MONTANA
ADMINISTRATIVE
REGISTER

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

NOTICE OF ADOPTION

MAR NOTICE NO. 37-1104

Summary

Amendment of ARM 37.27.902, 37.85.105, and 37.88.101 pertaining to updating Medicaid and non-Medicaid provider rates, fee schedules, and effective dates

Previous Notice(s) and Hearing Information

On September 20, 2024, the Department of Public Health and Human Services published MAR Notice No. 37-1104 pertaining to the public hearing on the proposed amendment of the above-stated rules at page 2173 of the 2024 Montana Administrative Register, Issue Number 18.

The public hearing was held on October 11, 2024.

Final Rulemaking Action – The department intends to apply the rule amendments retroactively to October 1, 2024.

AMEND AS PROPOSED

The department has amended the following rules as proposed:

37.27.902 SUBSTANCE USE DISORDER SERVICES: AUTHORIZATION REQUIREMENTS

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

37.88.101 MEDICAID MENTAL HEALTH SERVICES FOR ADULTS, AUTHORIZATION REQUIREMENTS

Statement of Reasons

The department has considered the comments and testimony received. A summary of the comments received, and the department's responses are as follows:

Comment #1: A commenter said the effective date for the policies referenced in this proposal notice is October 1, 2024. However, public comment regarding this policy is not occurring until October 11, 2024. The commenter asked the department to please clarify how agencies are to implement these policies prior to the public comment period.

Response #1: The department is implementing the changes to the fee schedule to cover the services and to pay for such services from October 1, 2024, so policies/requirements for such services as proposed in MAR Notice No. 37-1104 need to be in place to provide such coverages. The department will not enforce any changes from the proposed policies that have the effect of adding burden or requirements (as opposed to imposing less burden than proposed), for service dates on or before February 22, 2025.

Comment #2: A commenter asked the department to provide information as to why Targeted Case Management (TCM) was removed as a concurrent service for 2.1 and 3.1, but not 2.5.

Response #2: The department thanks the commenter for their comment on Policy 530. However, because the department did not propose changes to Policy 530, the comment is beyond the scope of the current rulemaking. The department will consider the comment in a future rulemaking.

Comment #3: A commenter identified that in MAR Notice No. 37–1104, on pages 2175 and 2176, there is a reference to Community Maintenance Program (CMP) Policy number as "465" when it's actually "486."

Response #3: The department recognizes the error, and will change proposed new CMP policy to number 486.

Comment #4: A commenter identified that in MAR Notice No. 37–1104, on page 2176, the third bullet point says "minimum" and should say "maximum" and requested the department change Policy 455, Provider requirement (6) from "minimum" to "maximum."

Response #4: The department recognizes its mistake, and will amend the wording to "maximum" in both MCT (455) and PACT (460) policies.

Comment #5: A commenter asked if there is a standard for approval/denial for the variance request form that could be shared with the PACT/MCT teams showing the parameters.

Response #5: The department will evaluate all variance requests on a case-by-case basis. A variance will be approved if it can be shown that the team requesting a temporary variance can

still maintain the integrity of the ACT services being provided. These evaluations will be performed based on/consistent with the service requirements found in the Substance Abuse and Mental Health Services Administration's (SAMHSA) Assertive Community Treatment Toolkit (ACT Toolkit).

Comment #6: A commenter asked if the policy Variance Request form should include CMP in the title and first sentence. If not, the commenter recommended removing "and" from the title.

Response #6: CMP will be removed from the title as variances are not offered for CMP since all variances will be approved or denied to the PACT or MCT team offering CMP services, and any variances will be requested through those teams.

Comment #7: A commenter asked for clarification regarding team size FTE % (i.e., small, medium, large) and ratio requirement or team need. The commenter asked if the only option to fill team need is a Generalist/Specialist as the other positions are required, based on team size.

Response #7: Teams may fill positions beyond the required core staff with a PACT/MCT generalist or specialist to maintain the required staff to client ratio.

Comment #8: A commenter requested the department include the annual requirement of comprehensive training, and initial training within 60 days of hire on the Staffing Roster, page 1.

Response #8: Training requirements are identified under provider requirements in both the PACT (460) and MCT (455) policies.

Comment #9: A commenter asked for clarification regarding who can sign the Staffing Roster and whether it needs to be signed by someone on the PACT/MCT team.

Response #9: The Staffing Roster needs to be signed off on by the team lead as they are attesting to the composition of their team. The proposed Staffing Roster form will be amended to indicate the need for the team lead's signature (written or electronic).

Comment #10: A commenter asked which procedure codes would be utilized if billing Fee for Service for the service components listed in the policies. The commenter also asked if a particular procedure code is not available, or the service component is not a Montana Medicaid reimbursable service, what the department's process is for reimbursing teams for services rendered.

Response #10: The proposed PACT (460), MCT (455), and CMP (486) policies outline requirements for reimbursement of PACT, MCT, or CMP services. Providers may refer to corresponding policies and fee schedules for service components being provided and billed

with respect to fee-for-service reimbursement. The relevant fee schedules can be found at https://medicaidprovider.mt.gov/.

Comment #11: A commenter noted that in the proposed staffing roster, PACT or MCT Specialist is listed twice, and there is no section for recording a PACT or MCT generalist. It is recommended changing one of the duplicated PACT or MACT Specialist to "PACT or MCT Generalist."

Response #11: The department acknowledges this mistake and will correct the proposed Staffing Roster to state PACT or MCT Generalist and PACT or MCT Specialist in place of the duplicated PACT or MCT Specialist.

Comment #12: A commenter requested that policy 230 be amended to allow Day Treatment to be billable concurrently with PACT/MCT/CMP, as this program provides socialization and community for members with their peers. According to SAMHSA, the four pillars of successful long-term recovery are health, home, purpose, and community. Day Treatment services align with these pillars and are vital for long-term recovery of SDMI members.

Response #12: The department agrees, and will amend policy 230 to allow Day Treatment to be billable concurrently with PACT/MCT/CMP services. Exception language will be added to policy 230 to provide that concurrent billing of Day Treatment will be allowable if PACT contacts are provided outside Day Treatment hours.

Comment #13: A commenter indicated that Policy 455 QM - Community Treatment Quality Measures is outdated, and requested the department update this policy by removing the quality measures currently listed and instead reference the quality measures listed on the current contact log.

Response #13: The department will amend Policy 455 QM to ensure it reflects quality measures identified and agreed upon by stakeholders. Although the contact log is one of the identified sources of data for those quality measures, it does not include all the quality measures.

Comment #14: A commenter requested the department change "resiliency oriented" to "resiliency-oriented" in both policies 455 and 460.

Response #14: The department agrees to change wording to "resiliency-oriented" in both policies 455 and 460.

Comment #15: A commenter requested the department to correct spelling for the word "member" in policy 455 under Medical Necessity Criteria, (1)(d).

Response #15: The department recognizes the misspelling and will amend the language to change policy 455 (1)(d) to read "member."

Comment #16: A commenter indicated that in both policies 455 and 460, Medical Necessity Criteria (1) states that the member "must meet the SDMI criteria as defined in this manual" which does not align with the requirements listed in Medical Necessity Criteria (2). The commenter requested the department align the policies with the SDMI criteria indicating the PACT/MCT member already must qualify for PACT/MCT services via SDMI diagnosis and by meeting outlined Level of Impairment (LOI) scoring. The additional scoring requirement in Areas 5 or 6 is unneeded if the individual's LOI score meets PACT/MCT service requirements and denoting the additional scoring requirements in one of two levels does not provide for holistic care. PACT/MCT serves clients who cycle through their illness and despite familial support and/or current mood/thought functioning the individual still is scoring high enough to meet service requirements via the already established LOI, which is a state-chosen screening tool that is clinically validated.

Response #16: The department would like to clarify that an SDMI diagnosis alone does not automatically qualify an individual for PACT/MCT services. While it is a minimum requirement, the ACT Toolkit sets forth additional factors that contribute to a determination if a person is appropriate for PACT/MCT services. The ACT Toolkit indicates PACT/MCT services are appropriate for individuals experiencing the "greatest level of functional impairment." This conclusion does not align with the "moderate" Level of Impairment (LOI) finding included in three of six Areas on the State Plan Evaluation and LOI Form. The ACT Toolkit states that areas of "significant (not moderate) functional impairment" include the inability to: "perform significant daily tasks" such as hygiene, and nutrition, to be employed or to maintain a safe living situation; history of psychiatric hospitalization, persistent psychotic symptoms, or criminal justice involvement, and inability to participate in traditional office-based services. The criteria identified in the ACT Toolkit require "high level" of intensity in these areas, which correspond with the State Plan Evaluation and LOI Form Areas 5 and 6, specifically. The department addresses specific situational determinants as defined in the ACT Toolkit under Medical Necessity Criteria (1) in each policy. The department will continue to define Medical Necessity as proposed.

Comment #17: A commenter requested the department define what "check-in" means for LPNs with RNs in policy 455. The commenter requested the department consider changing from "every 24 business hours" to once per week (aligns with licensure candidacy requirements) or twice a week (aligns with Peer Support licensure requirements), as daily supervision is highly intensive and would present a barrier given availability of RNs.

Response #17: The department thanks the commenter for their comment on Policy 455. However, because the department did not propose changes to the frequency of check-ins in Policy 455, the comment is beyond the scope of the current rulemaking. The department will consider the comment in a future rulemaking. The department does not define "check-in" and would defer to the level of supervision agreed upon by the supervising RN.

Comment #18: A commenter proposed changing the term “clients” written in the proposal (in reference to consumers) to be identified as “members” (and the term “team members” written in proposal to “staff/employees”) in policies 455, 455qm, 460, and 486 for clarification.

Response #18: The department agrees to this change and will change the proposed term “clients” to “members” and will change the proposed term “team members” to “staff.” The ACT Toolkit refers to clients as “consumers,” but the department will use the term “member” for consistency across policies.

Comment #19: A commenter indicated that in (12) under provider requirements in proposed Policies 460 and 455, the provider may bill at the weekly rate, provided they meet the 13 service requirements listed in the Service Requirements section of the policy. This implies that if a team is not able to meet all 13 Service Requirements each week, they should not bill the weekly bundle. However, some of the service requirements listed do not match up with a weekly reimbursement timeframe. For example, Service Requirement (4) is calculated every two weeks and Service Requirement (8) is calculated monthly. Based on how the policy is currently written, teams would have to either wait until the end of the month to bill their weekly contacts or they would bill the weekly rate and would have to go back and correct the bill. Neither option is ideal, as it creates operational and administrative bottlenecks. The commenter recommended the department remove the language, "provided they meet the service requirements below." However, if the department is unable to remove that language, commenter requested the department clarify in detail the reimbursement methodology and process for billing the weekly rate. Additionally, if the department intends to continue to allow teams to bill Fee for Service if weekly requirements are not met, we ask that the department add Procedure Codes for each service listed in (2) of Service Requirements into Policies 460 and 455.

Response #19: The department recognizes the unclear language presented and will amend Policies 460 and 455 to align with weekly requirements. Additionally, teams must meet all requirements in policy to receive reimbursement of that service.

Comment #20: A commenter stated that MCT is a modified version of the Assertive Community Treatment model with specific requirements for Montana and asked the department to consider removing or modifying the language that requires MCT must comply with the fidelity standards of SAMHSA because SAMHSA's fidelity standards are based on Assertive Community Treatment, not the modified MCT version for Montana.

Response #20: The department thanks the commenter for their comment on Policy 455. However, because the department did not modify or change language to fidelity standard requirements, the comment is beyond the scope of the current rulemaking. The department will consider the comment in future rulemaking.

Comment #21: A commenter recommended removing SUD as a required service component in proposed policy 455. The commenter noted the requirement to provide co-occurring care via

MCT services takes away an agency's previous ability to bill for substance use disorder (SUD) services for a MCT client without addressing that loss of SUD revenue in the outlined MCT bundled reimbursement.

Response #21: The department disagrees that the proposed changes would result in loss of revenue. Claims data does not show concurrent billing of SUD services. Providers are allowed to bill SUD services concurrently under the existing policy. However, the department reduced the staffing requirements for MCT in the proposed policy to allow MCT teams to serve additional CMP clients. The department believes these changes offset the inclusion of SUD in the bundled rate. Additionally, co-occurring therapy (including substance use) is a core principle of the SAMHSA ACT model (SAMHSA ACT Toolkit, Building your Program, 2008). The model requires teams to provide this service to clients and was considered in the bundled rate during the provider rate study. The department will keep the policy as proposed.

Comment #22: A commenter asked whether required contacts in polices 455, 460, and 486 include indirect services provided to members. Indirect services such as contact with payee, supports, Social Security, and the Office of Public Assistance (OPA) on a member's behalf.

Response #22: ACT services are intended to work concurrently with a client to build the skills necessary to independently network in the community. Although the SAMHSA ACT model encourages informal support system involvement to promote program success, informal supporters do not provide direct contact with members to promote intensive services because these supporters are not paid contributors to the client's treatment, and the client does not need to be present during contact with the informal support contacts. The department will keep the language as proposed.

Comment #23: A commenter stated that proposed Policy 455 doubles the number of contacts a MCT team is required to make per member per week and recommended keeping the contacts per week to one. A commenter noted the barriers faced in provision of MCT services in frontier areas of Montana (i.e., geographic area, two lane highways, intermittent internet connectivity, and weather conditions) were all reasons that the program initially required one contact per week. The MCT program already allows for MCT members to be seen as many times per week as needed to provide individual service and support when the member needs multiple contacts per week.

Response #23: The ACT Toolkit indicates that a team providing minimum face-to-face contact of two contacts would constitute a half-implementation fidelity score (3/5) for service intensity. This policy is based on these recommendations from the evidence for fidelity. Currently, reimbursement is determined on staff meetings, not service contacts. The added language allows billing for two weeks if the member is unable to make contact. The department will leave the language of the policy as proposed.

Comment #24: A commenter recommended removing language requiring that the PACT/MCT member have contact with more than one staff member every two weeks. The commenter

suggested this negates client preference in what service(s) they will take part in on the PACT/MCT team. PACT/MCT teams already staff members at the required frequency each week, which ensures there is ongoing involvement of the entire team for the provision of care for each member. Furthermore, based on clinical assessment and client preference, PACT/MCT services (i.e. medication management, therapy) may not be needed on a weekly basis and the PACT/MCT member is not required to take part in every service that the PACT/MCT team offers. How this requirement is currently written directly disregards client preference and individualized care. It also removes the team's ability to tailor services to an individual by requiring each client receive the same provision of service, which is inefficient and burdensome to the operations of PACT/MCT teams and leads teams to potentially provide more services than the member clinically requires at that moment. We recommend removing the requirement that a member have contact with more than one staff member every two weeks, to allow for client preference and individualized care. This would align with ACT Fidelity by allowing teams to calculate their percentage of members who have had face-to-face contact with more than one staff member in two weeks across their entire team caseload rather than per member.

Response #24: The department agrees to remove the two-week multiple staff contact requirement in the proposed policies 455 and 460 to align with the weekly statement in Comment #19. However, the department will keep the proposed language in both policies requiring contact with more than one team staff person. The language will be amended to read "more than one (PACT/MCT) team staff person during treatment." The ACT Toolkit continually reiterates ACT is a team approach with providers who "function as a team rather than individual ACT team staff person[,] [and] ACT team staff know and work with all consumers." [ACT Toolkit, Building Your Program, 2008)]. The ACT Fidelity Scale measures how well programs follow key elements of the ACT model. Evidence shows consumers (referenced as members in policy) are more likely to be successful with ACT when they receive services through this team approach with more than one ACT team staff person providing the ACT services. The department will keep the policy as proposed in regard to members/consumers receiving services from more than one staff person.

Comment #25: A commenter stated that members currently determine the location for delivery of services. The commenter requested the department consider allowing clients to choose where they are most comfortable and prefer receiving services rather than, as proposed in "Policy 455 stipulate 60% of contacts must take place per policy rather than client preference. This would align with ACT Fidelity by allowing the team to calculate the percentage of contacts in the community across the entire team caseload rather than per member."

Response #25: The department thanks the commenter for their comment on Policy 455. The department did not propose changes to the requirement that 60% of contacts occur in the client's natural setting, but after further review, the department will make the change to "50% of the time," in order to align with the 50% telehealth policy.

Comment #26: A commenter stated that MCT was designed to serve people in frontier Montana and there are times of the year, due to weather, that telehealth is the only option to provide services. The commenter recommended the department remove the restraints of telehealth for MCT members.

Response #26: The department acknowledges the comment and agrees to remove the monthly constraint by amending the sentence to state, "Telehealth may be used 50% of the time for the member's services."

Comment #27: A commenter requested the department includes a link to the SAMHSA ACT Toolkit. Additionally, this section indicates that PACT teams must complete all documentation outlined "in this manual" and in accordance with the SAMHSA Toolkit. This statement is overly broad, and the commenter asks if the department can provide clarification on what documentation is being required.

Response #27: The SAMHSA ACT Toolkit can be found at samhsa.gov. The direct link is https://store.samhsa.gov/product/assertive-community-treatment-act-evidence-based-practices-ebp-kit/sma08-4344. The department will also post the ACT Toolkit as a resource on the BHDD website. Section 1 of the BHDD Provider Manual for Substance Use and Adult Mental Health describes documentation requirements.

Comment #28: A commenter requested the department clarify if the requirement in policies 455 and 460 for Service Requirements (11)(c) is twice throughout a four-week inpatient hospitalization or twice weekly. The commenter also requested the department add "with inpatient staff and/or client to discuss client's continuum of care."

Response #28: The department will amend language in policies 455 and 460 to indicate that contact is required twice throughout the four-week period of the inpatient hospitalization. Provider requirement sections (11)(a) and (b) already indicate that services are provided during the inpatient hospitalization, whereas (11)(c) is specifically focused on contact with inpatient staff. The department will also amend language to replace "client" with "member."

Comment #29: A commenter stated that Prior Authorization, as defined in ACT policy, has never been a MCT requirement for a member to receive MCT services. The SDMI diagnosis and client need as demonstrated via the required LOI score admits the client into MCT. Prior authorization is not outlined in Policy #455 Medical Necessity. The commenter asked if the state can confirm that "Prior Authorization" in (1) of Utilization Management is either a typo or is referring to the process previously outlined earlier in the policy, not an actual Prior Authorization via Mountain Pacific.

Response #29: Prior Authorization is required. Though modified, MCT is still an ACT service, and ACT services require prior authorization. Individuals will still need to meet the level of care outlined under medical necessity criteria as explained in the Response to Comment 16. MCT policy currently requires requests for approval of continued stays (continued stay requests),

which were suspended until objective medical necessity criteria could be added to the policies. See provider notice Temporary Suspension of Prior Authorization and Continued Stay Review Requirements Update 6.25.24.

Comment #30: A commenter stated that guidance from the SAMHSA ACT Toolkit indicates ACT programs are time unlimited in addition to having clear medical necessity criteria within the proposed BHDD manual. The commenter recommends the removal of the Prior Authorization and Continued Stay process, as it appears to be redundant and delays the ability to provide services to Montana members and communities, in a timely manner.

Response #30: The department thanks the commenter for their comment. However, the department only added a prior authorization requirement for MCT. The department did not propose changes to prior authorization or continued stay requests for PACT, so this comment is beyond the scope of the current rulemaking.

Comment #31: A commenter requested the department include a range of percentage of total number of members receiving PACT/MCT services to allow flexibility with changes to staffing and/or member admits/discharges.

Response #31: The department declines to make the change requested by the commenter. Staffing requirements based on a range of percentages as proposed by commenter are not conducive to providing fidelity for core staff positions.

Comment #32: A commenter noted that language in the proposed policy 486 states, “The core service options which must be available by each CMP team member are as follows” and recommends the department change "options" to "components" to match language in policies 455 and 460. The commenter also recommends the department change “available” to "available and provided by" to match language in policies 455 and 460.

Response #32: The department acknowledges the comment and will amend Policy 486 to use similar language in Policies 455 and 460.

Comment #33: A commenter asked the department to clarify if each CMP team member must be available to provide the services or if policy 486 should be changed to say, "CMP team."

Response #33: The department appreciates this comment and will amend Service Requirements to read that core service options provided by a PACT/MCT team must be available to every CMP participant.

Comment #34: A commenter asked for clarification regarding the following language in proposed policies 455 and 460 which states, “Each member must receive weekly quality contacts, which may be provided using face-to-face contact or telehealth." The commenter asked the department to define “face-to-face contact" and "telehealth contact."

Response #34: Face-to-face services would be delivered in-person. The department does not agree the manual needs definitions because the language distinguishes the terms “face-to-face” and “telehealth.” This same language occurs in other policies as well indicating that telehealth can be substituted for face-to-face services. Additionally, for purposes of Medicaid, ”telehealth” is defined in 53-6-155(17), MCA, and the requirements for, and limitations on, Medicaid telehealth services are set forth by 53-6-122, MCA.

Comment #35: A commenter noted that proposed policies 455 and 460 state, “Quality contacts are comprised of services listed in (2) of this section" and requested the department change “(2) of this section” to “(1) of this section.”

Response #35: The department acknowledges the comment but will not make the requested change. The reference to “(2) of this section” is correct as (2) lists the service components which comprise a quality contact.

Comment #36: A commenter noted that policy 455 states, “Quality Contacts are the purposeful interaction between the MCT team and members" and requested the department to change “MCT” to "PACT or MCT team."

Response #36: The department acknowledges the comment but will not make the requested change as policy 455 is the MCT policy.

Comment #37: A commenter asked the department for clarification whether each day of the week the team discusses a CMP member's progress, and therefore documented, still counts as a billable day, or is this billable separately from the days members have contact with CMP staff (for up to four times per month)?

Response #37: Reimbursement for CMP services is based on services rendered to members, as opposed to team meetings. The proposed policy requires weekly team meetings to discuss a member’s progress, but team meetings are not billable.

Comment #38: A commenter stated that proposed Policy 486 states, "Each day that the member receives a contact in (4) qualifies as a billable day and can be billed at the daily rate, with up to 3 billable days per week." The commenter asked if (4) should be (1) or (3). The commenter also asked for clarification if a team provides CMP services for more than three billable days in the week, is anything over three contacts not billable or can the teams bill services as Fee for Service for over three contacts?

Response #38: PACT/MCT teams provide CMP services. If teams are having to make more contacts than allowable for CMP services, it could indicate the member might need to be assessed for transition to PACT/MCT services.

Comment #39: A commenter requested the department consider eliminating the proposed continued stay requirement in Policy 486. The commenter noted that providers would have to

submit extensive documentation to justify keeping a member in services when the member can be admitted to the services if the provider determines they meet diagnostic and other criteria in the proposed policy.

Response #39: The department agrees to remove the proposed Continued Stay Request (CSR) criteria from Policy 486.

Comment #40: A commenter proposed the department keep level of impairment (LOI) form as 3 (or 4) areas of moderate or higher impairment based on scores. The commenter noted that Increasing the LOI to high in one specific area could limit access to care for many clients who still require Behavioral Health Group Home (BHGH) services due to limitations in other areas. This change would not allow for individualized care to unique members and could cause restrictions to the necessary level of care.

Response #40: The department thanks the commenter for their comment on Policy 445. However, because the department did not propose changes to the LOI form, the comment is beyond the scope of the current rulemaking.

Comment #41: A commenter requested that while authorizations are pending, BHGH services be paid through determination date, even if waiting for additional information before denial. If the Initial Authorization or Continued Stay request takes five business days for review, then additional information is requested five days later, and it takes an additional five days before final determination. This is almost a full month of billing that agencies cannot afford to not be reimbursed for when they are still providing the prior approved services to members in their care.

Response #41: The department thanks the commenter for their comment. However, because the department did not propose changes to the Utilization Management policies in the manual, the comment is beyond the scope of the current rulemaking.

Comment #42: A commenter requested the department increase initial approval for BHGH (Policy 445) from 120 to 270 days. The nature of illness for SMDI members at this level of care requires a longer timeframe to stabilize. They could be prescribed new medication upon admission and need time to adjust to this, then make additional changes if needed. Once stabilized and able to work on their care plan, they need time to meet goals and increase stability. This process can take six or more months to get members stable to the point that they can work toward discharge planning.

Response #42: The department thanks the commenter for their comment on Policy 445, Behavioral Health Group Home. However, because the department did not propose changes to the number of days for prior authorization or continued stay reviews in Policy 445, the comment is beyond the scope of the current rulemaking. The department will consider the comment in a future rulemaking.

Comment #43: A commenter requested the department allow 90 days for ongoing treatment planning and discharge planning for BHGH for successful discharge to appropriate level of services, which often have waitlists.

Response #43: The department thanks the commenter for their comment on Policy 445. However, because the department did not propose changes around additional days for treatment/discharge planning once a member no longer meets medical necessity criteria in Policy 445, the comment is beyond the scope of the current rulemaking. The department will consider the comment in a future rulemaking.

Comment #44: A commenter asked the department to clarify if Community Based Psychiatric Rehabilitative Services (CBPRS) count towards the required hours for American Society of Addiction Medicine (ASAM) 2.1 (Policy 525), under service requirements.

Response #44: The required hours for ASAM 2.1 (Policy 525) are intended to be skilled treatment services as outlined in the 3rd Edition of the ASAM Criteria, which do not include CBPRS. The department will remove CBPRS as a service component in Policy 525.

Comment #45: A commenter asked the department to clarify if CBPRS counts towards the required hours for ASAM 3.1 (Policy 535), under Service requirements.

Response #45: The required hours for ASAM 3.1 (Policy 535) are intended to be clinical services that facilitate the application of recovery skills, relapse prevention, and coping strategies. Clinicians provide clinical services. ASAM 3.1 includes a residential setting component that is separate from the clinical component. Staffing for the residential setting component was considered for the bundled rate so CBPRS provided by non-clinical staff would not count toward the required hours and would not be billable separately.

Comment #46: A commenter asked the department to confirm in Policy 460, that team meetings no longer need to be documented in the clinical record for each member.

Response #46: Teams should document the meeting(s) as described in the ACT Toolkit. Reimbursement is no longer based on team meetings, so the department does not require documentation of those meetings in the individual member's clinical record.

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Approval

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