

# **DEVELOPMENTAL DISABILITIES PROGRAM MANUAL OF FEE FOR SERVICE REIMBURSEMENT RATES AND PROCEDURES**

Published by the Department Of Public Health & Human Services  
Disability Services Division

## **SECTION ONE: Rates Of Reimbursement For The Provision Of Developmental Disabilities Case Management Services For Persons with Developmental Disabilities 16 Years Of Age and Older or Who Reside in a DD Children's Group Home.**

**Effective: July 1, 2008**

# **STANDARD RATE FOR REIMBURSEMENT OF CASE MANAGEMENT SERVICES**

## **I. Introduction**

This section presents the standard rate of reimbursement by the Montana Department of Public Health and Human Services (DPHHS), Developmental Disabilities Program (DDP) for the provision of case management services to persons with developmental disabilities 16 years of age and older or who reside in a DD children's group home. DDP provides both state-operated and contracted case management services. The standard rate of reimbursement for contracted case management services funded by DDP is as follows:

1. Beginning April 1, 2008 and ending June 30, 2008 the rate is \$17.37 per each fifteen minute unit of service delivered to a consumer.
2. Beginning July 1, 2008 and ending June 30, 2009 the rate is \$16.74 per each fifteen minute unit of service delivered to a consumer.
3. Beginning July 1, 2009 and ending June 30, 2010 a utilization expansion/rate compression methodology is utilized to facilitate the transition to the \$15.45 rate.
4. Beginning July 1, 2010 the rate is \$15.45 per each fifteen minute unit of service delivered to a consumer.

## **II. Availability of Case Management Services Reimbursement and the Maximum Billable Amount**

Reimbursement for case management services is available to a TCM provider for any fifteen minute unit in which a case management service is delivered to the consumer up to the yearly maximum billable amount. At such time as the Contractor has billed for the maximum units equivalent to the total reimbursement performance of the Contractor, the Contractor, having been fully compensated for the delivery of all case management services during the fiscal year under the rate reimbursement methodology, must continue until the close of the current fiscal year to deliver services to all consumers being served and to be served by the Contractor in service for case management services.

## **III. Methodology for the Calculation of the Case Management Services Fifteen Minute Reimbursement Rates:**

## **A. State Employed Case Managers and Contracted Case Managers:**

The Montana Developmental Disabilities Program (DDP) has two types of targeted case managers (TCM) for individuals with developmental disabilities age 16 and over or who reside in a DD children's group home.

Some case managers are employees of the state of Montana, and the cost of providing state plan TCM services by the state employed case managers are charged at actual cost to Medicaid. The methodology below does not apply to state plan case management provided by state employees.

Most TCM providers are private contracted providers, paid on a fee for services basis. The Department uses the following methodology for initially calculating and then periodically re-basing the 15 minute standardized rate for case management services provided to individuals with developmental disabilities age 16 and over or who reside in a DD children's group home.

## **B. Transition from a monthly rate to a 15 minute rate:**

1. Prior to the beginning of April, 2008, the date we began using a 15 minute rate, the Developmental Disabilities Program (DDP) utilized a monthly rate to compensate the four (4) contracted TCM providers.
  - a. One of these providers had over 10 years experience in delivering CM services utilizing 15 minute rates and applied the 15 minute rate training processes and expectations in delivering monthly units to the DD clients.
  - b. The other three (3) providers had several years experience delivering services using the monthly rate, but no experience with 15 minute rates.
2. Our concern, even as early as April 2008, was the ability of the three providers (with monthly billing experience) to transition to the 15 minute rate process.
3. The transition to 15 minute rates was set up in stages in which the utilization factor (the number of 15 minutes billing units the average TCM FTE generates) increases and conversely the 15 minute rate decreases until all four providers have trained their staff to generate billing units at the July 2010 utilization level (stage 4).
  - a. Stage 1: April 2008 through June 2008 (First three months)
  - b. Stage 2: July 2008 through June 2009 (First full year of utilization data)
  - c. Stage 3: July 2009 through June 2010 (Individualized utilization factors and individualized rates)
  - d. Stage 4: July 2010 and there-after (Ongoing rate methodology)

## **C. General Overview:**

1. The Montana DDP rate setting follows the rate setting methodology proposed and or recommended by CMS.
2. This methodology is utilized for all four transition stages (see B-3 above) and then utilized periodically for re-basing the on-going rate.
3. The Cost Pool:
  - a. DDP requires the contracted TCM providers to give DDP their most recent annual TCM wage costs, TCM benefit costs, and TCM other costs, which DDP uses to develop the Cost Pool (cost per TCM FTE per year).
  - b. Wages, benefits, and all other costs may be increased by a small inflation factor (0% to 5% depending on inflation documentation) intended to cover cost increases for the up-coming two years.
  - c. These adjusted Cost Pool costs are then converted to a Yearly Wage Cost per TCM FTE, a Yearly Benefit Cost per TCM FTE, and a Yearly Other Costs per TCM FTE. The total of these three groups is the **Total Cost Pool per TCM FTE**.
4. The total Cost Pool per TCM FTE is divided by the number of expected billable 15 minute increments each TCM FTE is expected to generate (**utilization factor**) to determine the 15 minute rate. While each stage of the rate transition (see B-3) uses the same **Total Cost Pool Per TCM FTE**, an increasing utilization factor is used at each stage to calculate a decreasing rate as part of transitioning to the 15 minute unit.

#### **D. Utilization Factors:**

1. As part of the transition from a monthly rate to a 15 minute rate the **utilization factor** (which is the expected number of billable 15 minute units each TCM FTE is expected to generate), increases from stage 1 through stage 4 and conversely the rate decreases from stage 1 to stage 4.
  - a. Stage 1: April 2008 through June 2008 (First three months)
    1. The utilization factor for stage 1 is just over 3947 units per TCM FTE per Year.
    2. Because we had little data this number was an estimate aimed at generating about the same amount of provider revenue as would have been generated under the monthly rate.
  - b. Stage 2: July 2008 through June 2009 (First full year of utilization data)
    1. The utilization factor for stage 2 is just under 4096 units per TCM FTE per Year.
    2. While full year utilization data was available at the end of this year it was not available at the beginning of the year and as such this utilization factor was more of an educated estimate. We did a 100% reporting survey of utilization by all TCM's early in the year as part of the logic for this number.

c. Stage 3: July 2009 through June 2010 (Individualized utilization factors and individualized rates)

1. The utilization data from FY 2009 was quite revealing:

a. Actual utilization was higher than that indicated from the 100% reporting survey done early in the year.

b. All providers were not equal in their ability to record and bill for 15 minute units. The provider with extensive experience in billing 15 minute rates had significantly higher utilization experience as compared with the other three providers with no such experience.

2. To help the three providers to more quickly transition to the 15 minute rate we decided to step up utilization in three individualized steps for each provider. The steps were based on bringing their FY 2009 actual utilization up to the on-going (stage 4) 4438.72 units per year utilization factor in three increments.

d. Stage 4: July 2010 and there-after (Ongoing rate methodology)

1. Each TCM FTE is expected to generate 4438.72 15 minute billing units per year

2. Once the transition period is complete (at least one year beyond the first year of stage 4) the actual billing utilization experience from the previous fiscal year is used as a starting point or base to calculate the expected number of billable 15 minute units each TCM FTE is expected to generate.

a. In order to promote increased utilization by the providers, the provider with the highest utilization number has this number weighted much more heavily than the other providers in calculating the weighted average. The goal is for the highest utilization provider to have a calculation weight of 85%. The rate is then calculated based on the adjusted weighted average billing units per TCM FTE. This results in the rate being lower, the utilization expectation being higher, and the expectation that providers below the adjusted weighted average calculation will work to increase the number of units billed by their average TCM FTE.

## **E. The Total Cost Pool Per TCM FTE (detail):**

Wages, wage benefits, and other TCM costs make up the three components of the cost pool.

1. Wages and Benefit Costs:

a. DDP analyzes wages and benefits through contractor reports of the actual TCM wages and TCM benefits paid by Montana's DDP TCM contracted agencies for 100% of the case managers that they employ.

b. From the list of all hourly wages and all benefit rates DDP determines the average wage per hour and the average benefit per hour for all TCM case managers.

- c. The average rate per hour is then increased by an inflation factor from 0% to 5% depending upon inflation documentation and the availability of funding. (This inflation adjustment to the average cost does not become part of the base unless the provider incurs additional expenses in the next re-basing cycle.)
  - d. These calculated or re-based hourly rates are then multiplied by 2080 (hours per year) to determine the Yearly Wage Cost per TCM FTE and the Yearly Benefit Cost per TCM FTE.
  - e. This rate methodology applies to all transition stages.
2. Other TCM Recoverable Costs:
- a. DDP analyzes the most current financial expenditure reports provided by TCM providers.
  - b. Volatile cost items will be analyzed closely to see if adjustments need to be made up or down based on reasonable expectations of current and future changes. If necessary, these changes will be incorporated into the costs.
  - c. DDP analyzes non-TCM wage and non-TCM benefit costs (all the other costs of providing TCM services). Each of the provider's 'Other TCM Costs per TCM FTE' is then combined to calculate one weighted average 'Other TCM Costs per TCM FTE'.
  - d. An inflation adjustment from 0% to 5%, depending on inflation documentation, is applied to the Other TCM Costs per TCM FTE.
  - e. This Yearly Other TCM Costs per FTE is included in the total cost pool.
  - f. This rate methodology applies to all transition stages.

**F. DDP TCM Rate Setting Final Calculation:**

- a. The Cost Pool per TCM FTE equals the total of the Yearly Wage Cost Per FTE, the Yearly Benefit Cost Per FTE, and the Yearly Other TCM Cost Per FTE.
- b. The amount of recoverable costs (Cost Pool per TCM FTE) is divided by the number of expected billable 15 minute increments per year per TCM FTE to determine the DDP TCM 15 minute rate.
- c. This rate methodology applies to all transition stages. The Cost Pool per TCM FTE is the same amount in all four stages of the transition, but the utilization factor, the number of billable units each TCM FTE, increases over time (from stage to stage) as the providers transition into the 15 minute rate.

**G. Annual Billable Unit Cap:**

- 1. Stage 1: April 2008 through June 2008 (First three months)

- a. No billing cap for this stage.
- 2. Stage 2: July 2008 through June 2009 (First full year of utilization data)
  - a. No billing cap for this stage.
- 3. Stage 3 and stage 4: July 2009 through June 2010 (Individualized utilization factors and individualized rates) and July 2010 and after (Ongoing rate methodology).

a. To avoid over utilization of this rate by providers and thus recovering revenue in excess of costs, each provider is capped as to the total billable amount they can receive in the year based on the number of TCM FTE reported for this rate setting process and the weighted average total cost per TCM FTE for all providers as reported for the rate setting process. The rate is intended to allow providers, on average, to recover the reported weighted average costs plus a small inflation adjustment.

b. At such time as the Contractor has billed for the maximum units equivalent to the total reimbursement performance of the Contractor, the Contractor, having been fully compensated for the delivery of all case management services during the fiscal year under the rate reimbursement methodology, must continue until the close of the current fiscal year to deliver services to all consumers being served and to be served by the Contractor in service for case management services. If the average caseload per TCM FTE stays at or below 35, then the maximum compensation to the Contractor for the full year can not exceed a dollar amount equal to: the expected billable units per year per TCM FTE *TIMES* the number of TCM FTE (@35 or less caseload) *TIMES* the 15 minute rate. This calculation is also equal to the Recoverable Cost Pool Per TCM FTE *TIMES* the number of TCM FTE (@35 or less caseload) working for that provider. This rate methodology applies to transition stages 3 and 4.

c. Because the billable units per TCM FTE and the 15 minute rates are individualized in stage 3 the billing cap is also individualized based on the unique numbers for each provider.

## **H. Caseload Increase Adjustment to the Billing Cap:**

- 1. Stage 1: April 2008 through June 2008 (First three months)
  - a. No caseload increase adjustment to the billing cap for this stage.
- 2. Stage 2: July 2008 through June 2009 (First full year of utilization data)
  - a. No caseload increase adjustment to the billing cap for this stage.
- 3. Stage 3: July 2009 through June 2010 (Individualized utilization factors and individualized rates)
  - a. If the average monthly caseload goes above 35 by the end of the year then the billing cap is increased by a dollar amount for each client above 35. The calculation is based on the average # of units per client per year (@ a caseload of 35) *TIMES* the 15

- minute rate. This rate methodology applies to stages 3 and 4.
- b. Because the billable units per TCM FTE and the 15 minute rates are individualized in stage 3 the caseload increase adjustment to the billing cap is also individualized based on the unique numbers for each provider.
4. Stage 4: July 2010 and there-after (Ongoing rate methodology)
    - a. If the average monthly caseload goes above 35 by the end of the year then the billing cap is increased by a dollar amount for each client above 35. The calculation is based on the average # of units per client per year (@ a caseload of 35) *TIMES* the 15 minute rate. This rate methodology applies to stages 3 and 4.

### **I. Effective Date:**

1. Except as otherwise noted in the plan, the DDP TCM 15 minute rate is the same for both governmental and private providers of case management for persons with developmental disabilities.
2. The TCM non-mental health fee schedule is published on the Montana Medicaid Provider Website at:  
<http://medicaidprovider.hhs.mt.gov/providerpages/providertype/providertype.shtml>.
3. The effective date for the final rates will be July 1, 2008.

### **IV. Calculation of the Fifteen Minute Rates Utilizing the Rate Methodology:**

These are the individual components of the rate methodology with the actual calculations in *italics*:

#### **To determine the average cost pool per TCM FTE to be recovered via the rate:** (this applies to all four transition stages)

1. There are three pieces to the cost pool:
  - a. Average Wage cost per TCM FTE per year:
    - a1. Using 100% reporting from TCM providers determine the FTE weighted average wage rate per hour.

***\$16.004 per hour***

- a2. Increase this rate from 0% to 5% based on inflation documentation and the availability of funding.

***While average inflation documentation has been just under 3% per year, it was determined that funding availability would only support a 1% inflationary increase. So  $1.01 \times \$16.004 = \$16.164$  per hour.***

a3. Multiply the adjusted wage rate per hour times 2080 hours per year to determine the wage cost per TCM FTE per year.

***$2080 \text{ hours} \times \$16.164 \text{ per hour} = \$33,621 \text{ per year}$***

b. Average Benefit cost per TCM FTE per year:

b1. Using 100% reporting from TCM providers determine the FTE weighted average benefit rate per hour.

***$\$4.889 \text{ per hour}$***

b2. Increase this rate from 0% to 5% based on inflation documentation and the availability of funding.

***While average inflation documentation has been just under 3% per year, it was determined that funding availability would only support a 1% inflationary increase. So  $1.01 \times \$4.889 = \$4.938$  per hour.***

b3. Multiply the adjusted benefit rate per hour times 2080 hours per year to determine the benefit cost per TCM FTE per year.

***$2080 \text{ hours} \times \$4.938 \text{ per hour} = \$10,271 \text{ per year}$***

c. Average Other costs per TCM FTE per year:

c1. Using 100% reporting from TCM providers determine the non-wage and non-benefit or Other costs for each TCM provider and then calculate the average other cost per TCM FTE per year by dividing the total of all the provider's other costs per year by the total number of TCM FTE.

***Other costs per TCM FTE = \$24,430***

c2. Increase this rate from 0% to 5% based on inflation documentation and the availability of funding.

***While average inflation documentation has been just under 3% per year, it was determined that funding availability would only support a 1% inflationary increase. So  $1.01 \times \$24,430 = \$24,674$***

***2. Add the three costs together to determine the total cost per TCM FTE per year. This is the cost pool used in all four transition stages.***

***Wage cost per year per TCM FTE = \$33,621***

***Benefit cost per year per TCM FTE = \$10,271***

***Other costs per year per TCM FTE = \$24,674***

***TOTAL cost per year per TCM FTE = \$68,566***

**To determine the number of expected 15 minute billable units per year per TCM FTE for each transition stage:**

Stage 1: April 2008 through June 2008 (First three months)

***a. The utilization factor is 3947.38 units per year per TCM FTE for the first three months of our experience with 15 minute rates.***

b. It is based on the providers generating about the same amount of revenue as would have been generated under the monthly rate.

Stage 2: July 2008 through June 2009 (First full year of utilization data)

***a. The utilization factor for stage 2 is 4095.94 units per TCM FTE per Year.***

b. While full year utilization data was available at the end of this year it was not available at the beginning of the year and as such this utilization

factor was more of an educated estimate. We did do a 100% reporting survey of utilization by all TCM's early in the year as part of the logic for this number.

c. The goal of this transition stage was to increase the expected utilization and conversely decrease the rate.

Stage 3: July 2009 through June 2010 (Individualized utilization factors and individualized rates)

a. The individualized utilization factors and rates used in stage 3 were calculated based on first calculating the on-going utilization factor and on-going rate for stage 4. The utilization goal is 4438.72 units per TCM FTE beginning July 2010.

***b. AWARE's three step utilization transition is 4655.57, 4547.15, and 4438.72 units per TCM FTE respectively for July through December 2009, January through June 2010, and beginning July 2010.***

***c. CMMC's three step utilization transition is 4138.91, 4288.81, and 4438.72 units per TCM FTE respectively for July through December 2009, January through June 2010, and beginning July 2010.***

***d. HI's three step utilization transition is 3809.32, 4124.02, and 4438.72 units per TCM FTE respectively for July through December 2009, January through June 2010, and beginning July 2010.***

***e. ORI's three step utilization transition is 3909.31, 4174.01, and 4438.72 units per TCM FTE respectively for July through December 2009, January through June 2010, and beginning July 2010.***

Stage 4: July 2010 and there-after (Ongoing rate methodology)

***a. From FY 2009 utilization data:***

***AWARE: FTE = 15.5, units = 71351, units/FTE = 4603.3***

***CMMC: FTE = 2, units = 7978, units/FTE = 3989.0***

***HI: FTE = 18.75, Units = 65524, units/FTE = 3494.6***

***ORI: FTE = 20.543, Units = 74871, units/FTE = 3868.9***

***b. Applying a weighted average calculation in which AWARE's FTE and Unit count is weighted at 84% and 87% respectively results in a total weighted average calculation of 4438.72 units per TCM FTE per year.***

**To determine the 15 minute TCM rate:**

1. Divide the Cost Pool per TCM FTE by the number of 15 minute billable units per TCM FTE at each stage of the transition.

a. Stage 1: April 2008 through June 2008 (First three months)

***\$68,566 cost per year / 3947.38 units per year = \$17.37 per 15 minute unit***

b. Stage 2: July 2008 through June 2009 (First full year of utilization data)

***\$68,566 cost per year / 4095.94 units per year = \$16.74 per 15 minute unit***

c. Stage 3: July 2009 through June 2010 (Individualized utilization factors and individualized rates)

1. AWARE

a. July through December 2009

***\$68,566 cost per year / 4655.57 units per year = \$14.73 per 15 minute unit***

b. January through June 2010

***\$68,566 cost per year / 4547.15 units per year = \$15.08 per 15 minute unit***

2. CMMC

a. July through December 2009

***\$68,566 cost per year / 4138.91 units per year = \$16.57 per 15 minute unit***

b. January through June 2010

***\$68,566 cost per year / 4288.81 units per year = \$15.99 per 15 minute unit***

3. HI

a. July through December 2009

***\$68,566 cost per year / 3809.32 units per year = \$18.00 per 15 minute unit***

b. January through June 2010

***\$68,566 cost per year / 4124.02 units per year = \$16.63 per 15 minute unit***

4. ORI

a. July through December 2009

***\$68,566 cost per year / 3909.31 units per year = \$17.54 per 15 minute unit***

b. January through June 2010

***\$68,566 cost per year / 4174.01 units per year = \$16.43 per 15 minute unit***

d. July 2010 and there-after (Ongoing rate methodology)

***\$68,566 cost per year / 4438.72 units per year = \$15.45 per 15 minute unit***

## V. Calculation of the Annual Billable Unit Cap per Provider

1. Stage 1: April 2008 through June 2008 (First three months)

*No billing cap for this stage.*

2. Stage 2: July 2008 through June 2009 (First full year of utilization data)

*No billing cap for this stage.*

3. Stage 3: July 2009 through June 2010 (Individualized utilization factors and individualized rates)

*a. For AWARE the billing cap at 35 or less caseload is \$1,062,773.00 which is calculated from: 36080.69 units @ \$14.73 = \$531,386.50 plus 35240.39 units @ \$15.08 = \$531,386.50*

*b. For CMMC the billing cap at 35 or less caseload is \$137,132.00 which is calculated from: 4138.91 units @ \$16.57 = \$68,566 plus 4288.81 units @ \$15.99 = \$68,566*

*c. For H I the billing cap at 35 or less caseload is \$1,285,612.50 which is calculated from: 35712.33 units @ \$18.00 = \$642,806.25 plus 38662.67 units @ \$16.63 = \$642,806.25*

*d. For ORI the billing cap at 35 or less caseload is \$1,408,551.34 which is calculated from: 40154.44 units @ \$17.54 = \$704,275.67 plus 42873.37 units @ \$16.43 = \$704,275.67*

4. Stage 4: July 2010 and there-after (Ongoing rate methodology)

a. Each provider can bill for no more than \$68,566 for each full time TCM FTE per year. Each provider can have no more than an average of 35 clients per case manager as a caseload. The provider organization's FTE level for calculating the total billing cap is determined by the number of FTE required to maintain a caseload of 35.

*b. AWARE reported 15.5 TCM FTE: 4438.72 units/yr/FTE X 15.5 FTE X \$15.45 (rate) = \$1,062,962*

*c. CMMC reported 2.0 TCM FTE: 4438.72 units/yr/FTE X 2.0 FTE X \$15.45 (rate) = \$137,156.*

*d. HI reported 18.75 TCM FTE: 4438.72 units/yr/FTE X 18.75 FTE X \$15.45 (rate) = \$1,285,842.*

*e. ORI reported 20.543 TCM FTE: 4438.72 units/yr/FTE X 20.543 FTE X \$15.45 (rate) = \$1,408,802.*

## **VI. Calculation of the Caseload Increase Adjustment to the Billing Cap:**

1. Stage 1: April 2008 through June 2008 (First three months)

*No caseload increase adjustment to the billing cap for this stage.*

2. Stage 2: July 2008 through June 2009 (First full year of utilization data)

*No caseload increase adjustment to the billing cap for this stage.*

3. Stage 3: July 2009 through June 2010 (Individualized utilization factors and individualized rates)

*a. For AWARE the billing cap adjustment for each average caseload above 35 is \$1,975.48 which is calculated as: \$15.08 per unit X 131 average # of billed units per client per year.*

*b. For CMMC the billing cap adjustment for each average caseload above 35 is \$1,918.80 which is calculated as: \$15.99 per unit X 120 average # of billed units per client per year.*

*c. For H I the billing cap adjustment for each average caseload above 35 is \$1,879.19 which is calculated as: \$16.63 per unit X 113 average # of billed units per client per year.*

*d. For ORI the billing cap adjustment for each average caseload above 35 is \$1,889.45 which is calculated as: \$16.43 per unit X 115 average # of billed units per client per year.*

4. Stage 4: July 2010 and there-after (Ongoing rate methodology)

*a. At 4438.72 units/yr/FTE and 35 clients on the caseload for each FTE the number of units per client per year is  $4438.72 / 35 = 126.82$  (round to 127).*

*b. 127 units per client X \$15.45 (rate) = \$1,962.15 per client per year.*

*c. For each client on the caseload above 35 the billing cap is increased by \$1,962.15.*

## **VII. Reimbursable Targeted Case Management Services**

### **1. Medicaid Reimbursable Targeted Case Management Services**

Case management services delivered in accordance with the federal authorities governing targeted case management services as an optional service under a Medicaid state plan are reimbursable with Medicaid monies. Montana has implemented targeted case management services for persons with developmental disabilities who are 16 years of age or older or who reside in a children's group home. A person with developmental disabilities must be Medicaid eligible before the State may use Medicaid monies to reimburse any of the case management services provided to that person.

Those case management services that are reimbursable with Medicaid monies fall within the following core activities: 1) assessment/evaluation of service needs, 2) development of the care plan to address the service needs, 3) referral and linkage to service providers to address the needs identified in the care plan, and 4) monitoring/follow-up to ensure the needs are being met.

## **VIII. Case Management Reimbursement and Billing Requirements and Limitations**

1. The methodology and procedures for determining case management reimbursement rates and the billing criteria and procedures for obtaining reimbursement will be set forth in the Developmental Disabilities Program Manual of Fee for Service Reimbursement Rates and Procedures.

2. Adult case management activities and case management for consumers in DD children's group homes are reimbursable only to the extent stated in this section. Any limitations or requirements stated in the Manual or this section are comprehensively applicable and supersede any limitations or requirements expressed in any Case Management Handbook, and program policies that are not in conformity with those expressed in this section.

3. Reimbursement is only available for case management services provided to a consumer that are medically necessary in accordance with ARM 37.85.410, which may be accessed at

<http://www.dphhs.mt.gov/legalresources/administrativerules/title37/chapter85.pdf>.

4. A Contractor may not submit units for reimbursement that encompass time periods devoted to any of the following activities. These are activities that CMS or the Department have determined should not be billable time for purposes of Medicaid reimbursement.

- a. beginning July 1, 2008 writing and entering case notes for the consumer's case management file;
- b. counseling the consumer and others;
- c. coordination of or investigation of consumer abuse, neglect, and exploitation;
- d. travel to and from consumer and consumer related contacts;
- e. monitoring the consumer's financial status and goals; and
- f. administrative activities such as breaks, training, meetings and other work related activities that are not related to the consumer's case management.

5. Federal authority, except as noted below, prohibits a case management provider from receiving Medicaid reimbursement for the delivery of case management services to a consumer if the consumer is in receipt of any type of federally or state funded case management services from another provider. Two case management providers cannot bill for services to the same consumer in the same month with one exception. DD adult case management services may be reimbursed if the other case management service the consumer is receiving is Medicaid funded targeted case management services for a consumer determined to be "high risk" during her pregnancy. The consumer, during her pregnancy and 60 days following the birth of the baby, may receive case management services from both case management providers.

6. The units billed by the Contractor for case management services delivered to a consumer may only consist of units that conform with the requirements of the Manual and this section and may not exceed the total of permissible units for a consumer as billed in accordance with the Manual and this section.

7. A unit of developmental disabilities case management service is 15 minutes. When billing for each 15 minutes, one unit of service is equal to at least 8 minutes, but less than 23 minutes. (An hour of services would contain no more than four (4) 15 minute units of service.) A unit of service is defined as direct face to face time spent with the consumer in services or on behalf of a consumer in services.

8. The Contractor must submit monthly invoices. Cost Recovery Data Sheets (CRDS) documenting the units of service delivered to each recipient of DD case management

must be attached to the invoice.

9. The Department has chosen to implement interim rates per unit of service. A rate affecting federal Medicaid expenditures must first be approved by the federal Centers For Medicaid/Medicare (CMS) which is the federal Medicaid oversight agency.

a. If CMS rejects the Department's interim rate methodology for adult case management services or the retroactive application of the rate, the Contractor must reimburse to the Department the amount calculated by the Department to be unallowable. Unallowable costs would be calculated, based upon CMS direction, to represent that portion of the rate or of the rate as applied to fiscal years 2009, 2010 and 2011 that is unallowable as a Medicaid expenditure. Unallowable costs would also encompass state general fund monies expended for non-Medicaid adult case management services as well as those federal/state monies expended on Medicaid reimbursable adult case management services.

b. If CMS rejects the Department's fiscal year 2009, 2010, and 2011 interim rate methodology for adult case management services or the retroactive application of the rate, the Contractor must accept the resulting changes in reimbursement that the Department implements in response to the exigency of the federal disapproval of or ordered changes to the interim rate.

10. If the average caseload per TCM FTE stays at or below 35, then the maximum compensation to the Contractor from this contract for the full year can not exceed the  $\text{CONTRACTORS TCM FTE} \times \text{Billing units per TCM FTE (built into the rate)} \times \text{the 15 Minute rate/unit}$  . If however the average monthly caseload goes above 35 by the end of the year then the billing cap is increased by the  $\text{15 Minute rate/unit} \times \text{Average Units/Client/Year}$  for each client above 35. The billing cap may be adjusted by the Department relative to the unit rate of reimbursement approved by CMS.

a. At such time as the Contractor has billed for the maximum units equivalent to the total reimbursement performance of the Contractor, the Contractor, having been fully compensated for the delivery of all case management services during the fiscal year under the rate reimbursement methodology, must continue until the close of the current fiscal year to deliver services to all consumers being served and to be served by the Contractor in service for case management services.

File Path: H:\dd\cs1094\RateSet\TCM Rate\Under\_New\_TCM\_Rules\Rate\_Calculation\Rate July 1 2008\TCM Rate Manual Section One 2008.07.01\_v6.doc