MONTANA
ADMINISTRATIVE
REGISTER

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED RULEMAKING

MAR NOTICE NO. 2026-525.1

Summary

Amendment of ARM 37.85.105, 37.87.102, 37.87.903, 37.87.1226, 37.87.1404, 37.87.1414, 37.87.1415, 37.87.1803, 37.106.1902, 37.106.1956, and 37.106.1961, pertaining to CSCT and HSS Rate Restructure and Service Provision

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Hearing Date and Time

Friday, April 10, 2026, at 11:00 a.m.

Virtual Hearing Information

Join Zoom Meeting: https://mt-gov.zoom.us/j/85174817727?pwd=FMO13b4LbhnqkaBJTy5qZ7FMaNYNIQ.1

Meeting ID: 851 7481 7727 and Password: 371111

Dial by Telephone: +1 646 558 8656

Meeting ID: 851 7481 7727 and Password: 371111

Find your local number: https://mt-gov.zoom.us/u/koyuKrLc2

Comments

Comments may be submitted using the contact information below. Comments must be received by Friday, April 17, 2026, at 5:00 p.m.

Accommodations

The agency 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. Requests must be made by Friday, March 27, 2026, at 5:00 p.m.

Contact

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Rulemaking Actions

AMEND

The rules proposed to be amended are as follows, stricken matter interlined, new matter underlined:

37.85.105 EFFECTIVE DATES, CONVERSION FACTORS, POLICY ADJUSTERS, AND COST-TO-CHARGE RATIOS OF MONTANA MEDICAID PROVIDER FEE SCHEDULES

(1) The Montana Medicaid Program establishes provider reimbursement rates for medically necessary, covered services based on the estimated demand for services and the legislative appropriation and federal matching funds. Provider reimbursement rates are stated in fee schedules for covered services applicable to the identified Medicaid program. New rates are established by revising the identified program's fee schedule and adopting the new fees as of the stated effective date of the schedule. Copies of the department's current fee schedules are posted at http://medicaidprovider.mt.gov. A description of the method for setting the reimbursement rate and the administrative rules applicable to the covered service are published in the chapter or subchapter of this title regarding that service. The department will make periodic updates, as necessary, to the fee schedules noted in this rule to include new procedure codes and applicable rates and to remove terminated procedure codes.

(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) Resource-based relative value scale (RBRVS) means the version of the Medicare resource-based relative value scale contained in the Medicare

Physician Fee Schedule adopted by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services and published at 89 Federal Register 97710 (December 9, 2024), effective January 1, 2025, which is adopted and incorporated by reference. Procedure codes created after January 1, 2025, will be reimbursed using the relative value units from the Medicare Physician Fee Schedule in place at the time the procedure code is created.

(b) Fee schedules are effective July 1, 2025. The fee schedules are applicable to claims for services that are provided on or after the effective date; prior fee schedules remain applicable to claims for services provided prior to that date.

(i) The conversion factor for physician services is $45.41. The conversion factor for allied services is $28.23. The conversion factor for mental health services is $22.24. The conversion factor for anesthesia services is $32.82.

(c) Policy adjustors are effective July 1, 2023. The maternity policy adjustor is 100%. The family planning policy adjustor is 105%. The psychological testing policy adjustor is 200%. The psychological testing policy adjustor applies only to psychologists.

(d) The BCBA/BCBA-D services policy adjuster is 115.8%, effective July 1, 2021.

(e) The payment-to-charge ratio is effective July 1, 2025, and is 47.42% of the provider's usual and customary charges.

(f) The specific percentages for modifiers adopted by the department are effective July 1, 2016.

(g) Psychiatrists receive a 112% provider rate of reimbursement adjustment to the reimbursement of physicians effective July 1, 2016.

(h) Midlevel practitioners receive a 90% provider rate of reimbursement adjustment to the reimbursement of physicians for those services described in ARM 37.86.205(5)(b), effective July 1, 2016.

(i) Optometric services receive a 114.53% provider rate of reimbursement adjustment to the reimbursement for allied services, as provided in ARM 37.85.105(2), effective July 1, 2025.

(j) Reimbursement for physician-administered drugs described in ARM 37.86.105 is determined pursuant to 42 U.S.C. 1395w-3a.

(k) Reimbursement for vaccines described at ARM 37.86.105 is effective July 1, 2020.

(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 July 1, 2025; and

(ii) the Montana Medicaid APR-DRG relative weight values, average national length of stay (ALOS), outlier thresholds, and APR grouper version 42.0, contained in the APR-DRG Table of Weights and Thresholds, effective July 1, 2025. The department adopts and incorporates by reference the APR-DRG Table of Weights and Thresholds effective July 1, 2025.

(b) The outpatient hospital services fee schedules including:

(i) the Outpatient Prospective Payment System (OPPS) fee schedule as published by the CMS in 89 Federal Register 93912 (Nov. 27, 2024), effective January 1, 2025, and reviewed annually by CMS, as required in 42 CFR 419.50 and as updated by the department;

(ii) the conversion factor for outpatient services on or after July 1, 2025 is $62.54;

(iii) the Medicaid statewide average outpatient cost-to-charge ratio is 48.59%; and

(iv) the bundled composite rate of $290.32 for services provided in an outpatient maintenance dialysis clinic effective on or after July 1, 2025.

(c) The hearing aid services fee schedule, as provided in ARM 37.86.805, is effective July 1, 2025.

(d) The Relative Values for Dentists, as provided in ARM 37.86.1004, reference published in 2025 resulting in a dental conversion factor of $39.52 and fee schedule is effective July 1, 2025.

(e) The Dental and Denturist Program Provider Manual, as provided in ARM 37.86.1006, is effective July 1, 2025.

(f) The outpatient drugs reimbursement dispensing fees range as provided in ARM 37.86.1105(3)(b), is effective July 1, 2025:

(i) for pharmacies with prescription volume between 0 and 39,999, the minimum is $4.11 and the maximum is $17.52;

(ii) for pharmacies with prescription volume between 40,000 and 69,999, the minimum is $4.11 and the maximum is $15.17; or

(iii) for pharmacies with prescription volume greater than or equal to 70,000, the minimum is $4.11 and the maximum is $12.83.

(g) The outpatient drugs reimbursement compound drug dispensing fee range, as provided in ARM 37.86.1105(5), will be $12.50, $17.50, or $22.50, based on the level of effort required by the pharmacist, effective July 1, 2013.

(h) The outpatient drugs reimbursement vaccine administration fee, as provided in ARM 37.86.1105(6), will be $21.32 for the first vaccine and $16.04 for each additional vaccine administered on the same date of service, effective July 1, 2025.

(i) The outpatient drugs reimbursement, unit dose prescriptions fee as provided in ARM 37.86.1105(10), will be $0.75 per pharmacy-packaged unit dose medication, effective November 1, 2013.

(j) The home infusion therapy services fee schedule, as provided in ARM 37.86.1506, is effective July 1, 2025.

(k) Montana Medicaid adopts and incorporates by reference the Region D Supplier Manual, 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 July 1, 2025. The prosthetic devices, durable medical equipment, and medical supplies fee schedule, as provided in ARM 37.86.1807, is effective July 1, 2025.

(l) The nutrition services fee schedule, as provided in ARM 37.86.2207(2), is effective July 1, 2025.

(m) The children's special health services fee schedule, as provided in ARM 37.86.2207(2), is effective July 1, 2019.

(n) The orientation and mobility specialist services fee schedule, as provided in ARM 37.86.2207(2), is effective July 1, 2025.

(o) The transportation and per diem fee schedule, as provided in ARM 37.86.2405, is effective July 1, 2025.

(p) The specialized nonemergency medical transportation fee schedule, as provided in ARM 37.86.2505, is effective July 1, 2025.

(q) The ambulance services fee schedule, as provided in ARM 37.86.2605, is effective July 1, 2025.

(r) The audiology fee schedule, as provided in ARM 37.86.705, is effective July 1, 2025.

(s) The therapy fee schedules for occupational therapists, physical therapists, and speech therapists, as provided in ARM 37.86.610, are effective July 1, 2025.

(t) The optometric services fee schedule, as provided in ARM 37.86.2005, is effective July 1, 2025.

(u) The chiropractic fee schedule, as provided in ARM 37.85.212(2), is effective July 1, 2025.

(v) The lab and imaging services fee schedule, as provided in ARM 37.85.212(2) and 37.86.3007, is effective July 1, 2025.

(w) The Targeted Case Management for Children and Youth with Special Health Care Needs fee schedule, as provided in ARM 37.86.3910, is effective July 1, 2025.

(x) The Targeted Case Management for High-Risk Pregnant Women fee schedule, as provided in ARM 37.86.3415, is effective July 1, 2025.

(y) The mobile imaging services fee schedule, as provided in ARM 37.85.212, is effective July 1, 2025.

(z) The licensed direct-entry midwife fee schedule, as provided in ARM 37.85.212, is effective July 1, 2025.

(aa) The private duty nursing services fee schedule, as provided in ARM 37.86.2207(2), is effective July 1, 2025.

(4) The department adopts and incorporates by reference, the fee schedule for the following programs within the Senior and Long Term Care Division on the date stated:

(a) The Big Sky Waiver home and community-based services for elderly and physically disabled persons fee schedule, as provided in ARM 37.40.1421, is effective July 1, 2025.

(b) The home health services fee schedule, as provided in ARM 37.40.705, is effective July 1, 2025.

(c) The personal care services fee schedule, as provided in ARM 37.40.1135, is effective July 1, 2025.

(d) The self-directed personal care services fee schedule, as provided in ARM 37.40.1135, is effective July 1, 2025.

(e) The community first choice services fee schedule, as provided in ARM 37.40.1026, is effective July 1, 2025.

(5) The department adopts and incorporates by reference, the fee schedule for the following programs within the Behavioral Health and Developmental Disabilities Division on the date stated:

(a) The mental health center services for adults fee schedule, as provided in ARM 37.88.907, is effective July 1, 2025.

(b) The home and community-based services for adults with severe disabling mental illness fee schedule, as provided in ARM 37.90.408, is effective July 1, 2025.

(c) The substance use disorder services fee schedule, as provided in ARM 37.27.905, is effective July 1, 2025.

(6) For the Behavioral Health and Developmental Disabilities Division, the department adopts and incorporates by reference the Medicaid youth mental health services fee schedule, as provided in ARM 37.87.901, ~~effective July 1, 2025~~ May 9, 2026.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-125, 53-6-402, MCA

37.87.102 MENTAL HEALTH SERVICES (MHS) FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE (SED), DEFINITIONS

As used in this chapter, the following terms apply:

(1) "In-training mental health professional services" ~~refers to~~means services provided by a licensure candidate in accordance with ARM 37.85.213.

(2) "Licensed mental health center" means a mental health center licensed in accordance with ARM 37.106.1906 through 37.106.1965.

(3) "Medically necessary service" ~~for Medicaid is defined~~ has the same meaning as provided in ARM 37.82.102.

(4) "Mental health professional" means one of the following practitioners:

(a) physician;

(b) licensed professional counselor;

(c) licensed psychologist;

(d) licensed clinical social worker;

(e) licensed marriage and family therapist; or

(f) advanced practice registered nurse, with a clinical specialty in psychiatric mental health nursing.

(5) "Provider" means a person or entity that has enrolled and entered into a provider agreement with the department in accordance with the requirements of ARM

37.85.401 through 37.85.513 to provide mental health services to youth with SED on Medicaid.

(6) "Provider agreement" means the written enrollment agreement entered into between the department and a person or entity to provide mental health services to youth with SED.

(7) "Serious emotional disturbance (SED)" criteria are defined in the Children's Mental Health Bureau, Medicaid Services Provider Manual as adopted and incorporated by reference in ARM 37.87.903.

(8) "System of care account" ~~is defined~~ has the same meaning as provided in 52-2-309, MCA, and allows the department to fund via the state special revenue fund the administering and delivering of services to high-risk youth with multiagency service needs and to provide for the youth's care, protection, and mental, social, and physical development.

(9) "Youth" means, for Medicaid services, ~~a person 17 years of age and younger or~~ a person who is up to 20 years of age ~~and is enrolled in an accredited secondary school~~. A youth may receive Psychiatric Residential Treatment Facility services through the age of 17.

Authorizing statute(s): 53-2-201, 53-6-113, 53-21-703, MCA

Implementing statute(s): 53-1-601, 53-1-602, 53-1-603, 53-2-201, 53-21-701, 53-21-702, MCA

37.87.903 MEDICAID MENTAL HEALTH SERVICES FOR YOUTH, AUTHORIZATION REQUIREMENTS

(1) The department will not reimburse providers for two services that duplicate one another on the same day.

(2) The department will reimburse providers of Medicaid mental health youth services if they meet the prior authorization or continued stay review requirements specified in the Children's Mental Health Medicaid Services Provider Manual, referenced in (7).

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

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

(b) group outpatient therapy.

(4) The department may waive a requirement for prior authorization or continued authorization when the provider submits documentation that:

(a) there was a clinical reason why the request for prior authorization or continued authorization could not be made at the required time, and the provider submitted a subsequent authorization request within ten business days; or

(b) a timely request for prior authorization or continued authorization was not possible because of an equipment failure or malfunction of the department or its designee that prevented the transmittal of the request at the required time and the provider submitted a subsequent authorization request within ten business days.

(5) In computing any time period specified in this subchapter, every day is counted, including Saturdays, Sundays, and legal holidays. If the last day falls on a weekend or holiday, the deadline is the next business day.

(6) If the department finds exceptional circumstances that reasonably justify a provider's failure to timely request prior authorization or continued authorization, it may extend the deadline for meeting the requirement.

(7) In addition to the requirements contained in rule, the department has developed and published a provider manual entitled Children's Mental Health Medicaid Services Provider Manual (manual), dated ~~May 12, 2023~~ May 9, 2026, for the purpose of implementing requirements for utilization management. The department adopts and incorporates by reference the Children's Mental Health Medicaid Services Provider Manual, dated ~~May 12, 2023~~ May 9, 2026. A copy of the manual may be obtained at https://dphhs.mt.gov/bhdd/cmb/Manuals.

(8) The department may review the medical necessity of services or items at any time either before or after payment in accordance with the provisions of ARM 37.85.410. If the department determines that services or items were not medically necessary or were otherwise not in compliance with applicable requirements, the department may deny payment or may recover any overpayment in accordance with applicable requirements.

(9) The department or its designee may require providers to report outcome data or measures regarding mental health services, as determined in consultation with providers and interested persons.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-111, MCA

37.87.1226 OUT-OF-STATE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES, REIMBURSEMENT

(1) The Montana Medicaid Program will reimburse a provider of inpatient psychiatric services provided to a youth in a psychiatric residential treatment facility (PRTF) for each patient day, in accordance with the requirements of this subchapter and the Children's Mental Health Bureau Medicaid Services Provider Manual, adopted and incorporated by reference in ARM 37.87.903.

(2) The Montana Medicaid Program will reimburse a provider for each Medicaid patient day the following bundled per diem rate less any third party or other payments. The bundled per diem rate for out-of-state PRTF services is the lesser of:

(a) the amount specified in the department's Medicaid Youth Mental Health fee schedule, as adopted in ARM 37.85.105; or

(b) the provider's usual and customary charges.

(3) The bundled per diem rate for out-of-state PRTFs services coverage includes the following services:

(a) all services, therapies, and items related to treating the psychiatric condition of the youth;

(b) all services provided by licensed physicians, psychiatrists, midlevel practitioners, psychologists, clinical social workers, and professional counselors;

(c) psychological testing;

(d) lab and pharmacy services <u>related to treating the psychiatric condition of the youth</u>; and

(e) supportive services necessary for daily living and safety.

(4) The Montana Medicaid Program will reimburse enrolled providers directly for the following services which are not included in the out-of-state per diem rate:

(a) up to 60 consecutive days of targeted case management services for the purpose of planning the youth's transition to the community. A youth should retain the case manager the youth had prior to entry into PRTF services, if applicable. If the youth is assigned a case manager who is different from the one previous to PRTF services, the case manager must document the rationale for the change; and

(b) a clinical intake assessment by a licensed mental health center, with an endorsement to provide adult services for transition age youth 17 to 18, to determine whether they have a severe and disabling mental illness and if they qualify for adult mental health services.

(5) The Montana Medicaid Program will reimburse state plan ancillary services in addition to the out-of-state bundled per diem rate when these ancillary services are provided by a different provider under arrangement with the PRTF. The ancillary services provided must be:

(a) directed by the PRTF physician;

(b) stated in the treatment plan of the youth; and

(c) documented in the medical records for the youth.

Authorizing statute(s): 53-6-101, MCA

Implementing statute(s): 53-6-113, MCA

37.87.1404 HOME SUPPORT SERVICES (HSS) AND THERAPEUTIC FOSTER CARE (TFC), INDIVIDUALIZED TREATMENT PLAN

(1) The individualized treatment plan (ITP) must be developed in accordance with ARM 37.106.1916.

(2) The caregiver may select the members of the ITP team.

(3) Providers must inform the youth and their caregiver that Medicaid requires coordination of HSS and TFC with comprehensive school and community treatment (CSCT) planning, when applicable<u>, and coordination of HSS with therapeutic group home (TGH) and outpatient therapy treatment planning, when applicable</u>.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, MCA

37.87.1414 HOME SUPPORT SERVICES (HSS), PROVISIONS OF SERVICE

(1) Home support services (HSS) providers must support the strengths of youth and caregivers by:

(a) identifying behavioral health abilities and needs across key areas such as school, family, social, community, and vocational environments;

(b) identifying strengths that can form the basis of the treatment plan in the areas of school, family, social, community, and vocational functioning; and

(c) prioritizing the most critical behavioral health needs and concerns as the focus of the treatment planning and delivery.

(2) HSS providers must engage in treatment planning that:

(a) clearly states the treatment goals identified in the clinical eligibility recommendation;

(b) is based on the functional assessment conducted pursuant to the manual adopted and incorporated by reference in ARM 37.87.903;

(c) is a collaborative process that involves youth and caregivers in developing a treatment plan with a manageable number of prioritized needs along with goals and strategies for addressing each need and goal;

(d) includes goals with measurable and observable outcomes;

(e) includes ~~monthly summaries and~~ updates every 90 days, which include outcome measurements of treatment goals; and

(f) unifies treatment plans with a targeted case ~~manager~~ management (TCM) provider, if applicable, and identifies all services and supports to caregivers.

(3) The provider must conduct a treatment team meeting with the caregiver to develop an individualized treatment plan in accordance with ARM 37.106.1916.

(4) The provider must measure progress on individualized treatment goals, using both the department-approved standardized assessment and treatment goal indicators to measure progress from baseline. Progress towards individualized treatment goals must be considered as part of discharge planning.

(5) The provider must collaborate and coordinate with the TCM provider, if youth and caregivers are engaged in TCM services.

(a) HSS team members may not provide TCM and HSS services to the same youth.

(6) The provider must collaborate with youth and caregivers to identify and address suicidality, risk, and safety concerns at home, in school, and in the community to develop an individualized safety plan for each youth. Individual safety plans must be completed within 21 days of admission to HSS and must be reviewed monthly and after crisis with updates as necessary. Individual safety plans must contain the following components:

(a) delineate required safety planning and processes, youth and caregiver involvement, and plan dissemination;

(b) identification of what is considered a crisis for youth and caregivers;

(c) natural supports currently accessible to the youth and caregivers;

(d) current resources and skills accessible to the youth and caregivers;

(e) crisis escalation patterns and triggers;

(f) de-escalation strategies that are easily understood and can be implemented by the youth and caregivers;

(g) if indicated by suicidality screening, a specific plan to address suicidal thoughts or ideations;

(h) when to call the HSS team; and

(i) when to call 911.

(7) The provider must maintain requirements for crisis response as defined in ARM 37.106.1945. Individual treatment and safety plans must be immediately available to mental health center employees engaged in crisis response.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, MCA

37.87.1415 HOME SUPPORT SERVICES (HSS), PROVIDER REQUIREMENTS

(1) The HSS provider must be a mental health center as described in ARM Title 37, chapter 106, subchapter 19.

(2) HSS teams should consist of a family support specialist (FSS) and a clinical lead.

(3) HSS providers must ensure caseload sizes are sufficiently small to permit home support teams to respond flexibly to differing service needs of youth and families, including frequency of contact. FSS caseloads may vary between ~~4~~ 1 to 14 families.

(4) HSS providers must provide coaching to an FSS on in-home behavioral health skills. The clinical lead shall provide feedback based on observation of practice, review of plans of care and other documentation, and progress for each youth and caregiver. The FSS must meet with their clinical lead regularly. Frequency must be at least once a week, or more frequently based on documented skills and competencies.

(5) Coaching and mentoring must be skills-based and include coaching to promote competencies in key skill sets such as safety planning, behavior management, cognitive behavioral interventions, caregivers and systemic interventions, and psychoeducation.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, MCA

37.87.1803 COMPREHENSIVE SCHOOL AND COMMUNITY TREATMENT PROGRAM: REIMBURSEMENT

(1) Comprehensive school and community treatment (CSCT) services delivered by a licensed mental health center with an endorsement under ARM 37.106.1955 must be billed under the school district's provider number.

(2) CSCT services may be provided to:

(a) youth ages three through five who are receiving special education services from the public school in accordance with an individualized education program (IEP) under the Individuals with Disabilities Education Act (IDEA) or attending a preschool program offered through a public school; and

(b) youth ages six up to age 20, if they are enrolled in a public school.

(3) ~~One team with up to three employees will not be reimbursed for more than 360 service days per team per month~~ A team with one employee will not be reimbursed for more than 450 units per month, and a team with two employees will not be reimbursed for more than 900 units per month. A team of three employees will not be reimbursed for more than 1350 units per month. Billing units are calculated based on the sum total of minutes of CSCT service for the youth per day.

(a) ~~A service day is a minimum of 30 total minutes of core services provided by the CSCT team~~ Core services, meeting the definition of CSCT as a community mental health outpatient treatment under ARM 37.106.1902, include intake and annual assessment, individual therapy, family therapy, group psychotherapy or psychoeducation, behavioral interventions, crisis response during typical working hours, and care coordination.

(b) Care coordination may only be considered a core service and be billable if two other core services are provided within that week. Care coordination includes phone calls, treatment team meetings, IEP meetings, referrals, and school advocacy for youth. Care coordination does not include documentation time. For the purposes of this subsection, a week begins on Monday and ends on Sunday.

~~(i) Core services include intake and/or annual assessment, individual therapy, family therapy, group psychotherapy or psychoeducation, behavioral interventions, crisis response during typical working hours, and care coordination.~~

~~(ii) Care coordination may only be considered a core service and be billable if two other core services are provided within that week (with a week being the period from Monday to Sunday). Care coordination includes phone calls, treatment team meetings, individualized education program (IEP) meetings, referrals, and school advocacy for youth. Care coordination does not include documentation time.~~

(4) If the sum total of daily units per youth is over 16 units, the claim will suspend for clinical review. The provider must submit documentation to the department demonstrating medical necessity of service.

~~(4)~~(5) Up to ~~ten service days~~ 20 CSCT units per youth, per state fiscal year, may be billed for an intervention, assessment, and if necessary, referral to other services. There is no limit on the number of youth that may be served. ~~These service days must be billed as part of the 360 service days monthly team total~~ These units must be billed as part of the 1350-unit monthly team total.

~~(5)~~(6) For a youth to qualify for more than ~~ten service days~~ 20 units of CSCT, a full clinical assessment is required, and the youth must meet the SED criteria identified in the Children's Mental Health Bureau Medicaid Services Provider Manual as referenced in ARM 37.87.903(7).

~~(6)~~(7) The school district as a Medicaid provider of CSCT is subject to all Medicaid state and federal billing rules and regulations. The school district must:

(a) bill all available financial resources for support of services including third party insurance and parent payments, if applicable; and

(b) document services to support the Medicaid reimbursement received.

~~(7)~~(8) The school district or the contracted provider must bill for youth not eligible for Medicaid. The school district may use a sliding-fee schedule.

~~(8)~~(9) The school district must meet the match requirements through the intergovernmental transfer (IGT) process.

~~(9)~~(10) CSCT services rendered to youth attending school in a Montana county with a per capita population of fewer than 6 people per square mile are eligible to receive a frontier community differential of 115% of the current fee schedule, as provided in ARM 37.85.106.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 50-5-103, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.106.1902 MENTAL HEALTH CENTER: DEFINITIONS

In addition to the definitions in 50-5-101, MCA, the following definitions apply to this subchapter:

(1) "Administrator" means a designated individual having daily overall management responsibility for the operation of a mental health center.

(2) "Adult day treatment" means a program which provides a variety of mental health services to adults with mental illnesses.

(3) "Chemical dependency services" means:

(a) screening of a client for substance abuse issues by the mental health center through its clinical intake assessment;

(b) as indicated by the substance abuse screening, the provision or arrangement by the mental health center for a client to be evaluated by a licensed addiction counselor;

(c) in accordance with the evaluation by a licensed addiction counselor, the provision or arrangement by the mental health center of chemical dependency treatment by a licensed addiction counselor or state-approved chemical dependency treatment program; and

(d) the integration and coordination by the mental health center of the client's mental health treatment with the chemical dependency treatment.

(4) "Client" means an adult, child or adolescent, or resident receiving services from a mental health center.

(5) "Community-based psychiatric rehabilitation and support" ~~is as defined~~ has the same meaning as provided in ARM ~~37.88.901~~ 37.87.702.

(6) "Community residential facility" ~~means the definition provided~~ has the same meaning as provided in 76-2-411, MCA.

(7) "Comprehensive school and community treatment program (CSCT)" means a comprehensive, planned course of community mental health outpatient treatment provided in cooperation and under written contract with the school district where the youth attends school. The program must be provided by a licensed mental health center with an endorsement under ARM 37.106.1955, 37.106.1956, 37.106.1960, 37.106.1961, and 37.106.1965.

(8) "Crisis telephone services" means 24 hour telephone response to mental health emergencies for the mental health center's clients.

(9) "Department" means the Department of Public Health and Human Services.

(10) "Forensic mental health facility" (FMHF) means 24-hour, seven days a week, secured nonhospital-based forensic psychiatric treatment for criminal justice involved adults who are committed by a court of competent jurisdiction for the purpose of psychiatric treatment or evaluation.

(11) "Guardian" means a person appointed by a court to make medical, and possibly financial, decisions as provided in Title 72, chapter 5, MCA.

(12) "Individualized education program" (IEP) means a written plan developed and implemented for each student with a disability in accordance with 34 CFR 300.320 through 300.325 amended as of October 30, 2007. The department adopts and incorporates by reference that version of 34 CFR 300.320 through 300.325. A copy of the regulations may be obtained from the Department of Public Health and Human Services, Office of Inspector General, 2401 Colonial Drive, P.O. Box 202953, Helena, MT 59620-2953.

(13) "Individualized treatment plan" means a written plan that outlines individualized treatment activities for maximum reduction of mental disability and restoration of the client's ability to function adequately in the family, at work or school, and as a member of the community.

(14) "Inpatient crisis stabilization facility" means 24 hour supervised treatment for adults with a mental illness for the purpose of stabilizing the individual's symptoms.

(15) "In-training mental health professional" ~~refers to~~ means an individual providing services in accordance with in-training mental health professional services as defined in ARM 37.87.702.

(16) "In-training mental health professional services" ~~is defined~~ has the same meaning as provided in ARM 37.87.702.

(17) "Licensed health care professional" means a licensed physician, physician assistant, advanced practice registered nurse, or registered nurse who is practicing within the scope of the license issued by the Department of Labor and Industry.

(18) "Licensed mental health professional" means:

(a) a physician, clinical psychologist, licensed clinical social worker, licensed marriage and family therapist, or professional counselor licensed to practice in Montana;

(b) an occupational therapist licensed to practice in Montana who has had at least three years' experience dedicated substantially to serving persons with serious mental illnesses and is working in a youth day treatment program or adult day treatment program; or

(c) a registered nurse who has had at least three years experience dedicated substantially to serving persons with serious mental illnesses and is licensed to practice in Montana.

(19) "Medical director" means a physician licensed by the Montana Board of Medical Examiners who oversees the mental health center's clinical services and who has:

(a) at least a three-year residency in psychiatry; or

(b) at least three years' post-graduate psychiatric training in a program approved by the Counsel on Medical Evaluation of the American Medical Association; or

(c) at least three years of experience in a medical practice dedicated substantially to serving persons with serious mental illnesses.

(20) "Mental health group home" means a community residential facility as defined in ARM 37.88.901.

(21) "Mental illness" means that condition of an individual in which there is either psychological, physiological, or biochemical imbalance which has caused impairment in functioning and/or behavior.

(22) "Outpatient therapy services" means the provision of psychotherapy and related services by a licensed mental health professional acting within the scope of the professional's license or these same services provided by an in-training mental health professional in a mental health center.

(23) "Program supervisor" means a designated licensed mental health professional having daily overall responsibility for the operation of a mental health center area of endorsement.

(24) "Program therapist" means a licensed mental health professional with the training and knowledge to provide psychotherapy.

(25) "Representative payee" means a payee appointed by the Social Security Administration when a beneficiary is unable to manage their social security benefits, supplementary security income or Medicare benefits.

(26) "Seclusion" means staff initiating or escorting a youth to a seclusion time-out room to calm down and appropriately manage their behavior.

(27) "Severe disabling mental illness" means, with respect to a person who is 18 or more years of age, that the person meets the requirements defined in ARM 37.86.3502.

(28) "Serious emotional disturbance" means, with respect to a youth, that the youth meets the requirements defined in ARM 37.87.303.

(29) "Site based" means a specific location where the treatment services are consistently provided.

(30) "Targeted case management " means the activities of a single person or team that assists individuals with mental illness to make informed choices for community services which seek to maximize their personal abilities and enable growth in some

or all aspects of the individual's vocational, educational, social, and health related environments.

(31) "Time-out" means staff or youth initiating a time-out generally away from the group activity to enable the youth to calm down and appropriately manage their behavior.

(32) "Youth" means a person ~~17 years of age or younger and includes students~~ up to 20 years of age ~~who still attend a secondary public school~~.

(33) "Youth day treatment" means a program which provides an integrated set of mental health, education, and family intervention services to youth with a serious emotional disturbance.

Authorizing statute(s): 50-5-103, MCA

Implementing statute(s): 50-5-103, 50-5-204, MCA

37.106.1956 MENTAL HEALTH CENTER: COMPREHENSIVE SCHOOL AND COMMUNITY TREATMENT PROGRAM (CSCT), SERVICES AND STAFFING

(1) For any youth receiving CSCT services, the CSCT program must be able to provide the following services to each youth as specified in that youth's individualized treatment plan (ITP):

(a) individual, group, and family therapy;

(b) behavioral intervention;

(c) other evidence and research-based practices effective in the treatment of youth with a serious emotional disturbance (SED);

(d) direct crisis intervention services during the time the youth is present in a school-owned or operated facility;

(e) a crisis plan that identifies a range of potential crisis situations with a range of corresponding responses including physically present face-to-face encounters and telephonic responses 24/7, as appropriate;

(f) treatment plan coordination with substance use disorder and mental health treatment services the youth receives outside the CSCT program;

(g) access to emergency services;

(h) referral and aftercare coordination with inpatient facilities, psychiatric residential treatment facilities, or other appropriate out-of-home placement programs; and

(i) continuous treatment that must be available twelve months of the year. The program must provide a minimum of ~~four service days~~ 16 hours per month of CSCT services in summer months. For any youth who does not receive CSCT services in the summer, providers must document in the youth's medical record the reason why the youth did not receive such services, as well as a summary of attempts to engage the youth and family.

(2) If the sum total of daily units per youth is over 16 units, the claim will suspend for clinical review. Providers must submit documentation to the department demonstrating medical necessity of service.

~~(2)~~(3) CSCT services for youth with SED must be provided according to an ITP designed by a licensed or in-training mental health professional who is a staff member of a CSCT program team.

~~(3)~~(4) The CSCT ITP team must include:

(a) licensed or in-training mental health professional;

(b) school administrator or designee;

(c) parent(s) or legal representative/guardian;

(d) the youth, as appropriate; and

(e) other person(s) who are providing services, or who have knowledge or special expertise regarding the youth, as requested by the parent(s), legal representative/guardian, or the agencies.

~~(4)~~(5) Providers must inform the youth and the parent(s)/legal representative/guardian that Medicaid requires coordination of CSCT with home support services and outpatient therapy.

~~(5)~~(6) The CSCT program must employ sufficient qualified staff to deliver all CSCT services to the youth as outlined in the ITP for the youth and in accordance with the contract between the school and the licensed mental health center.

~~(6)~~(7) The CSCT team may be assigned to provide services in two schools if the CSCT team responds to crisis situations for youth enrolled in CSCT in each school building during typical school hours.

~~(7)~~(8) The CSCT program must employ or contract with a program supervisor who has daily overall responsibility for the CSCT program and who is knowledgeable about the mental health service and support needs of the youth. The program supervisor may provide direct CSCT services, but this position may not fill the functions of the staff positions described in ~~(8)~~(9) and ~~(9)~~(10) for more than six months.

~~(8)~~(9) Each CSCT team must include a mental health professional, who may be a licensed or in-training mental health professional, as defined in ARM 37.87.702. In-training mental health professionals must be:

(a) supervised by a licensed mental health professional; and

(b) supervised in accordance with ARM Title 24, chapter 219.

~~(9)~~(10) Each CSCT team may include up to two behavioral aides. A behavioral aide must work under the clinical oversight of a licensed mental health professional and provide services for which they have received training that do not duplicate the services of the licensed or in-training mental health professional. All behavioral aides initially employed after July 1, 2013 must have a high school diploma or a GED and at least two years:

(a) experience working with emotionally disturbed youth;

(b) providing direct services in a human services field; or

(c) post-secondary education in human services.

~~(10)~~(11) The licensed mental health center CSCT program supervisor and an appropriate school district representative must meet regularly, at least four times per calendar year, during the time period CSCT services are provided to mutually assess program effectiveness utilizing the following indicators:

(a) progress on the individual treatment plan of each youth receiving CSCT services;

(b) attendance;

(c) CSCT program referrals;

(d) contact with law enforcement;

(e) referral to a higher level of care; and

(f) discharges from the program.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 50-5-103, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.106.1961 MENTAL HEALTH CENTER: COMPREHENSIVE SCHOOL AND COMMUNITY TREATMENT (CSCT) PROGRAM, RECORD REQUIREMENTS

(1) In addition to any clinical records required in ARM 37.85.414 or elsewhere in these rules, the licensed mental health center's CSCT program must maintain the following records for youth with serious emotional disturbance (SED):

(a) a signed verification indicating the parent(s), legal representative, or guardian has been informed by the licensed mental health center that Medicaid requires coordination between CSCT, home support services, and outpatient therapy;

(b) a copy of the clinical assessment which documents the presence of SED;

(c) the individualized treatment plan for CSCT;

(d) daily progress notes from each team member that document individual therapy sessions and other direct services provided to the youth and family throughout the day including:

(i) when any therapy or therapeutic intervention begins and ends; and

(ii) the sum total number of minutes spent each day with the youth.

(e) 90-day treatment plan reviews;

(f) discharge plan; and

(g) the Comprehensive School and Community Treatment Data Collection Template, that must be completed each March and September for each youth enrolled in CSCT and submitted to the Children's Mental Health Bureau by the licensed mental health center. The department adopts and incorporates by reference the Comprehensive School and Community Treatment Data Collection Template (form)~~, dated November 1, 2021~~. A copy of this form 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 found at https://dphhs.mt.gov/dsd/CMB/.

(2) In addition to any clinical records required in ARM 37.85.414 or elsewhere in these rules, records for youth referred to CSCT regardless of their diagnosis as described in ARM 37.87.1803(4) must include the following:

(a) progress notes for each individual therapy session and other direct services provided to the youth and family throughout the day; and

(b) discharge plan with referral to additional services, if appropriate.

(3) Records for youth referred to CSCT and denied acceptance into the program must include documentation detailing the reason for the denial.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 50-5-103, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

General Reasonable Necessity Statement

The Department of Public Health and Human Services (department) is proposing to amend the following rules: ARM 37.85.105, 37.87.102, 37.87.903,37.87.1226, 37.87.1404, 37.87.1414, 37.87.1415, 37.87.1803, 37.106.1902, 37.106.1956, and 37.106.1961.

Mental Health Centers providing Comprehensive School and Community Treatment (CSCT) and the Behavioral Health Alliance of Montana (BHAM) requested the DPHHS consider changing the Medicaid CSCT reimbursement back to a 15-minute unit from the current daily rate due to "unintended financial consequences."

Schools are the provider of record for CSCT, but they contract with mental health centers (MHCs) to provide this service. MHCs claim that the current system is not financially viable, and several MHCs have stated that they have or might need to stop providing CSCT and provide other services, such as Home Support Services (HSS), instead.

There is a potential fiscal impact to the state Medicaid budget if providers move away from providing CSCT to services, like school-based HSS, that are covered by state Medicaid dollars. Additionally, several MHCs are considering workforce reductions and therefore, a reduction in services to youth to address low operation reserves. Additional fee schedule updates can be found in MAR Notice No. 2025-152.1.

A return to the CSCT 15-minute unit and service updates to CSCT and HSS would require the following rules to be updated. In addition, the department will be updating rules and conducting general rule cleanup for the definition of "youth" as well as out-of-state Psychiatric Residential Treatment Facility (PRTF) pharmacy and lab reimbursement requirements to align with those for in-state PRTFs.

37.85.105
The department is updating the the Medicaid youth mental health services fee schedule effective date.

37.87.102
The department is updating the definition of "youth" to align with CMS requirements and remove a current requirement that the youth must be enrolled in secondary education to be eligible for youth mental health services for ages 18-20. CSCT will not be impacted by the youth definition change because that population is already treated. The update in definition will impact HSS eligibility.

37.87.903
The department is updating the Children's Mental Health Medicaid Services Provider Manual (manual) effective date.

37.87.1226
The department is updating the rule to align out-of-state PRTF pharmacy and lab reimbursement requirements with in state PRTF as defined in ARM 37.87.1223.

37.87.1404
The department is updating the Therapeutic Foster Care (TFC) and HSS service coordination with CSCT and coordination of HSS and Therapeutic Group Home (TGH) and Outpatient therapy treatment planning**.**

37.87.1414
The department is updating the rule to remove monthly summary requirements and add requirements that HSS team members may not provide Targeted Case Management (TCM) and HSS services to the same youth.

37.87.1415
The department is updating the Family Support Specialist caseload range.

37.87.1803
The department is updating in the rule the allowable per team per month billing limit from service days to 15-minute units. The department is also updating allowable sum total daily units per youth limit before claims suspend for clinical review; updating allowable units per non-SED youth per state fiscal year that may be billed for brief intervention, assessment and referral (IAR) from service days to 15-minute units; and updating the requirement that IAR units be billed as part of the monthly team total from service days to 15-minute units.

37.106.1902
The department is updating the definition of "Community-based psychiatric rehabilitation and support" to reference the correct administrative rule. The department is updating the definition of "youth" to align with CMS requirements and remove a current requirement that the youth must be enrolled in secondary education to be eligible for youth mental health services for ages 18-20. CSCT will not be impacted by the youth definition change because that population is already treated. The update in definition will impact HSS eligibility.

37.106.1956
The department is updating the minimum units in the summer months from service days to 15-minute units and defining the allowable sum total daily units per youth limit before claims suspend for clinical review.

37.106.1961
The department is removing the date associated with the Comprehensive School and Community Treatment Data Collection Template (form).

Small Business Impact

Pursuant to 2-4-111, MCA, the class of small businesses probably affected by the proposed rules are those businesses seeking to serve as a provider of Comprehensive School and Community Treatment (CSCT) and/or Home Support Services (HSS) services. The probable direct effects of these proposed rules on these small businesses would allow for a provider-requested change in the CSCT rate methodology and increased limits and a clearer service description for HSS. These proposed rules changes would impact community mental health centers.

Fiscal Impact

Currently public school districts provide the CSCT state match, and are reimbursed the entire service fee, so keeping CSCT is financially beneficial to the state general fund and the school districts. The goal of the rate restructure is to increase access to this service. With this change, there will not be a fiscal impact to the state general fund. The following charts show estimated fiscal impacts to both CSCT and HSS.

CSCT Description	SFY 2026	SFY 2027
State Share Impact (IGT School Match)	$474,970	$1,906,593
Federal Share Impact	$788,444	$3,145,920
Total Impact	$1,263,413	$5,052,513

HSS Group Description	SFY 2026	SFY 2027
State Share Impact	$316,740	$1,225,509
Federal Share Impact	$532,173	$2,046,608
Total Impact	$848,913	$3,272,116

The proposed CSCT rulemaking is estimated to affect an estimated 1,808 Medicaid members, 7 mental health centers, and 30 public school districts.

Bill Sponsor Notification

The bill sponsor contact requirements do not apply.

Interested Persons

The department maintains a list of interested persons who wish to receive notices of the rulemaking actions proposed by the department. 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 emailed, mailed or otherwise delivered to the contact person above.

Effective Date

The department intends to apply these rule amendments effective May 9, 2026.

Medicaid Performance-Based Statement

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 rate increases 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.

Rule Reviewer

Chanan Brown

Approval

Charles T. Brereton, Director
Department of Public Health and Human Services