services.

COMMENT #9: A commenter requested to add additional options for selection on the Montana Healthcare Programs Medication Assisted Treatment Form. The commenter suggested:

- (a) Vivitrol/Naltrexone
- (b) Acamprosat (Camprol)
- (c) Disulfiram (Antabuse)
- (d) Gabapentin (Neurontin)
- (e) Topomax (Topiramate)

RESPONSE #9: The commenter is referencing a form that is outside of the scope of this rulemaking process. The department forwarded this comment to the pharmacy department for review.

COMMENT #10: A commenter requested clarification regarding the definition of an adolescent for OP bundled services. Page 51, number 9 states that an adolescent is someone 17 years and younger. The commenter brings attention to ARM

37.106.1413 which indicates an adult is a person 21 years of age or older and an adolescent means a person under 21 years of age.

RESPONSE #10: The department acknowledges this inconsistency and will remove the language specifying that an adolescent is 17 years and under.

COMMENT #11: Two commenters asked for clarification regarding licensed addiction counselors and enrollment as provider type 80.

RESPONSE #11: Provider type 80 is no longer a requirement to bill for MAT service bundles. Physicians, mid-levels, and psychiatrists must bill the applicable procedure codes when billing for MAT services. Licensed addiction counselors providing therapeutic services would bill outside of the bundled rate using the applicable CPT codes for the service they provided.

COMMENT #12: A commenter requested "telecommunication" be allowable for patient contact and "telemedicine" be allowed for intakes rather than face-to-face visits only for Medicaid Assisted Treatment to remote areas.

RESPONSE #12: Montana Healthcare Programs do not reimburse for "telecommunication." Telemedicine is allowable under Montana Healthcare Programs. The department will consider the request to allow for telemedicine to be provided for intake for future rulemaking; however, at this time, the department will not amend the rule.

COMMENT #13: Two comments were received concerning the various formulations of "buprenorphine," including brand name and generic strips and tablets, combination and mono products, long acting injectable formulations, and any new medications for formulations that are approved in the future. Additionally, one commenter requested that bundled rates for methadone and buprenorphine to be different because the medication costs are different.

RESPONSE #13: Any medication, including "buprenorphine," that is currently covered under Montana Healthcare Programs will continue to be covered. The bundled rates proposed in the rulemaking do not include the cost of medication, which should be billed separately.

COMMENT #14: The department received one comment requesting the appropriation amount related to hospital in-patient services.

RESPONSE #14: The department considered the entire appropriation for the Health Resources Division and determined that appropriations are sufficient to support the adoption of the newly adopted APR-DRG grouper. Updating to grouper version 36 and adjusting the policy adjusters for adults and neonates is necessary to establish reimbursement within appropriations outlined in HB 2. The fiscal impact for Medicaid and Medicaid expansion will be budget neutral.

COMMENT #15: The department received one comment requesting reports for hospital-specific impact and overall hospital impact.

RESPONSE #15: The department has already provided, upon request to this commenter, in-state hospital specific and overall hospital impact reports. The reports that are available give a percentage of overall cost impacts for adult DRGs, neonate DRGs, and all other DRGs and an overall impact for each hospital. Regarding the request for specific DRG reports for each hospital in Montana, it is simply not possible to provide such detailed information in a timely manner, for the reason that there are more than 1,300 DRGs and such a report would be burdensome for the department to generate. The available hospital reports that were provided to the commenter did reflect budget neutrality and did reflect enough information for hospitals to calculate fiscal impact. The department also posted the proposed APR-DRG calculator at the following weblink: <https://medicaidprovider.mt.gov/enduserproposedfs>.

COMMENT #16: A commenter stated the department did not provide an adequate financial impact analysis in the notice of proposed rulemaking.

RESPONSE #16: The statement of reasonable necessity stated that there is no anticipated fiscal impact pertaining to the amendment of fee schedules and provider manuals. The statement of reasonable necessity stated further that the proposed changes are intended to be budget neutral.

4. These rule amendments are effective October 1, 2019.

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

/s/ Erica Johnston for
Sheila Hogan, Director
Public Health and Human Services

Certified to the Secretary of State September 10, 2019.