DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES	**Behavioral Health and Developmental Disabilities (BHDD) Division** Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health
	Date effective: ~~May 12, 2023~~ October 1, 2024
Policy Number: *445*	**Subject:** Behavioral Health Group Home (BHGH)

Definition

A BHGH provides short-term supervision, stabilization, treatment, and behavioral modification in order for the member to be able to reside outside of a structured setting. Trained staff members are present 24/7 to provide care and assistance with daily needs like medication, daily living skills, meals, paying bills, transportation, and treatment management.

Medical Necessity Criteria

(1) The member meets the Severe and Disabling Mental Illness (SDMI) criteria, as described in this manual and ONE of the following;

- (a) Recurrent inpatient admissions (2 or more inpatient psychiatric admissions within the last 12 months);
- (b) Re-occurring homelessness, and/or at risk of homelessness, due to mental health symptoms, within the last 12 months;
- (c) Incarceration and/or involvement in the criminal justice system, due to mental health symptoms, within the last 12 months;
- (d) Member has utilized emergency services more than 2 times within the last 90 days, such as emergency department, police department, crisis receiving/stabilization, mobile crisis response services, or 988; and/or
- (e) Member has shown difficulty benefiting or properly utilizing mental health outpatient services, outlined in this manual, and requires a coordinated and intensive delivery approach to meet the needs of the member.

(2) ~~The member meets the Level of Impairment for this level of care; and~~ The member must meet a high level of impairment (LOI), regardless of diagnosis, in Area 1: Self-Care/Basic Needs.

The state plan LOI can be found at: https://dphhs.mt.gov/assets/BHDD/AdultMHGeneralDocs/StatePlanSDMILOIForm508compliant.pdf

(3) ~~The member requires the provision of service for BHGH level of care.~~

Provider Requirements

(1) A provider of BHGH must be a licensed MHC with an endorsement to provide group home services.

(2) BHGHs must have the following full-time equivalency (FTE) staff:

(a) Program Supervisor, .5 FTE;
(b) Residential Manager, 1 FTE;
(c) Care Manager, 1 FTE;
(d) 24-hour awake staff; and
(e) Certified Behavioral Health Peer Support Specialist, .5 FTE.

(3) The role of the program supervisor is to:

(a) provide clinical oversight to the treatment team within the group home;
(b) conduct and supervise the treatment plan;
(c) provide clinical treatment to the member, as medically necessary;
(d) have knowledge of each member in the house; and
(e) have at least one contact with each member per week.

(4) The role of the residential manager is to:

(a) coordinate and manage the operation of group homes and supervise staff;
(b) provide training and supervision to staff in accordance with state and federal requirements and regulations;
(c) participate as part of an interdisciplinary team in the development and implementation of each member's individual treatment plans;
(d) maintain staff schedule according to staffing limitations;
(e) seek input and maintain effective communication with clinical program supervisor;

(f) plan and participate directly in recreational, therapeutic, and training activities of the members;

(g) provide on-call services and respond to house needs;

(h) comply with all standards to assure the health and safety of member and staff; and

(i) report any suspected abuse, neglect or exploitation to the department.

Service Requirements

(1) BHGH must be billed as a bundled rate and includes the following:

(a) residential services for supervision and safety, 24-hours a day;

(b) behavioral modification and management; ~~and~~

(c) care management~~.~~; and

(d) peer support

(2) BHGHs must complete the following documentation for all services billed, as described in the BHDD Medicaid Provider Manual for each member:

(a) an annual clinical assessment;

(b) a social determinants of health assessment upon admission and annually for each member who is authorized to receive services for more than 365 days;

(c) an individualized treatment plan;

(d) a Serious and Disabling Mental Illness and Level of Impairment worksheet upon admission and updated annually as required in Policy 105 of this manual; and

(e) a progress note for each shift.

(3) Members receiving BHGH may choose to receive Day Treatment services concurrently with BHGH.

Utilization Management

(1) Prior authorization is required and may be approved for up to 120 days.

(2) Continued stay reviews are required every 60 days thereafter.

(3) For continued stays, the member must meet the following:

(a) Member continues to meet the SDMI criteria as defined in this manual;

(b) Member continues to meet the high level of impairment required for BHGH services;

(c) Member is assessed to not be at risk of imminent danger to self or others, as defined in 53-21-102, MCA (7)(a)(b), as an "emergency situation";

(d) Member is willing and able to continue participation in BHGH services; and

(e) Member also meets at least one of the following:

(i) Member has not achieved the desired outcome(s) of their treatment plan, which continues to address the medical necessity deficiencies;

(ii) Member's level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual treatment plan;

(iii) Member has achieved current individual treatment plan goals, but additional goals are indicated as evidenced by documented symptoms;

(iv) Member is making satisfactory progress towards meeting goals and there is documentation that supports the continuation of BHGH services shall be effective in addressing the goals outlined in the individualized treatment plan; or

(v) Member is failing to make progress, or shows regression in meeting goals, though interventions and modifications have been made in the treatment plan to continue to address medical necessity deficiencies.

~~(3)~~ (4) If a member requires services beyond 180 days, the member must be referred for screening and evaluation for the SDMI, Home and Community Based Services (HCBS) waiver. If the member does not qualify for the SDMI HCBS waiver, or is placed on the SDMI HCBS waiver waitlist, the provider may request additional continued stay reviews as directed in (2) of this section.

~~(4)~~ (5) The provider must document in the file of the member that the member meets the medical necessity criteria.