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 October 20, 2023, the Department of Public Health and Human Services published MAR Notice No. 37-1039 pertaining to the public hearing on the proposed amendment of the above-stated rules at page 1292 of the 2023 Montana Administrative Register, Issue Number 20.

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: A commenter stated, "The majority of Montanans are above poverty line. Therefore, it's theorized that most Mobile Crisis Responses will not be reimbursable by Medicaid. MCR teams are expected to respond to all calls regardless of ability to pay. Further, it would be nearly impossible to financially clear an individual prior to arrival at a crisis. It is requested that the state block grant be expanded to allow coverage up to 417% above FPL."

RESPONSE #1: The department has reviewed the comment and will amend the policy to increase the federal poverty limit (FPL) for department coverage under the Non-Medicaid Mental Health Crisis Services Fee Schedule to cover individuals not otherwise Medicaid eligible with income between 0-200% FPL for the following services: psychotherapy for crisis, targeted case management, and crisis receiving and stabilization program. The intent is to mirror the FPL in the Non-Medicaid Substance Use Disorder Fee Schedule. Additionally, the department will remove FPL limits for individuals not otherwise Medicaid eligible for Mobile Crisis Response Services and Mobile Crisis Care Coordination Services covered by the Non-Medicaid Mental Health Crisis Services Fee Schedule.

COMMENT #2: A commenter referred to Policy 001NM, which states, "State funding for behavioral health crisis services is available..." and asked if "State funding" referred to block grants. If so, is an agency required to be approved for block grant funding to be reimbursed for services provided to clients who meet the requirements stated in Policy 001NM.

RESPONSE #2: Policy 001NM indicates that block grant funding, provided under a federal block grant, is available to "cover certain substance use disorder (SUD) services." Reimbursement of non-Medicaid substance use disorder services requires a contract awarded through a Request for Proposal (RFP). Providers are not required to be approved for block grant funding for reimbursement of Non-Medicaid Mental Health Crisis Services, which requires a provider to be enrolled in Montana Medicaid.

COMMENT #3: A commenter asked, "If an agency needs to be approved for block grant funding, is there an opportunity to modify previously submitted requests for block grant funding based on this new information?"

RESPONSE #3: As noted in Response #2, providers are not required to be approved for block grant funding for reimbursement of Non-Medicaid Mental Health Crisis services.

COMMENT #4: A commenter asked if the department could clarify whether Targeted Case Management services listed on the Non-Medicaid Mental Health Crisis services fee schedule refers to both Mental Health TCM and SUD TCM, or just one of those.

RESPONSE #4: Targeted Case Management (TCM) services listed under Non-Medicaid Mental Health Crisis services is intended to be Mental Health TCM. The requirements for Mental Health TCM can be found in Policy 405.

COMMENT #5: The department received a comment regarding Policy 215NM – Case Consultation. A commenter asked, "How is Case Consultation billed? It is not listed as a service on the Non-Medicaid Mental Health Crisis Services Fee Schedule." The commenter also noted existing billing codes in the most current American Medical Association's (AMA) Common Procedural Terminology (CPT) manual that cover consultative care services.

RESPONSE #5: Fee schedules are not part of this rulemaking. The department notes that case consultation is listed on the Substance Use Disorder (SUD) Non-Medicaid Fee Schedule found on the Montana Healthcare Programs Provider Information website, https://medicaidprovider.mt.gov/.

COMMENT #6: A commenter stated, "MCR teams likely don't have access to see if a client is enrolled in other Medicaid services, therefore, won't be able to determine if a service component of Mobile Crisis Response services would overlap with any other service components that a client may be receiving through other Medicaid funded services."

RESPONSE #6: Agencies operating Mobile Crisis Response Programs will be enrolled in Montana Medicaid as crisis providers and will have access to the provider web portal.

COMMENT #7: A commenter identified a typographical error in Non-Medicaid Mental Health Crisis Services policy 001 and suggests correction from "Pyschotherapy" to "Psychotherapy."

RESPONSE #7: The department agrees with this comment and will make the identified change in Policy 001NM.

COMMENT #8: A commenter gave the following example: someone calls for Mobile Crisis Response services, but the client is also receiving ASAM 2.1 IOP services and the IOP policy states "Provider must arrange for 24/7 crisis services." It is unrealistic and poor client care for Mobile Crisis Response to either not respond to the call because the client is enrolled in another program, or essentially redirect the crisis call back to the IOP provider in order to arrange crisis services for the client. The commenter then asked, "If Mobile Crisis Response provides services to a client enrolled in a Medicaid service with overlapping service components, will Mobile Crisis Response services not be reimbursed by Medicaid?"

RESPONSE #8: The IOP Policy 525 does not require that service providers of SUD Intensive Outpatient (IOP) provide 24/7 crisis services. The policy requires that IOP providers arrange for crisis services (e.g., answering machine message referring clients to 988 after normal business hours). Additionally, IOP and mobile crisis response services are not listed as concurrent services, pursuant to Policy 230. Please refer to Policy 230 for additional guidance regarding concurrent services.

COMMENT #9: A commenter stated, "It also makes it difficult for Mobile Crisis Response providers to know if they are actually going to be reimbursed for the service because they are not able to tell if a client may have overlapping service components from other programs/services."

RESPONSE #9: The department acknowledges this may be difficult, but Medicaid does not allow concurrent reimbursement of services that share any service components because of federal Medicaid regulations which prohibit duplicative billing. Policy 230 indicates, "Services must not be provided to a member at the same time as another service if the service is the same in nature and scope regardless of funding source, including federal, state, local, and private entities." Additional CMS guidance regarding separate encounters provided on the same day can be found at: https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf.

COMMENT #10: A commenter stated, "We would hope that both Crisis Receiving and Crisis Care Coordination could bill for their services, as long as the timeframe/duration of the services did not overlap within that day, even if the service were provided on the same day or if a client saw their MH Outpatient Therapist in the morning and then Mobile Crisis Response services responded in the evening."

RESPONSE #10: The commenter's understanding of this aligns with the department's intentions and meets requirements found in Policy 230.

COMMENT #11: A commenter would like clarification: "A client is enrolled in a program that has overlapping service components, but the client is not engaged in one of the overlapping service components because, it is not required that each member receiving X bundle receive every service component listed above. Medically necessary services must be provided and documented in the individualized treatment plan and the services received must be documented clearly in the member's treatment file."

RESPONSE #11: The department understands this to be a request for clarification as to whether these services would constitute concurrent services. If the service components are required to be made available, and the timeframe/duration of services overlap, these would be considered concurrent services. Please refer to Policy 230 for additional guidance regarding concurrent services.

COMMENT #12: A commenter asked for clarification regarding Policy 230. Is the state saying that one or both of the service providers cannot be reimbursed by Medicaid for their services because the services were provided on the same day? Or is it reimbursable as long as the services were not provided at the same time during that day?

RESPONSE #12: Daily and weekly bundled rates timeframes are dependent on the services being provided. Policy 230 states, "Services must not be provided to a member at the same time as another service if the service is the same in nature and scope regardless of funding source, including federal, state, local, and private entities." Additional CMS guidance regarding separate encounters provided on the same day can be found at: https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf.

COMMENT #13: A commenter asked for clarification of Policy 230. The commenter asked, "How does Medicaid define time? Is time based on literal service time, not allowing overlapping services (service A is billed from 12:00-1:00 and service B is billed from 12:45 to 1:45 – then the 15 minutes of overlap between 12:45 and 1:00 cannot be reimbursed); or is time based on services billed for on one day (first service is received from 12:00-1:00 on 1/1/2023 and second service is from 1:00-2:00 on 1/1/2023); or is time based on client enrollment in a program, which would span multiple days (if client is enrolled in IOP for 5 weeks, the provider cannot bill for any other services throughout the 5 week period)."

RESPONSE #13: The department understands this to be a request for clarification as to whether these services would constitute concurrent services. If the service components are required to be made available, and the timeframe/duration of services overlap, these would be considered concurrent services. The unit of time for billable services is outlined on department fee schedules. Please refer to Policy 230 for additional guidance regarding concurrent services.

COMMENT #14: A commenter asked for the federal regulation that defines concurrent service reimbursement. The commenter asked if the department could provide the federal Medicaid regulations that are referenced in Policy 230 regarding the prohibition of duplicative billing.

RESPONSE #14: There are several federal regulations indicating non-duplication of payment, including 42 U.S. Code sec. 1396b, 42 CFR Part 431.958, and 42 CFR Part 447.45.

COMMENT #15: A commenter asked if a client is in any of the services listed in Policy 230 as not reimbursable concurrently with Mobile Crisis Response, and a Mobile Crisis Response team responds to a call that night, will Mobile Crisis Response services not be reimbursed?

RESPONSE #15: The client could not receive Mobile Crisis Response Services at the same time as one of the services listed. For example, Mobile Crisis Response Services would not be reimbursed if the Mobile Crisis Response team responded to a facility at night. If the client is not in a facility at the time of the response and instead in the community, Mobile Crisis Response services would be reimbursable.

COMMENT #16: A commenter asked for clarification regarding the reference to ARM 37.86.3305 in Policy 230. Per ARM 37.86.3305 - Case Management Services, General Provisions, (1) "Case management plan and setting goals" and (10) "A case management plan must be developed jointly by the case manager and the client and, where appropriate, the client's caregivers."

RESPONSE #16: The reference to ARM 37.86.3305 is not correct. The department intended the reference to be ARM 37.86.3306, which discusses "Case Management Services: General Eligibility." The department will update the Policy to identify the correct rule.

COMMENT #17: A commenter asked the department to clarify if the Crisis Care Coordinator must complete the requirements listed in ARM 37.86.3305.

RESPONSE #17: No. As indicated in response #16, the reference to ARM 37.86.3305 is incorrect and will be updated.

COMMENT #18: A commenter asked if a client is in a program that includes care coordination/care management and Mobile Crisis Response responds to a call at night, then Crisis Care Coordination follows up and works with the client for 14 days, will Crisis Care Coordination services not be reimbursed?

RESPONSE #18: The Mobile Crisis Care Coordination service provider is required to follow up to ensure the client has been connected to ongoing services. If the ongoing services has a case management or care coordination component, then the provider would be reimbursed for the follow-up to ensure the client is connected to a

service provider, but would not receive reimbursement for further mobile crisis care coordination once the client is receiving case management or care coordination through the ongoing services.

COMMENT #19: A commenter recommended the following language be deleted or moved from Policy 452 to Policy 454: follow up to ensure that member's crisis is resolved, or that they have successfully been connected to ongoing services.

RESPONSE #19: The department acknowledges the comment, but will not be making the recommended change because the identified requirement is a federal requirement by the Centers for Medicare & Medicaid Services for all mobile crisis response services.

COMMENT #20: A commenter recommended amending language in Policy 452 by changing "Referrals to outpatient care" to "referrals for further care" because Mobile Crisis Response will still refer a client to services based on their assessed need, regardless of if that's outpatient, inpatient/hospitalization services.

RESPONSE #20: The department agrees with the commenter. Policy 452 will be amended to include "referrals to outpatient care and/or other appropriate care."

COMMENT #21: A commenter asked for Policy 452 to reference the specific statute that is referenced by the following language, Title 37, MCA, Clinical Mental Health Professional.

RESPONSE #21: The statute is 53-21-102, MCA. The department will amend the policy to reference this statute.

COMMENT #22: Multiple commenters stated concern about the following requirement in Policy 452: "Qualified to provide a biopsychosocial assessment." It was noted stated that MCR services are provided by mental health centers, and under ARM 37.106.1915, mental health centers do not complete biopsychosocial assessments.

RESPONSE #22: Policy 452 does not require Mobile Crisis Response Services to be provided exclusively by mental health centers. It indicates a licensed clinical mental health professional needs to be part of the mobile crisis response and that professional be able to provide a biopsychosocial assessment within their scope of practice under their Montana license. ARM 37.106.1915, which is not part of this rulemaking, does not reference Mobile Crisis Response Services.

COMMENT #23: A commenter asked for a definition of "abbreviated intake assessments" found in ARM 37.106.1987.

RESPONSE #23: ARM 37.106.1987 is contained in the OIG licensing rules and is, thus, outside the scope of this rulemaking.

COMMENT #24: Multiple commenters asked for clarification around the following language in Policy 452: "(4) All staff must be trained in trauma-informed care, de-escalation strategies, harm reduction, and any other trainings, as specified by the State in the provider approval process." Commenters asked the department to share the specified trainings that are required of providers, as these were not provided during the provider approval process.

RESPONSE #24: The department acknowledges the comment. The department's intent was to follow SAMHSA's guidance for the Crisis Now Model, which also lists suicide awareness. Policy 452 will be amended to include suicide awareness and to remove the general language that refers to any other trainings.

COMMENT #25: A commenter asked if a mobile crisis response team/provider arrives on scene that happens to be a hospital or other facility, is Mobile Crisis Response reimbursable by Medicaid?

RESPONSE #25: Medicaid reimbursement of mobile crisis response services is not allowable in a hospital or other facility. Mobile Crisis Response services are required to be delivered in the community, pursuant to the Crisis Now Model.

COMMENT #26: Multiple commenters asked if a MCR team is connected to client via phone/telehealth while en route to scene, is this time reimbursable by Medicaid?

RESPONSE #26: The reimbursement for mobile crisis response team service is not allowable during crisis calls or while a team member is en route. Services can only be reimbursed when at least one member of the mobile crisis responding team is on-site. However, psychotherapy for crisis services is allowable via telehealth, which seems to be applicable in this example.

COMMENT #27: A commenter asked if the warm handoff for ongoing care required in Policy 452 happens outside of the initial response by the MCR team, is this billable under Mobile Crisis Response services? For example, if MCR responds to initial call from 1:00-2:00, but warm handoff for ongoing services is not available until a few hours later, say at 5:00.

RESPONSE #27: The warm handoff described here by the commenter is Mobile Crisis Care Coordination, not Mobile Crisis Response services, and would have to follow the requirements for Mobile Crisis Care Coordination.

COMMENT #28: A commenter asked if Mobile Crisis Care Coordination services may be provided up to 14 days after the member receives Mobile Crisis Response Services as described in Policy 454 or 72 hours as indicated in the Non-Medicaid Mental Health Crisis services fee schedule.

RESPONSE #28: The department intends to update fee schedules in a future rulemaking to align with Policy 454 and the approved Medicaid State Plan. The

department currently intends make such changes to the fee schedules to be retroactive.

COMMENT #29: A commenter indicated that ARM 37.106.1976 allows hospitals to be an outpatient crisis response facility. How does this work if the crisis work is in a hospital?

RESPONSE #29: ARM 37.106.1976 is contained in the OIG licensing rules and is, thus, outside the scope of this rulemaking.

COMMENT #30: A commenter asked for clarification regarding the following service components in Policy 454: "Services include the availability of the following: (a) assessment of needs; (b) linkage with necessary social, medical, and behavioral health services; (c) crisis planning; and (d) follow-up." The commenter asked if it is up to the discretion of the provider to determine how to meet the service requirements, or does the State have guidelines/recommendations for meeting these service requirements?

RESPONSE #30: The department appreciates the comment and will amend the referenced (b) and (c) language in Policy 454 to clarify, as follows: "(b) linkage with necessary services, which includes facilitating and coordinating treatment and services among other professionals and agencies; (c) individualized crisis planning to create or update a range of planning tools, including a safety plan, which is a prioritized list of coping strategies and sources of support." The department believes that the following components are self-explanatory and require no addition clarification: assessment of needs ((a)) and follow-up ((d)).

COMMENT #31: The department received a comment regarding Policy 452: Service Requirements: Section 4. The commenter suggested language be changed to clarify law enforcement's involvement during the crisis response. The commenter suggested changing "Services must be able to be dispatched and able to respond without law enforcement" to allow mobile crisis teams to work 90% side by side with law enforcement during a crisis due to additional risks to crisis teams without law enforcement present.

RESPONSE #31: The department appreciates the comment. The referenced language in Policy 452 is based on federal guidance. It does not preclude law enforcement from being involved in a crisis response. The expectation is that mobile crisis response services are not contingent on law enforcement co-response.

COMMENT #32: A commenter asked if the crisis facility moves the patient into ongoing outpatient services or the patient is already in that facility's outpatient services, will a note that indicates the patient is discharged from "crisis" rather than an entire discharge summary meet client discharge requirements in ARM 37.106.1989.

RESPONSE #32: The requirement for crisis facilities established under ARM 37.106.1989 does not apply to mobile crisis response services and mobile crisis care coordination. ARM 37.106.1989 is contained in the OIG licensing rules and is, thus, outside the scope of this rulemaking.

/s/ Brenda K. Elias
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Rule Reviewer

/s/ Charles T. Brereton
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Certified to the Secretary of State April 2, 2024.