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State/Territory Name: Montana

State Plan Amendment (SPA) #: 18-0063

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
1961 Stout Street, Room 08-148
Denver, CO 80294



Denver Regional Operations Group

March 26, 2019

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

Dear Ms. Matthews:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-18-0063. This amendment brings the rate methodology for Community First Choice services up to date and clarifies the fee schedule effective date.

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

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 Community First Choice services, the expenditures should be reported on: Line 19D – HCBS State Plan 1915(k) Community First Choice.



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

Sincerely,

A solid black rectangular box redacting the signature of the sender.

Mary Marchioni
Acting Deputy Director

cc: Sheila Hogan, Department Director
Mary Eve Kulawik

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 18-0063	2. STATE Montana
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		4. PROPOSED EFFECTIVE DATE 10/01/2018	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES			
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 441.500-590		7. FEDERAL BUDGET IMPACT: a. FFY19: \$2,952,070 b. FFY20: \$2,952,070	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19B Service 1915K, Community First Choice Pages 1-3 of 3		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19B Service 1915K, Community First Choice Pages 1-3 of 3	
10. SUBJECT OF AMENDMENT: Community First Choice will be amended to clarify the payment methodology and update the date of the fee schedule.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Single Agency Director Review <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Montana Department of Public Health and Human Services Marie Matthews Attn: Mary Eve Kulawik PO Box 4210 Helena MT 59620	
13. TYPED NAME: Marie Matthews			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: original submittal 12/31/18 Resubmittal 3/25/19			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: December 31, 2018		18. DATE APPROVED: March 26, 2019	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2018		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Mary Marchioni		22. TITLE: Acting Deputy Director, DROG	
23. REMARKS:			

MONTANA

I. In-State Community First Choice Services (CFCS)

a. CFCS Reimbursement

The CFCS rates for (1) CFCS attendant service, (2) CFCS mileage, and (3) CFCS Personal Emergency Response System (PERS) are set fees established by the Department based upon historical costs. Fee schedule rates are effective for the dates listed below. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Community First Choice Services. The agency's fee schedule rate for CFCS services is effective October 1, 2018 for CFCS provided on or after that date. All rates are published on the agency's website <http://medicaidprovider.mt.gov>.

The Department assures there is no duplication of Personal Care Services (PCS) and Transportation with CFCS attendant services and CFCS mileage.

1. The Department will pay a provider for each Medicaid unit of CFCS attendant service. A unit of CFCS attendant service means a unit of attendant service that is an on-site visit specific to a client. A unit of attendant service is 15 minutes. The on-site visit unit rate includes the administrative components of providing the direct care service, including nurse supervision, planning and oversight components.

Medicaid payment for CFCS attendant services is not allowable for services provided in a hospital or nursing facility.

2. The Department will pay a provider for mileage incurred while transporting a client. A CFCS mileage unit of service is a minimum of one mile and means that a provider's employee used their personal vehicle or an agency-owned vehicle to provide transportation to a client during the provision of CFCS.

3. The Department will pay a provider for a CFCS PERS unit. The PERS unit is electronic, telephonic, or mechanical system used to summon assistance in an emergency situation. The CFCS PERS unit must be connected to a local emergency response system with the capacity to activate emergency medical personnel.

MONTANA

b. CFCS Direct Care Wage Add-on Payment

Additional payment pools will be established for CFCS providers for direct care wage reimbursement effective on or after October 1, 2018 through June 30, 2020. These payment pools will provide supplemental payments which will be distributed proportionally to the participating CFCS provider based on the number of units of Medicaid CFCS provided by each provider. The calculated pro rata amount is distributed to each participating provider two times a year. Providers select payment distribution dates from the available distribution periods identified by the Department.

To qualify for the direct care wage reimbursement supplemental payments a provider must be currently enrolled and billing direct care worker CFCS services, submit an application to the Department, and outline the agency plan to distribute the supplemental payments to direct care workers.

Example: If the total to be distributed was \$500,000

Provider	Units	Percentage	Allocation Formula	Annual Pro Rata Share	First Payment	Second Payment
A	15,000	30%	\$500,000 x.30	\$150,000	\$75,000	\$75,000
B	15,000	30%	\$500,000 x.30	\$150,000	\$75,000	\$75,000
c	20,000	40%	\$500,000 x.40	\$200,000	\$100,000	\$100,000
Total	50,000	100%		\$500,000	\$250,000	\$250,000

Payments will be made as a lump-sum add-on payment according to the following payment pool amount:

October 1, 2018-June 30, 2019	\$5,922,458
July 1, 2019-June 30, 2020	\$5,922,458

The Department assures there is no duplication of CFCS Direct Care Wage Add-on Payment and PCS Direct Care Wage Add-on.

MONTANA

c. CFCS Health Insurance for Health Care Worker Payment

Additional payment pools will be established for Community First Choice providers for health insurance for health care workers reimbursement, for the purpose of providing health insurance coverage to eligible CFCS workers. This reimbursement will be effective on or after October 1, 2018 through June 30, 2020. These payment pools will provide supplemental payments which will be distributed proportionally to the participating Community First Choice providers based on the number of units of Medicaid CFCS provided by each provider.

To qualify for the health insurance for health care worker reimbursement supplemental payments, a provider must be currently enrolled and billing direct care worker CFCS services, submit an application to the Department, and outline the provider's plan to provide health insurance coverage to direct care workers.

Payments will be made as a lump-sum add-on payment according to the following payment pool amounts. Payments are made monthly.

October 1, 2018 - June 30, 2019	\$ 4,108,881
July 1, 2019 - June 30, 2020	\$ 4,108,881

Example: If the total to be distributed was \$500,000

Provider	Units	Percentage	Allocation Formula	Annual Pro Rata Share	Monthly Payment
A	15,000	30%	\$500,000 x .30	\$150,000	\$12,500
B	15,000	30%	\$500,000 x .30	\$150,000	\$12,500
C	20,000	40%	\$500,000 x .40	\$200,000	\$16,667
Total	50,000	100%		\$500,000	\$41,667

The Department assures there is no duplication of CFCS Health Insurance for Health Care Worker Payments and PCS Health Insurance for Health Care Worker Payments.

II. Out of State Community First Choice Services

Reimbursement for CFCS for services provided outside the borders of the State of Montana is established by the Department and published on the agency's website at <http://medicaidprovider.mt.gov>. Consideration may be given to reimburse out of state CFCS providers, up to their state's established Medicaid rate if the following criteria are met: Montana's established rates are lower, the out of state provider refuses to serve the member at Montana's standard rate, and the other state's Medicaid established rate is a rate established for a service similar in scope and duration to the CFCS Medicaid service.

TN: 18-0063

Approval Date: 03/26/2019 Effective date: 10/01/2018

Supersedes TN: 15-0009