



ADMINISTRATIVE RULES OF MONTANA



37.40.1415 HOME AND COMMUNITY BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: REIMBURSEMENT

- (1) Services available through the program are reimbursed as specified in this rule.
- (2) The following services are reimbursed as provided in (3):
 - (a) adult day health;
 - (b) adult residential care;
 - (c) case management services;
 - (d) community transition services;
 - (e) consultative clinical and therapeutic services;
 - (f) consumer-directed goods and services;
 - (g) dietetic services;
 - (h) environmental accessibility adaptations;
 - (i) family training and support;
 - (j) financial management;
 - (k) habilitation;
 - (l) health and wellness;
 - (m) homemaker chore services;
 - (n) homemaker;
 - (o) independence advisor;
 - (p) nonmedical transportation;
 - (q) nursing;
 - (r) nutrition services;
 - (s) pain and symptom management;
 - (t) personal emergency response systems;
 - (u) post-acute rehabilitation services;
 - (v) respite care;

- (w) senior companion services;
 - (x) specialized child care for medically fragile children; and
 - (y) vehicle modifications.
- (3) The services specified in (2) are, except as otherwise provided in (4), reimbursed at the lower of the following:
- (a) the provider's usual and customary charge for the service; or
 - (b) the rate negotiated with the provider by the case management team up to the department's maximum allowable fee.
- (4) The services specified in (2) are reimbursed as provided in (3) except that reimbursement for components of those services that are incorporated by specific cross reference from the general Medicaid program may only be reimbursed in accordance with the reimbursement methodology applicable to the component service as a service of the general Medicaid program.
- (5) The following services are reimbursed in accordance with the referenced provisions governing reimbursement of those services through the general Medicaid program:
- (a) personal assistance as provided at ARM 37.40.1105 and 37.40.1302;
 - (b) outpatient occupational therapy as provided at ARM 37.86.610;
 - (c) outpatient physical therapy as provided at ARM 37.86.610;
 - (d) speech therapy as provided at ARM 37.86.610; and
 - (e) audiology as provided at ARM 37.86.705.
- (6) Case management services are reimbursed, as established by contractual terms, on either a per diem or hourly rate.
- (7) Respite care services provided by a nursing facility are reimbursed at the rate established for the facility in accordance with ARM Title 37, chapter 40, subchapter 3.
- (8) Specialized medical equipment and supplies are reimbursed as follows:
- (a) equipment and supplies which are reimbursable under ARM 37.86.1801, 37.86.1802, 37.86.1806, and 37.86.1807 shall be reimbursed as provided in ARM 37.86.1807;
 - (b) equipment and supplies which are not reimbursable under ARM 37.86.1801, 37.86.1802, 37.86.1806, and 37.86.1807 shall be reimbursed at the lower of the following:
 - (i) the provider's usual and customary charge for the item; or
 - (ii) the negotiated rate up to the department's maximum allowable fee.
- (9) Reimbursement is not available for the provision of a service to a person that may be reimbursed through another program.
- (10) No copayment is imposed on services provided through the program but recipients are responsible for copayment on other services reimbursed with Medicaid monies.
- (11) Reimbursement is not available for the provision of services to other members of a recipient's household or family unless specifically provided for in these rules.

- (12) Payment for the following services may be made to legally responsible individuals, if all program criteria in ARM 37.40.1407 are met:
- (a) personal assistance;
 - (b) homemaker;
 - (c) specially trained attendant;
 - (d) specialized child care for medically fragile children;
 - (e) private duty nursing;
 - (f) transportation;
 - (g) respite;
 - (h) consumer-directed goods and services;
 - (i) homemaker chore;
 - (j) pain and symptom management;
 - (k) vehicle modifications; and
 - (l) environmental accessibility adaptations.
- (13) When the Legislature funds a direct care wage initiative, waiver providers targeted by the initiative must report to the department, for a determined time period, actual hourly wage and benefit rates paid for all direct care workers or the lump sum payment amounts for all direct care workers that will receive the benefit of the increased funds. The reported data shall be used by the department for the purpose of tracking distribution of direct care wage funds to designated workers.
- (a) The department will pay targeted waiver providers that submit an approved request to the department a lump sum payment in addition to the Medicaid reimbursement rate to be used only for wage and benefit increases or lump sum payments for direct care workers.
 - (b) To receive the direct care workers' lump sum payment, a targeted provider shall submit for approval a request form to the department stating how the direct care workers' lump sum payment will be spent to comply with all department requirements. The provider shall submit all of the information required on the form in order to continue to receive subsequent lump sum payment amounts.
 - (c) If these funds will be distributed in the form of a wage increase to direct care workers the form for wage and benefit increases will request information including, but not limited to:
 - (i) the number of category of each direct care worker that will receive the benefit of the increased funds;
 - (ii) the actual per hour rate of pay before benefits and before the direct care wage increase has been implemented for each worker that will receive the benefit of the increased funds;
 - (iii) the projected per hour rate of pay with benefits after the direct wage increase has been implemented;

- (iv) the number of staff receiving a wage or benefit increase by category of worker, effective date of implementation of the increase in wage and benefit; and
 - (v) the number of projected hours to be worked in the budget period.
 - (d) If these funds will be used for the purpose of providing lump sum payments (i.e., bonus, stipend, or other payment types) to direct care workers the form will request information including, but not limited to:
 - (i) the number of category of each direct care worker that will receive the benefit of the increased funds;
 - (ii) the type and actual amount of lump sum payment to be provided for each worker that will receive the benefit of the lump sum funding;
 - (iii) the breakdown of the lump sum payment by the amount that represents benefits and the direct payment to workers by category of worker; and
 - (iv) the effective date of implementation of the lump sum benefit.
 - (e) A provider that does not submit a qualifying request for use of the funds distributed under (2), or does not include all of the information requested by the department, within the time established by the department, or a provider that does not wish to participate in this additional funding amount shall not be entitled to their share of the funds available for wage and benefit increases or lump sum payments for direct care workers.
- (14) A provider that receives funds under this rule must maintain appropriate records documenting the expenditure of the funds. This documentation must be maintained and made available to authorize governmental entities and their agents to the same extent as other required records and documentation under applicable Medicaid record requirements, including but not limited to the provisions of ARM 37.40.345, 37.40.346, and 37.85.414.

Authorizing statute(s): 53-2-201, 53-6-113, 53-6-402, MCA

Implementing statute(s): 53-6-101, 53-6-111, 53-6-113, 53-6-402, MCA

History: NEW, 2000 MAR p. 2023, Eff. 7/28/00; AMD, 2004 MAR p. 82, Eff. 1/1/04; AMD, 2011 MAR p. 1722, Eff. 8/26/11; AMD, 2025 MAR, Notice No. 2025-524, Eff. 11/22/25.