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

In the matter of the adoption of New Rules I through XX, amendment of ARM 37.27.101, 37.27.102, 37.27.105, 37.27.106, 37.27.107, 37.27.115, 37.27.116, 37.27.120, 37.27.902, 37.88.101, 37.106.1411, 37.106.1413, 37.106.1415, 37.106.1420, 37.106.1425, 37.106.1430, 37.106.1432, 37.106.1435, 37.106.1440, 37.106.1450, 37.106.1452, 37.106.1454, 37.106.1460, 37.106.1470, 37.106.1475, 37.106.1480, and 37.106.1485, and repeal of ARM 37.27.108, 37.27.121, 37.27.136, 37.27.137, 37.27.138, 37.106.1401, 37.106.1462, 37.106.1482, 37.106.1487, and 37.106.1491 pertaining to state approval of substance use disorder programs, licensure of substance use disorder facilities, and the Behavioral Health and Developmental Disability Medicaid & Non-Medicaid Manuals	)	NOTICE OF ADOPTION, AMENDMENT, AND REPEAL

TO: All Concerned Persons

1. On August 5, 2022, the Department of Public Health and Human Services published MAR Notice No. 37-1010 pertaining to the public hearing on the proposed adoption, amendment, and repeal of the above-stated rules at page 1539 of the 2022 Montana Administrative Register, Issue Number 15.

2. The department has adopted the following rules as proposed: New Rules I (37.27.122), II (37.27.117), III (37.27.118), IV (37.27.119), V (37.89.201), VI (37.106.1416), VII (37.106.1426), VIII (37.106.1427), IX (37.106.1434), X (37.106.1455), XI (37.106.1457), XII (37.106.1466), XIII (37.106.1467), XVII (37.106.1469), and XVIII (37.106.1468).

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

NEW RULE XIV (37.106.1473) ASAM 3.5 CLINICALLY MANAGED HIGH INTENSITY RESIDENTIAL (ADULT)/MEDIUM INTENSITY RESIDENTIAL (ADOLESCENT) SUBSTANCE USE DISORDER FACILITY REQUIREMENTS

(1) To be licensed to provide ASAM 3.5 services as outlined in the ASAM Criteria, a SUDF must provide on-site 24-hour awake staffing and meet the following staffing requirements:

(a) a physician, physician assistant, or advanced practice registered nurse acting within the scope of the license issued by the Department of Labor and Industry available for consultation within 24 hours in person or by telephone;

(a) through (d) remain as proposed, but are renumbered (b) through (e).

~~(e)~~(f) rehabilitation aides in sufficient number to provide ~~on-site 24 hours a day, seven days a week staffing to assure the safety of clients and to provide~~ direct care support services ~~and supervision of clients~~ as outlined in the clients' individualized treatment plans.

(2) Daily clinical skilled treatment services, in addition to ~~and~~ other scheduled ~~skilled treatment~~ psychosocial rehabilitation services, must be provided on-site a minimum of ~~seven~~ 30 hours ~~(four hours for adolescent programs)~~ per ~~day~~ week.

(3) through (5) remain as proposed.

AUTH: 50-5-103, MCA
IMP: 50-5-103, MCA

NEW RULE XV (37.106.1472) ASAM 3.3 CLINICALLY MANAGED POPULATION-SPECIFIC HIGH INTENSITY RESIDENTIAL (ADULT ONLY) SUBSTANCE USE DISORDER FACILITY (1) To be licensed to provide ASAM 3.3 services as outlined in the ASAM Criteria, a SUDF must provide on-site 24-hour awake staffing and meet the following staffing requirements:

(a) a physician, physician assistant, or advanced practice registered nurse acting within the scope of the license issued by the Department of Labor and Industry available for consultation within 24 hours in person or by telephone;

(a) through (d) remain as proposed, but are renumbered (b) through (e).

~~(e)~~(f) rehabilitation aides in sufficient number to provide ~~on-site 24 hours a day, seven days a week staffing to assure the safety of clients and to provide~~ direct care support services ~~and supervision of clients~~ as outlined in the clients' individualized treatment plans.

(2) Daily ~~scheduled~~ clinical skilled treatment services in addition to other scheduled psychosocial rehabilitation services must be provided on-site. Services must be adapted to the client's developmental stage and level of comprehension in accordance with the client's individualized treatment plan.

(3) through (5) remain as proposed.

AUTH: 50-5-103, MCA
IMP: 50-5-103, MCA

NEW RULE XVI (37.106.1471) ASAM 3.1 CLINICALLY MANAGED LOW INTENSITY RESIDENTIAL (ADULT OR ADOLESCENT) SUBSTANCE USE DISORDER FACILITY (1) through (1)(c) remain as proposed.

(d) rehabilitation aides in sufficient numbers to provide ~~on-site 24 hours a day, seven days a week staffing to assure the safety of clients and to provide~~ direct care support services ~~and appropriate supervision of clients~~ as outlined in the clients' individualized treatment plans.

(2) Weekly scheduled clinical skilled treatment services in addition to other scheduled psychosocial rehabilitation services must be provided on-site or off-site a minimum of five hours per week. Documentation of skilled treatment services provided both on-site and off-site must be available at the facility.

(3) and (4) remain as proposed.

AUTH: 50-5-103, MCA
IMP: 50-5-103, MCA

NEW RULE XIX (37.106.1457) COMMUNICABLE DISEASE CONTROL

(1) through (3) remain as proposed.

(4) Facilities must implement TB ~~protocols~~ screening for all staff members and clients based upon an annual TB Risk assessment as set forth by the Montana Tuberculosis Prevention and Control Program pursuant to ARM Title 37, chapter 114, subchapter 10. Risk assessment and TB manuals are found at https://dphhs.mt.gov/publichealth/cdepi/diseases/Tuberculosis/.

AUTH: 50-5-103, MCA
IMP: 50-5-103, MCA

NEW RULE XX (37.106.1456) CARE MANAGEMENT (1) remains as proposed.

(2) A care manager must have a bachelor's degree in a human services field, an equivalent combination of education and experience, or a minimum of two years of experience serving individuals with behavioral health issues. Evidence of experience must be documented in the employee personnel record.

(3) through (4)(d) remain as proposed.

(e) the ability of the ~~targeted~~ care manager to contact an advocacy organization if the care manager believes the SUDF is unresponsive to the needs of the client.

AUTH: 50-5-103, MCA
IMP: 50-5-103, MCA

4. The department has amended the following rules as proposed: ARM 37.27.101, 37.27.105, 37.27.106, 37.27.107, 37.27.116, 37.27.902, 37.88.101, 37.106.1411, 37.106.1415, 37.106.1420, 37.106.1430, 37.106.1432, 37.106.1440, 37.106.1450, 37.106.1452, 37.106.1454, 37.106.1460, 37.106.1470, and 37.106.1485.

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

37.27.102 DEFINITIONS In addition to the terms defined in 53-24-103, MCA:

(1) through (3) remain as proposed.

(4) "Biopsychosocial assessment" means ~~an evaluation of the client's strengths, resources, preferences~~, limitations, problems, needs, and priorities as a comprehensive multidimensional assessment process that includes risk ratings, addresses immediate needs, and is organized in accordance with the six dimensions described in the ASAM Criteria and meets the requirements described in the BHDD Medicaid Manual.

(5) "Continuing care plan" means a ~~discharge or recovery management~~ plan for when a client is discharged or transferred from a particular level of care as described in the BHDD Medicaid Manual.

(6) and (7) remain as proposed.

(8) "Licensed addiction counselor (LAC)" means an individual licensed under requirements pursuant to Title 37, chapter 35 MCA, and ARM Title 24, chapter 219, subchapter 50, to provide addiction counseling. References in ~~this subchapter~~ ARM 37.27.107 to a LAC do not include an addiction counselor licensure candidate registered pursuant to Title 37, chapter 35, part 2, MCA.

(9) through (16) remain as proposed.

AUTH: 53-24-204, 53-24-208, 53-24-209, 53-24-215, MCA
IMP: 53-24-204, 53-24-208, 53-24-209, 53-24-215, MCA

37.27.115 ALL STATE APPROVED PROGRAMS – ACCEPTANCE OF PERSONS INTO THE TREATMENT PROGRAM (1) and (2) remain as proposed.

(3) The program shall work together with the client to implement ~~an~~ a written individualized~~, written~~ treatment plan that identifies services and supports needed to address problems and needs identified in the biopsychosocial assessment. The individualized treatment plan ~~includes goals, objectives, and strategies. It~~ is maintained on a current basis for each client.

(4) and (5) remain as proposed.

AUTH: 53-24-209, MCA
IMP: 53-24-209, MCA

37.27.120 ALL STATE APPROVED PROGRAMS – ORGANIZATION AND MANAGEMENT (1) through (1)(i) remain as proposed.

(j) Programs will submit ~~participate in~~ quarterly updates ~~with~~ to the department to ensure contact information, organizational chart, locations, hours of operation, and services provided are up to date ~~for the public to obtain access to care~~.

AUTH: 53-24-204, 53-24-207, 53-24-208, MCA
IMP: 53-24-208, 53-24-209, 53-24-306, MCA

37.106.1413 DEFINITIONS In addition to the terms defined in 53-24-103, MCA, the following definitions shall apply in the interpretation and enforcement of the rules in this subchapter:

(1) through (9) remain as proposed.

(10) "Continuing care plan" means a ~~provision of the treatment~~ plan outlining anticipated interventions needed at the time of discharge or transfer to another level of care.

(11) through (14) remain as proposed.

(15) "Educational group" means structured service provided in a group setting designed to educate clients about substance abuse and the consequences of substance abuse. ~~It may be provided by rehabilitation aides or other direct care staff.~~

(16) through (28)(a) remain as proposed.

(b) participant name~~s~~;

(c) through (34) remain as proposed.

(35) "Skilled treatment services" means structured services such as individual and group counseling, medication management, family therapy, educational groups, ~~psychosocial rehabilitation,~~ occupational and recreational therapy, and other therapies provided to the client. Skilled treatment services do not include attendance at self/mutual help meetings, volunteer activities, or homework assignments such as watching videos, journaling, and workbooks. Skilled treatment services must be provided by clinical staff licensed pursuant to requirements adopted under Title 37, MCA.

(36) through (40) remain as proposed.

AUTH: 50-5-103, 53-24-208, 53-24-301, MCA
IMP: 50-5-101, 50-5-103, 53-24-208, 76-2-411, MCA

37.106.1425 GOVERNANCE AND ADMINISTRATION (1) The substance use disorder facility (SUDF) must establish a governing body or oversight committee with responsibility for operating and maintaining the SUDF.

(2) The governing body or oversight committee must provide organizational oversight to ensure that adequate resources are available to ensure staff members provide safe and adequate care.

(3) The governing body or oversight committee must establish written policies and procedures that:

(a) remains as proposed.

(b) establish procedures for selecting and periodically evaluating a qualified administrator to ensure the administrator carries out the goals and policies of the governing body or oversight committee;

(c) through (e) remain as proposed.

(f) include annual review of the quality improvement report by the governing body or oversight committee.

(4) through (5)(a) remain as proposed.

(b) be available, or ensure a designated alternate who has similar qualifications is available, to carry out the goals, objectives, and standards of the

governing body or oversight committee and to implement the rules of this subchapter; and

(c) review progress on the quality improvement plan with the governing body or oversight committee on a quarterly basis.

(6) remains as proposed.

AUTH: 50-5-103, 53-24-208, MCA
IMP: 50-5-101, 50-5-103, 53-24-301, MCA

37.106.1435 TRAINEES/INTERNS OR VOLUNTEER REQUIREMENTS

(1) and (1)(a) remain as proposed.

(b) a description of the training ~~/~~ or volunteer work to be provided at the SUDF for trainees, interns, or volunteers, respectively, and any limitations;

(c) through (4) remain as proposed.

AUTH: 50-5-103, 53-24-208, MCA
IMP: 50-5-101, 50-5-103, 53-24-208, MCA

37.106.1475 ASAM 3.7 MEDICALLY MONITORED INTENSIVE INPATIENT REQUIREMENTS (1) and (2) remain as proposed.

(3) Daily clinical skilled treatment services and medical services must be provided on-site by an interdisciplinary team seven days a week.

(4) through (7) remain as proposed.

AUTH: 50-5-103, 53-24-208, MCA
IMP: 50-5-101, 50-5-103, 53-24-208, 53-24-209, 76-2-411, MCA

37.106.1480 WITHDRAWAL MANAGEMENT PROGRAM REQUIREMENTS

(1) through (1)(h) remain as proposed.

(i) The SUDF must provide daily clinical skilled treatment services to address the needs of each client. Clinical skilled treatment services may include medical services, individual and group therapy, and withdrawal support as required in the client's individualized treatment plan.

(j) through (3) remain as proposed.

AUTH: 50-5-103, 53-24-208, MCA
IMP: 50-5-101, 50-5-103, 53-24-208, 53-24-209, 76-2-411, MCA

6. The department has repealed the above-stated rules as proposed.

7. 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: A commenter recommended the department combine crisis receiving and stabilization into one policy and approach it as a tiered system instead of separating the services into two different and distinct services. The commenter

also recommended removing hospital as an allowable provider type and adding Federally Qualified Health Centers (FQHC) and Certified Community Behavioral Health Clinics (CCBHC). In addition, the commenter recommended adding quality measures to the services.

RESPONSE #1: The department agrees with the suggestion of combining crisis receiving and stabilization into one policy and will make the recommended changes to combine Policies 450 and 451. The department also agrees with removing hospitals from the allowable provider type. Section 53-21-1203, MCA, however, requires that the department allow reimbursement for short-term inpatient treatment. Therefore, the department will move reimbursement for hospital-based crisis stabilization into the Crisis Diversion Grant program. The department will take the recommendation to add FQHCs and CCBHCs into consideration for a future rulemaking.

COMMENT #2: A commenter stated that the concurrent services policy appears to be "arbitrary and unnecessarily confusing." The commenter provided a detailed review of the concurrent services table found in Policy 230 and provided suggestions for alternate options.

RESPONSE #2: The department will review Policy 230 to ensure that the concurrent services table is accurate and reflects any changes made through this rulemaking. In response to this comment, the department has amended the policy to provide better clarification and address some of the recommendations and to ensure alignment with criteria established by the American Society of Addiction Medicine (ASAM), including permitting: 1) mental health outpatient therapy to be billed concurrently with SUD services; 2) specimen collection for drug testing to be reimbursed concurrently with all services except acute inpatient hospital and partial hospitalization; and 3) BHGH/AFC to be billed concurrently with SUD OP/ASAM 2.1/ASAM 2.5. The department will take the commenter's other suggestions into consideration for future rulemaking.

COMMENT #3: A commenter submitted multiple questions regarding Policy 460, Program for Assertive Community Treatment (PACT), which are outside the scope of this administrative rulemaking proposal.

RESPONSE #3: The department acknowledges receipt of these questions and will reach out to the commenter to provide training or technical assistance to address the questions that fall outside of this administrative rulemaking proposal.

COMMENT #4: Several comments were received supporting the Governor's HEART initiative and appreciative of the department's work on the proposed rules.

RESPONSE #4: The department acknowledges and appreciates the comments.

COMMENT #5: A commenter stated that Policy 525 (ASAM 2.1) no longer allows for high- and low-tier considerations within that level of care. Under the current

system, the policy allowed reimbursement under the low tier if the client was attending some treatment, but not fully engaged. The commenter stated this circumstance prompts the clinic to either get the client engaged or change the client's level of care to a higher or lower level of care. Some treatment is better than no treatment, and this is going to result in fewer ASAM 2.1 clients in the state.

RESPONSE #5: This rulemaking represents the department's intention to align the rules and policies with the ASAM Criteria. The department notes that the tiered billing structure under the current policy is not aligned with ASAM Criteria. Under the criteria, ASAM 2.1 programs provide a minimum of nine hours per week of skilled treatment services for adults and six hours per week of skilled treatment services for adolescents. The department made an allowance in Policy 525 for providers to bill the bundled rate for up to two if the client does not meet the minimum hourly requirement, which should provide some flexibility. The proposed changes to the policy allow the department to be aligned with the ASAM Criteria regarding the minimum required hours of skilled treatment services for ASAM 2.1.

COMMENT #6: Several commenters stated that staffing requirements described in the BHDD Medicaid manual SUD policies do not conform with the ASAM Criteria. These staffing requirements represent a hardship on providers during the current workforce shortage.

RESPONSE #6: The department will amend the policies to remove required full time equivalent (FTE) staff and will instead provide clarification of available service components. This will give providers staffing flexibility and allow them to provide individualized care based on the needs of the member.

COMMENT #7: A commenter asked several questions pertaining to the specifics of program administration for the PACT program that are outside the scope of this rulemaking.

RESPONSE #7: The department acknowledges receipt of these questions. It has been the experience of the department that providers prefer to have a level of discretion in how they manage the provision of services based upon their clinical expertise; therefore, the department will take these questions under consideration for future rulemaking after consultation with the provider community.

COMMENT #8: A commenter disagreed with changing "psychosocial rehabilitation" to Community Based Psychiatric Rehabilitative Support Services (CBPRS) in the services components for ASAM 2.1 in Policy 525. The commenter stated a belief that CBPRS is a psychiatric service, and as a substance use disorder provider, they do not qualify to provide that service.

RESPONSE #8: As long as the provider is a state approved facility, it is qualified to provide the CBPRS service. State approved facilities have been added under provider requirements in the CBPRS policy. CBPRS is a behavior management and stabilization service provided in the home, workplace, or community settings to

reduce disability and restore functioning, and to help individuals return to natural settings and activities that are part of a socially integrated life. Substance use disorder has been added to the medical necessity criteria in that policy as well.

COMMENT #9: A commenter asked if they still need to do a level of impairment worksheet if the member has a severe and disabling mental illness (SDMI) diagnosis and meets the eligibility requirements.

RESPONSE #9: Based on this comment, the department will remove the requirement for a level of impairment worksheet from Policy 460 for determination of medical necessity. Providers should follow Policy 105 when determining if someone has a severe and disabling mental illness.

COMMENT #10: A commenter suggests adding "utilizing the ASAM criteria" in Policy 115 to read, "trained in performing biopsychosocial assessments utilizing the ASAM Criteria."

RESPONSE #10: The department acknowledges the comment and will take it into consideration for future rulemaking. Policy 115 is intended to encompass all behavioral health assessments, not just those for substance use disorder.

COMMENT #11: A commenter asked who determines if a member meets the medical necessity criteria and who provides the assessment. In addition, the commenter asked what "willing and able" looks like.

RESPONSE #11: A licensed mental health professional as defined in 53-21-102, MCA, can provide the assessment and through that assessment can determine if the member meets the medical necessity criteria of the service. Through the medical necessity criteria and ongoing assessment, providers can determine a client's interest and ability to participate in treatment.

COMMENT #12: A commenter requested the department define child/family support specialist, which is listed as required staff in Policy 535.

RESPONSE #12: The department will amend Policy 535 and remove the required full time equivalent (FTE) staff. Please see the department's response to Comment #6.

COMMENT #13: A commenter recommended adding a timeline for completion of the treatment plan and a requirement that the client be included in completion of the treatment plan under Policy 120.

RESPONSE #13: The department will amend Policy 120 to add that language back as it was proposed as stricken language in the proposed policy.

COMMENT #14: A commenter stated they are unable to find discharge summary information in the manual policies.

RESPONSE #14: The department amended Policy 135 to reflect a continuing care plan instead of a discharge summary to address provider feedback that not all clients are discharged. The need for a summary of treatment services is included as a component of the continuing care plan.

COMMENT #15: A commenter recommended updating the definition of the service in ASAM 3.2-WM in Policy 536 to align with the current ASAM Criteria.

RESPONSE #15: The language used for the definition of the service in this policy was taken from pages 137 and 138 of the ASAM Criteria.

COMMENT #16: A commenter made multiple comments on the proposed Policy 460QM, PACT Quality Measures. Some of the comments were vague and did not reference anything specific in the policy, including: "There are no instructions." "Who do we send this to?" "How often?" "What is it used for?" (without reference to what "it" refers to.) "Is there a form we're supposed to fill out?"

RESPONSE #16: The department created the quality measures outlined in the newly proposed Policy 460QM in collaboration with Montana's PACT providers prior to the COVID-19 public health emergency. Based upon the questions received from the commenter, the department has decided to withdraw this policy at this time and revisit the quality measures with providers in the context of the current environment.

COMMENT #17: A commenter asked about lower and higher levels of care relating to the Program of Assertive Community Treatment (PACT) service.

RESPONSE #17: Assertive community treatment is the highest level of intensity service that can be received in the outpatient setting; therefore, lower levels of care would be any other outpatient services and higher levels of care would include those that are not in an outpatient setting.

COMMENT #18: A commenter asked why it is necessary to complete updates to a member's continuing care plan when PACT is a long-term service.

RESPONSE #18: The department agrees with the commenter, and will amend the language in Policy 460 to add a reference to individualized treatment plan along with continuing care plan.

COMMENT #19: A commenter asked what would happen if they chose not to meet the service requirement that 60% of PACT services must be provided in a member's natural environment.

RESPONSE #19: Based upon the PACT fidelity standards scale, 60% is the minimum amount of time which must be spent in the members natural environment and still achieve a rating score of "4." If a provider chose to not deliver that level of care in a member's natural environment, it will have a negative effect on the

provider's PACT fidelity scoring. In addition, a provider's failure to meet the minimum requirements as outlined in the manual could result in an enforcement action and possible return of Medicaid funding.

COMMENT #20: A commenter asked how the provider is to know what services may or may not be duplicative with services provided in an inpatient or hospital setting.

RESPONSE #20: According to Policy 460, PACT team members should coordinate with the hospital regarding the provision of PACT services while the member is in the hospital setting.

COMMENT #21: A commenter asked if the PACT team is expected to reassess medical necessity criteria to determine if the member continues to meet the criteria while they are in an inpatient setting.

RESPONSE #21: In responding to this comment, the department reviewed the proposed language in Policy 460 and will remove the requirement that the member must continue to meet the medical necessity criteria for PACT while in an inpatient setting.

COMMENT #22: A commenter asked if a member who is on the Community Maintenance Program (CMP) can also receive concurrent services while the member is in an inpatient setting.

RESPONSE #22: The proposed amendments allow for concurrent reimbursement for the PACT tier, not for the CMP tier. The language in Policy 460 has been amended to clarify "core PACT."

COMMENT #23: A commenter submitted several recommendations for multiple policies pertaining to the specifics of program administration for services that are outside the scope of this rulemaking.

RESPONSE #23: The department acknowledges receipt of these questions. It has been the experience of the department that providers and partner agencies have invaluable knowledge and experience regarding the delivery of services; therefore, the department will take these recommendations under consideration for future rulemaking after consultation with the commenter and the larger provider community.

COMMENT #24: A commenter asked if a provider cannot achieve the minimum contacts and the client must be reassessed, does this requirement apply to CMP. In addition, the commenter asked for clarification if the two weeks were per month, per year, or consecutively.

RESPONSE #24: The requirement to assess a member for the appropriate level of care when the PACT team cannot make the required contacts applies to both the

core PACT service and to CMP. The two-week timeframe refers to two consecutive weeks.

COMMENT #25: A commenter asked what assessment the PACT teams are supposed to use to determine "appropriateness for level of care."

RESPONSE #25: Under Policy 460, providers are expected to apply their clinical expertise when determining if a member is appropriate for the PACT level of care.

COMMENT #26: A commenter asked if they could bill for PACT services if a member is incarcerated.

RESPONSE #26: Medicaid cannot pay for services provided to a member who is incarcerated.

COMMENT #27: A commenter asked a few questions about Policy 530 relating to utilization management.

RESPONSE #27: The department acknowledges receipt of these questions and notes that Policy 530 was not proposed for change, and thus, the comments are outside the scope of the rulemaking. The department will follow up with the commenter with some technical assistance around utilization management.

COMMENT #28: A commenter recommended changing the requirement for quarterly review of the quality improvement plan to annually.

RESPONSE #28: The department disagrees with the commenter. The quality improvement plan must be completed annually and reviewed quarterly. This allows the administrator and the governing body or oversight committee to assess and ensure progress under the plan and make any appropriate changes to the plan.

COMMENT #29: A commenter requested clarification if skilled treatment services need to be provided on-site or can they be provided at an outpatient treatment center that runs the facility.

RESPONSE #29: The department has amended the rule to allow services to be provided on-site or off-site for ASAM 3.1 services as indicated in the ASAM Criteria. This allows outpatient treatment programs to provide skilled treatment services off-site.

COMMENT #30: A commenter requested clarification regarding outcomes measures in ARM 37.106.1462.

RESPONSE #30: The department cannot provide clarification as the referenced rule has been repealed under this rulemaking.

COMMENT #31: A commenter suggested that ARM 37.106.1470 does not require one operational outside window in each bedroom.

RESPONSE #31: The proposed rule does not have this requirement as this language was removed following public meetings prior to publication of this MAR rulemaking notice.

COMMENT #32: A commenter requested "mental health component" be defined because a mental health assessment is not required by a nurse as required in ARM 37.106.1475. The commenter states if "component" means risk screening, the commenter has no concerns.

RESPONSE #32: The department agrees a nurse is not required to complete a mental health assessment. The proposed rule does not have this requirement as this language was removed following public meetings prior to the publication of this MAR rulemaking notice. The rule was revised to require a mental health screening pursuant to the ASAM Criteria.

COMMENT #33: A commenter requested safety rails on beds be available for use, not required on all beds.

RESPONSE #33: The department agrees with the commenter. ARM 37.106.1480 as written does not require safety rails on all beds. It states the facility beds must be equipped with safety rails for patients who may require them.

COMMENT #34: A commenter requested clarification on what evidence-based program is required for Life Skills.

RESPONSE #34: The proposed rule does not specify a specific model and allows providers the flexibility to select the evidence-based program that works best for their organizations.

COMMENT #35: A commenter requested clarification regarding if the clinicians will need to do an ASAM six-dimensional analysis for every patient every week for the treatment plan review.

RESPONSE #35: A biopsychosocial assessment includes all six dimensions of the ASAM model and is to be completed prior to, or at the time of, admission. Progress in each of the six dimensions needs to be reviewed during the treatment team review. A new biopsychosocial assessment does not need to be completed again every week.

COMMENT #36: A commenter requested clarification on the use of "mental health professional" as that terminology can only be used by other licensed mental health providers as it is defined in ARM Title 37, chapter 91. The commenter states there are very few licensed mental health providers in Montana that have gone through this specific training and certification to be designated a "mental health professional."

RESPONSE #36: "Mental health professional" as defined in ARM 37.104.1413 does not reference requirements in ARM Title 37, chapter 91. Thus, the requirements of ARM Title 37, chapter 91 do not apply to this chapter and are outside the scope of this rulemaking.

COMMENT #37: A commenter suggested certification training for CPR, first aid, and physical restraint training required for adolescent programs be complete within 30 days of hire for patient safety and an efficient use of staff resources. The commenter stated providers should prioritize certification training to ensure competency and transition to allow independent direct services in a timely manner.

RESPONSE #37: The department agrees training should be prioritized; however, it disagrees with requiring providers to complete training within 30 days. These are specialized training requirements that providers may not be able to access every 30 days. When providers do not have certified trainers on staff, they may need additional time to schedule this training with outside organizations. This rule does not prohibit providers from completing training within 30 days when available to allow staff to work independently sooner. The rule requires untrained staff to always work with individual staff members who have received the required training in order to ensure one staff member on shift is fully trained for safety reasons.

COMMENT #38: A commenter requested clarification on whether the SUDF must provide either 20 hours of annual training or the time for employees to complete 20 hours of annual training. The commenter believed this would benefit the organization to allow training to be completed by another agency.

RESPONSE #38: The rule allows training that is completed by outside organizations to be counted in the 20 hours of annual training.

COMMENT #39: A commenter strongly supported requirements that prohibit SUDFs from discontinuing medications prescribed by a licensed health care professional, as described in NEW RULE XI.

RESPONSE #39: The department acknowledges and appreciates the comment.

COMMENT #40: A commenter strongly recommended NEW RULE XIV require direct access by consultation or referral to medical and psychiatric services as required in New Rule XVII or align with current ASAM requirements for Level 3.5 to include telephone or in-person consultation with health care professional 24 hours a day, seven days a week.

RESPONSE #40: The department agrees, and will amend the rule to include physicians and physician extenders as required for ASAM 3.5 services in the ASAM Criteria.

COMMENT #41: A commenter recommended the clinical director have at least three years of experience in a similar setting with supervisory responsibilities to ensure competency and to support quality and patient safety.

RESPONSE #41: The department disagrees with the commenter as requiring three years of experience puts an additional burden on providers when there are limited mental health professionals available to fill this role. The department prohibits licensure candidates from filling this role to ensure the clinical director has completed all the education and clinical requirements for the position.

COMMENT #42: A commenter informed the department that "participant names" in ARM 37.106.1413(28) should not be plural.

RESPONSE #42: The department agrees, and has amended the rule accordingly.

COMMENT #43: A commenter suggested language in ARM 37.106.1435(1)(b) be written the same as (1)(c).

RESPONSE #43: The department agrees that ARM 37.106.1435(1)(b) should address trainees, interns, and volunteers, and has amended the rule accordingly. Because of the context, the department does not think that the provision can be written identically to (1)(c).

COMMENT #44: A commenter recommended citing reporting law instead of requiring SUDFs report allegation of abuse, neglect, and exploitation within 24 hours. The commenter stated imminent danger is an immediate report to law enforcement.

RESPONSE #44: The department disagrees with the commenter as Montana reporting laws for abuse, neglect, or exploitation do not require reports within a certain timeframe. Moreover, the reporting laws referenced in the rule do not reference imminent danger or require an immediate report to law enforcement. The regulatory requirement provides a reasonable timeframe for facilities to report abuse, neglect, or exploitation to the appropriate authorities.

COMMENT #45: A commenter submitted concerns regarding the requirement for an SUDF to fully cooperate with an investigation that results from an abuse, neglect, or exploitation report. The commenter stated they have worked APS/CPS cases where the department or case worker demands hours and hours of staff time. The commenter would like to know who will reimburse for that.

RESPONSE #45: It is necessary to require an SUDF to fully cooperate with any investigation into concerns of abuse and neglect or exploitation. This will help to ensure investigators have access to all the information required to complete a thorough investigation. Such cooperation in investigations of potential violations by the provider is generally a cost of doing business, but in extraordinary circumstances, or when the investigation does not concern compliance by the

providers or their workforce, providers should discuss any potential reimbursement with the agency or department with whom they are working.

COMMENT #46: A commenter would like to know how the facility can legally pull an employee from work on a suspicion of abuse or neglect when guilt has not been established by a court of law. Do SUDFs have a new special legal status where we can establish guilt before innocence?

RESPONSE #46: Allegations of abuse or neglect must be taken seriously, and facilities must err on the side of caution when handling such allegations. Ensuring staff accused of abuse or neglect not provide direct care during the pendency of an investigation not only protects the alleged victim, but the staff accused as well. This allows an investigation into the allegation to occur without any potential interference.

COMMENT #47: A commenter stated the language "must not work" without the training, as described in NEW RULE IX, needs clarification.

RESPONSE #47: The department disagrees that the rule needs clarification. The rules state staff that have not received the certification "must not work unsupervised with clients."

COMMENT #48: A commenter stated that requiring 20 hours of training will inhibit the clinics' ability to have certain residents/students do rotations through their clinics.

RESPONSE #48: The commenter is referencing the requirement for annual training. Students and interns are not required to complete annual training unless they continue to work at a facility for over a year.

COMMENT #49: A commenter asked if someone 18, 19, or 20 is considered an adolescent.

RESPONSE #49: A person 18, 19, or 20 can be defined as an adolescent if the individual meets the requirements outlined in the definition section of this rule for "adolescent."

COMMENT #50: A commenter stated the language around legal adult and youth is ambiguous and could create legal issues for providers. The commenter wondered how this definition will interact with existing state law.

RESPONSE #50: The department disagrees with the comment. The rule clearly defines "adult" and "adolescent" and provides clear guidelines on when an individual over the age of 17 can be treated in an adolescent facility. This rule will not interfere or interact with existing state law regarding the definition of "adult."

COMMENT #51: A commenter stated requiring one awake night staff person in each unit of a facility that serves adolescents goes against trauma informed best practice. The commenter believes more programs are trying to become more

trauma informed and allow older youth more space and suggested allowing four youth to a bunkhouse. The commenter stated that this requirement, as written, will cause programs to go bankrupt and having a staff sit in a bedroom at night is "creepy."

RESPONSE #51: The department disagrees with the commenter. The requirement for awake night staff provides the appropriate level of supervision for adolescents to ensure the safety and security of residents.

COMMENT #52: A commenter recommended "licensed" be included before mental health professional.

RESPONSE #52: The department disagrees with adding licensed in front of mental health professional as the term is defined in ARM 37.106.1413.

COMMENT #53: A commenter stated requiring staff to be at least 21 years of age or older is age discrimination. The commenter advised the department to consider striking this requirement as employers are already very aware of the risks of young staff members.

RESPONSE #53: The department disagrees with the commenter as the age requirement is reasonable, given the age of residents/clients in adolescent programs may be the same age as staff members responsible for caring for them.

COMMENT #54: A commenter asked if all SUDFs are required to have a policy for standards related to food or can it be limited to facilities that provide food.

RESPONSE #54: The rule regarding food standards policy requires only inpatient and residential programs, all of which provide food, complete policies.

COMMENT #55: A commenter suggested that the word "targeted" should be removed from "targeted care manager."

RESPONSE #55: The department agrees, and has amended the rule accordingly.

COMMENT #56: A commenter expressed concerns regarding who within the SUDF under NEW RULE XV can determine both developmental states and comprehension of clients to modify interventions and how are significant cognitive deficits defined.

RESPONSE #56: The department agrees, and will amend the rule to include physicians and physician extenders as required for ASAM 3.3 services in the ASAM Criteria.

COMMENT #57: A commenter stated NEW RULE XVIII does not mention ASAM 2.1 or lower and wonders if that is implicit to outpatient or does it need to be included.

RESPONSE #57: Outpatient substance use disorder facilities can provide ASAM 2.1 level of care, as an outpatient setting would encompass both ASAM 1.0 and ASAM 2.1 levels of care.

COMMENT #58: A commenter requested clarification on what care managers do, how they document, and how they are represented in a treatment plan.

RESPONSE #58: Care managers are defined in ARM 37.106.1413, and programs must develop written policies and procedures for the care management program as described in NEW RULE XX. Care managers should be part of the interdisciplinary treatment team and participate in the development and review of treatment plans.

COMMENT #59: A commenter submitted concern that allowing rehabilitation aides to lead education groups negates clinical directions and would impact anger management under law or parenting courses that are evidence based.

RESPONSE #59: The department disagrees with the commenter, as all facilities are required to have a clinical director to supervise the provision of skilled treatment services which include educational groups. The rule does not prohibit any facility from requiring the licensed addiction counselor or mental health professional from providing/leading these groups if the facility chooses to do so.

COMMENT #60: A commenter stated that ASAM allows for attendance in an AA group to count as a clinical intervention counting towards 9+ hours for level ASAM 2.1 intensive outpatient services if it has been clinically indicated by the rendering provider and documented in a treatment plan.

RESPONSE #60: The department disagrees. The ASAM Criteria indicates that "attendance" at self-help/mutual help meetings such as Alcoholics Anonymous or Narcotics Anonymous, volunteer activities, or homework assignments involving watching videos, journaling, and workbooks do not represent "skilled treatment services" for the purpose of meeting the required clinical hours for each level of care.

COMMENT #61: A commenter asked if the department would define group size for inpatient.

RESPONSE #61: The department will not define group size for inpatient treatment purposes. The department recognizes that all facilities are different and may serve different populations with different needs. Accordingly, the rule requires facilities to have policies and procedures defining client/staff member ratios for group counseling sessions.

COMMENT #62: A commenter asked how the department defines "significant other."

RESPONSE #62: The department does not define "significant other." The client/patient should determine what individual would be considered a "significant other."

COMMENT #63: A commenter stated that the rule requiring volunteers not be part of staff ratio contradicts "earlier" sections that said volunteers must be referred to as staff.

RESPONSE #63: The department disagrees with the commenter as the rule states volunteers must not be counted as part of the client/staff ratio. While the department is unable to determine what "earlier" section(s) the commenter is referencing, the rule is not inconsistent with requiring that volunteers meet certain requirements that are applicable to staff (or, for purposes of such requirements, including volunteers in the category of "staff").

COMMENT #64: A commenter submitted concerns that private practices and smaller SUDFs cannot comply with the requirement to have an interdisciplinary team. The requirement creates an undue hardship and should read that we capture holistic wraparound in treatment planning.

RESPONSE #64: The department disagrees with the commenter. All treatment plans must be developed by an interdisciplinary team. All licensed SUDFs subject to this rule employ or contract with staff from many disciplines who can be included as part of the interdisciplinary team as required by ASAM Criteria. Private practice clinicians are not required to be licensed as an SUDF and can provide services as an independent clinician.

COMMENT #65: A commenter submitted a 15-page document. Several comments were based on an early draft of the rules and do not correlate to the new rule numbers in the final version of the proposed rule filed with the Secretary of State's office.

RESPONSE #65: The department made efforts to identify any substantive comments in the submission that continue to be relevant to the proposed rulemaking published on August 5, 2022 (and to the final version found in this MAR notice) and to address such comments.

COMMENT #66: A commenter asked what liabilities exist when having a legal adult patient 20 years of age with a 15-year-old.

RESPONSE #66: SUDF facilities choosing to serve individuals over the age of 17, as defined in this rule, should consult their own legal adviser on such issues and determine if they are able to appropriately treat and supervise all patients. The rule does not require adolescent facilities to admit individuals over the age of 17.

COMMENT #67: A commenter requested the definition of "Recovery Residence" in ARM 37.106.1413 include a statement that "Recovery Residences are certified by

the Recovery Residences Alliance of Montana and do not require licensure." Adding the language would benefit the state by placing responsibility for technical assistance onto this new governing body.

RESPONSE #67: The department disagrees with adding language to the "Recovery Residence" definition. The department does not have the authority to impose requirements on other entities or facilities not required to be licensed by the department.

COMMENT #68: A commenter requested clarification on what "training in adolescent development" means in NEW RULE IX.

RESPONSE #68: Training in adolescent development should be tailored to address the physical, intellectual, behavioral, social, and emotional development of adolescents between childhood and adulthood.

COMMENT #69: A commenter requested clarification if NEW RULE X applies to 3.1 women and children's facilities.

RESPONSE #69: The rule would apply to 3.1 level of care if licensed to serve adolescents as defined in this rule. The rule would not apply to licensed adult 3.1 homes where children under the age of 18 are only present because they are living with a parent who is receiving treatment at the facility.

COMMENT #70: A commenter asked if the requirement to have staff members of the same sex as the client applies to children in a 3.1 women and children home.

RESPONSE #70: The rule would not apply to require a licensed adult 3.1 home to have staff members of a particular sex based on the sex of a child under the age of 18 who is only present because the child is living with a parent who is receiving treatment at the facility.

COMMENT #71: A commenter requested clarification if it is okay for clients to assist in food preparation as described in NEW RULE XIII.

RESPONSE #71: Yes, clients may assist in food preparation as part of the facility programming.

COMMENT #72: A commenter asked if a 3.1 adolescent facility can also be a 3.1 women and children home as described in NEW RULE XVI.

RESPONSE #72: A facility could be licensed as an adolescent single parent women and children home if they only admit adolescents up to the age of 18 or 21 under circumstances as defined in NEW RULE XVI.

COMMENT #73: A commenter requested clarification on what "sufficient number" means, and how it will be determined and measured.

RESPONSE #73: The rules provide clear guidelines for "sufficient number" under each staffing requirement. When facilities are not meeting these requirements, the department may make the determination they do not have enough staff filling that role.

COMMENT #74: A commenter asked if medical marijuana would be included in NEW RULE XI, which prohibits prescribed medications from being discontinued.

RESPONSE #74: Medical marijuana is prohibited in health care facilities pursuant to 50-5-101, MCA. Procedures to follow for health care facilities admitting patients that have medical marijuana are outlined in 16-12-514, MCA.

COMMENT #75: A commenter stated that ASAM does not identify the number of hours per day that a program must conduct "skilled treatment services." The commenter recommended state guidelines follow ASAM.

RESPONSE #75: The department partially agrees, and has amended the rule accordingly. ASAM 2.5 requires a minimum of 20 hours of skilled treatment services per week; therefore, the department has added language that requires ASAM 3.5 level of care to provide 30 or more hours per week. This requirement is reasonable for a residential facility that is required to have a 24-hour, seven days per week treatment environment. The hourly requirement per week provides a measurable way to determine compliance.

COMMENT #76: Several commenters stated that definitions differed across the rules and manual policies. The commenters recommended the department revise rules and policies to ensure that definitions are consistent between licensure, state approval, and Medicaid rules.

RESPONSE #76: The department agrees and has amended the rules and manual policies accordingly to the extent possible.

COMMENT #77: A commenter noted that the definition of "licensed addiction counselor" (LAC) specifies that it does not include LAC candidates. The commenter expressed concern this would affect providers' ability to staff their programs.

RESPONSE #77: The department will amend the rule to clarify that the definition of LAC in ARM 37.27.102 is referencing individual LACs who are state approved under ARM 37.27.107. State approval under ARM 37.27.107 is intended for LACs that are fully licensed and able to practice independently without the need for supervision.

COMMENT #78: A commenter asked for clarification of the term "state approved program" now that individuals and clinics are also approved.

RESPONSE #78: Individual LACs have been able to become state approved under ARM 37.27.107, which was effective 2/13/2021. These rules further delineate that

state approved programs include licensed SUD facilities, individual LAC providers, and prevention providers.

COMMENT #79: A commenter requested clarification on "programs participate in quarterly updates with the department" as described in ARM 37.27.120.

RESPONSE #79: The department will amend the rule to clarify that state approved "providers will submit quarterly updates to the department" to ensure that the department has current information for each provider and the services they offer.

COMMENT #80: A commenter asked if daily scheduled services are required five or seven days per week. If required seven days per week, the commenter requested an amended schedule be allowed for Sundays and holidays in order for clients to possibly attend religious services, observe holidays, and give staff the ability to have a holiday or a Sunday off.

RESPONSE #80: Daily scheduled services are required seven days per week including Sundays and holidays. The department removed the hourly requirement for daily clinical services and replaced it with a weekly requirement in order for the facility to have the ability to provide an amended schedule to incorporate religious services and holiday celebrations.

COMMENT #81: A commenter stated that 24/7 staffing in NEW RULE XVI for ASAM 3.1 homes will be extremely difficult, if not impossible to maintain. The commenter stated residents are typically outside of the home 8 to 10 hours per day, and during the weekdays a house parent/staff will be home alone 90% of the shift.

RESPONSE #81: The department agrees, and will amend the rule to require awake staff on-site when clients are present in the facility as required for ASAM 3.1 level of services in the ASAM Criteria.

COMMENT #82: A commenter stated the department needs to clarify why ASAM 3.1 homes need to provide five hours of treatment in the actual home as required in NEW RULE XVI. The commenter stated the requirement puts an unfair burden on residents who are attending IOP treatment at local outpatient clients or attending other levels of treatment in the community.

RESPONSE #82: The department will amend the rule to be consistent with ASAM Criteria, which requires a clinical services component that includes five hours of treatment per week provided on-site or off-site, and a recovery residence component that includes recovery support services that promote interpersonal and group living skills.

COMMENT #83: A commenter asked if the ARM referenced in NEW RULE XIV follows CDC guidelines for tuberculosis (TB) screening.

RESPONSE #83: The ARM referenced in NEW RULE XIV incorporates CDC guidelines. The department has amended the rule to ensure that the TB screening requirements are clear.

COMMENT #84: A commenter recommended a care manager required in NEW RULE XX be allowed to have three years of documented equivalent experience as an alternative option.

RESPONSE #84: The department partially agrees with commenter as the rule already allows for care managers to have two years of experience. The rule states education and experience, or a minimum of two years of experience serving individuals with behavioral issues. The department disagrees with the commenter's recommendation of three years of experience because the department believes that two years of experience is sufficient. The department amends the rule to indicate that the experience be documented in the personnel record. The department also amends the rule to indicate that the combination of education and experience should be an equivalent combination of education and experience.

COMMENT #85: A commenter suggested changing the rule title of ARM 37.106.1401.

RESPONSE #85: The department disagrees, as this rule has been repealed under this rulemaking.

COMMENT #86: A commenter stated NEW RULE XX will place the non-clinician care manager at odds with decisions of the therapist and clinical director and serve to divide the care team.

RESPONSE #86: The department partially agrees with comment. However, it is the responsibility of the care manager to advocate for the client in instances when additional services or services provided by another agency may further benefit the client. A facility's policies and procedures should address when this situation arises and ability for the care manager to contact an advocacy organization on behalf of the client, as appropriate or as needed.

COMMENT #87: A commenter stated language around care plans and treatment plans are confusing and asks for clarification.

RESPONSE #87: The department is unable to adequately respond as the commenter does not specify what they find confusing. However, the department will amend rules to ensure that definitions are consistent throughout these rules.

COMMENT #88: Multiple commenters requested the department define "face-to-face" in the rules.

RESPONSE #88: The department disagrees with this comment as the term "face-to-face" is not used in these proposed (or final) rules. This language was revised

following public meetings prior to publication of the MAR notice for the proposed rules.

COMMENT #89: A commenter requested clarification on how ARM 37.106.1425 would apply to for-profit organizations without a governing body that are individually owned.

RESPONSE #89: The department will provide clarification and amend the rule to add an oversight committee as an option for such individually owned for-profit organizations.

COMMENT #90: A commenter recommended changing the requirement for routine reviews of policies and procedures to annual reviews.

RESPONSE #90: The department disagrees as the proposed rule does not require policy and procedures to be reviewed "routinely." The department notes, however, that all health care facilities must review their policies and procedures annually, pursuant to ARM 37.106.330.

COMMENT #91: A commenter had a concern that job qualifications that include a requirement that staff must be free of substance use problems for at least two years as part of the hiring process is impossible to enforce.

RESPONSE #91: The proposed rule, ARM 37.106.1430, does not have this requirement as this language was removed following public meetings prior to publication of the MAR notice for the proposed rules.

COMMENT #92: A commenter asked if ASAM 3.2-WM can be a free-standing facility or does it need to be a part of an existing ASAM 3.5 or 3.7 facility.

RESPONSE #92: ARM 37.106.1480 lists ASAM 3.2-WM treatment services as being provided in a licensed inpatient or residential facility licensed under Title 50, chapter 5, MCA. These services cannot be provided in a free-standing facility.

COMMENT #93: A commenter indicated that the definition of "skilled treatment services" is word for word the same as ASAM's definition, except for the addition of one service: Psychosocial Rehabilitation. Skilled treatment services, as defined by ASAM, are services such as: individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy, and other therapies. The commenter expressed concern that Montana Medicaid altered a standard definition published by the ASAM without research or evidence.

RESPONSE #93: The department agrees with the commenter and has amended the definition of "skilled treatment services" to exclude psychosocial rehabilitation to align with the ASAM Criteria. The department consulted with ASAM and was provided guidance to clarify that skilled treatment services must be provided by

clinical staff licensed pursuant to Title 37, MCA. In accordance with the guidance, the department has made corresponding changes to New Rule XIV(2), New Rule XV(2), New Rule XVI(2), ARM 37.106.1413(15) and (35), ARM 37.106.1475(3), and ARM 37.106.1480(1)(i).

/s/ FLINT MURFITT
Flint Murfitt
Rule Reviewer

/s/ CHARLES T. BRERETON
Charles T. Brereton, Director
Department of Public Health and Human Services

Certified to the Secretary of State September 13, 2022.