

# MONTANA DEVELOPMENTAL DISABILITIES PROGRAM SERVICES MANUAL

Effective July 1, 2019

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GENERAL INTRODUCTION: This manual outlines the programs delivered and billed in the Montana MMIS system through the Developmental Disabilities Program (Provider Type 82). As Developmental Disabilities transitions more programs to billing within the MMIS system, more Sections will be added about those programs.

## **SECTION 1: HOME AND COMMUNITY BASED SERVICES (HCBS)**

### **INTRODUCTION of HCBS:**

**SCOPE:** This section applies to all contracted staff and service providers that serve DDP members under the Medicaid Home and Community-Based Services (HCBS) Waiver programs, and certain non-Medicaid programs.

**PROGRAM OVERVIEW:** Home and Community-Based Services (HCBS) are designed to support people with developmental disabilities in integrated and inclusive community settings. Services are provided in accordance with individual's assessed needs in plan of care which specify the scope, duration, and frequency of services for each person. The following references should be used in conjunction with the approved waiver(s), Montana Medicaid Provider Agreement, DD Provider Contract, A.R.M.s, Montana Code Annotated, Personal Supports Plan, and service authorization.

The waiver reimburses using a Medicaid based, Fee-for-Service model. In order to deliver services available through the Developmental Disabilities Waiver(s), the provider must meet all the qualifications and standards associated with the particular service(s) the provider wishes to offer. [These qualifications and standards are described for each service in the approved waiver at https://dphhs.mt.gov/dsd/developmentaldisabilities/ddpmedicaidwaivers](https://dphhs.mt.gov/dsd/developmentaldisabilities/ddpmedicaidwaivers). Additionally, providers must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual on the Montana Medicaid provider website.

### **RULE REFERENCES:**

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Links to rule references are available on the Provider Information website. Paper copies of rules are available through the Secretary of State's office. The following rules are specific to the Developmental Disabilities Program: Rule citations in the text are a reference tool; they are not a summary of the entire rule.

Administrative Rules of Montana (ARM)

- ARM 37.34.101 through 37.34.3005

Montana Code Annotated (MCA)

- MCA Title 53, Chapter 20 Developmental Disabilities

Code of Federal Regulations (CFR)

- Title 42 Public Health

## **ELIGIBILITY:**

In order to receive services through the Developmental Disabilities waiver program, a member must be Medicaid eligible, and must meet criteria determined by the department as described in A.R.M. 37.34.201.

## **STANDARD COST CENTERS**

The HCBS Waiver Reimbursement consists of the following:

1. Direct Care Staff Time is the Billable Unit for most HCBS services and it's the basis for daily or monthly billing units. In order to meet the conditions for payment, the HCBS member must be Medicaid eligible, enrolled, attend, and receive a HCBS Waiver Service; and the direct care staff must be actively employed and present to provide the HCBS Waiver Service. In addition, the service provided must be consistent with the member's plan of care.
2. Staff is defined to be those staff whose primary responsibility is the day to day, hands-on, direct support of people with disabilities, training and instruction, and assistance with and management of activities of daily living.
3. Standardized Cost Centers: Per the process creating fee-for-service rates, most provider reimbursement rates consist of 4 cost centers which can be adjusted exclusive of the others. These cost centers are:

**\*\*Direct Care Staff Compensation**

**\*\*Employee-Related Expenses – Mandatory and non-mandatory expenses and benefits.**

**\*\*Program Supervision and Indirect Expenses – Expenses, travel, supervision, and indirect costs of running the program.**

**\*\*General and Administrative Expenses – Upper level management and operating costs.**

In addition to the standardized cost centers, geographical factors are applied to Supported Living (which is the billing category for a type of residential habilitation) and Residential Training Support. Geographical cost adjustment factors consider the cost of living, employment compensation, cost of housing, and labor market trends. These factors are as follows:

- Medium = 1.84% add-on: Beaverhead, Park, Blaine, Lake, Hill, Ravalli, Madison, Dawson, Lincoln, Custer.
- High = 4.48% add-on: Gallatin, Missoula, Yellowstone, Lewis & Clark, Stillwater, Jefferson, Fallon, Flathead, Rosebud, Big Horn, Powell, Richland, Silver Bow, Sweet Grass, Toole, Cascade, Musselshell, Glacier.
- All other counties have no geographic factor adjustment.
- SMALL Agency = Specific economy of scale factors are applied to very small providers of Supported Living and Residential Training Supports.

Billable units for most HCBS services are defined as either 15 minutes, hourly, daily, or monthly. The following definitions apply:

- The term “15 minutes” refers to fifteen minutes of staff time spent with or on behalf of an HCBS member. For this definition, fifteen minutes is considered to be no less than 8 minutes or no more than 22 minutes. Minutes cannot be combined over different days. Partial units are not allowed to be billed.
  - Units:** 1 **Time:** Greater than or equal to 8 minutes, but less than 23 minutes
  - Units:** 2 **Time:** Greater than or equal to 23 minutes, but less than 38 minutes
  - Units:** 3 **Time:** Greater than or equal to 38 minutes, but less than 53 minutes
  - Units:** 4 **Time:** Greater than or equal to 53 minutes, but less than 68 minutes
  - Units:** 5 **Time:** Greater than or equal to 68 minutes, but less than 83 minutes
  - Units:** 6 **Time:** Greater than or equal to 83 minutes, but less than 98 minutes
  - Units:** 7 **Time:** Greater than or equal to 98 minutes, but less than 113 minutes
  - Units:** 8 **Time:** Greater than or equal to 113 minutes, but less than 128 minutes
- The term “Hours” refers to one hour of direct care staff time spent with or on behalf of an HCBS member. For this definition, an hour is a minimum of 45 minutes.
- The term “Daily” refers to services provided in that day. A day is defined as direct care activities which occur between the hours of 12:00 a.m. and 11:59 p.m. Partial units are not allowed to be billed.
- The term “Month” refers to a single month billing unit. For services using this billable unit, reimbursement is made at a fixed monthly amount for care hours provided to those people enrolled in their service for that month. Monthly rates are used when individual support needs can vary widely on a daily basis. Partial units are not allowed to be billed.

For selected services, the following additional billable unit definitions apply:

- Congregate Residential Services – the rates are organized into several tiers based on average levels of support outlined by the member’s plan of care. Providers will bill hourly for all members receiving Children’s Group Home and Medically Intense Group Home services. Additionally if a member’s level of support exceeds average levels of support in the highest Tier, the provider will bill for those members hourly.
- Day Supports and Activities, Retirement, Small Group Employment - the rates are organized into several tiers based on average levels of support needed by the member. If a member’s level of support exceeds average levels of support in the highest Tier, the provider will bill for those members hourly.
- Supported Employment Follow Along - the monthly rate is organized into three tiers which reflect different amounts of employment support staff’s time and contacts.
- Supported Living - the “base” and “flex” levels are monthly rates based on the amount of support needed in two ranges, and an hourly rate is used for members needing more than an average 45 hours of support per month or when a monthly unit is cost prohibitive.

## **COVERED SERVICES:**

This section provides service information specifically for services offered in the Developmental Disabilities 0208 Comprehensive waiver and provides additional information and clarifications for certain services if applicable. [The full details of the services and requirements approved by the Centers for Medicare/Medicaid Services \(CMS\) can be found at: https://dphhs.mt.gov/dsd/developmentaldisabilities/ddpmedicaidwaivers](https://dphhs.mt.gov/dsd/developmentaldisabilities/ddpmedicaidwaivers) .

### **ADULT FOSTER SUPPORT**

This service pays for extraordinary supervision and support by a principal care giver licensed as an adult foster care provider who lives in the home. The total number of members living in the adult foster home, who are unrelated to the principal care provider, cannot exceed four persons (ARM 37.100.121).

Payments for adult foster support are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult foster support does not include payments made, directly or indirectly, to members of the individual's immediate family. The methodology by which the costs of room and board are excluded from payments for adult foster support is described in Appendix I.

Payment to an adult foster care provider is available to assist in placing and maintaining members with extraordinary support needs in licensed adult foster care settings.

Reimbursements are based on assessments completed by the service coordinator. Payments are based on the member supported meeting a required threshold in the hours of direct support and supervision required of the foster care provider.

The net effect of this service option is to strengthen the foster home network available to serve adults with developmental disabilities who would otherwise require services in more restrictive and costly service settings (e.g., an ICF-IID or an adult group home).

DDP will reimburse the adult foster care provider for no more than four members. Members with varying supervision needs can be served with Adult Foster Supports, but the Adult Foster Support reimbursement to a single foster home cannot exceed the Adult Foster Supports reimbursement rate for serving one member with intensive support needs.

Members receiving Adult Foster Support may not receive Personal Supports, Adult Companion, Homemaker or Personal Care services.

Residential Training Supports delivered in the context of an adult foster home will be invoiced, reimbursed and reported as a separate and distinct service from the Adult Foster Support service. Reimbursements for the service will be rolled into the cost of Adult Foster Support for the purpose of Federal reporting.

Provision has been made in the Adult Foster Support qualified provider standards for the adult foster care provider to provide Adult Foster Support only, or both Adult Foster Support and Residential Training Support. In the event the Adult Foster Support Provider is not qualified to provide Residential Training Support, the service will be made available by a qualified employee of an agency with a DDP contract.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

S5141	Adult Foster Support (low supervision)	\$783.65/month
S5141	Adult Foster Support (moderate supervision)	\$1376.71/month
S5141	Adult Foster Support (enhanced supervision)	\$2354.16/month
S5141	Adult Foster Support (intensive supervision)	\$4869.20/month

The monthly stipend does not include day or other services. If subcontracting, the provider determines the total amount per month paid to the foster parent. If subcontracting the service, any of the agency’s administrative/supervision fee comes from the monthly rate and includes the following: compliance with OHCDs standards per the DD contract, written policies and procedures, maintaining service delivery documentation and reimbursements, provide initial and ongoing training and supervision to the foster parent, and ensure subcontractor compliance with DD rules, waiver requirements, site regulations for licensed foster homes, and the HCBS Settings Rules.

**Supervision Guidelines:**

**Low Supervision** - For AFS programs, supervision requirements are intended for those times the individual is in the adult foster home. LOW SUPERVISION means that AFS parents must be aware of the location of the person. Such supervision is considered “point-to-point” and focuses on ensuring that the person is in the setting or situation as defined by their plan of care. No physical assistance is required. The individual does not have any health or behavioral needs that require attention. Examples of LOW SUPERVISION could include but not be limited to: Knowledge of individual’s presence and schedule during the day. Reminders to individuals of daily schedule of activities and outings. Few or no prompts/reminders are necessary. Backup assistance when primary transportation supports are temporarily not available. LOW SUPERVISION focuses on “point-to-point” supervision to ensure that the individual is in the location. Individuals who can safely engage with their environment AND DO NOT need assistance with activities of daily living would be examples of LOW SUPERVISION needs.

**Moderate Supervision** - For AFS programs, supervision requirements are intended for those times the individual is in the adult foster home. MODERATE SUPERVISION means that AFS parents must be aware of the location of the person and available to physically assist when needed. The individual does not have any health or behavioral needs that require constant attention. Examples of MODERATE SUPERVISION could include but not be limited to: Observing when an individual leaves or enters the home, prompting to encourage individuals to complete daily living skills and routine personal hygiene, assistance in accessing transportation and community-inclusion opportunities. MODERATE SUPERVISION focuses on “on-site”

supervision to ensure that the individual is in the location and appropriately engaged in relevant and safe activities. Individuals who can safely engage with their environment BUT NEED assistance with activities of daily living would be examples of MODERATE SUPERVISION needs.

**Enhanced Supervision** - For AFS programs, supervision requirements are intended for those times the individual is in the adult foster home ENHANCED SUPERVISION means that AFS parents must be able to observe the person at all times and available to physically assist when needed. For ENHANCED SUPERVISION to be required, the individual must have a health, behavior, or functional limitation need that requires constant attention. Examples of ENHANCED SUPERVISION could include but not be limited to: Observing the individual at all times when in the home, physically assisting individuals to complete daily living skills and routine personal hygiene, physical assistance to participate in transportation and community-inclusion opportunities. ENHANCED SUPERVISION focuses on “line-of-sight” supervision to ensure that the individual is in the location and appropriately engaged in relevant and safe activities. Individuals that wander away from the AFS, are not able to interact safely with their environment, or who engage in nuisance behavior are examples ENHANCED SUPERVISION needs.

**Intensive Supervision** - For AFS programs, supervision requirements are intended for those times the individual is in the adult foster home. INTENSE SUPERVISION means that AFS parents must be able to physically intervene with the person at all times in order to ensure health and safety. For INTENSE SUPERVISION to be required, the individual must have a health, behavior, or functional limitation need that requires constant attention, and represents a serious threat to health and safety. Examples of INTENSE SUPERVISION could include but not be limited to: Being in close proximity to the individual at all times when in the home, physically intervening with individuals in situations where self or others are at high risk. Providing one-to-one supervision with limited capacity to leave the individual unattended INTENSE SUPERVISION focuses on “arms-length” supervision where the AFS parent is physically able to intervene immediately when needed. Individuals who engage in self-injurious behavior, behaviors that risk physical harm to people or property, or serious seizure episodes are examples of INTENSE SUPERVISION needs.

## **ASSISTED LIVING**

Payments for services rendered in an assisted living facility, including personal care, homemaker services, medication oversight, social and recreation activities, 24 hour on site response staff to meet the unpredictable needs of individuals and supervision for safety and security. Separate payment will not be made for those services integral to and inherent in the provision of the personal care facility service.

This service is targeted to those members with a developmental disability whose specific condition and/or physical conditions preclude placement in a less restrictive setting. Members in this service option are not precluded from attending DD waiver-funded work/day or supported employment options.

Separate payment is not made for homemaker or chore services, personal supports, residential habilitation, residential training supports, live in care giver or personal care services furnished to



a member receiving assisted living services, since these services are integral to and inherent in the provision of assisted living services.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

T2031	Assisted living moderate	\$183.38/day
T2031	Assisted living enhanced	\$244.51/day

Assumes and reimburses 24/7 care, and other direct care services cannot be billed concurrently with assisted living.

### **BEHAVIORIAL SUPPORT SERVICES**

Behavioral Support Services may be provided by:

1. A Board-certified Behavior Analyst (BCBA) or Board-certified Behavior assistant Analyst (BCaBA);
2. A Family Support Specialist with an Autism Endorsement (FSS-AE);
3. A person with an Institute for Applied Behavior Analysis (IABA) consultant certification; or
4. A person with a degree in Applied Behavior Analysis, Psychology, or Special Education who has provided documentation of training and experience in the use of the principles of applied behavior analysis in the habilitation of person(s) with developmental disabilities and the development of behavior support plans to the developmental disabilities program director.

The Behavioral Support Services include the following:

1. Designing behavioral assessments and functional analyses of behavior and interpreting assessment and evaluation results for staff and unpaid caregivers providing services to enrolled members.
2. Designing, monitoring and modifying written behavior intervention procedures and skill acquisition procedures. Written plans of intervention developed generally require the collection of data by staff or unpaid caregivers providing direct support. Decisions made in designing, monitoring and modifying behavior intervention and skill acquisition procedures are generally based on the review and analysis of collected data.
3. Training staff and unpaid caregivers in the implementation of formal and informal procedures designed to reduce problem behaviors and/or to increase appropriate behaviors.
4. Attending planning meetings for purpose of providing guidance and information to planning team members in the setting of appropriate goals and objectives for members who need Behavioral Support Services.

In general Behavioral Support Services offer appropriate assessment and intervention methods for use in unfamiliar situations and for a range of cases of all ages. Behavioral Support Services

teaches others to carry out ethical and effective behavior interventions based on positive behavior supports. Behavioral Support Services staff may supervise the work of others who implement behavior interventions. All behavior intervention procedures developed by the Behavioral Support Services staff are in compliance with the Administrative Rules of Montana governing the use of Positive Behavioral Supports.

Behavioral Support Services will not supplement or supplant services available to children under IDEA, or otherwise available to a school age child.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

H0046 Behavioral Support Services \$60.03/staff hour

**CAREGIVER TRAINING AND SUPPORT**

Caregiver training and support services for individuals who provide unpaid training, companionship or supervision to members. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance or companionship to a member. This service may not be provided in order to train paid caregivers. Caregiver training and support will be provided in the home or community environments that are part of the member’s typical day. Training includes instruction coaching and/or modeling to learn skills to safely and fully participate in the community. All training for individuals who provide unpaid support to the participant must be included in the member’s plan of care.

Services to be provided do not duplicate service coordinator services. The role of the staff person providing Caregiver Training and Support is defined by the planning team.

This service is only available to members living in a family setting or private non-congregate residence where support and supervision is provided by unpaid care givers. It is not available to persons living in group homes, assisted living facilities, or foster homes when the foster care provider is paid for support and supervision.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT. Caregiver Training and Support can only be used when the approved service is not covered under any other private or publicly funded resource or other waiver service. The plan of care actions must be specific as to the training caregivers will receive. Providers and case managers are responsible to ensure that the specific caregiver training is not available under a Medicaid State Plan service and the waiver is the payer of last resort.

T1027 Caregiver Training & Support \$53.81/staff hour

If CTS is delivered during a month, at least ONE contact with the caregiver must be provided during the invoiced hours for that month. At least 6 of the monthly contacts per year must be a visual contact (video conferencing or in-person) with both the caregiver and individual present.

The waiver cannot be billed for any equipment or software required for or associated with video conferencing capability.

### **COMMUNITY TRANSITION SERVICES**

Community Transition Services are non-recurring set-up expenses for members who are transitioning from an institution to a DDP waiver funded HCBS residential service. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- a. Security deposits required to obtain a lease on an apartment or home.
- b. Essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items and bath/bed linens.
- c. Set-up fees or deposits for utility or services access, including telephone, electricity, heating and water.
- d. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
- e. Moving expenses.
- f. Necessary home accessibility adaptations.
- g. Activities to assess need, arrange for and procure needed resources.

Community transition services are furnished only to the extent that they are reasonable and necessary through the service plan development process, clearly identified in the service plan and the member is unable to meet such expense or when the services cannot be obtained from other sources. Community transition services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes, such as television, cable TV access or VCRs.

This service is capped at \$3,000 per member, per transition. This service is not available to members transitioning into residential settings that are owned or leased by a DDP-funded service provider, rather, the residential setting must be owned, leased or rented by the member and must be considered the member's private residence.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

T2038            Community Transition Services            \$ cost varies

### **COMPANION**

Non-medical care, supervision and socialization, provided to a functionally impaired member age 14 or older. Companions may assist or supervise the member with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the member. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.



to; the identification of resources necessary for transportation, social participation, inclusion, and independence;

3. Support as needed, for a member's communication, personal care and safety as needed;
  4. Increased awareness and exposure to self-determination and self-advocacy;
  5. Development of a career profile and employment goal or career plan of which employment may be an identified need; and
  6. Provide formalized training and work experiences intended to teach the member skills necessary to succeed in an employment setting.
7. Members may utilize Individual and Small Group Employment Support, Follow Along Support, and Co Worker Support in conjunction with Day Supports & Activities.
8. Total hours for a member's attendance shall not include time spent during transporting to/from the member's residence. Day Supports and Activities services will not duplicate or supplant other services provided under IDEA (20 U.S.C. 1401 et seq) and cannot be billed for during the same time frame as Individual or Small Group Employment Support, Follow Along Support, or Co Worker Support.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

Daily - based on assessment of average hours of support a member needs per day.

			Program Related
T2021	Day Supports and Activities Tier 1	\$11.22/day	\$3.93/day
T2021	Day Supports and Activities Tier 2	\$22.98/day	\$8.04/day
T2021	Day Supports and Activities Tier 3	\$28.89/day	\$10.11/day
T2021	Day Supports and Activities Tier 4	\$40.44/day	\$14.15/day
T2021	Day Supports and Activities Tier 5	\$52.29/day	\$18.30/day
T2021	Day Supports and Activities Tier 6	\$63.91/day	\$22.37/day
T2021	Day Supports and Activities Tier 7	\$75.96/day	\$26.59/day
T2021	Day Supports and Activities Tier 8	\$93.49/day	\$32.72/day
T2021	Day Supports and Activities Tier 9	\$111.65/day	\$39.08/day
T2021	Day Supports and Activities Tier 10	\$130.73/day	\$45.76/day
T2021	Day Supports and Activities Tier 11	\$150.21/day	\$52.57/day
T2021	Day Supports and Activities Tier 12	\$169.84/day	\$59.44/day
T2021	Day Supports and Activities Tier 13	\$195.19/day	\$68.32/day

Program Related may be billed on days that a member plans to attend, but does not attend.

Hourly - Congregate groups of employees working in the community that share staff. Based on assessment of average hours of support a member needs per day exceeding an average of 7.99 hours of staff time per day.

T2021	Day Supports and Activities HOURLY	\$26.41/staff hour	\$35% of ave daily hours
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Program Related may be billed on days that a member plans to attend, but does not attend.

**ENVIRONMENTAL MODIFICATIONS**

Those physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or which enable the member to function with greater independence in the home, and without which, the member would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment which are necessary for the welfare of the member.

In addition to the above, environmental modifications services are measures that provide the member with accessibility and safety in the environment so as to maintain or improve the ability of the member to remain in community settings and employment. Environmental modifications may be made to a member's home or vehicle (wheelchair lift, wheelchair lock down devices, adapted driving controls, etc.) for the purpose of increasing independent functioning and safety or to enable family members or other care givers to provide the care required by the member.

An environmental modification provided to a member must:

- (a) Relate specifically to and be primarily for the member's disability;
- (b) Have utility primarily for a member who has a disability;
- (c) Not be an item or modification that a family would normally be expected to provide for a non-disabled family member;
- (d) Not be in the form of room and board or general maintenance;
- (e) Meet the specifications, if applicable, for the modification set by the American National Standards Institute (ANSI);
- (f) Be prior authorized by the DDP.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the member, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

All requests require documentation of an assessed need and prior approval from DDP.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

S5165	Environmental Modifications	\$ cost varies
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All modifications must meet all state/local building codes, meet specifications of ANSI, and be guided by the Americans with Disability Act or ADA Accessibility Guidelines. For modifications estimated to be under \$4000, the DDP Targeted Case Manager will determine the amount of reimbursement after review of their own research or information submitted by the Provider. If the cost of the project exceeds \$4000, then 3 written, itemized bids should be

submitted to the RM for review. The bids must contain cost of labor equipment, permits, and materials, including subcontractor amounts. The Regional Manager will review the information on all requests for this service before authorizing a prior approval. No part of the modification can be diverted to, or billed separately under a different waiver category (e.g. Individual Goods and Services or Specialized Medical Equipment and Supplies)

### **HOMEMAKER**

Homemaker services consist of general household activities provided by a homemaker when the person regularly responsible for these activities is unable to manage the home and care for himself/herself or others in the home, or is engaged in providing habilitation and support services to the member with disabilities.

Services in this program include meal preparation, cleaning, simple household repairs, and laundry, shopping for food and supplies and routine household care.

Homemaker services are not available under the State Plan.

This service is not available to members in residential settings in which primary care is funded 24/7 by the DDP (e.g., group homes and assisted living facilities). Homemaker services may be bundled with other services when delivered as a component of Self-Directed Services and Supports (SDSS) and is therefore not available as a discrete service to persons receiving SDSS. Homemaker services provided by a non-DD service provider agency employee (i.e. business entity) are not required to submit to a background check. Under no circumstances will a homemaker who has not had a background check provide a service if the person is alone in the residential setting at the time the service is being provided.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

S5130 Homemaker \$20.91/staff hour

### **INDIVIDUAL GOODS AND SERVICES**

Individual Goods and Services are services, equipment or supplies that enhance opportunities for the person to achieve outcomes for full membership in the community as clearly identified in the plan of care. Individual goods and services fall into the following categories:

\*Memberships and Fees including but not limited to:

- Fees associated with classes for the person supported
- Social club memberships
- Fees associated with Special Olympics
- Health memberships as prescribed by a licensed health care provider
- Recreational activities specific to a habilitative goal in the plan of care

Recreational activities provided under Individual Goods and Services may be covered only when they are included in a planning outcome related to a specific residential habilitation goal.

\*Equipment and Supplies including but not limited to:

- Assistive technology devices, controls, appliances or other items that enable persons to increase their abilities to perform activities of daily living, or to recognize, control or communicate with the environment, thus decreasing the need for assistance from others.
- Accessories essential to prolong life of assistive technology devices such as batteries, protective cases, screen protectors.
- Nutritional supplements,
- Non-reusable medical supplies related to the person's disability,
- Instructional supplies,

IGS can only be used when the approved item or service is not covered under any other private or publicly funded resource or other waiver service.

Individual Goods and Services can pay for repair of equipment when the equipment meets the authorization criteria and the repair is a cost-effective alternative (e.g., is expected to last and without repair the equipment would have to be purchased new at a great cost). A maintenance or insurance agreement may be purchased for items that meet authorization criteria when the maintenance agreement is expected to be cost-effective.

Individual goods and services projected to exceed \$1,000 (annual aggregate) may be subject to review and approval by the DDP Regional Manager.

Equipment purchases are expected to be a one-time only purchase. Replacements, upgrades or enhancements made to existing equipment will be paid if documented as a necessity and approved by DDP Regional Manager.

The following represents a non-inclusive list of non-permissible Goods and Services:

1. Individual goods and services provided under this definition are not covered under the Individuals with Disabilities Education Act (IDEA), home-based schooling, or Section 110 of the Rehabilitation Act or available through any other public funding mechanism.
2. Goods, services or supports benefiting persons other than the individual
3. Room and board
4. Personal items and services not related to the disability
5. Gifts, gift certificates, or gift cards for any purpose
6. Items used solely for entertainment or recreational purposes
7. Personal hygiene items
8. Discretionary cash
9. General clothing, food, or beverages (not specialized diet or clothing)
10. Household furnishings
11. Household cleaning supplies
12. Home maintenance

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.



Shipping and handling costs may be paid if the shipping cost is included in the price of the item, and the waiver is purchasing the item.

Reconditioned equipment may be purchased if all authorization criteria are met and the item is considered of adequate quality, expected to be durable, and the cost is commensurate with the age and condition of the item (e.g., if a new item could be purchased at the similar cost, it may be worthwhile to purchase the new item).

Nutritional supplements, vitamins, and the like may be reimbursed when there is no other source for reimbursement, and the specific items have been reviewed and approved, in writing, by the person's licensed health care provider.

Individual goods and services must be directed exclusively toward the benefit of the individual and are the least costly alternative that reasonably meets the individual's assessed need and meets the following requirements A-D:

A. One or more of the following criteria are met:

1. The service, equipment or supply promotes inclusion in the community, and/or
2. The service, equipment or supply increases the person's safety in the home environment, and/or
3. The service, equipment or supply decreases the need for other Medicaid services,

B. The service, equipment or supply is designed to meet the person's functional (remedially necessary: appropriate to assist a person in increased independence and integration in their environment/community), medical (Medically necessary: appropriate and effective for the medical needs and health and safety of the person) by advancing the outcomes in the plan of care;

C. The service, equipment or supply is not available through another source; and can be accommodated within the person's individual cost plan without compromising the health and safety.

D. The service, equipment or supply is not experimental or prohibited.

Individual goods and services must be approved prior to purchase and reimbursement. In addition, individual goods and services purchased on behalf of the person by legal guardians, legally responsible persons, or other non-employees acting on behalf of the person are reimbursable only if receipts for such purchases are submitted to the agency with a DDP contract. The receipts are reimbursable only if all the requirements listed above have been met.

T1999

Individual Goods and Services

\$ cost varies

## **MEALS**

This service provides hot or other appropriate meals once or twice a day, up to seven days a week to a member in their own private residence. A full nutritional regimen (three meals per day) will not be provided, in keeping with the exclusion of room and board as covered services.

Some members need special assistance with their diets and the special meals service can help ensure that these members would receive adequate nourishment. This service will only be provided to members who are not eligible for these services under any other source, or need

different or more extensive services than are otherwise available. This service must be cost effective and necessary to prevent institutionalization.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

S5170 Meal Services \$5.81 per meal

Requires a physician's prescription or referral prior to being added to a member's service plan.

### **NUTRITIONIST**

These services provided by a registered dietitian or licensed nutritionist include meal planning, consultation with and training for care givers, and education for the individual served. The service does not include the cost of meals. Nutritionist services, for adults, are not available under Montana's State Plan.

This service must be cost effective and necessary to prevent institutionalization.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

S9470 Nutritionist Services Professional \$82.40 hour

Requires a physician's prescription or referral prior to being added to a member's service plan.

### **OCCUPATIONAL THERAPY**

These services will be provided through direct contact between therapist and individual as well as between the therapist and other people providing services to the individual.

Occupational therapists may provide evaluation, consultation, training and treatment.

Occupational therapy services under the State Plan are limited. Maintenance therapy is not reimbursable, nor is participation in the interdisciplinary planning process.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

97110 Occupational Therapy \$21.17/15 minutes

Requires a physician's prescription or referral prior to being added to a member's service plan.

**PERSONAL CARE**

Personal Care Services Include:

1. Assistance with personal hygiene, dressing, eating and ambulatory needs of the member; and
2. Performance of household tasks incidental to the member's health care needs or otherwise necessary to contribute to maintaining the member at home;
3. Supervision for health and safety reasons.

Frequency or intensity will be as indicated in the plan of care.

For State Plan Personal Care the plan of care must be approved by a physician and developed by a licensed nurse employed by the provider. The delivery of State Plan Personal Care Services must be supervised by a licensed nurse. Waiver Personal Care does not require this.

This service is available under the waiver only if the scope, amount or duration of the available Medicaid State Plan Personal Care is insufficient in meeting the needs of the person. Personal care may be bundled with other services when delivered as a component of Self-Directed Services and Supports (SDSS) and is therefore not available as a discrete service to persons receiving SDSS.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

T1019	Personal Care	\$22.09/staff hour
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**PERSONAL SUPPORTS**

The personal supports worker assists the member in carrying out daily living tasks and other activities essential for living in the community. Services may include assistance with homemaking, personal care, general supervision and community integration. Personal Supports may also provide the necessary assistance and supports to maintain employment in a competitive, customized, or self-employment setting and/or day service needs of the in integrated, community settings. Personal supports activities are generally defined in the plan of care and are flexible in meeting the changing needs of the member. Workers may be assigned activities that involve mentorship, and activities designed to develop or maintain skills. Personal supports workers may be required to provide non-medical transportation to a person for activities as outlined in the plan of care, including community integration activities, work or school and other community activities. A member receiving personal supports is self-directing this service with employer authority (either common law or agency with choice). Other waiver services that may overlap with the activities of the personal supports worker are prohibited.

**REIMBURSABLE ACTIVITIES:**

1. Providing supervision and monitoring for the purpose of ensuring the member's health and safety.
2. Assisting the member with hygiene, bathing, eating, dressing, grooming, toileting, transferring, or basic first aid.

3. Assisting the member to access the community. This may include someone hired to accompany and support the member in all types of community settings. Personal supports is available to a person only when the planning team has approved a back-up plan, serving to ensure the health and safety of the person in the event of a service disruption.
4. Assisting the member to develop self-advocacy skills, exercise rights as a citizen, and acquire skills needed to exercise control and responsibility over other support services, including managing generic community resources and informal supports.
5. Assisting the member in identifying and sustaining a personal support network of family, friends, and associates.
6. Assisting the member with household activities necessary to maintain a home living environment on a day-to-day basis, such as meal preparation, shopping, cleaning, and laundry.
7. Assisting the member with home maintenance activities needed to maintain the home in a clean, sanitary, and safe environment.
8. Assisting the member to maintain employment. This may include someone to accompany and support the member in a competitive, customized, or self-employment setting. The employment supports are delivered informally.
9. Assisting the member to access services and opportunities available in community settings. This may include accompanying the member to and facilitating participation in general community activities and community volunteer work.

A member receiving Personal Supports may also receive Respite.

A member receiving personal supports is self-directing this service with employer authority (either common law or agency with choice). Other waiver services that may overlap with the activities of the personal supports worker are prohibited. These include live in care giver services, adult companion, extended personal care services and homemaker.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

While a person may receive both Respite and Personal Supports they can't be billed for during the same timeframe.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

T2033	Personal Supports	\$22.09/staff hour
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**PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)**

PERS is an electronic device that enables members to secure help in an emergency. The member may also wear a portable "help" button to allow for mobility. The response center is staffed by trained professionals.

PERS services may be appropriate for members who live alone, or who are alone for parts of the day, and have no regular caregiver for periods of time.

Because of the limitations of the PERS service, a cell phone may be a more flexible, cost effective solution in ensuring health and safety for some individuals. Cell phones are not for convenience or general purpose use.

Guidelines for the use of cell phones include:

1. The member requires access to assistance or supports and is frequently beyond the range of coverage of a PERS system.
  2. Cell phone plans will be basic plans and will not include features unrelated to health and safety issues, such as web access or music services.
  3. Members may elect to add a usage control feature to their basic plan to eliminate the potential for fee overage.
  4. Members who do not elect to add a usage control feature and who exceed the fees associated with their plan may require the implementation of a usage control feature to prevent future overages. In all cases of an overage the service coordinator will be notified. If a member goes over their usage limit they are responsible for those charges and the team will evaluate the needs of the member and look at the most cost effective options.
  5. Members may elect to add an insurance feature to prevent health and safety concerns should the phone need to be replaced.
  6. These cell phone guidelines will be reviewed with the member prior to or at the annual planning meeting.
1. Installation, maintenance and monthly fees associated with PERS services and cell phone services may be reimbursed with waiver funds as outlined in the plan of care.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

	Personal Emergency Response System (PERS)	
S5160	Installation and Testing	\$ cost varies
S5161	Personal Emergency Response <b>Monthly</b> Service	\$ cost varies

**PHYSICAL THERAPY**

These services will be provided through direct contact between therapist and individual as well as between the therapist and other people providing services to the individual. Physical therapists may provide treatment training programs that are designed to:

1. Preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and activities of daily living; and
2. Prevent, insofar as possible, chronic or progressive conditions through means such as the use of orthotic prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

Therapists will also provide consultation and training to staff or caregivers who work directly with individuals.

Physical therapy services under the State Plan are limited. Maintenance therapy is not reimbursable, nor is participation in the interdisciplinary planning process.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

97530 Physical Therapy \$27.40/15 minutes

Requires a physician's prescription or referral prior to being added to a member's service plan.

**PRIVATE DUTY NURSING**

Waiver Private Duty Nursing service provides medically necessary nursing services, to members 21 years of age and older and are provided in any setting in which they are needed. Private Duty Nursing State Plan services are available only to children up to age 21.

Services may include medical management, direct treatment, consultation, and training for the member and/or caregivers.

Services provided under the home health requirement of the State Plan are limited and for those considered "home bound" and for the purposes of postponing or preventing a higher level of care.

State Plan home health services may only be provided in a member's private residence, while some members need nursing services in settings outside of the home.

Private Duty Nursing services must be specified in the plan of care. It must be ordered in writing by the member's physician and it must be delivered by a registered nurse (RN) or a licensed practical nurse (LPN).

Waiver Private Duty Nursing services, for individuals 21 years of age and older, will be used after the State Plan home health nursing limits have been reached, or if the service required is different from that authorized under the State Plan. State Plan Home Health services include skilled nursing for people 21 and over.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

T1003 Private Duty Nursing (LPN) \$9.03/15 minutes  
 T1002 Private Duty Nursing (RN) \$11.38/15 minutes

Requires a physician's prescription or referral prior to being added to a member's service plan.

**PSYCHOLOGICAL EVALUATION, COUNSELING, AND CONSULTATION**

Evaluation, Counseling and Consultation services are those services provided by a licensed psychologist, licensed professional counselor or a licensed clinical social worker within the scope of the practice of the respective professions.

Psychological and counseling services may include individual and group therapy; consultation with providers and care givers directly involved with the member; development and monitoring of behavior programs; participation in the member planning process; and counseling for primary care givers (i.e., family members and foster parents) when their needs are related to problems dealing with the member with the disability. Psychological and counseling services available under the Montana State Plan will be used before invoicing the waiver.

Psychological and counseling services under the State Plan are limited. Under the waiver, this service is available to adults when the service is recommended by a qualified treatment professional, approved by the planning team and written into the plan of care.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

H2019	Psychological Services	Professional \$166.65 Hour
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### **REMOTE MONITORING**

The provision of oversight and monitoring within the residential setting of a member, age 18 and older, through off-site electronic surveillance by staff using one or more of the following systems: live video feed, motion sensing system, radio frequency identification, web-based monitoring system, or other device approved by the DDP. It also allows live two-way communication with the person being monitored as described in the member's plan of care.

Remote monitoring shall be done in real time, not via a recording, by awake staff at a monitoring base using the appropriate connection. When remote monitoring is being provided, the remote monitoring staff shall not have duties other than remote monitoring.

The provider of remote monitoring shall have an effective system for notifying emergency personnel such as police, fire, and back up support staff.

The member who receives the service and each person who lives with the member shall consent in writing after being fully informed of what remote monitoring entails. If the member or a person who lives with the member has a guardian, the guardian shall consent in writing. The member's service coordinator shall keep a copy of each signed consent form with the member's plan of care.

Remote Monitoring shall only be used in supported living settings and is only used for the purpose of reducing or replacing the amount of residential habilitation needed.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

T1014 Remote Monitoring \$8.26/staff hour

### **REMOTE MONITORING EQUIPMENT**

The equipment used to operate systems such as live feed video, motion sensing system, radio frequency identification, web-based monitoring system, or other device approved by the DDP. It also refers to the equipment used to engage in live two-way communication with the member being monitored.

Equipment must be leased at a maximum monthly amount of \$300. This service allows for the monthly lease of remote monitoring equipment and does not duplicate any equipment purchased under Specialized Medical Equipment and Supplies.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

T2028 Remote Monitoring Equipment \$300.00/max per month

### **RESIDENTIAL HABILITATION**

Services designed to assist members in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Habilitation is to be provided where the member lives: Settings include group homes, congregate and non-congregate living apartments and natural homes.

All facilities covered by Section 1616(e) of the Act comply with State licensing standards that meet the requirements of 45 CFR Part 1397.

Board and room is not a covered service. Members served are responsible for paying for board and room through other funding sources such as Supplemental Security Income (SSI).

The plan of care, based upon the results of a formal assessment and identification of needs, provides the general goals and specific objectives toward which training efforts are directed. The plan of care also specifies the appropriate residential setting in which services will be provided.

Training is provided in basic self-help skills, home and community living skills, leisure and social skills. Support is provided as necessary for the care of the member. Each training objective is specified in the plan of care and is clearly related to the member's long term goal and is not simply busywork or diversional in nature.

Residential habilitation services are not available to members residing in assisted living or adult foster home settings.



Medicaid reimbursement for room and board is prohibited. This service will not duplicate any other services that the member receives. The provider may not bill Medicaid for services on days the member is absent from the facility, unless retainer days have been approved by the Regional Manager. The provider may bill on date of admission and discharge from a hospital or nursing facility. If the member is transferring from one residential care setting to another, the discharging facility may not bill on day of transfer. Members in residential habilitation may not receive the following services under the HCBS program: 1) Personal Supports; 2) Homemaker; 3) Environmental Modifications; 4) Respite; or 5) Meals. These restrictions only apply when the HCBS payment is being made for the residential service.

Providers of this service may be eligible for a retainer payment if authorized by the Regional Manager. Retainer payments may be made to providers of residential habilitation while the waiver participant is hospitalized or absent from his/her home for period of no more than 30-days per state fiscal year. Retainer payments will be reimbursed upon authorization by the Regional Manager.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

“Support” also includes general care giving activities such as assistance with daily living activities, meal preparation, laundry, transportation, supervision, community integration, and may include meetings or phone calls on behalf of the individual in service. One or more staff activities providing support, training or actions specified in the individual’s plan of care constitutes billable activities. Residential Habilitation services are not allowed for members also receiving Adult Foster waiver services through DDP. Contractors shall meet licensing requirements and provide sufficient numbers of daily staff and materials to meet individual plans of care. For Congregate Living homes, this shall include awake staff on all shifts where individuals are present. For Supported Living, contractors shall provide 24 hour on-call staff support.

**Congregate Living**

Daily- Includes licensed group homes and congregate supported living sites where members share staff. Assignment of Tiers are based on assessment of average hours of support a member needs per day. This service is eligible for retainer payments.

T2017	Congregate Living Tier 1	\$98.74/day
T2017	Congregate Living Tier 2	\$115.71/day
T2017	Congregate Living Tier 3	\$130.76/day
T2017	Congregate Living Tier 4	\$153.78/day
T2017	Congregate Living Tier 5	\$167.71/day
T2017	Congregate Living Tier 6	\$185.65/day
T2017	Congregate Living Tier 7	\$194.81/day
T2017	Congregate Living Tier 8	\$221.61/day
T2017	Congregate Living Tier 9	\$245.12/day

**Hourly** - Includes licensed group homes and congregate supported living sites where members share staff. Based on assessment of average hours of support a member needs

per day at or exceeding an average of 10.95 hours of staff time per day. This service is eligible for retainer payments.

T2017 Congregate Living Hourly \$24.20/staff hour

**Congregate Living Medical hourly** – Designated licensed Group Home sites where 24/7 LPN is required on site. Based on assessment of average hours of support a member needs per day. LPN and habilitation staff are both billable. This service is eligible for retainer payments.

T2017 Congregate Living Medical \$30.56/staff hour

**Congregate Living Children’s hourly** – Designated licensed Group Home services for young adults aged 20 or younger. This service is eligible for retainer payments.

T2017 Congregate Living Children’s \$26.25/staff hour

**Supported Living** - 1:1 service for individuals living in a family home, their own home, or an apartment in which they do not share staff with other residents during the same time period.

Hourly - An hourly unit is for members needing an average of more than 45.1 hours of supported living services per month, for adults if remote monitoring services will be provided concurrently with hourly supported living, or can be applied in any situation where monthly units would be cost prohibitive. Geographical adjustments apply based on where the member lives and are determined by the member’s county. This service is not eligible for retainer payments.

T2013 Res Hab Supported Living no geographic factor \$24.46/staff hour

T2013 Res Hab Supported Living medium geographic factor \$24.89/staff hour

T2013 Res Hab Supported Living high geographic factor \$25.50/staff hour

Rural Remote - Services delivered in remote locations that take at least 80 miles round trip (from the closest provider location) to access the service, for members needing an average of more than 45.1 hours of supported living services per month, for adults if remote monitoring services will be provided concurrently with hourly supported living, or can be applied in any situation where monthly units would be cost prohibitive. There is no geographic adjustment and must be prior approved. This service is not eligible for retainer payments.

T2013 Res Hab Supported Living rural remote \$26.44/staff hour

**Supported Living Base** - for individuals with supported living needs that vary significantly each month (between one (1) and thirty (30.99) hours of support) and must include at least ONE face-to-face contact per during the hours provided. This is a

monthly billing unit. There is no geographic adjustment. This service is not eligible for retainer payments.

T2032            Res Hab Supported Living – Base                            \$733.80/month

**Supported Living Flex** - for individuals with supported living needs that vary significantly each month (between thirty-one (31.0) to forty-five (45.0) hours of support) and must include at least TWO face-to-face contacts during the hours provided. This is a monthly billing unit. There is no geographic adjustment. This service is not eligible for retainer payments.

T2032            Res Hab Supported Living – Flex                                \$1100.70/month

Supported Living SMALL Agency - for very small providers who meet ALL of the following criteria: support less than 10 individuals, who employ 12 or fewer staff, and whose Director routinely provides some of the direct support hours every week. Rates for this service are for members needing an average of more than 45.1 hours of supported living services per month, for adults if remote monitoring services will be provided concurrently with hourly supported living, or can be applied in any situation where monthly units would be cost prohibitive. Geographical adjustments apply based on where the member lives and are determined by the member’s county. Hours that the Director provides direct services are billable. This service is not eligible for retainer payments.

T2013            Res Hab Supported Living (Small Agency) no geo factor     \$31.92/staff hour  
T2013            Res Hab Supported Living (Small Agency) med geo factor    \$32.48/staff hour  
T2013            Res Hab Supported Living (Small Agency) high geo factor    \$33.30/staff hour

**RESIDENTIAL TRAINING SUPPORTS**

Residential Training Supports delivered in the context of an adult foster home will be invoiced, reimbursed and reported as a separate and distinct service from the Adult Foster Support service. Reimbursements for the service will be rolled into the cost of Adult Foster Support for the purpose of Federal reporting.

Provision has been made in the Adult Foster Support qualified provider standards for the adult foster care provider to provide Adult Foster Support only, or both Adult Foster Support and Residential Training Support. In the event the Adult Foster Support Provider is not qualified to provide Residential Training Support, the service will be made available by a qualified employee of an agency with a DDP contract.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

Residential Training Supports – based on assessment of average hours needed. Geographical adjustments apply based on where the member lives and are determined by the member’s county.

H2015	Residential Training Support (no geo factor)	\$24.32/staff hour
H2015	Residential Training Support (medium geo factor)	\$24.74/staff hour
H2015	Residential Training Support (high geo factor)	\$25.35/staff hour

**RTS SMALL Agency** – based on assessment of average hours needed. RTS Small is for very small providers who meet ALL of the following criteria; support less than 10 DD individuals, who employ 12 or fewer direct care staff, and whose Director routinely provides some of the direct support hours every week. Geographical adjustments apply based on where the member lives and are determined by the member’s county. Hours that the Director provides direct services are billable.

H2015	Residential Training Support (small agency no geo)	\$31.73/staff hour
H2015	Residential Training Support (small agency medium geo)	\$32.30/staff hour
H2015	Residential Training Support (small agency high geo)	\$33.11/staff hour

**RESPITE**

Respite care includes any services (e.g., traditional respite hours, recreation or leisure activities for the individual to enable the caregiver to remain at home for a break; summer camp) designed to meet the safety and daily care needs of the member and the needs of the member's care giver in relation to reducing stress generated by the provision of constant care to the member receiving waiver services. These services are selected in collaboration with the parents and are provided by persons chosen and trained by the family. Persons providing respite services will be in compliance with all state and federal respite standards. Respite services are delivered in conformity with an individualized plan of care. Respite services are temporary in nature, meaning a member is not permitted to receive respite care for a period of 24 hours per day for more than 29 consecutive days. If this level of care is needed the member's team will identify other residential service options available in the waiver that better meets the member's needs.

Respite care is for the temporary relief of the caregiver. The amount and frequency of respite care (with the exception of emergencies) is included in each members’ plan of care.

FFP (Federal Financial Participation) will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Age appropriate licensed day care is a respite care option for persons of all ages. Licensed day care is a subcomponent of respite and is treated as a discrete service in the plan of care, the individual cost plan and in the Department’s billing and payment system. Day care is reported as respite in federal reports.

Respite cannot be used during services otherwise available through public education programs including education activities, after school supervision, daytime services when the school is not in session, or services available to preschool age children.

Respite (including day care) is only available to members residing with primary caregivers in family settings, including adult foster homes. Respite is available when a primary caregiver is

not compensated for providing some or all of the supervision and support needed by the member. Reimbursement for respite in any setting may not exceed the Department's currently approved hourly respite reimbursement rate. Under no circumstances will childcare reimbursed under this service be used to replace routine childcare that a caregiver is responsible to provide.

Children from birth through age 17 may be served in licensed children's day care centers and in licensed family and group day care homes. For children under the age of 13, the waiver will cover the difference in cost between usual and customary rates and the increased rate charged by the provider to serve a child with extraordinary support needs. Children aged 13 through age 17 may be served in licensed children's day care centers and in licensed family and group day care homes, as allowed by the Montana Quality Assurance Division. Individuals aged 18 and older may receive support and supervision services in licensed adult day centers. Under no circumstances will adults be served in settings licensed to serve children. Neither will children be served in settings licensed to serve adults.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

S5150	Respite	\$17.14/staff hour
S5151	Respite Other	\$ cost varies

## **RETIREMENT**

Retirement services are available to a member who is of the typical retirement age (age 62 or older) or is limited due to health and safety issues. Members of this service are no longer able to maintain employment due to health and safety risks OR are of retirement age. Retirement services are structured services consisting of day activities and residential support.

Retirement services may be provided in a provider operated residence (licensed DD group home) or community day activity setting and may be provided as a continuous or intermittent service.

The outcome of Retirement services is to treat each member with dignity and respect, to the maximum extent possible maintain skills and abilities, and to keep the member engaged in their environment and community through optimal care and support. Retirement services are designed to actively stimulate, encourage and enable active participation; develop, maintain, and increase awareness of time, place, weather, persons, and things in the environment; introduce new leisure pursuits; establish new relationships; improve or maintain flexibility, mobility, and strength; develop and maintain the senses; and to maintain and build on previously learned skills.

Retirement services must be furnished in a way which fosters the independence of each member. Strategies for the delivery of Retirement services must be person centered and person directed to the maximum extent possible and is identified in the plan of care.

When Retirement services are delivered in a provider operated residence (licensed DD group home), staff must meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, to provide supervision, safety and security, and to provide activities to keep the member engaged in their environment.

The personal living space and belongings of individuals living at the provider operated residence (licensed DD group home) must not be utilized by those receiving Retirement services at the residence. Only shared living spaces such as the living room, kitchen, bathroom, and recreational areas may be utilized.

Payments for Retirement services are not made for room and board.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

**Daily** - based on assessment of average hours of support a member needs per day.

			Program Related
S5100	Retirement Services Tier 1	\$11.22/day	\$3.93/day
S5100	Retirement Services Tier 2	\$22.98/day	\$8.04/day
S5100	Retirement Services Tier 3	\$28.89/day	\$10.11/day
S5100	Retirement Services Tier 4	\$40.44/day	\$14.15/day
S5100	Retirement Services Tier 5	\$52.29/day	\$18.30/day
S5100	Retirement Services Tier 6	\$63.91/day	\$22.37/day
S5100	Retirement Services Tier 7	\$75.96/day	\$26.59/day
S5100	Retirement Services Tier 8	\$93.49/day	\$32.72/day
S5100	Retirement Services Tier 9	\$111.65/day	\$39.08/day
S5100	Retirement Services Tier 10	\$130.73/day	\$45.76/day
S5100	Retirement Services Tier 11	\$150.21/day	\$52.57/day
S5100	Retirement Services Tier 12	\$169.84/day	\$59.44/day
S5100	Retirement Services Tier 13	\$195.19/day	\$68.32/day

Program Related may be billed on days that a member plans to attend, but does not attend.

**Hourly** - Congregate groups of employees working in the community that share staff. Based on assessment of average hours of support a member needs per day at or exceeding an average of 8 hours of staff time per day.

			Program Related
S5100	Retirement Services HOURLY	\$26.41/staff hour	\$35% of ave daily hours

Program Related may be billed on days that a member plans to attend, but does not attend.

**SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES**

Specialized Medical Equipment and Supplies include:

Devices, controls or appliances, specified in the plan of care, that enable members to increase their ability to perform activities of daily living; devices, controls or appliances that enable the member to perceive, control or communicate with the environment in which they live; items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; such other durable and non-durable medical equipment not available under the State plan that is necessary to address member functional limitations; and necessary medical supplies not available under State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards or manufacture, design and installation. Specialized Medical Equipment and Supplies purchases require prior approval by the DDP Regional Manager.

The following represents a non-inclusive list of non-permissible Specialized Medical Equipment and Supplies:

1. Specialized Medical Equipment and Supplies provided under this definition are not covered under the Individuals with Disabilities Education Act (IDEA), home-based schooling, or Section 110 of the Rehabilitation Act or available through any other public funding mechanism.
2. Specialized medical equipment or supplies benefiting persons other than the member
3. Room and board
4. Personal items and services not related to the disability
5. Gifts, gift certificates, or gift cards for any purpose
6. Items used solely for entertainment or recreational purposes
7. Personal hygiene items
8. Discretionary cash
9. General clothing, food, or beverages (not specialized diet or clothing)
10. Household furnishings
11. Household cleaning supplies
12. Home maintenance

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

The Department requires all other funding sources be utilized, such as Vocational Rehabilitation, or a denial from other funding sources before this service is entered into the cost plan and approved by the Regional Manager.

T2029	Specialized Medical Equipment	\$ cost varies
T2028	Specialized Medical Supplies	\$ cost varies

**SPEECH THERAPY**

These services will be provided through direct contact between therapist and individual as well as between the therapist and other people providing services to the individual.

Speech therapy services may include:

1. Screening and evaluation of individuals with respect to speech and hearing functions;
2. Comprehensive speech and language evaluations when indicated by screening results;
3. Participation in the continuing interdisciplinary evaluation of individuals for purposes of beginning, monitoring and following up on individualized habilitation programs; and
4. Treatment services as an extension of the evaluation process, which include:
  - Consultation with appropriate people involved with the individual for speech improvement and speech education activities to design specialized programs for developing each individual's communication skills in comprehension, including speech, reading, auditory training, and skills in expression.

Therapists will also provide training to staff and caregivers who work directly with individuals. Speech therapy services under the State Plan are limited. Maintenance therapy is not reimbursable, nor is participation in the interdisciplinary planning process.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

92507	Speech Therapy	Professional \$54.22 hour
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Requires a physician's prescription or referral prior to being added to a member's service plan.

**SUPPORTED EMPLOYMENT – CO-WORKER SUPPORT**

Co-Worker Support allows the DD Program and DD provider agencies to contract with a business to provide co-worker provided job supports as a part of the natural workplace. The supports will be provided directly to the member and may include:

1. the development of positive work-related habits, attitudes, skills,
2. work etiquette directly related to their specific employment,
3. health and safety aspects/requirements of their particular job,
4. assisting the member to become a part of the informal culture of the workplace,
5. job skill maintenance or assistance with incorporating new tasks,
6. facilitation of other supports at the work site such as employer sponsored employee activities beyond job tasks,
7. assistance during breaks and/or lunch.

Members participating in this service are employed by a business and are paid at or above the state's minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. This service differs from Supported Employment – Follow along Support in that it creates opportunity for services/supports to be provided by the local business' employee where the member is employed. Receiving mentoring from a fellow employee increases opportunities for acceptance into and thus success in the workplace community. This service is intended to provide ongoing Co-Worker Support allowing Follow along Support to be decreased.



Members may utilize, Individual and Small Group Employment Support, Follow along Support and Day Supports & Activities in conjunction with Co-Worker Support.

The activities of this service are over and above the obligations an employer has for an employee without a disability, and does not duplicate nor supplant those provided under the provisions of the Individuals with Disabilities Education Improvement Act, or Section 110 of the Rehabilitation Act of 1973, or the Americans with Disabilities Act.

Co-Worker Support and Follow-Along Support cannot be billed for during the same time but could be billed for during the same day.

The Department requires all other funding sources be utilized, such as Vocational Rehabilitation, or a denial from other funding sources before this service is entered into the cost plan and approved by the Regional Manager.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

T2025            Supported Employment – Co Worker Support            \$10.67/day at work

**SUPPORTED EMPLOYMENT – FOLLOW ALONG**

Supported Employment - Follow Along Support consists of services and supports that enable a member who is paid at or above the state’s minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individual's without disabilities to maintain employment in a competitive, customized, or self-employment setting.

Supported Employment – Follow along Support includes habilitation services needed to stabilize and maintain a member in a competitive, customized, or self-employment setting. Examples of stabilization and support may include, but are not limited to, the following situations described below.

1. Job in jeopardy – the member will lose his/her job without additional intervention.
2. Job promotion within same employment setting - it is determined that the new job requires more complex, comprehensive, intensive supports that can be offered under the waiver.

Extended ongoing or intermittent services needed to maintain and support a member in a competitive, customized, or self-employment setting. Outcomes and Actions needed for the member to maintain employment must be identified in the plan of care.

REIMBURSABLE ACTIVITIES: Follow Along Support:

1. Member-centered employment planning with or on behalf of the member supported,
2. Development of skills that will make the member employable for more hours or for additional duties,
3. Job promotion activities,

4. Extended supports allow for time spent at the member's work site: Observation and job support to assist the member to enhance job task skills, and monitoring at the work site to ascertain the success of the job placement,
5. The provision of job coaches who accompany the member for short-term job skill training at the work site to help maintain employment,
6. Regular contact and/or follow-up with the employers, co-workers, member, parents, family members, guardians, advocates or authorized representatives of the member, and other appropriate professionals, in order to reinforce and stabilize the job placement,
7. Facilitation of natural supports at the work site,
8. Individual program development, writing task analyses, monthly reviews, and behavioral intervention programs,
9. Advocating for the member at the employment site (i.e., employers, co-workers, customers) and only for purposes directly related to employment; OR with members not directly affiliated with the employment site (i.e., parents, bus drivers, case managers, school personnel, landlords, etc.) if the member is hired and currently working,
10. Assistance with financial paperwork and management related to the member's employment and/or maintaining Medicaid eligibility (which includes activities such as assisting the waiver participant in submitting pay stubs to the Office of Public Assistance)
11. Assistance with medication administration considered incidental to the Follow along Support.

Behavioral intervention programs, when developed and approved by according to the Positive Behavioral Support rule, may be applied as a component of Follow along Support Services when the plan is specifically designed to be implemented in the employment setting by the follow along staff. The person who developed the plan would train the follow along staff to utilize the interventions to reduce the challenging behaviors in the employment setting.

Members may utilize, Individual and Small Group Employment Support, Co Worker Support and Day Supports & Activities in conjunction with Follow along Support.

A member who is unable to sustain competitive, customized, or self-employment may be considered inappropriately placed and movement to a better-fit employment setting should be considered or the person may need to be referred to, or back to, Vocational Rehabilitation for services and reimbursement, in which case, reimbursement for Supported Employment - Follow Along Support and Vocational Rehabilitation Services will not be allowed concurrently for the same job placement.

**ACTIVITIES NOT REIMBURSABLE: Follow Along Support:**

1. Transportation of a member to and from the job site.
2. Any service that is otherwise available under the Rehabilitation Act of 1973.
3. Activities taking place in a group, (i.e., work crews or enclaves).
4. Public relations activities.
5. Staff continuing education - In-service meetings, department meetings, individual staff development.

6. Incentive payments made to an employer to subsidize the employer's participation in a supported employment program.
7. Payments that are passed through to users of supported employment programs.
8. Payments for vocational training that is not directly related to a member's supported employment program.
9. The job coach is working the job instead of the member (i.e. Member is not present, or training is not occurring).
10. Any activities which are not directly related to the member's career plan.
11. Services furnished to a minor by a parent(s), step-parent(s) or legal guardian.
12. Services furnished to a member by the member's spouse.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore Documentation is required to ensure that the service is not available or is no longer available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

The Department requires all other funding sources be utilized, such as Vocational Rehabilitation, or a denial from other funding sources before this service is entered into the cost plan and approved by the Regional Manager.

**Base** - Members receive up to 10.5 hours of follow along support per month including at least one (1) contact either with the member or employer per month regarding their employment.

H2025            Supported Employment Follow Along – BASE                            \$407.61/month

**Tier 1** - Members receive between 10.6 to 21.9 hours of follow along support per month with at least 2 face-to-face contacts per month during the hours provided. A **face-to-face contact** involves direct observation and communication with the member for the purpose of implementing their personal supports plan / individual career plan. This is a monthly billing unit.

H2025            Supported Employment Follow Along – TIER 1                            \$815.22/month

**Tier 2** - Members receive between 22 to 31.9 hours of follow along support per month with at least 4 face-to-face contacts per month during the hours provided. A **face-to-face contact** involves direct observation and communication with the member for the purpose of implementing their personal supports plan / individual career plan. This is a monthly billing unit.

H2025            Supported Employment Follow Along – TIER 2                            \$1,203.42/month

**Hourly** – Members who require in excess of 32 hours per month of follow along support have levels of support based upon the assessment(s) of needs and are hourly. Hourly can

also be applied in any situation where monthly units would be cost prohibitive, and hourly should be applied for all self-direct employer authority.

H2025            Supported Employment Follow Along hourly            \$38.82/staff hour

**SUPPORTED EMPLOYMENT – INDIVIDUAL EMPLOYMENT SUPPORT**

Individual Employment Support consists of habilitation services and staff supports needed by a person to acquire a job/position or career advancement in the general workforce at or above the state’s minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Supported Employment - Individual Employment Support is delivered in a competitive, customized, or self-employment setting.

The outcome of this service is paid employment in a competitive, customized, or self-employment setting within the general workforce that meets personal and career goals, as documented in the plan of care. Supported Employment –Individual Employment Support services are person-centered to address the person’s employment needs and interests.

**REIMBURSABLE ACTIVITIES: Individual Employment Support:**

1. Person-centered employment planning (assisting an individual in identifying wants and needs for supports and in developing a plan for achieving integrated employment),
2. Job development,
3. Negotiation with prospective employers,
4. Job carving,
5. Job placement,
6. Career advancement activities,
7. Job analysis,
8. Training, support, coordination and communication in related skills needed to obtain and retain employment such as using community resources and public transportation,
9. Job coaching,
10. Job loss - the person may need to be referred to, or back to, Vocational Rehabilitation for services and reimbursement, in which case, concurrent reimbursement for Supported Employment – Individual Employment Support and Vocational Rehabilitation Services will not be allowed,
11. Benefits planning support,

Members may utilize, Small Group Employment Support, Follow Along Support, Co Worker Support, and Day Supports & Activities in conjunction with Individual Employment Support.

**ACTIVITIES NOT REIMBURSABLE: Individual Employment Support:**

1. Ongoing transportation of a member to and from the job site once the person has been hired.
2. Any service that is otherwise available under the Rehabilitation Act of 1973.

3. Employment activities taking place in a group, i.e., work crews or enclaves.
4. Public relations activities.
5. Staff continuing education - In-service meetings, department meetings, individual staff development.
6. Incentive payments made to an employer to subsidize the employer's participation in a supported employment program.
7. Payments that are passed through to users of supported employment programs.
8. Payments for vocational training that is not directly related to a member's supported employment program.
9. Any other activities that are non-member specific, i.e., the member has the job and can't work their scheduled hours so the job coach is working the job instead of the member.
10. Any activities which are not directly related to the member's career plan.
11. Services furnished to a minor by a parent(s), step-parent(s) or legal guardian.
12. Services furnished to a member by the member's spouse.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore Documentation is required to ensure that the service is not available or is no longer available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

Income from customized home-based businesses may not be commensurate with minimum wage requirements with other employment.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

The Department requires all other funding sources be utilized, such as Vocational Rehabilitation, or a denial from other funding sources before this service is entered into the cost plan and approved by the Regional Manager.

H2023            Supported Employment – Individual Employment Support \$38.82/staff hour

**SUPPORTED EMPLOYMENT – SMALL GROUP EMPLOYMENT SUPPORT**

Supported Employment - Small Group Employment Support consists of habilitation services and staff supports needed for groups of two (2) to eight (8) workers with disabilities to maintain a job/position in the general workforce at or above the state's minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small Group Employment examples include enclaves, mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Small Group Employment Support

must be provided in a manner that promotes integration into the workplace and interaction between people with and without disabilities in those workplaces. Work occurs in business settings and hours typical for the industry.

**REIMBURSABLE ACTIVITIES: Small Group Employment Support:**

1. Person-centered employment planning with or on behalf of the member supported,
2. Job development,
3. Negotiation with prospective employers,
4. Job carving,
5. Job placement,
6. Job analysis,
7. Training and support in related skills needed to obtain and retain employment such as using community resources and public transportation,
8. Job coaching,
9. Benefits planning support,
10. Job promotion support,
11. Career advancement support.

People may utilize Individual Employment Support, Co Worker Support and Day Supports & Activities in conjunction with Small Group Employment Support.

**ACTIVITIES NOT REIMBURSABLE: Small Group Employment Support**

1. Transportation of a person to and from the job site.
2. Any service that is otherwise available under the Rehabilitation Act of 1973.
3. Public relations activities.
4. Staff continuing education - In-service meetings, department meetings, individual staff development.
5. Incentive payments made to an employer to subsidize the employer's participation in a supported employment program.
6. Payments that are passed through to members of supported employment programs.
7. Payments for vocational training that is not directly related to a member's supported employment program.
8. Any activities which are not directly related to the member's career plan.
9. Services furnished to a minor by a parent(s), step-parent(s) or legal guardian.
10. Services furnished to a member by the member's spouse.

Total hours for a member's attendance shall not include time spent during transporting to/from the member's residence.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore Documentation is required to ensure that the service is not available or is no longer available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

The Department requires all other funding sources be utilized, such as Vocational Rehabilitation, or a denial from other funding sources before this service is entered into the cost plan and approved by the Regional Manager.

Daily - based on assessment of average hours of support a member needs per day.

			Program Related
T2019	Supported Employment Small Group Tier 1	\$11.22/day	\$3.93/day
T2019	Supported Employment Small Group Tier 2	\$22.98/day	\$8.04/day
T2019	Supported Employment Small Group Tier 3	\$28.89/day	\$10.11/day
T2019	Supported Employment Small Group Tier 4	\$40.44/day	\$14.15/day
T2019	Supported Employment Small Group Tier 5	\$52.29/day	\$18.30/day
T2019	Supported Employment Small Group Tier 6	\$63.91/day	\$22.37/day
T2019	Supported Employment Small Group Tier 7	\$75.96/day	\$26.59/day
T2019	Supported Employment Small Group Tier 8	\$93.49/day	\$32.72/day
T2019	Supported Employment Small Group Tier 9	\$111.65/day	\$39.08/day
T2019	Supported Employment Small Group Tier 10	\$130.73/day	\$45.76/day
T2019	Supported Employment Small Group Tier 11	\$150.21/day	\$52.57/day
T2019	Supported Employment Small Group Tier 12	\$169.84/day	\$59.44/day
T2019	Supported Employment Small Group Tier 13	\$195.19/day	\$68.32/day

Program Related may be billed on days that a member plans to attend, but does not attend.

Hourly - Congregate groups of employees working in the community that share staff. Assignment of Tiers are based on assessment of average hours of support a member needs per day at or exceeding an average of 8 hours of staff time per day.

			Program Related
T2019	Supported Employment Small Group Hourly	\$26.41/staff hour	\$35% of ave daily hours

Program Related may be billed on days that a member plans to attend, but does not attend.

### **SUPPORTS BROKERAGE**

Support Brokerage Service assists the member (or the member's family, or representative, as appropriate) in arranging for, directing and managing self-directed services. Serving as the agent of the member or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and members to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring workers, managing workers and providing information on effective communication and problem-solving. The service includes providing information to ensure that members understand the responsibilities involved with directing their services. The extent of the assistance furnished to the member or family is specified in the plan of care.

As discussed in the instructions for Appendix E (Participant Direction of Services), the scope and nature of this service hinges on the type and nature of the opportunities for participant direction afforded by the waiver. Through this service, information may be provided to the member about:

- \* Person centered planning and how it is applied;
  - \* The range and scope of member choices and options;
  - \* The process for changing the plan of care and member's budget;
  - \* The grievance process;
  - \* Risks and responsibilities of self-direction;
  - \* Freedom of choice of providers;
  - \* Member rights;
  - \* The reassessment and review schedules; and,
  - \* Such other subjects pertinent to the member and/or family in managing and directing services.
- Assistance may be provided to the member with:
- \* defining goals, needs and preferences, identifying and accessing services, supports and resources;
  - \* Practical skills training (e.g., hiring, managing and terminating workers, problem solving, conflict resolution)
  - \* Development of risk management agreements;
  - \* Development of an emergency backup plan;
  - \* recognizing and reporting critical events;
  - \* Independent advocacy, to assist in filing grievances and complaints when necessary; and,
  - \* Other areas related to managing services and supports.

This service may include the performance of activities that nominally overlap the provision of case management services. Where the possibility of duplicate provision of services exists, the person's plan of care should clearly delineate responsibilities for the performance activities. This service is capped annually at \$6,000 or 20% of value of the member's cost plan, whichever is smaller. These values can be exceeded for a limited time period in extraordinary circumstances, with the prior approval of the DDP Bureau Chief or designee.

This service is limited to members who direct some or all of their waiver services with employer authority.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

T2041	Supports Broker	\$29.97/staff hour
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**TRANSPORTATION**

Service offered in order to enable members served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the plan of



care. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Legally responsible persons, relatives, legal guardians and other persons who are not employees of agencies with a DDP contract may be reimbursed for the provision of rides. In these cases, reimbursement will be less than or equal to the mileage rate set by the Department for a State employee operating a personal vehicle. The mileage rate is based on the operational expense of a motor vehicle and does not include reimbursement for work performed, or the driver's time. Reimbursement for rides provided by legally responsible persons or others must be related to the specific disability needs of a member, as outlined in the plan of care. Persons providing transportation must be licensed, insured and drive a registered vehicle, in accordance with the motor vehicle laws of the State of Montana.

Reimbursable transportation expenses may also include assistance with reasonable (as determined by the department) costs related to one or more of the following areas: operator training and licensure, insurance, registration or other costs associated with an individual's dependence on the use of a personal vehicle owned by the person in accessing work or other community integration activities as outlined in the plan of care.

Transportation as a self-directed services with employer authority (either common law or agency with choice):

Mileage reimbursement at the lowest current state plan rate is available when the member is transported to an approved community functions, in accordance with the plan of care and the individual cost plan. Mileage reimbursement paid by the FMS is contingent upon the FMS receiving documentation that transportation was provided in accordance with Montana state requirements for operating a motor vehicle. Reimbursement is contingent upon vehicles being registered and insured, and the operator of the vehicle must have a valid driver's license. Mileage reimbursement does not pay for a person's time, rather, the mileage reimbursement partially offsets the cost of operating a motor vehicle. Mileage reimbursement may also be available to the owner of the vehicle when friends and non-employees provide transportation services to the member for approved community functions, when all the requirements for operating a motor vehicle have been met, and the mileage reimbursement provision is approved in the plan of care. Mileage reimbursement is not available for medically necessary transportation reimbursable under the state plan.

Rates for services in residential settings and work/day settings in which paid, on-site primary care givers provide routine, non-medically necessary transportation (community outings, picnics, etc.) may include cost of these integrated transportation services.

The following are excluded:

- 1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the member;
- 2) Purchase or lease of a vehicle; and

3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of any modifications.

Transportation services are not reimbursable in residential and work/day settings, if the transportation service is folded into the rates for these residential and/or work/day settings. Under no circumstances will medically necessary transportation (transportation to medical services reimbursed under the State Plan) be reimbursed under the waiver if the service is reimbursable under State Plan transportation.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

T2002	Transportation – Individual Commute	cost varies per month
T2002	Transportation – Individual Commute (wheelchair van)	cost varies per month
T2002	Transportation – Shared Commute	cost varies per month
T2002	Transportation – Shared Commute (wheelchair van)	cost varies per month
T2003	Transportation – Work/Day Integration 12 max units/yr	\$11.93 per ride/trip
T2003	Transportation – Work/Day Integration (wheelchair van) 12/yr	\$14.32 per ride/trip
T2003	Transportation – Residential Integration	\$38.79 per unit
T2003	Transportation – Residential Integration (wheelchair van)	\$46.54 per unit
T2004	Transportation OTHER (taxi, bus pass,)	cost varies
S0215	Transportation Mileage Reimbursement	\$.39 per mile

**ALL SELF DIRECTED WAIVER SERVICES**

For all waiver services that are delivered through one of the self-directed service option, you will bill the regular code shown above for each specific waiver service. Additionally, make sure that the **Modifier SC** is entered on the claim so the claim will pay correctly. This does not apply to the Acumen fiscal agent fees below.

**FISCAL AGENT FEES FOR SELF DIRECT**

The fiscal agent is a private or public entity that is approved by the IRS (under IRS Revenue Procedure 70-6) to act as the employer’s intermediary for the purpose of managing employment taxes, including income tax withholding, FICA, FUTA/SUTA, and worker’s compensation. The fiscal agent collects employment documents and verifies signatures from employers prior to distributing paychecks to the employees.

The fiscal agent fees should cover the FMS costs of issuing reimbursements, cost of employee background checks, monthly List of Excluded Individuals and Entities.(LEIE) and Medicare Exclusion Database (MED) monitoring, monitor and maintain records of employee qualifications, instruction on methods of interviewing, selecting and hiring staff, legal requirements for retaining and discharging staff according to Montana laws and rules, methods of staff supervision, and such other topics as are required in the opinion of the contractor to assist individuals to effectively self-direct their services.

T2040	Enrollment (for families new to self-direct services)	\$150.00 (one-time fee)
T2040	Per Member Per Month	\$62.00/month

T2040	New Employee Hire	\$50.00 per employee
T2040	Monthly Check Transaction Fee:	
	<ul style="list-style-type: none"> <li>• 0 – 2 checks \$0.00 (included in the Per Member Per Month)</li> <li>• 3-5 checks \$50.00 (in addition to the \$62.00 Per Member Per Month)</li> <li>• 6+ checks \$100.00 (in addition to the \$62.00 Per Member Per Month)</li> </ul>	
T2040	Vendor Only enrollment	\$30.00 (one-time fee)
T2040	Vendor Only check transaction fee	\$24.00 per check

### **ALL TEMPORARY SERVICE INCREASES (TSI)**

For all waiver services that are designated as a TSI, you will bill the regular code shown above for each specific service. Additionally, make sure the **Modifier TU** is entered on the claim so the claim will pay correctly.

### **PROVIDER RESPONSIBILITIES SPECIFIC TO WAIVERS**

Providers must understand the service definitions in the waiver and parameters for each service that is authorized. It's the Provider's responsibility to contact the case manager in the event there is a discrepancy in the service(s) authorized or rendered and the approved service authorization. It's the provider's responsibility to check a member's Medicaid eligibility and to obtain an appropriate denial for services that may be covered by other revenue streams. A denial must be related to the service not being covered, and not related to the claims process. For example, a denial that *a provider did not submit the required documentation* would not be considered an appropriate denial.

#### **Individual Cost Plans**

All waiver services require prior authorization before the service is delivered. The member's Case Manager is responsible for completing the Plan of Care. Based on Actions identified in the Plan of Care, the Case Manager will enter the service details, units, provider, and date spans in the ICP where it will be stored as a Service Authorization. Claims will deny if there is not an active service authorization associated with the claim, or if a code other than the approved code is billed. Providers should not render or bill services without an approved service authorization.

**The Service Authorization serves as the official authorization for service delivery and reimbursement.**

### **BILLING PROCEDURES:**

The Department is committed to paying Medicaid providers claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were billed appropriately. Although the computerized system can detect and deny some erroneous claims, there are many

erroneous claims which it cannot detect. Therefore, payment of a claim does not mean the service was correctly billed or the payment made to the provider was correct. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in another way, the Department is required by Federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of the Department or provider error or other cause. (MCA 53-6-111, ARM 37.85.406)

A provider shall use the Department's designated claims processing system to submit claims. Services provided must be billed electronically or on a CMS-1500 claim form. CMS claim forms are available from various publishing companies and are not available from the Department or Provider Relations. For more information on submitting a claim, see the *Billing Procedures chapter in the General Information for Providers* manual on the Montana Medicaid provider website. Additionally, see the *General Information for Providers* for information on remittance advices and adjustments.

Also:

- Do not bill for services before they are provided.
- If a unit of service equals 15 minutes, a minimum of 8 minutes of service must be provided to bill for one unit. Partial units totaling less than eight minutes may not be billed. Activities requiring less than eight minutes for each member may be accrued to the end of that day. A range of 8-23 minutes is 1 unit.
- Claims for daily or hourly units may be submitted daily, weekly, or less frequently.
- Payments are issued on a weekly basis according to the MMIS payment schedule.
- Enter the modifier **TU** for all Temporary Service Increase (TSI) claims.
- Enter the modifier **SC** for all Self Direct claims.

#### *CLAIM REMINDERS AND TIPS*

When billing Medicaid waiver claims, the provider must consider the following:

- The waiver does not reimburse directly any time spent by office staff billing claims or staff travel time when a member is not in the vehicle.
- Providers may only bill for services authorized in the service authorization(s).
- A claim may include different dates of service.
- The units of service reimbursed through the waiver must meet documentation requirements in rule, federal code, and within the waiver.
- Services billed must meet the service definitions and parameters as described in the waiver, rule, or federal code.
- When a claim is submitted for payment, the provider is verifying the claim is true, correct, and accurate.
- Updated billing information may be provided through provider bulletins and other methods. Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in the notices.

#### **BILLING FOR RETROACTIVELY ELIGIBLE MEMBERS**

When a member becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible members, attach a copy of the 160-M to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

When a provider chooses to accept the member from the date retroactive eligibility was effective, and the member has made a full or partial payment for services, the provider must refund the member's payment for the services before billing Medicaid for the services.

For more information on retroactive eligibility, see the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

### **MEMBERS WITH OTHER INSURANCE OR REVENUE OPTIONS:**

If a member is also covered by Medicaid State plan, EPSDT, Vocational Rehabilitation, or other insurance or funding streams then those avenues must be exhausted first before utilizing waiver services or billing the DD waiver. If those other revenue streams are an option, only bill the Developmental Disabilities Waiver after denial is received from the other payer(s), or when there is documentation that the billable units from the other payer(s) have been depleted.

### **MEDICAID FEE SCHEDULE:**

Please use the Department's fee schedule for your provider type in conjunction with the appropriate procedure code, using the pricing method associated with the procedure code such as per hour, per day, per month, etc. Current fee schedules are available on the Medicaid Provider and on the DDP websites. The agency contracting with the Developmental Disabilities Program (the "Contractor") shall assume responsibility for all services provided by their staff or subcontractors. Per the Medicaid Agreement, all claims are considered to be paid in full.

When Medicaid payment differs from the fee schedule, consider the following:

The Department pays the lower of the established Medicaid fee or the provider's charge  
Modifiers

Provider Type

Date of Service

Check for TPL payments shown on the remittance advice

### **DOCUMENTATION**

Documentation of the delivery of service must be maintained to substantiate claims. The provider's documentation must support the claim, including the type, scope, amount, duration, and frequency of the service as described in the Plan of Care. It should include the date(s), start and end times, and number of units of the delivered service for each member and must align with the prior authorization received for the provision of services. Per the waiver, there may be a need to have documentation that the service is not available or is no longer available under other

funding sources. Additionally, for certain services there may be a need to document face-to-face contacts.

- Records must be clear, concise, complete, and current.
- Information must be factual and absent of any fabricated or falsified names, dates, data or narratives. Entries should contain objective information relevant to individual care.
- Information and documents must be organized in a systematic and chronological format.
- Information must be written in ink, recorded in a typed/printed format, or in an electronic file with appropriate back-up.
- Correction fluid, correction tape or similar applications may not be used to correct errors in the record.
- Errors are to be corrected by marking through the incorrect entry with a single line and recording the date and initials of the person correcting the entry.
- Information must be legible.
- Information must be dated, signed, and have the title of the person recording each entry. Initials can be appropriate for entries such as flow sheets or medication records, but a full signature should be used for entries such as narratives or assessments.
- Information entered into the record must be recorded in a timely manner, as soon as possible following the completion of the event or activity described by the entry.
- Providers must maintain original (e.g., paper or electronic) documents for the services provided by their employed staff.
- Providers must maintain copies of required documentation obtained from contracted staff and other providers/contractors.

## KEY CONTACTS

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated “In state” will not work outside Montana. [For a comprehensive list of contacts and websites, go to: https://medicaidprovider.mt.gov/ .](https://medicaidprovider.mt.gov/)

## Provider Relations

[For questions about eligibility, payments, denials, general claims questions, Medicaid or PASSPORT provider enrollment, address or phone number changes, or to request provider manuals or fee schedules, go to https://medicaidprovider.mt.gov/ or:](https://medicaidprovider.mt.gov/)

**(800) 624-3958**  
**(406) 442-1837** (Helena/Local)

Send written inquiries to:

Montana Provider Relations Unit  
P.O. Box 4936  
Helena, MT 59604

## **Claims**

Send paper claims to:

Claims Processing Unit  
P. O. Box 8000  
Helena, MT 59604

## **Member Eligibility**

For information on a member's eligibility for services through the Developmental Disabilities Program, access the [Eligibility Reference Manual at: https://dphhs.mt.gov/dsd/developmentaldisabilities](https://dphhs.mt.gov/dsd/developmentaldisabilities)

Eligibility Specialist  
Developmental Disabilities Program  
111 Sanders Rom 305  
PO Box 4210  
Helena MT 59604

(406) 444-5930 phone  
(406) 444-0230 fax

[For information on a Member's Medicaid Eligibility go to https://medicaidprovider.mt.gov](https://medicaidprovider.mt.gov) .

## **Third Party Liability**

For questions about private insurance, Medicare or other third-party liability:

**(800) 624-3958** In state  
**(406) 443-1365** Out of state and Helena  
**(406) 442-0357** Fax

Send written inquiries to:

Third Party Liability Unit  
P. O. Box 5838  
Helena, MT 59604

## **Secretary of State of Montana**

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

**(406) 444-2055** Phone

Secretary of State of Montana  
P.O. Box 202801  
Helena, MT 59620-2801

## **Medicaid Fraud**

Medicaid Provider Fraud – when a provider knowingly makes or causes to be made, a false or misleading statement or representation for use in obtaining reimbursement from the Medicaid Program. To report Medicaid provider fraud:

Medicaid Fraud Control Unit (MFCU)  
Montana Department of Justice  
Division of Criminal Investigations  
(800) 376-1115

Member/Client Fraud – intentional deception or misrepresentation with knowledge the deception could result in some unauthorized benefits to the individual or some other person. To report Medicaid member/client fraud:

Department of Health and Human Services  
Fraud Hotline  
(800)201-6308