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 and 37.88.101 pertaining to Medicaid and non-Medicaid manual updates	))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On May 15, 2020, the Department of Public Health and Human Services published MAR Notice No. 37-917 pertaining to the public hearing on the proposed amendment of the above-stated rules at page 856 of the 2020 Montana Administrative Register, Issue Number 9.

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

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:

In order to provide an organized review of the comments, the department has noted that comments seem to fall into four broad categories. First, the department received many positive comments about the collaborative process that led to this rulemaking. Second, there were policy-related suggestions that look toward the future of services and how the department might improve outcomes for Montana Medicaid members with severe and disabling mental illness (SDMI). Third, we received multiple comments from one provider and individuals affiliated with this provider pertaining to the proposed Behavioral Health Group Homes (BHGH). Last, the department received many comments that showed that reviewers/commenters read the proposed rule very carefully and provided detail-oriented edits and clarifications. Our responses are organized in this order.

The department thanks commenters for their careful review, insights, and the collaboration on this rulemaking that sets a foundation through which we can continue to improve the mental health system for adults with SDMI.

COMMENT #1: Multiple commenters spoke out in favor of the proposed amendments and thanked the department for collaboration with providers in preparing the proposed changes.

RESPONSE #1: The department thanks the commenters and the Behavioral Health Alliance of Montana for the collaboration involved with these proposed rule amendments. The department looks forward to further collaboration with the Behavioral Health Alliance of Montana and other stakeholders, including Montana

Medicaid members, as we work towards implementing these changes and evaluating this program outcomes.

COMMENT #2: A commenter requested additional information about where to find fidelity standards for Assertive Community Treatment (ACT).

RESPONSE #2: The model the department will use is the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT fidelity model. This is the national evidence-based standard that was initially published in 2008. (https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344.)

COMMENT #3: A commenter requested the department strengthen the requirements for "linkage" with primary care to require true care coordination and management of chronic illnesses in partnership with primary care providers.

RESPONSE #3: This is a visionary statement. The department hopes this is the direction that healthcare is moving. The separation of behavioral healthcare from primary care can be stigmatizing. However, this rulemaking recognizes that mental health centers providing Program of Assertive Community Treatment (PACT) are true specialty care providers for members whose needs exceed traditional outpatient behavioral health treatment. The department has proposed quality measures for the proposed PACT tiered system and intends to monitor those measures to ensure coordination of care with primary care providers. The expectation is that providers will coordinate physical health care as part of PACT.

COMMENT #4: A commenter requested the department to consider choosing one outcome that moves beyond a "checkbox" (i.e., it was done or not) to incentivize change. The commenter suggested that this could be done with the community participation scale or with days in independent housing; something that either directly or indirectly measures progress toward recovery.

RESPONSE #4: The quality measures for PACT were chosen to ensure that the department was monitoring all the changes in the program. The department understands the intent and goal of the comment, however, and will review the quality measures for the proposed PACT tiered system and add a measurement that measures progress towards recovery.

COMMENT #5: A commenter asked the department to consider building a clinical model that does more than "maintain" people in the community but truly guides and supports them toward recovery when considering technical assistance support.

RESPONSE #5: The department understands that this comment expresses a desire to ensure that clinical improvement is part of any technical assistance processes provided for PACT. The department agrees that the standards of quality care for PACT services supports the clinical model and will endeavor to consider this as part of any technical assistance that may be provided in the future.

COMMENT #6: A commenter requested the department consider changing the frequency of the level of impairment for PACT from every 90 days to annually because they believe that level of functioning with members who have SDMI does not change significantly within a 90-day period of time.

RESPONSE #6: Inherent in the collaborative process involved with this rulemaking was a shared desire to improve the outcome and quality measures with the proposed new service system. The level of impairment form is an integral first step towards meeting that goal. The department aligned the level of impairment form with the timeframe required for treatment planning to allow for providers to complete both simultaneously. Furthermore, the department would expect that if a member is receiving an intensive rehabilitative program such as assertive community treatment that there would be improvements to a member's level of functioning, and if there are not, the provider should reassess the appropriateness of the service for the member before a year has passed. The department will review the frequency of change and the usefulness of the assessment after at least a year of implementation and will determine collaboratively with providers if changes should be made.

COMMENT #7: Many commenters who had either worked for or received services from one specific mental health provider expressed concerns pertaining to the proposed BHGH. There were four primary concerns expressed as summarized below:

Commenters expressed concern over the proposed staffing requirements for BHGH and the drastic revisions of operations it would cause for the current adult mental health group homes' daily operating procedures. In particular, commenters expressed concern that having clinical staff employed by the mental health center and working at the group home would impede the member's choice of service providers.

Commenters expressed concern regarding the continued stay requirements, stating that referring the member to the Home and Community Based Services (HCBS), Severe and Disabling Mental Illness (SDMI) waiver and having 60-day continued stay review requests will cause unnecessary stress to the members.

Commenters stated that due to the lack of housing opportunities, they are concerned that implementing the proposed rule will leave members homeless and require members who, while not meeting the medical necessity of a group home setting, are not ready for independent living but nonetheless will be required to live independently. They also stated that they encourage the department to continue long term group homes for members who need that level of care.

One commenter stated that allowing Community Based Psychiatric Rehabilitation (CBPRS) concurrent with group home services is an integral part of a member's recovery in a group home and that not having the ability to utilize this service will set members back and is not conducive to their recovery.

Commenters stated that the reimbursement for the proposed BHGH is too low to adequately staff the home based upon the staffing requirements.

One commenter expressed a concern that the proposed BHGH does not allow members to slowly decrease staff supervision as they work towards independent living skills.

RESPONSE #7: BHGHs are authorized by the Centers for Medicare and Medicaid Services (CMS) in the Other Rehabilitative Services state plan benefit under Social Security Act 1905(a)(13) and 42 CFR 440.130(d). Rehabilitative services are specialty, short-term healthcare services that help a member regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. Rehabilitation services help members return to daily life and live up to their best functioning potential. Rehabilitative services are not intended to be long-term services.

Staffing requirement: Staffing requirements were added to BHGH to ensure a multidisciplinary team is available to members that require group home level of care. This team includes clinical staff, care management, and a certified behavioral health peer support specialist. The department regrets any negative impact this could potentially have on a provider's business model; however, it was necessary to ensure the provision of this service was therapeutic in nature to meet CMS requirements. In addition, the department collaborated with providers to minimize and mitigate negative provider impact while ensuring that Montana Medicaid members receive high quality therapeutic services.

Choice of provider: The department does not agree that the proposed rules remove member's choice in clinical providers. Members may choose which residential setting they receive services in, or alternatively, may select other services from Montana Medicaid's array of services. It is inherent in a therapeutic residential setting that clinical staff are employed and provide services to the members residing in the home.

Housing concerns: The department agrees with the commenters that some communities in Montana have a low stock of low-income housing. In order to improve housing-related concerns, Montana Medicaid has included tenancy support services in both the proposed PACT and BHGH. However, one thing Medicaid cannot do is pay for housing. It is federally disallowed to use a clinical service as a substitute for housing. It is expected that the care management component in a BHGH is providing tenancy services to secure permanent housing when that member is ready to step down.

Concurrent services: The department agrees with the commenter that services provided through CBPRS are an integral part of a member's recovery. The department allows concurrent billing of CBPRS if the service is provided outside the group home setting, in the community, by staff who are not employed in the group

home when it is medically necessary. In addition, it is expected that services provided in CBPRS are provided by group home staff when the member is present in the group home as an integral component of a therapeutic group home setting.

Reimbursement: The services in a BHGH instruct, assist, and support a member in areas such as medication education and monitoring, basic social and living skills in mental illness symptom management, household management and community living transitions to encourage self-sufficiency. These services must be included in the bundled rate for BHGH as payment for room and board are not authorized through Medicaid (42 CFR 441.360). The reimbursement rate for BHGH was determined using the methodology agreed upon between the department and stakeholders. The department received feedback from stakeholders regarding the salaries that are required to hire and retain staff. Included in the calculation are the salaries provided from this feedback, benefits, overhead, and a productivity factor. This is consistent with the recommended rate methodology employed by CMS.

Length of stay and continued stay requirements: The proposed BHGH encompasses mental health services that are rehabilitative and enable the member to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills when these abilities are impaired by the symptoms of mental illness. The department expects that members would require and receive less supervision as their treatment progresses and they have gained necessary skills towards independent living. In addition, the department did not designate the amount of each service component each member receives and expects members receive individualized treatment.

Due to the short-term nature inherent with rehabilitative services the department believes a 60-day continued stay review is appropriate to ensure members continue to meet the medical necessity requirements for this service and are making progress towards self-sufficiency. Providers are required to refer members to be screened for the HCBS SDMI waiver program if they require more than a 120-days' stay to determine if the member would be better served with long term services and supports. If the member does not meet the requirements for the waiver, the member may continue to receive services at the BHGH if they continue to meet the medical necessity requirements of this service. The department disagrees with comments that we have removed long-term group homes; we have simply put them under the appropriate federal authority, the 1915(c) HCBS SDMI waiver.

The department also disagrees that we have introduced a rule that will make members homeless; to the contrary we have built in tenancy services and instituted a requirement for waiver referral in the event that a member requires long term services and supports.

COMMENT #8: Commenters requested the department reconsider the progress note requirement on BHGH due to the time it would take away from client care and burden it places on staff. In addition, a commenter requested clarification on the turnaround time for progress notes for when they must be in the member's chart.

RESPONSE #8: The progress notes are required in ARM 37.85.414, ARM 37.106.1909, and the General Medicaid Manual and are not new requirements. Policy 130 was added to assist providers in complying with these requirements. Pursuant to ARM 37.85.414(1)(a), "All records which support a claim for a service or item must be complete within 90 days after the date on which the claim was submitted to Medicaid for reimbursement. A record that is required to be signed and dated, including but not limited to an order, prescription, certificate of medical necessity, referral or progress note, is not complete until it has been signed and dated." The services that are in the Addictive and Mental Disorder Division, Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health are all clinical in nature and, beyond the rule, it is a best practice in healthcare to document clinical care precisely and accurately.

COMMENT #9: A commenter requested that, in Policy 115 [*Assessments]* (5), the word "narrative" be optional or replaced with "content must be present" with regard to assessment requirements.

RESPONSE #9: This comment is outside of this rulemaking process; however, ARM 37.106.1915(1) requires information to be presented in a narrative form.

COMMENT #10: A commenter requested Policy 115 [*Assessments*] be revised to remove (5)(n) initial treatment plan goals. The commenter stated that since assessments do not always result in a recommendation for treatment that the treatment recommendations in (5)(m) should suffice.

RESPONSE #10: The department has considered the commenter's request and will revise the language in Policy 115 (5) to reflect the requested change.

COMMENT #11: A commenter requested the following change to Policy 120 (4): replace "The treatment plan must be completed upon admission to be revised" with "Initial treatment goals will be established per ARM 37.106.1915 (1)(d). The treatment plan must be complete within 21 days of admission and reviewed and updated…" The commenter suggested this change is consistent with Mental Health Center requirements in ARM 37.106.1916.

RESPONSE #11: The department has considered the commenter's request and will revise language in Policy 120 *Individualized Treatment Plans for Behavioral Health Treatment* to be consistent with Mental Health Center requirements in ARM 37.106.1916.

COMMENT #12: Commenters noted the following errors:

- An error in Policy 530, page 2 under Utilization Management #3; "(ASAM 3.5) level of care" should be "(ASAM 2.5) level of care".
- An error in Policy 525 under Utilization Management #3; "(ASAM 3.5) level of care" should be "(ASAM 2.1) level of care"

RESPONSE #12: The department recognizes these errors and will correct the referenced policies.

COMMENT #13: A commenter requested adding "mental health professional" in Provider Requirements in Policy 425, so the policy will read: "MH OP Therapy may be provided by a ~~licensed~~ licensure candidate clinical mental health professional or a *mental health professional"*.

RESPONSE #13: The department has considered this request and will change Policy 425 *Mental Health (MH) Outpatient (OP) Therapy* under Provider Requirements to read "MH OP Therapy may be provided by a master's level licensed mental health professional. Licensure candidates may provide MH OP Therapy when employed by a licensed Mental Health Center."

COMMENT #14: A commenter stated that Policy 455 (8) and (10) and Policy 460 (9) and (11) need clarification as they seem to conflict. One states they must bill the bundled rate and the other states that they must bill fee for service if they have had vacant positions for 90 days.

RESPONSE #14: Assertive Community Treatment (ACT) is an evidence-based practice that improves outcomes for members with severe mental illness who are most at-risk of psychiatric crisis and hospitalization and involvement in the criminal justice system through a multidisciplinary team approach with assertive outreach in the community. PACT teams who have been understaffed for an extended period of time no longer meet the multidisciplinary team approach paramount to the fidelity of the PACT. In addition, the established fee structure for PACT services assumes a fully staffed PACT team; therefore, in order to continue to bill for this service, providers must have staffed PACT teams. The department will waive the staffing requirement in order to give providers time to rehire for team members as vacancies occur; however, if after 90 days the vacancies are not filled, the provider must convert to billing fee for the actual services rendered until the vacancies are filled.

COMMENT #15: A commenter requested the department consider removing the phrase "that are relevant to service provision" from the proposed language in Policy 120 to ensure all issues related to a person's condition are identified.

RESPONSE #15: The department has considered the commenter's request and will revise language in Policy 120 Individualized Treatment Plans for Behavioral Health Treatment and will make the requested change.

COMMENT #16: A commenter requested the department consider allowing reimbursement for three to five Certified Behavioral Health Peer Support Specialist sessions prior to determining a SDMI or Substance Use Disorder (SUD) diagnosis. This request relates to Policies 415 and 515 (Mental Health and Substance Use Disorder Peer Support Services).

RESPONSE #16: This request is outside the scope of the proposed rule change; however, the department implemented the program consistent with 37-38-102(2), MCA, as well as Medicaid billing requirements.

COMMENT #17: A commenter requested the department include a definition of "face-to-face" in the Definitions Policy and that "face-to-face" include video therapy.

RESPONSE #17: The department has considered this request and will add a definition of "face-to-face services" to Policy 002 *Definitions* to the *Addictive and Mental Disorders Division Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health*.

COMMENT #18: A commenter requested the department provide clarification between Policy 455 (3) *Community Maintenance Program - Stand-alone (sCMP)* and Policy 460 (4) *Program of Assertive Community Treatment (PACT)* regarding number of members served. The commenter brought attention to sCMP policy stating that services can be provided to up to 50 members while PACT services can be provided to up to 100 members for all three tiers.

RESPONSE #18: Policy 455 *Community Maintenance Program – stand-alone (sCMP)* and the Community Maintenance Program as part of the PACT tiered system are two entirely distinct programs. Based upon this statement, as well as other occasions when this has caused confusion, the department has decided to rename the stand-alone community maintenance program to Montana Assertive Community Treatment program. The purpose of this service is to provide an assertive community treatment program that reflects the rural and frontier nature of the state of Montana.

In sum, there are four bundled assertive community treatment services. In addition to the newly named Montana Assertive Community Treatment (MACT), there are three bundled services that are part of the PACT tiered system:

- InPACT - an intensive transitional PACT service within a residential setting for members who need short-term supervision, stabilization, treatment, and behavior modification in order for a member to be able to reside outside of a structured setting.
- PACT - a member-centered, recovery oriented, mental health services delivery model for facilitating community living, psychosocial rehabilitation, and recovery for members who have not benefited from traditional outpatient services.
- Community Maintenance Program (CMP) - is intended to provide medication and community support for members who require long-term, ongoing support at a higher level than traditional outpatient services in order to be maintained successfully in the community and remain out of higher levels of care.

The fourth service, proposed in Policy 455, Community Maintenance Program – Standalone (sCMP), is a standalone service that is provided in an area that does not have enough Montana Medicaid members/available staffing to merit the provision of

a full PACT team. This service's name will be changed to Montana Assertive Community Treatment (MACT) in the final rule to avoid confusion.

The first three services are all provided as part of the PACT tiered system and provided by a PACT team operating under the staffing and client ratios described in Policy 460, Program for Assertive Community Treatment.

COMMENT #19: A commenter requested the department consider the 2 FTE in Policy 460 (7)(k) be optional due to many organizations having existing infrastructures in place that make these positions essential. This requirement makes these positions redundant for those organizations.

RESPONSE #19: The PACT fidelity model requires a dedicated administrative assistant for a PACT team. The department increased the number to two based upon feedback received from the Behavioral Health Alliance of Montana's stakeholder meetings to assist with the documentation and utilization requirements of this program. These positions are built into the rate structure agreed upon; therefore, they cannot be "optional" without changing the agreed upon rate structure. The department is open to continued conversations about this topic.

COMMENT #20: A commenter requested information about how nursing service will be reimbursed when a PACT provider is required to bill fee-for-service due to vacant positions.

RESPONSE #20: The department issued a Provider Notice, *Nurse Visit – Appropriate Billing Reminder,* dated May 29, 2019, that provides guidance on the appropriate billing for nursing services, located at: https://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2019PN/provnoticensursevisitappropriatebillingreminderrev05292019.pdf.

COMMENT #21: A commenter requested billing requirements to be clarified for PACT services.

RESPONSE #21: In order to bill for PACT services, a provider must have approval from the department for the PACT team, be a mental health center, have received appropriate training, and have the necessary staff in place. PACT is billed on a 1500 form and the member must meet medical necessity criteria.

COMMENT #22: A commenter requested changing preauthorization and review requirements from "36 hours" to "three business days" in Policy 545 *SUD Medically Monitored Intensive Outpatient (ASAM 3.7)*, utilization management section. This would match language in Section 2 *Utilization Management*.

RESPONSE #22: The department will add clarification for utilization management prior authorization for Policy 545 *SUD Medically Monitored Intensive Inpatient (ASAM 3.7)* to be consistent with Policy 206 *Requesting a Prior Authorization –Acute Services*.

COMMENT #23: A commenter recommended the following change to Policy 206/206a: *(2) Continued stay reviews are required for more than five ~~eight~~ days in the Crisis Stabilization Program, and will be required every three days thereafter, and may be submitted via Auto-Authorization (Policy 206/206a).*

RESPONSE #23: The department has considered the commenter's request and will make the requested change to Policy 206 *Requesting Auto Authorization – Acute Services* and Police 206a *Auto Authorization Quality Assurance.*

COMMENT #24: A commenter requested that Policy 550 (1)(a) Medication Assisted Treatment (MAT) include alcohol as clinically indicated for this service. The commenter additionally requested that alcohol be added to the Policy 002 Definitions.

RESPONSE #24: This request is outside the scope of proposed rule changes. The department intends to review the MAT section of the manual in the fall and will consider this comment at that time.

COMMENT #25: Two commenters requested the department reconsider requiring providers to use the Milliman Care Guidelines (MCG) due to the unexpected cost to providers to access the material.

RESPONSE #25: The department will remove the reference to MCG and include medical necessity criteria consistent with the PACT fidelity model in the Addictive and Mental Disorders, Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health.

COMMENT #26: A commenter asked if beds in BHGH may be used to serve member who are in InPACT.

RESPONSE #26: The department has determined that members who are receiving InPACT may reside in a BHGH. Providers must bill for the service being provided and may not bill for both InPACT and BHGH concurrently. The provider must meet the licensure requirements for the service being billed. The member receiving services in InPACT must be provided services from the PACT team. PACT team members are dedicated staff; therefore, the clinical, care management, and certified behavioral peer support components in the BHGH cannot replace services of the PACT team nor can the PACT team provide services to members who are not admitted into the PACT program. This must be clearly documented.

COMMENT #27: A commenter asked if a BHGH can be used to house members receiving PACT if they are homeless.

RESPONSE #27: Montana Medicaid cannot pay for room and board. If a homeless individual meets the criteria for either inPACT or BHGH, the appropriate service may be billed. Clinical criteria are independent of housing status but housing status

should be considered as part of the holistic assessment that includes social determinants of health when determining a member's clinical needs.

COMMENT #28: A commenter asked if a member could receive Day Treatment services in the morning and Community Based Psychiatric Rehabilitative Services (CBPRS) in the afternoon.

RESPONSE #28: There were no substantive changes to these two services in this proposed rulemaking. A member can still receive Day Treatment Services in the morning and CBPRS in the afternoon. The department recommends providers follow best practices for coordination of care and documentation that speaks to the medical necessity of each service.

COMMENT #29: A commenter requested that the language in Policy 460, page two, Medical Necessity for PACT, be modified from "three days per week" to "three contacts per week."

RESPONSE #29: The department reviewed Policy 460 and determined that it already reads "three contacts per week."

COMMENT #30: A commenter asked that since members in PACT need to be staffed three times per week and members in InPACT need to be staffed five times per week, do they need to document the staff who are present at the meetings.

RESPONSE #30: The ACT model states that the team must meet daily; this includes the entire team. The team must document which members they discussed during the meetings. Documentation of staff members present at daily team meetings would reflect adherence to the PACT fidelity model.

COMMENT #31: A commenter requested information pertaining to the admission process and how to notify the state when a member is admitted, as prior authorization is not required but continued stay reviews are required for PACT and Community Maintenance Program.

RESPONSE #31: The admission process for each provider does not change with the exception that the provider will not need to submit a prior authorization request. It is the provider's responsibility to track the number of service days provided and request a continued stay review pursuant to policy/rule.

COMMENT #32: A commenter requested that the DLA-20 assessment that is required for Substance Use Disorder Intensive Outpatient Therapy Services be amended to reflect that it is required for only adult patients as there is not a DLA-20 assessment for adolescent members.

RESPONSE #32: The comment is outside of this rulemaking process. The department will issue a provider notice that will provide direction regarding this request.

4. These rule amendments are effective July 1, 2020.

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

Certified to the Secretary of State June 16, 2020.