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

In the matter of the amendment of ARM 37.27.902, 37.88.101, and 37.89.201 pertaining to chemical dependency programs and Medicaid mental health services	)))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On July 21, 2023, the Department of Public Health and Human Services published MAR Notice No. 37-1033 pertaining to the public hearing on the proposed amendment of the above-stated rules at page 693 of the 2023 Montana Administrative Register, Issue Number 14.

2. The department has amended the following rules as proposed: ARM 37.27.902, 37.88.101 and 37.89.201.

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

COMMENT 1: The department received several comments asking for clarifying language to the medical necessity criteria for Program of Assertive Community Treatment (PACT) and Montana Assertive Community Treatment (MACT) services. One commenter requested that “Medical Necessity for both PACT and MACT should be the same as they are both Assertive Community Treatment programs.” One commenter proposed language allowing the service for “a stable client who is at serious risk of involuntary hospitalization due to their chronic diagnosis without the help of the PACT team.” Another commenter requested “additional clarification for continued stay reviews for PACT, MACT, and Community Maintenance Program (CMP) services, specifically for clients being allowed to maintain these services if the service is preventing a client from entering a higher level of care.”

RESPONSE 1: The department agrees with commenters that medical necessity criteria should be aligned between MACT and core PACT services. The department also agrees the current medical necessity criteria language is not reflective of support provided by ongoing services. Medical necessity criteria are referenced under utilization management and will be amended to reflect different criteria for “admission” and “continued services.” However, there are differences in medical necessity criteria for InPACT and CMP in Policy 460 that vary from PACT and MACT.

COMMENT 2: Multiple commenters requested the department consider extending the number of days before a continued stay request is required for PACT and MACT, policies 460 and 455.

RESPONSE 2: The department reviewed data gathered by its contracted quality improvement organization and agrees to extend the timeframe. Policy 460 and Policy 455 are amended to provide, “Continued stay reviews are required every 270 days.”

COMMENT 3: A commenter recommended the department amend Policy 455 under “Provider Requirements” by combining (g) to (h) and include "preferred" to these roles to allow flexibility for MACT programs.

RESPONSE 3: The department acknowledges receipt of this comments. This is outside the scope of this rulemaking as there were no proposed changes to these requirements for MACT in Policy 455.

COMMENT 4: A commenter requested that continued stay requests for CMP be required every two years because CMP is meant to be a long-term program.

RESPONSE 4: Under the policy, CMP is intended to provide support for members who require long-term, ongoing support. Continued stay requests for CMP are only required every 365 days and members can continue in the service, provided they meet medical necessity criteria. The department will amend the medical necessity criteria for CMP in Policy 460 to better reflect the nature of this service and alleviate provider concerns.

COMMENT 5: A commenter recommended the required contacts under medical necessity criteria for CMP be changed from “the member requires at least four contacts per month” to “the member requires four to eleven contacts per month.”

RESPONSE 5: The department acknowledges receipt of this comment. The department does not intend to change this language because the suggested “four to eleven contacts” is already covered under the current requirement of “at least four contacts.”

COMMENT 6: A commenter requested the department remove InPACT as a tier of PACT because it has not been a successful tier due to requiring services in a Behavioral Health Group Home (BHGH) setting, which historically has a long waitlist without InPACT services.

RESPONSE 6: The department acknowledges receipt of this comment. However, this comment is outside the scope of this rulemaking as there are no proposed changes resulting in the removal of services.

COMMENT 7: A commenter noted that Policy 460 under “Provider Requirements” incorrectly lists the Tenancy Specialist role under (8) when it should be listed under (7).

RESPONSE 7: The department agrees with the commenter and will amend policy 460 to reflect correct numbering under “Provider Requirements.”

COMMENT 8: Two commenters stated that rate changes from a previous rulemaking reduced the reimbursement for co-occurring clients receiving substance use disorder (SUD) Intensive Outpatient (ASAM 2.1) services.

RESPONSE 8: This comment, made by two commenters, is outside the scope of this rulemaking. The department amended policy during the previous rulemaking to allow co-occurring mental health services to be billed concurrently with the weekly bundled rate for ASAM 2.1. The bundled rate was developed by the contractor that performed the provider rate review for the department. However, the department will take the comment under consideration.

COMMENT 9: A commenter stated that telehealth services are simply another way of meeting with and treating a patient. Suggesting telehealth approaches are substandard — or the exception to the rule – discredits the benefits that telehealth has provided, especially in recent years in addressing challenges presented by the COVID-19 pandemic and ongoing healthcare professional shortages. If the telehealth encounter can deliver the same standard of care as a similar in-person encounter, there is no difference in the quality of care delivered and state policy should therefore support patient choice and practitioner discretion. The commenter encourages the department to consider minor changes to the proposed amendments to the draft provider manuals that will more accurately reflect telehealth’s equal standing in the delivery of healthcare services and instead empower the provider to choose the care delivery that best meets the needs of the patient and their individual circumstances.

RESPONSE 9: The department acknowledges the commenters feedback and is committed to expanding access to services through telehealth. However, our comprehensive benefit package includes services that are intended to be delivered in person due to the nature of the service (for example, skill acquisition and personal care services, assertive community treatment).

COMMENT 10: A commenter requested that “psychosocial rehabilitation” and “Community Based Psychiatric Rehabilitation Support Services – CBPRS (420)” be differentiated, so that clients in PACT/MACT may receive day treatment services concurrently. These services are conducted very differently in these different programs, and members have historically benefited greatly from being able to attend “psychosocial rehabilitation” services internally with other PACT members, in conjunction with CBPRS functions externally with other members of BHGH, SDMI HCBS, and Day Treatment programs separately.

RESPONSE 10: This comment is outside the scope of this rulemaking as there are no proposed changes regarding Policy 230, which discusses the delivery of concurrent services.

COMMENT 11: A commenter requested that Policy 460 under "Service Requirements" regarding core PACT services not encompass IOP services under "substance use disorder treatment". SUD IOP is considered a concurrent service in Policy 230 and not billable concurrently with PACT services. PACT co-occurring employees are not equipped to provide Substance Use therapy when providing SUD services to the number of PACT/MACT clients on their caseload to the extent that IOP requires, and therefore PACT/MACT clients should be permitted to receive both PACT/MACT and IOP services concurrently.

RESPONSE 11: This comment is outside the scope of this rulemaking as there were no proposed changes to Policy 230, which discusses the delivery of concurrent services.

COMMENT 12: A commenter requested that prior authorization not be required for PACT services.

RESPONSE 12: The department acknowledges receipt of this comment. The department is making changes to clarify the medical necessity criteria which is expected to better reflect the nature of this service and alleviate provider concerns. Additionally, the department reviewed data from its contracted quality improvement organization and will amend the amend Policy 460 to reflect "Prior authorization is required, and be approved for up to 270 days". Please see response #1 for additional information.

COMMENT 13: Two commenters requested that services provided to members during the appeal process for denied prior authorizations or continued stay reviews be reimbursed throughout the appeal process, potentially with a partial approval/extension.

RESPONSE 13: Montana Medicaid reimburses for medically necessary services provided to members. If the appeal process results in a denial being reversed, then the provider would be able to bill for services provided to a member.

COMMENT 14: A commenter recommended the department amend Policy 445 to allow prior authorization up to 120 days. Most providers are requesting additional Continued Stay Reviews for every member due to taking over 60 days to stabilize a member referred from institutional care into community-based care. Commenter also recommended that the required number of days before a member is referred to the SDMI waiver be changed from 120 days to 180 days.

RESPONSE 14: The department agrees with the commenter. Policy 445 will be amended to reflect the increased timeframe of 120 days of service.

COMMENT 15: A commenter recommended the department amend the SDMI Level of Impairment (LOI) requirement under service requirements for BHGH to include upon admission and annual review instead of updated with each treatment plan review.

RESPONSE 15: The department agrees with the commenter. Policy 445 will be amended to reflect that the LOI must be updated annually, which aligns with other policies.

4. These rule amendments are retroactively effective May 12, 2023.

/s/ Brenda K. Elias
Brenda K. Elias
Rule Reviewer

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

Certified to the Secretary of State December 12, 2023.