

Developmental Disabilities Program Policy and Procedures Manual		Control # 0704082
Volume 1: Program Administration	Section 3: DD Program Policies	
	Subject: INTERIM Policy for HCBS Waiver Rate Reimbursement Policy for Service Providers	

PURPOSE:

This policy implements the provider reimbursement fee for service schedule for Home and Community-Based Services (HCBS) waiver services and defines required activities of all service providers and state staff. The Montana Developmental Disabilities Program (DDP) is converting its provider reimbursement approach from a negotiated rate system to a standardized fee-for-service system for its Medicaid Home and Community-Based Services (HCBS) Waiver program. This conversion has been initiated in response to direction from the Montana state legislature and guidance from the federal Centers for Medicare and Medicaid (CMS).

EFFECTIVE DATE: This policy is effective August 31, 2006 for DDP Regions 1, 2, and 3, and becomes effective for Regions 4 and 5 by July 1, 2008

LEGAL REFERENCE: All services shall be provided in accordance with all relevant ARMs including 37.34.701 – 706, 621, 622, 711, 712, 713, 1101 – 1115, 941, 942, 985, and 986.

SCOPE: This policy applies to all contracted staff and service providers that serve DDP consumers under the Medicaid Home and Community-Based Services (HCBS) Waiver program, and to all state DDP staff.

PROGRAM OVERVIEW: Home and Community-Based Services (HCBS) are designed to support people with developmental disabilities in integrated and inclusive community settings. As such, HCBS provide alternatives to or prevent unnecessary institutionalization. Select HCBS developmental disabilities waiver services differ from Montana Medicaid State Plan services in both their delivery and reimbursement philosophy. Specifically, HCBS residential habilitation and day habilitation are considered long-term care services and involve both active training as well as health and safety monitoring and support. The balance of training and health / safety supports is based upon an individual service plan (ISP). Residential and day habilitation service providers are required to meet the individual service plan expectations defined for each person.

The HCBS provider reimbursement schedule defines the rates and units of service for each HCBS waiver category. As such the HCBS Waiver Reimbursement policy is intended to accomplish three purposes:

1. ensure that people have fair and equitable access to services;
2. ensure that providers are fairly and equitably reimbursed for delivering those services; and
3. ensure that services purchased by people are delivered in sufficient amounts and at acceptable quality standards.

The HCBS provider reimbursement system consists of four elements:

1. Each HCBS recipient develops an individual service plan (ISP) which identifies the amount (number of units) of each HCBS service to be provided.

2. Once a provider has accepted an HCBS recipient for service, the provider must deliver the amount of service units identified in the ISP.
3. The provider must document three conditions in order to receive reimbursement:
 - sufficient direct care staff were present to provide the amount of service in the ISP;
 - the HCBS recipient was present to receive the direct care staff support as defined in the ISP; and,
 - the ISP goals, objectives, and outcomes were achieved and met standards of quality care.
4. The provider maintains documentation to demonstrate that the conditions have been successfully met.

STATEMENT OF POLICY: The HCBS Waiver Reimbursement policy defines the amount of financial reimbursement for each HCBS service and consists of the following:

1. Direct Care Staff Time is the Billable Unit for all HCBS services with the exception of adaptive equipment / environmental modifications and transportation. All provider reimbursement is based upon the amount of direct care staff time delivered to or on behalf of the HCBS recipient by the provider. In order to meet the conditions for payment, the HCBS recipient must be Medicaid eligible, enrolled, in attendance, 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 service recipient's individual service plan.
2. Direct care staff is defined to be those individuals whose primary responsibility is the day to day support of people with disabilities, training and instruction, and assistance with and management of activities of daily living. Direct care workers can bill hours so long as 85% of their work activities include daily supports to people with disabilities. In addition, substitute direct care can be provided for short, specific periods of time by staff whose primary duties may be other than direct care when regular direct care staff are absent and not in billable status.
3. Billable units for each HCBS service are defined as either hourly, daily, or monthly. Table 1 defines the applicable billable unit and associated financial reimbursement rate for each HCBS service. These rates are the costs for a single unit of service. The following definitions apply:
 - the term "Hours" refers to one hour of direct care staff time spent with or on behalf of an HCBS recipient. For this definition, an hour is considered to be no less than 46 minutes and no more than 60 minutes of time.
 - the term "Daily" refers to the total number of staff hours provided in that day. For this definition, a day consists of the total number of hours of direct care support in a month divided by the number of days in that month. A day is also defined as all direct care activities which occur between the hours of 12:00 a.m. and 11:59 p.m.
 - The term "Month" refers to a single month billing unit. For services using this billable unit, agencies are reimbursed at a fixed monthly amount for all direct care hours provided to those people enrolled in their service for an entire month. Monthly rates are used when individual support needs can vary widely on a daily basis. For services billed by this monthly unit: if an individual "ports" from one service provider to another mid-month, each provider receives the appropriate pro-rated amount of the monthly fee for that month.
4. For selected services, the following additional billable unit definitions apply:
 - Residential Habilitation / Community Homes – in those instances when several people in the same home are supported by the same staff, the billable unit is

calculated by adding the total number of hours of service for all consumers in a month, and dividing by the number of days in that month. The result is a daily rate which is charged for each day a consumer receives residential habilitation.

- Supported Employment - the monthly rate is organized into three tiers which reflect different amounts of job coach 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 individuals needing more than 45 hours of support per month. This hourly rate also varies based on the provider’s assigned geographic factor.

STANDARD RATES AND STANDARDIZED COST CENTERS: All provider reimbursement rates consist of four cost centers. These cost centers are:

1. *Direct care Staff Compensation*: By direction from the Montana State Legislature, direct care compensation rates are established at the 35th percentile of Montana market value as described by compensation data collected by Hayes compensation studies, Health and Hospital compensation studies, and the U.S. Bureau of Labor Statistics. Job classifications used for Personal Support Workers are staff that perform at least 85% of the typical duties of a developmental disabilities attendant with a high school degree and no special training. Typical classifications include child care workers, home health care aides, nursing home aides, hospital orderlies, and assisted living workers. Job classifications used for Habilitation Workers are staff that perform at least 85% of the duties of a developmental disabilities attendant with an Associate Arts degree or Certified Nursing Assistant credentials, or special training. Typical classifications include nursing home assistants, vocational trainers, behavior assistants, special education teachers’ aides.
2. *Employee-Related Expenses*: Employment related expenditures refer to the benefits package that is offered to all employees who are involved in the care and services provided to the person with disabilities. These costs can be categorized into two groups:
 - Discretionary Costs - Discretionary costs are those associated with benefits provided at the discretion of the employer and are not mandated by local, state, or federal governments. Such benefits may include (but are not limited to) health insurance, profit sharing, and retirement benefits or stock options.
 - Non-Discretionary - Non-discretionary costs are those related to employment expenditures that are mandated by local, State, and Federal governments and are not optional to the employer. Such expenditures include (but are not limited to) FICA, FUTA, SUTA and workers’ compensation insurance. Employee-related expenses vary for people who are self-employed and agency employees. Employer agencies bear the financial responsibility for workers’ compensation, while self-employed workers are required to pay all federal income taxes.
3. *Program Supervision and Indirect Expenses*: Program Related Expenditures are those that are part of the operation of the setting in which services occur and related to the programs which occur within the setting, but are not directly tied to the direct care staff. Examples include the following:
 - Program support services such as staff trainers and clinical supervisors
 - Supervision of direct care staff
 - Qualified mental retardation professionals, registered records technicians
 - Program related supplies
 - Social services involving family counseling, estate and guardianship support

- Evening activities including recreation and community-inclusion opportunities
 - Program associated transportation
 - Documentation requirements (Documentation requirements are not a separate billable activity for any services)
4. *General & Administrative Expenses:* General and Administrative costs are those associated with operating the organization's business and administration and are not directly related to the clients or the programs that serve the clients. Examples include the following:
- Administrative salaries to include agency director and secretarial support
 - Professional services to include management of payroll and accounts receivable
 - Insurance to include liability
 - Travel and entertainment not related to direct care activities
 - Office expenses such as supplies, equipment, and telephone
 - Program development and fund raising
 - Occupational and Health Safety costs
 - Depreciation and amortization on capital assets
 - Interest on capital debt
 - Real estate taxes
 - Property insurance
 - Other interests, miscellaneous, equipment rental

REIMBURSEMENT RATE GEOGRAPHICAL FACTORS: In addition to the standardized cost centers, geographical factors are applied for residential habilitation and day habilitation services; economy-of-scale and holiday factors are applied to residential habilitation. These factors are as follow:

1. *Geographical factor:* Geographical cost adjustment factors consider the cost of living, employment compensation, cost of housing, and labor market trends. Based upon these factors, geographical cost adjustments are provided for residential and day habilitation providers in the following counties
 - Three (3) Percent add-on: Cascade, Flathead, Carbon, Hill, Sweet Grass
 - Six (6) Percent add-on: Gallatin, Missoula, Yellowstone, Lewis & Clark, Stillwater, Jefferson
2. *Economy-of-Scale factor:* Economy-of-scale factors are used to adjust provider reimbursement for general & administrative (G&A) and program-related (PR) costs for agencies of different sizes. Specifically, these cost factors are adjusted for residential habilitation providers as follow:
 - Providers offering services in one (1) to six (6) sites within the region – no adjustment.
 - Providers offering services in seven (7) to seventeen (17) sites within the region – 2% reduction in G&A and 2% reduction in PRE.
 - Providers offering services in eighteen (18) or more sites – 4% reduction in PRE and 2% reduction in G&A.
 - *Holiday Coverage factor:* Each residential provider may identify up to ten (10) holidays per fiscal year; direct care staff hours provided on those days will be compensated at 1.5 times normal salary which providers must pass on to direct care staff.

7/1/2007

Reimbursement rates and associated definitions are summarized in Table #1.

Jeff Sturm
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Date: