# Table of Contents

**State/Territory Name: Montana**

**State Plan Amendment (SPA) #: 17-0034**

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294

REGION VIII - DENVER

March 1, 2018

Marie Matthews, Medicaid & CHIP Director
Montana Department of Public Health & Human Services
P.O. Box 4210
Helena, MT 59604

Re: SPA MT-17-0034

Dear Ms. Matthews:

We have approved the State Plan Amendment (SPA) submitted under transmittal number MT-17-0034. The amendment implements a statewide 2.99% rate reduction for Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Please be informed that this State Plan Amendment was approved February 28, 2018, with an effective date of January 1, 2018. We are enclosing the summary page and the amended plan page(s).

The State assures that the change in reimbursement for EPSDT services is not expected to have an effect on access to care for Medicaid beneficiaries. The State did not receive public comments specific to the reimbursement reduction to EPSDT services, and the State provided evidence from analysis reflected in a revised Addendum to Montana Medicaid 2016 Access Monitoring Plan that revealed consistent beneficiary utilization and provider enrollment. Based on this information, CMS infers that the amendment does not affect consistency with the access to care requirements described in §1902(a)(30)(A) of the Social Security Act. While this SPA results in an overall decrease in State expenditures for EPSDT Services, it was determined to be a nominal change in overall reimbursement as described in State Medicaid Director Letter (SMDL) #17-004.

In order to track expenditures associated with this amendment, Montana should follow the CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual (SMM).

For those individuals whose expenditures qualify for the newly eligible federal medical assistance percentage, report on the Form CMS-64.9 VIII and those not enrolled in the new adult group, claims should be reported on the Form CMS-64.9.

For EPSDT Services, the expenditures should be reported on: Line 15 – EPSDT Screening.

If you have any questions regarding this SPA please contact Barbara Prehmus at (303) 844-7472.

Sincerely,

Richard C. Allen
Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: Sheila Hogan, Department Director
Mary Eve Kulawik

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 17-0034

2. STATE: Montana

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
1/01/2018

5. TYPE OF PLAN MATERIAL *(Check One)*:
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440
42 CFR 447.203
1902(a)(30)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:

**4.b Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services**

| | | |
|---|---|---|
| FFY 18 | (9 months) | (1,295,359) |
| FFY 19 | (12 months) | (1,775,437) |
| FFY 20 | (3 months) | (443,859) |

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19B, EPSDT, Pages 1-12 of 12

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19B, EPSDT, Pages 1 to 12 of 12

10. SUBJECT OF AMENDMENT:

The EPSDT reimbursement Attachment 4.19B pages are being amended to update the date of the fee schedule for EPSDT state plan services effective January 1, 2018.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Single Agency Director Review

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Marie Mathews

14. TITLE: **State Medicaid Director**

15. DATE SUBMITTED: 2-23-18

16. RETURN TO:
**Montana Dept. of Public Health and Human Services**
**Marie Mathews**
**State Medicaid Director**
**Attn: Mary Eve Kulawik**
**PO Box 4210**
**Helena, MT 59604**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 28, 2017

18. DATE APPROVED: February 28, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Richard C. Allen

22. TITLE: ARA, DMCHO

23. REMARKS:

MONTANA

I. The Department will reimburse Medicaid providers for EPSDT services the lower of:

   A. The provider's usual and customary (billed) charge for the service;

   B. The Department's fee schedule published on the agency's website at http://medicaidprovider.mt.gov. The rate for each EPSDT service is a set fee per unit of service. Unless otherwise specified in this state plan, reimbursement rates are the same for governmental and non-governmental providers. The reimbursement rates on the fee schedules are provided in accordance with the methodology described in this state plan.

      The Department's fee schedule rates were set as of January 1, 2018, and are effective for services provided on or after that date. January 1, 2018, providers of EPSDT services received a 2.99% rate decrease.

II. In accordance with the Social Security Act, the Department provides medically necessary EPSDT services. When the Department has not established a fee schedule for a service required by an individual covered under EPSDT, a rate is negotiated with the provider. This rate is set at a comparable rate to a service similar in scope.

III. The Department's fee schedule for all EPSDT rehabilitative services is determined as follows:

   A. Rate-Setting Method:

   Montana has a prospective Medicaid rate-setting method that was developed to reflect service definitions, provider requirements, operational service delivery, and administrative considerations. Each rate is calculated on a unit basis and set at an amount based on estimated reasonable and efficient cost at a certain point in time. Increases after that point in time calculation are based on legislative appropriations.

Montana

B. Rate Components

The calculation separates out direct service components from indirect program components and overhead expenses essential to administer the service and program. In some rates individual, family, and group therapies, along with community-based psychiatric and support services (CBPRS) are costed independently and then added into the unit rate as a direct service expenditure. The following elements are used to determine the rate, based on estimated reasonable costs, at a certain point in time, as applicable to each service:

1. *Direct Service Expenditures*

   - Direct staff wages
   - Employee benefit costs
   - Direct supervision
   - On-call differential for services that require 24-hour per day, 7-day a week on call for crisis intervention and response.
   - Program support costs
   - Mileage allowance. Mileage is only applicable to community services that require travel to a member's home.

2. *Administrative Overhead / Indirect Costs*

3. *Auxiliary Operational Expenditures*

4. *Productivity or Billable Time.* The productivity adjustment factor accounts for the amount of non-billable time spent by staff.

5. *Calculation Adjustors*
   - Medicaid Offsets. Offsets are accounted for when providers receive other revenues in relation to the service. (e.g., direct care wage).
   - CPI adjustment. A CPI adjustment is used to adjust economic series or surveys for price changes and to translate these series into inflation adjusted dollars at time of calculations.
   - Other inflationary adjustments. Inflationary adjustments are allowed for legislative provider rate changes, other legislative adjustments, or changes in service scope from year to year.
   - Policy adjustor. A policy adjustor may be applied to increase or decrease rates when the Department determines that relative adjustments to specific rates are appropriate to meet Medicaid policy goals and appropriated budgets.

MONTANA

Comprehensive School and Community Treatment rate setting takes into account additional factors not shared with other EPSDT rehabilitation bundles.

- *School personnel costs*. Related to time spent on activities by teachers and counselors. This item is self-reported by schools.
- *School direct program costs*: Represent an allocation of costs for services like copying, telephones, internet, electronic records, transportation if applicable, meeting expenses, equipment, supplies and other related expenditures. Category is exclusive of those costs incurred by contract provider.
- *School auxiliary operational expenditures*: Building (operational) and related expenses as related to program. Expenses for building rental and maintenance, insurance, equipment leasing, utility expenses, and other related capital costs. Self-reported by schools.
- *School indirect administrative costs*: School indirect costs include central office allocations, principal, business office, secretary and other overhead costs. This category also includes indirect costs for billing and record keeping as the school is responsible for these activities.

The described payment for comprehensive school-based services will end on December 31, 2019.

C. Bundle-specific rate setting.

EPSDT Rehabilitative services include the following components, as noted in the Supplements to Attachments 3.1A and 3.1B and are calculated in the units as noted. CBPRS is included in this table but is not a bundle. CBPRS is the sole unbundled service whose rate calculation is part of this State Plan Amendment. All other unbundled EPSDT rehabilitative services are covered by other state plans or their rates are included in the State's Resource Based Relative Value System (RBRVS).

The state will review utilization of services every two years. If utilization falls significantly, the state will review bundled rates for sufficiency to ensure beneficiaries receive the types, quantity and intensity of services required to meet their medical needs. Room and board costs are excluded from all rates.

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| Name of Service | Service Bundle Includes: | Rate Components Include: | Unit |
|---|---|---|---|
| Community-Based Psychiatric Rehabilitation and Support (CBPRS) | Not a bundle but included here because its rate setting methodology is not included elsewhere. | • Direct staff wages<br>• Employee benefit costs<br>• Direct supervision<br>• Program support costs<br>• Mileage allowance<br>• Administrative overhead/Indirect costs<br>• Auxiliary Operational Expenditures<br>• Productivity adjustment factor<br>• Medicaid offsets<br>• CPI adjustment<br>• Other inflationary adjustments<br>• Policy adjustor | Per 15-minutes |
| Comprehensive School and Community Treatment (CSCT) | • Individual Therapy<br>• Group Therapy<br>• Family Therapy<br>• CBPRS | • Direct staff wages<br>• Employee benefit costs<br>• Direct supervision<br>• Program support costs<br>• Administrative overhead/Indirect costs<br>• Productivity adjustment factor<br>• Medicaid offsets<br>• CPI adjustment<br>• Other inflationary adjustments<br>• Policy adjustor<br>• School personnel<br>• School direct program costs<br>• School Auxiliary Operational Expenditures<br>• School indirect administrative costs | Per 15 minutes |

MONTANA

| **Name of Service** | **Service Bundle Includes:** | **Rate Components Include:** | **Unit** |
|---|---|---|---|
| Therapeutic Group Home (TGH) | • Individual Therapy<br>• Group Therapy<br>• Family Therapy<br>• CBPRS<br><br>Within a TGH, additional CBPRS may be provided as a prior-authorized add-on service. This service is referred to as Extraordinary Needs Aide (ENA). | • Direct staff wages<br>• Employee benefit costs<br>• Direct supervision<br>• Program support costs<br>• Administrative overhead/Indirect costs<br>• Auxiliary Operational Expenditures<br>• Medicaid offsets<br>• CPI adjustment<br>• Other inflationary adjustments<br>• Policy adjustor | Per diem (TGH)<br><br>Per 15 minutes (CBPRS) |
| Home Support Services | • Functional assessment<br>• Crisis Services<br>• Family Support Services | • Direct staff wages<br>• Employee benefit costs<br>• Direct supervision<br>• On-call differential (crisis services)<br>• Program support costs<br>• Mileage allowance<br>• Administrative overhead/Indirect costs<br>• Auxiliary Operational Expenditures<br>• Productivity adjustment factor<br>• Medicaid offsets<br>• CPI adjustment<br>• Other inflationary adjustments<br>• Policy adjustor | Per diem |

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| **Name of Service** | **Service Bundle Includes:** | **Rate Components Include:** | **Unit** |
|---|---|---|---|
| Therapeutic Foster Care (TFC) | • Functional assessment<br>• Crisis Services<br>• Family Support Services | • Direct staff wages<br>• Employee benefit costs<br>• Direct supervision<br>• On-call differential (crisis services)<br>• Program support costs<br>• Mileage allowance<br>• Administrative overhead/Indirect costs<br>• Auxiliary Operational Expenditures<br>• Productivity adjustment factor<br>• Medicaid offsets<br>• CPI adjustment<br>• Other inflationary adjustments<br>• Policy adjustor | Per diem |
| Therapeutic Foster Care Permanency (TFC-P) | • Functional assessment<br>• Crisis Services<br>• Family Support Services<br>• Individual Therapy<br>• Group Therapy<br>• Family Therapy<br>• CBPRS | • Direct staff wages<br>• Employee benefit costs<br>• Direct supervision<br>• On-call differential (crisis services)<br>• Program support costs<br>• Mileage allowance<br>• Administrative overhead/ Indirect costs<br>• Auxiliary Operational Expenditures<br>• Productivity adjustment factor<br>• Medicaid offsets<br>• CPI adjustment<br>• Other inflationary adjustments<br>• Policy adjustor | Per diem |

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| **Name of Service** | **Service Bundle Includes:** | **Rate Components Include:** | **Unit** |
|---|---|---|---|
| Youth Day Treatment Services | • Individual Therapy<br>• Group Therapy<br>• Family Therapy<br>• CBPRS | • Direct staff wages<br>• Employee benefit costs<br>• Direct supervision<br>• Program support costs<br>• Administrative overhead/ Indirect costs<br>• Auxiliary Operational Expenditures<br>• Productivity adjustment factor<br>• Medicaid offsets<br>• CPI adjustment<br>• Other inflationary adjustments<br>• Policy adjustor | Per hour |

D. Rate Notes and Formula

1. Community-Based Psychiatric Rehabilitation and Support (CBPRS) services are the only unbundled EPSDT rehabilitative service whose rate calculation is part of this State Plan Amendment. All other unbundled EPSDT rehabilitative services are covered by other state plans or their rates are included in the State's Resource Based Relative Value System (RBRVS).

   Group therapy for Community-Based Psychiatric Rehabilitation and Support (CBPRS) has a maximum staff to member ratio of one to four. The rate for CBPRS group therapy is set at 30% of the individual rate.

   There is a separate rate for Community-Based Psychiatric Rehabilitation and Support (CBPRS) when CBPRS is provided within a Therapeutic Group Home (TGH). The separate rate calculation for CBPRS provided within a TGH excludes the mileage component.

   CBPRS Rate = ((((Hourly Provider Direct Costs + Hourly Provider Indirect Costs and Auxiliary Operational Expenditures) ÷ (Productivity Adjustment Factor or Billable Hours) x Calculation Adjustors)) ÷ 4 to convert to 15 minute unit)

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2. Therapeutic Group Home (TGH)

In the Therapeutic Group Home rate calculation, licensed therapies and non-licensed observations and supports are separate components of the rate. Room and board, educational components, and other non-allowable facility costs are excluded from the per diem Therapeutic Group Home rate.

For Auxiliary Operational Expenditures, only a designated dollar amount or percentage of the facility and equipment that is devoted to treatment and programming is included in the bundled rate (e.g. therapist office space, individual treatment or therapy rooms, and family or group treatment or therapy rooms).

In lieu of a productivity or billable time percentage, the Therapeutic Group Home rate calculation uses actual units of service or occupied bed days. The number of occupied bed days is used to allocate costs into a daily service unit. At time of calculation, the representative or current state fiscal year bed days or units is used to allocate expenditures into a daily unit rate.

TGH Rate = (((Provider Direct Costs + Provider Indirect Costs and Auxiliary Operational Expenditures) ÷ Medicaid Bed Days or Units of Service) x Calculation Adjustors)

3. Home Support Services (HSS)

HSS Rate = (((Hourly Provider Direct Costs + Hourly Provider Indirect Costs and Auxiliary Operational Expenditures) ÷ (Productivity Adjustment Factor or Billable Hours) x Productive FTE Hours) ÷ Daily Units) x Calculation Adjustors)

4. Therapeutic Foster Care (TFC)

TFC Rate = (((Hourly Provider Direct Costs + Hourly Provider Indirect Costs and Auxiliary Operational Expenditures) ÷ (Productivity Adjustment Factor or Billable Hours) x Productive FTE Hours) ÷ Daily Units) x Calculation Adjustors)

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5. Therapeutic Foster Care Permanency (TFC-P)

A minimum of ten hours per week of community-based psychiatric and supports (CBPRS) is required for each member under Therapeutic Foster Care Permanency (TFC-P). Community-based psychiatric and supports (CBPRS) is reimbursed per 15-minute increment on the basis of a separate departmental fee schedule rate. The estimated average service time for behavioral aide services per member, is multiplied by the current fee schedule rate for CBPRS. This amount is then added into direct service costs for the TFC-P daily rate.

The Therapeutic Foster Care Permanency (TFC-P) bundled rate includes individual, family, and group therapy services. The estimated average number of services necessary for individual, family, and group therapies per member is multiplied by the current rate schedule under RBRVS methodology. This component is then added into direct service costs for the TFC-P daily rate.

TFC-P Rate = (((Hourly Provider Direct Costs + Hourly Provider Indirect Costs and Auxiliary Operational Expenditures) ÷ (Productivity Adjustment Factor or Billable Hours x Productive FTE Hours)) ÷ (Daily Units x Calculation Adjustors))

6. Youth Day Treatment

All educational components are excluded from the Youth Day Treatment Medicaid rate. The Youth Day Treatment rate is based on caseload assumptions for Full Time Equivalents (FTE) necessary to provide day treatment for one classroom of twelve members. The rates are divided into hourly time increments for billing purposes.

Youth Day Treatment Rate = (((Hourly Provider Direct Costs + Hourly Provider Indirect Costs and Auxiliary Operational Expenditures) ÷ (Productivity Adjustment Factor or Billable Hours)) x Calculation Adjustors)

MONTANA

7. Comprehensive School and Community Treatment (CSCT)

Direct staff hourly wage, in lieu of actual wage information, was based on data from the Bureau of Labor Statistics (BLS). The wage is based on occupational and specific classifications reported by BLS and identified as comparable to staffing requirements needed to provide quality services under the program. Wages were compared and tested against a sample of actual wages paid to staff in similar job classifications by providers.

Productivity or billable time is capped per each team comprising of two FTE, at a maximum of 720 billable 15-minute units per month. CSCT Rate = ((Hourly Contract Provider Direct Costs + Hourly Contract Provider Indirect Costs + Hourly School Direct Costs + Hourly School Indirect Costs and Auxiliary Operational Expenditures) ÷ (Productivity Adjustment Factor or Billable Hours x Calculation Adjustors) ÷ 4 to convert to 15 minute unit)

**Local school districts will certify annually that they have expended public funds needed to match the federal share of their claims for service included in the State Plan provided to eligible recipients during the year. Certified expenditures are separately identified and supported in the state school accounting system MAEFAIRS. A certification of match statement must be signed and returned to the Department annually.** The described payment for comprehensive school-based services will end on December 31, 2019.

IV. The Department's methodology for all other, non- rehabilitative EPSDT services is determined as follows.

Provider-Orientation and Mobility Specialist (Provider, Service, Unit, Limits)

| **Service** | **Unit** | **Reimbursement** | **Limits** |
|---|---|---|---|
| Sensory Integration | 15 min units | Fee schedule referenced in I.B. | none |
| Self-Care Management | Per occurrence | Fee schedule referenced in I.B. | none |

MONTANA

Provider-Department approved Cleft/Craniofacial Interdisciplinary Teams *

| Service | Unit | Reimbursement | Limits |
|---|---|---|---|
| Cleft/Craniofacial Interdisciplinary Teams | Day | Fee schedule referenced in I.B. | N/A |

Provider-Department approved Metabolic Interdisciplinary Teams *

| Service | Unit | Reimbursement | Limits |
|---|---|---|---|
| Metabolic Interdisciplinary Teams | Day | Fee schedule referenced in I.B. | N/A |

Provider-Department approved Cystic Fibrosis Interdisciplinary Teams *

| Service | Unit | Reimbursement | Limits |
|---|---|---|---|
| Cystic Fibrosis Interdisciplinary Teams | Day | Fee schedule referenced in I.B. | N/A |

* The bundled rates for the three interdisciplinary teams providing EPSDT Services through the Public Health and Safety Division of the Department (Provider, Service, Unit, Limits) are arrived at using a prospective Medicaid rate-setting method that was developed to reflect service definitions, provider requirements, operational service delivery, and administrative considerations at a certain point in time. Each service provided by individual team members is included in the bundled Medicaid rate with an applied efficiency factor. The efficiency factor is set considering service configuration, team composition, scale of operation, expected costs, volume of service and overall caseload.

V. Direct Care Wage Add-on Reimbursement

Effective February 15, 2013, additional direct care wage reimbursement payments will be made to providers that employ direct-care workers (DCW).

These funds will be distributed proportionally in an annual payment to participating EPSDT rehab service providers based on the number of units of Medicaid EPSDT rehab direct care services provided by each provider during the most recent twelve months for which claims data is available.

The amount of direct care wage reimbursement payments allocated to each direct care service type for distribution is based on legislative appropriation, historical direct-care wage fund allocations from the most recent survey of providers, and the proportion of Medicaid expenditures each direct care service is in relation to all direct care services in a ***provider type*** allocation.

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Direct care worker (DCW) for EPSDT rehabilitative services means a non-professional employee of a Medicaid-enrolled provider who is assigned to work directly with youth or in youth-specific rehab service activities for no less than 75% of their hours of employment. A DCW is primarily responsible for the implementation of the treatment goals of the youth. The term "Direct Care Worker" includes Community Based Psychiatric Rehabilitation Services aides, Home Support Services or Therapeutic Foster Care Treatment staff and aides, Day Treatment aides, Therapeutic Group Home nonprofessional staff and Extraordinary Needs Aides. Wage add-on payments are made to direct care workers providing the following services: Community Based Psychiatric Rehabilitation services, family support services, and crisis services.

Distribution to each participating provider is calculated in the following manner:

Step 1: Total amount appropriated / historical direct care wage allocation = amount direct care wage per participating provider type.

Step 2: Amount of direct care wage per participating provider type / all participating provider units (standardized) in the provider type = amount direct care wage per standardized unit of service.

Step 3: Amount of direct care wage per standardized unit of service × amount of direct care wage per unit = amount of individual provider direct care wage reimbursement.

Total amount appropriated per year for all EPSDT rehabilitation direct care wage reimbursement is $2,337,109 per state fiscal year.