



ADMINISTRATIVE RULES OF MONTANA



37.40.1030 ADD-ON PAYMENTS AND REPORTING REQUIREMENTS FOR HEALTH CARE WORKERS

- (1) The department will pay Medicaid Personal Assistance Services and Community First Choice Services (CFCS) providers located in Montana, who submit an approved request to the department, an add-on payment in addition to the reimbursement fee as provided in ARM 37.40.1026, 37.40.1027, 37.40.1105, and 37.85.105. The add-on payment is to be used only to cover health insurance payments for direct-care workers who spend a majority of their time serving Medicaid personal care members.
 - (a) The department will determine the add-on payments, commencing July 1, 2014, as a pro rata share of appropriated funds allocated for health care for health care worker coverage. A provider agency is eligible to receive a portion of the total funds based on their percentage of total utilization of personal assistance services and CFCS over the previous fiscal year.
 - (b) To receive the health care for health care worker payment, a provider must submit for approval an application request to the department stating how the health care for health care worker add-on payment will be spent to comply with the application's requirements. The provider must submit all of the information required on a department-approved form in order to continue to receive subsequent add-on payment amounts for the entire year.
 - (c) A provider must submit an application request for the funds distributed under (1)(b). The request must include all required information, within the deadlines established by the department. Providers who do not submit the application request or do not wish to participate in the add-on funding may not be entitled to their pro rata share of the funds available for health care for health care worker coverage.
- (2) A provider that receives funds under this rule must maintain appropriate records documenting the expenditures of these funds. This documentation must be maintained and made available to authorized governmental entities and their agencies to the same extent as other required records and documentation under applicable Medicaid record requirements.
 - (a) Effective for the period beginning July 1, 2014, personal assistance services or CFCS providers must submit quarterly reports to the department. The report must include the names of eligible direct-care workers receiving health insurance coverage, the monthly cost of the insurance plan, and the total cost to the agency to provide health insurance coverage.

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

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

History: NEW, 2014 MAR p. 3075, Eff. 12/25/14.