Supplemental Payment
Provider Agreement - Phase 2

Purpose

The Purpose of Supplemental Payments is support and strengthen Home and Community Based Services (HCBS) by providing additional resources to providers that deliver physical and behavioral health services in the home or community. The Supplement Payment program is part of the Home and Community Services Spending Plan and Narrative.

The Supplemental Payment program is funded from Section 9817 of the American Rescue Plan Act (ARPA) of 2021, which provides states with a one year 10-percentage point increase to the federal medical assistance percentage for certain Medicaid expenditures that meet the APRA definition of HCBS.

To be eligible for Phase 2 Supplemental Payments the provider agrees to:

- Sustain or increase current levels of HCBS service delivery;
- Invest in workforce recruitment and retention; and
- Submit attestation and financial documentation at the end of each quarter demonstrating the cost of delivery of Medicaid services exceed the standard Montana Medicaid reimbursement.

Records and Documentation

A Provider that receives funds under this initiative should maintain documentation according to their normal records retention process.

Medicaid Provider Certification and Agreement

By signing this application and in consideration for the payment of funds based upon this application, the Medicaid Provider identified below, represents, and agrees as follows:

1. Provider certifies that Department and information included in this agreement are complete, accurate and true to the best of the Provider's knowledge. Provider agrees to the terms and conditions of this provider agreement. Provider agrees that it will make, maintain, and provide to authorize governmental entities and their agents, records, and documentation in accordance with the requirements specified in this agreement.
2. Provider understands that payment of funds based upon this request will be from federal and state funds, and that any false claims, documents, or concealment of material fact, may be prosecuted under applicable federal or state laws.
3. Provider understands that funds may be required to be repaid to the Department if the Provider fails to maintain the required records or meet the HCBS Supplemental Payment Phase 2 Requirements previously described.

Requesting Provider Identifying Information.

Provider Name: _____

Signature of Program Manager: _____ Date: _____

Name of Program Manager (please print): _____

Street Address: _____

City/Zip: _____

Contact Person: _____

Email: _____ Phone: (_____) _____

Please submit completed form to HHSHCBSSupplementalPayment@mt.gov