MONTANA
ADMINISTRATIVE
REGISTER

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

NOTICE OF ADOPTION

MAR NOTICE NO. 2026-525.2

Summary

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

Previous Notice(s) and Hearing Information

On March 20, 2026, the Department of Public Health and Human Services published MAR Notice No. 2026-525.1 pertaining to the public hearing on the proposed amendment of the above-stated rules in the 2026 Montana Administrative Register, Issue Number 6.

A public hearing was held on April 10, 2026.

Final Rulemaking Action – Effective August 22, 2026

AMEND AS PROPOSED

The agency has amended the following rules as proposed:

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

37.87.903 MEDICAID MENTAL HEALTH SERVICES FOR YOUTH, AUTHORIZATION REQUIREMENTS

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

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

37.87.1414 HOME SUPPORT SERVICES (HSS), PROVISIONS OF SERVICE

37.87.1415 HOME SUPPORT SERVICES (HSS), PROVIDER REQUIREMENTS

37.106.1902 MENTAL HEALTH CENTER: DEFINITIONS

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

AMEND WITH CHANGES

The agency has amended the following rules with the following changes from the original proposal, stricken matter interlined, new matter underlined:

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

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

(2) The department adopts and incorporates by reference, the resource-based relative value scale (RBRVS) reimbursement methodology for specific providers as described in ARM 37.85.212 on the date stated.

(a) Resource-based relative value scale (RBRVS) means the version of the Medicare resource-based relative value scale contained in the Medicare Physician Fee Schedule adopted by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services and published at 89 Federal Register 97710 (December 9, 2024), effective January 1, 2025, which is adopted and incorporated by reference. Procedure codes

created after January 1, 2025, will be reimbursed using the relative value units from the Medicare Physician Fee Schedule in place at the time the procedure code is created.

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

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

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

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

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

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

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

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

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

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

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

(3) The department adopts, and incorporates by reference, the fee schedule for the following programs within the Health Resources Division, on the date stated.

(a) The inpatient hospital services fee schedule and inpatient hospital base fee schedule rates including:

(i) the APR-DRG fee schedule for inpatient hospitals, as provided in ARM 37.86.2907, effective July 1, 2025; and

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

(b) The outpatient hospital services fee schedules including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) Montana Medicaid adopts and incorporates by reference the Region D Supplier Manual, which outlines the Medicare coverage criteria for Medicare covered durable medical equipment, local coverage determinations (LCDs), and national coverage determinations (NCDs), as provided in ARM 37.86.1802, effective July 1, 2025. The prosthetic devices, durable medical equipment, and medical supplies fee schedule, as provided in ARM 37.86.1807, is effective July 1, 2025.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37.87.1803 COMPREHENSIVE SCHOOL AND COMMUNITY TREATMENT PROGRAM: REIMBURSEMENT

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

(2) CSCT services may be provided to:

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

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

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

(a) Core services, meeting the definition of CSCT as a community mental health outpatient treatment under ARM 37.106.1902, include intake and annual assessment, individual therapy, family therapy, group psychotherapy or psychoeducation, behavioral interventions, crisis response during typical working hours, and care coordination.

(b) Care coordination may only be considered a core service and be billable if two other core services are provided within that week. Care coordination includes

phone calls, treatment team meetings, IEP meetings, referrals, and school advocacy for youth. Care coordination does not include documentation time. For the purposes of this subsection, a week begins on Monday and ends on Sunday.

(4) If the sum total of daily units per youth is over ~~16~~ 20 units, the claim will suspend for clinical review. The provider must submit documentation to the department demonstrating medical necessity of service.

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

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

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

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

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

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

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

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

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

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

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

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

(a) individual, group, and family therapy;

(b) behavioral intervention;

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

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

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

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

(g) access to emergency services;

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

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

(2) If the sum total of daily units per youth is over ~~16~~ 20 units, the claim will suspend for clinical review. Providers must submit documentation to the department demonstrating medical necessity of service.

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

(4) The CSCT ITP team must include:

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

(b) school administrator or designee;

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

(d) the youth, as appropriate; and

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

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

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

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

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

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

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

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

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

(a) experience working with emotionally disturbed youth;

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

(c) post-secondary education in human services.

(11) The licensed mental health center CSCT program supervisor and an appropriate school district representative must meet regularly, at least four times per calendar

year, during the time period CSCT services are provided to mutually assess program effectiveness utilizing the following indicators:

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

(b) attendance;

(c) CSCT program referrals;

(d) contact with law enforcement;

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

(f) discharges from the program.

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

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

Statement of Reasons

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

COMMENT #1: A commenter expressed support for ARM 37.87.903(9) and indicated it is important for all providers to collect outcome data to support continued funding for needed services.

RESPONSE #1: The department thanks the commenter for their support of the rule.

COMMENT #2: A commenter expressed support for the removal of the monthly summary requirement under ARM 37.87.1414.

RESPONSE #2: The department thanks the commenter for their support of the proposed rule amendment.

COMMENT #3: A commenter requested clarification on the intent of the change in terminology from "targeted case manager" to "targeted case management provider" under ARM 37.87.1414 and inquired whether this is simply a language change or if there are other implications associated with the change.

RESPONSE #3: The proposed change is simply to update terminology, and the department does not intend for the language change to have any other implications.

COMMENT #4: A commenter expressed support for the proposed change under ARM 37.87.1803 increasing the monthly team unit limit to allow for more flexibility in service delivery.

RESPONSE #4: The department thanks the commenter for their support of the proposed rule change and extends its gratitude to the partners and stakeholders who participated in the process to update CSCT. The department believes the increased monthly team limit will enhance the provision of CSCT services.

COMMENT #5: A commenter expressed support for the proposal under ARM 37.87.1803 to continue different team composition options for CSCT for more flexibility in service delivery.

RESPONSE #5: The department thanks the commenter for their support of the proposed rule change.

COMMENT #6: Several commenters requested clarification on the proposed change under ARM 37.87.1803 establishing a 20-unit per state fiscal year limit for non-SED youth being billed as part of the 1,350 monthly team limit for teams of three members and if the limit also applies one- or two-member teams.

RESPONSE #6: The department appreciates the comments and has revised ARM 37.87.1803 to clarify that the units for non-SED youth apply regardless of the team size.

COMMENT #7: Several commenters expressed concern with the proposed amendment under ARM 37.87.1803(4) providing that a claim will be suspended for clinical review if the sum total of units per day per youth is over 16 units. The commenters indicated that this requirement will increase the administrative burden for both the department and providers. The commenters also expressed concern that the proposed change will affect the ability to provide services during a crisis and potentially require repeated medical necessity reviews for the same child. The commenters request the department consider a 28-unit daily limit per youth.

RESPONSE #7: The department acknowledges the commenters' concerns and has revised the rule to increase the daily sum total of units per day per youth to 20 units before the claims suspend for clinical review. The department believes that more than 20 units (5 hours) of mental health services in one day should require clinical review of documentation that demonstrates medical necessity.

COMMENT #8: A commenter requested clarification on the return to 15-minute units under ARM 37.87.1803, the proposed service limits, and if care coordination is included.

RESPONSE #8: The proposed rule amendment returns CSCT to a 15-minute unit rate from the current daily rate. The proposed monthly team maximum is 1,350 units for a team of three members. CSCT allows for care coordination as described in ARM 37.87.1803.

COMMENT #9: Several commenters expressed concern with the proposed amendment under ARM 37.106.1956(2) providing that a claim will be suspended for clinical review if the sum total of units per day per youth is over 16 units. The commenters indicated that this requirement will increase the administrative burden for both the department and providers. The commenters also expressed concern that the proposed change will affect the ability to provide services during a crisis and potentially require repeated medical necessity reviews for the same child. The commenters request the department consider a 28-unit daily limit per youth.

RESPONSE #9: The department acknowledges the commenters' concerns and has revised the rule to increase the daily sum total of units per day per youth to 20 units before the claims suspend for clinical review. The department believes that more than 20 units (5 hours) of mental health services in one day should require clinical review of documentation that demonstrates medical necessity.

COMMENT #10: A commenter requested clarification on the minimum service requirements during summer months under ARM 37.106.1956.

RESPONSE #10: CSCT involves continuous treatment that must be available throughout the calendar year. During summer months, the program must provide a minimum of 16 hours per month of CSCT services. Additional units may be provided as guided by the treatment plan and the youth's mental health needs.

COMMENT #11: A commenter requested that the Medicaid Youth Mental Health Fee Schedule be revised to remove the limit of two sessions per week for youth Home Support group services. The commenter indicates that group sessions benefit clients and improve outcomes.

RESPONSE #11: The department agrees that group sessions support clients' outcomes but believes the limit of two sessions per week is appropriate. The limit endorses the importance of the provision of intensive therapeutic interventions focused on the youth and family's behavioral health needs.

COMMENT #12: A commenter requested clarification on the application of group session counts referenced in the Medicaid Youth Mental Health Fee Schedule when a child attends a group session with their parents.

RESPONSE #12**:** If a youth attends a group session, regardless of the type of group session, the session counts toward the group session limit for the week in which it was attended.

COMMENT #13: A commenter supports treatment options available to youth and families that support in-home living and community supports and requests the department consider adding therapeutic group homes to maximize community living and place priority on outpatient treatment.

RESPONSE #13: The department appreciates the comment, but believes it is outside the scope of this rulemaking.

COMMENT #14: Several commenters offered general support for the proposed rule amendments and thanked the department for working with stakeholders to create positive changes to the CSCT and HSS programs to support youth and their families so they can remain in school, in their community, and in their home.

RESPONSE #14: The department appreciates the commenters' support for the proposed rule amendments and extends its gratitude for the partners and stakeholders who participated in the process to update the CSCT and HSS rules.

COMMENT #15: A commenter inquired what other supports are offered across all waivers if a person has other co-occurring disabilities like a physical disability and a mental health diagnosis.

RESPONSE #15: The department acknowledges the comment, but believes it is outside the scope of this rulemaking.

COMMENT #16: A commenter requested clarification on whether a youth discharged from a CSCT program can receive CSCT in the future if they meet clinical requirements.

RESPONSE #16: If a youth meets eligibility requirements as described in the administrative rules and Children's Mental Health Bureau Medicaid Services Provider Manual governing the CSCT program, they would be eligible for CSCT services again.

COMMENT #17: Several commenters raised concern about the intergovernmental transfer process under ARM 37.87.1803.

RESPONSE #17: The department acknowledges these comments, but believes they are outside the scope of this rulemaking.

COMMENT #18: Several commenters requested that the department consider including HMK/CHIP coverage for additional mental health services, such as CSCT and Targeted Case Management.

RESPONSE #18: The department acknowledges these comments, but believes they are outside the scope of this rulemaking.

Contact

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Rule Reviewer

Robert Lishman

Approval

Charles T. Brereton, Director

Department of Public Health and Human Services