



**DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES**

Developmental Disabilities Program

(Draft) Rates and Billing Manual

Effective July 1, 2026

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GENERAL INTRODUCTION: This manual outlines the programs delivered and billed in the Montana Medicaid Management Information System (MMIS) system through the Developmental

Disabilities Program (DDP) Provider Type 82. As DDP transitions more programs to billing within the MMIS system, more sections will be added about those programs.

SECTION 1: HOME AND COMMUNITY BASED SERVICES (HCBS)

INTRODUCTION of HCBS:

SCOPE: This section applies to all qualified provider staff and service providers that serve DDP members under the Medicaid Home and Community-Based Services (HCBS) Waiver programs, and certain non-Medicaid programs.

PROGRAM OVERVIEW: Home and Community-Based Services (HCBS) are designed to support people with developmental disabilities in integrated and inclusive community settings. Services are provided in accordance with individual's assessed needs in a plan of care which specify the scope, duration, and frequency of services for each person. The following references should be used in conjunction with the approved waiver(s), Montana Medicaid Provider Agreement, Administrative Rules of Montana (A.R.M.s), Montana Code Annotated (MCA), Developmental Disabilities Program 0208 Comprehensive Waiver Provider Manual, Personal Supports Plan/Plan of Care, and service authorization.

The waiver reimburses using a Medicaid based, Fee-for-Service model. In order to deliver services available through the waiver(s) administered by the DDP, the provider must meet all the qualifications and standards associated with the particular service(s) the provider wishes to offer. These qualifications and standards are described for each service in the approved waiver at <https://dphhs.mt.gov/bhdd/DisabilityServices/developmentaldisabilities/ddpmedicaidwaivers> . Additionally, providers must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual on the Montana Medicaid provider website.

RULE REFERENCES:

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Links to rule references are available on the Provider Information website. Paper copies of rules are available through the Secretary of State's office. The following rules are specific to the Developmental Disabilities Program: Rule citations in the text are a reference tool; they are not a summary of the entire rule.

Administrative Rules of Montana (ARM)

- ARM 37.34.101 through 37.34.3005

Montana Code Annotated (MCA)

- MCA Title 53, Chapter 20 Developmental Disabilities

ELIGIBILITY:

In order to receive services through the Developmental Disabilities waiver program, a member must be Medicaid eligible, and must meet criteria determined by the department as described in A.R.M. 37.34.201.

STANDARD COST CENTERS

The HCBS Waiver Reimbursement consists of the following:

1. Direct Care Staff Time is the Billable Unit for most HCBS services and it's the basis for daily or monthly billing units. In order to meet the conditions for payment, the HCBS member must be Medicaid eligible, enrolled in, attend, 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 member's plan of care.
2. Staff is defined to be those staff whose primary responsibility is the day to day, hands-on, direct support of people with disabilities, training and instruction, and assistance with and management of activities of daily living.
3. Standardized Cost Centers: Per the process creating fee-for-service rates, most provider reimbursement rates consist of 4 cost centers which can be adjusted exclusive of the others. These cost centers are:

- **Staffing and Productivity – Staff Wages, all Benefits, Supervisory costs, Staff Productivity
- **Admin and Program – Program support percent, client transportation where applicable
- **Occupancy – Client attendance/Occupancy (if applicable)
- **Mileage – staff mileage (if applicable)

In addition to the standardized cost centers, geographical factors are applied to Supported Living (which is the billing category for a type of residential habilitation) and Residential Training Support. Geographical cost adjustment factors consider the cost of living, employment compensation, cost of housing, and labor market trends. These factors are as follows:

- Medium = 1.84% add-on: Beaverhead, Park, Blaine, Lake, Hill, Ravalli, Madison, Dawson, Lincoln, and Custer counties.
- High = 4.48% add-on: Gallatin, Missoula, Yellowstone, Lewis & Clark, Stillwater, Jefferson, Fallon, Flathead, Rosebud, Big Horn, Powell, Richland, Silver Bow, Sweet Grass, Toole, Cascade, Musselshell, and Glacier counties.
- All other counties have no geographic factor adjustment.
- SMALL Agency = Specific economy of scale factors are applied to very small providers of Supported Living and Residential Training Supports.

Billable units for most HCBS services are defined as either 15 minutes, hourly, daily, or monthly. The following definitions apply:

- The term “15 minutes” refers to fifteen minutes of staff time spent with or on behalf of an HCBS member. For this definition, fifteen minutes is considered to be no less than 8 minutes and no more than 22 minutes. Minutes cannot be combined over different days. Partial units are not allowed to be billed.
 - Units: 1 Time: Greater than or equal to 8 minutes, but less than 23 minutes
 - Units: 2 Time: Greater than or equal to 23 minutes, but less than 38 minutes
 - Units: 3 Time: Greater than or equal to 38 minutes, but less than 53 minutes
 - Units: 4 Time: Greater than or equal to 53 minutes, but less than 68 minutes
 - Units: 5 Time: Greater than or equal to 68 minutes, but less than 83 minutes
 - Units: 6 Time: Greater than or equal to 83 minutes, but less than 98 minutes
 - Units: 7 Time: Greater than or equal to 98 minutes, but less than 113 minutes
 - Units: 8 Time: Greater than or equal to 113 minutes, but less than 128 minutes
- The term “Hours” refers to one hour of direct care staff time spent with or on behalf of an HCBS member. For this definition, an hour is a minimum of 45 minutes. Partial units are not allowed to be billed.
- The term “Daily” refers to services provided in that day. A day is defined as direct care activities which occur between the hours of 12:00 a.m. and 11:59 p.m. Partial units are not allowed to be billed.
- The term “Month” refers to a single month billing unit. For services using this billable unit, reimbursement is made at a fixed monthly amount for care hours provided to those people enrolled in their service for that month. Monthly rates are used when individual support needs can vary widely on a daily basis. Partial units are not allowed to be billed.

For selected services, the following additional billable unit definitions apply:

- Congregate Residential Services – the rates are organized into several tiers based on average levels of support outlined by the member’s plan of care. Providers will bill hourly for all members receiving Children’s Group Home and Medically Intense Group Home services. Additionally, if a member’s level of support exceeds average levels of support in the highest Tier, the provider will bill for those members hourly.
- Day Supports and Activities, Retirement, Small Group Employment, Behavioral Intervention Assistant, Registered Behavioral Technician - the rates are organized into several tiers based on average levels of support needed by the member. If a member’s level of support exceeds average levels of support in the highest Tier, the provider will bill for those members hourly.
- Supported Employment Follow Along - the monthly rate is organized into three tiers which reflect different amounts of employment support staff’s time and 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 members needing more than an average 45 hours of support per month or when a monthly unit is cost prohibitive.

COVERED SERVICES:

This section provides service information specifically for services offered in the Developmental Disabilities 0208 Comprehensive waiver and provides additional information and clarifications

for certain services if applicable. The full details of the services and requirements approved by the Centers for Medicare & Medicaid Services (CMS) can be found at:
<https://dphhs.mt.gov/bhdd/DisabilityServices/developmentaldisabilities/ddpmedicaidwaivers> .

ADULT FOSTER SUPPORT

S5141	Adult Foster Support (low supervision)	\$3423.63/month
S5141	Adult Foster Support (moderate supervision)	\$3900.15/month
S5141	Adult Foster Support (enhanced supervision)	\$4376.66/month
S5141	Adult Foster Support (intensive supervision)	\$5351.82/month

The monthly stipend does not include day or other services, but it does include member transportation. If subcontracting, the provider determines the total amount per month paid to the foster parent. If subcontracting the service, any of the agency's administrative/supervision fee comes from the monthly rate and includes the following: compliance with Organized Health Care Delivery System (OHCDS) standards pursuant to the DDP addendum, written policies and procedures, maintaining service delivery documentation and reimbursements; provision of initial and ongoing training and supervision to the foster parent; and ensuring subcontractor compliance with DD rules, waiver requirements, site regulations for licensed foster homes, and the HCBS Settings Rules.

Supervision Guidelines:

Low Supervision - For AFS programs, supervision requirements are intended for those times the individual is in the adult foster home. LOW SUPERVISION means that AFS parents must be aware of the location of the person. Such supervision is considered "point-to-point" and focuses on ensuring that the person is in the setting or situation as defined by their plan of care. No physical assistance is required. The individual does not have any health or behavioral needs that require attention. Examples of LOW SUPERVISION could include:

- Knowledge of individual's presence and schedule during the day.
- Reminders to individuals of daily schedule of activities and outings. Few or no prompts/reminders are necessary.
- Backup assistance when primary transportation supports are temporarily not available.

LOW SUPERVISION focuses on "point-to-point" supervision to ensure that the individual is in the location. Individuals who can safely engage with their environment AND DO NOT need assistance with activities of daily living would be examples of individuals with LOW SUPERVISION needs.

Moderate Supervision - For AFS programs, supervision requirements are intended for those times the individual is in the adult foster home. MODERATE SUPERVISION means that AFS parents must be aware of the location of the person and available to physically assist when needed. The individual does not have any health or behavioral needs that require constant attention. Examples of MODERATE SUPERVISION could include:

- Observing when an individual leaves or enters the home.
- Prompting to encourage individuals to complete daily living skills and routine personal hygiene.
- Assistance in accessing transportation and community-inclusion opportunities.

MODERATE SUPERVISION focuses on “on-site” supervision to ensure that the individual is in the location and appropriately engaged in relevant and safe activities. Individuals who can safely engage with their environment BUT NEED assistance with activities of daily living would be examples of individuals with MODERATE SUPERVISION needs.

Enhanced Supervision - For AFS programs, supervision requirements are intended for those times the individual is in the adult foster home. ENHANCED SUPERVISION means that AFS parents must be able to observe the person at all times and available to physically assist when needed. For ENHANCED SUPERVISION to be required, the individual must have a health, behavior, or functional limitation need that requires constant attention. Examples of ENHANCED SUPERVISION could include:

- Observing the individual at all times when in the home.
- Physically assisting individuals to complete daily living skills and routine personal hygiene.
- Physical assistance to participate in transportation and community-inclusion opportunities.

ENHANCED SUPERVISION focuses on “line-of-sight” supervision to ensure that the individual is in the location and appropriately engaged in relevant and safe activities. Individuals that wander away from the AFS, are not able to interact safely with their environment, or who engage in nuisance behavior are examples of individuals with ENHANCED SUPERVISION needs.

Intensive Supervision - For AFS programs, supervision requirements are intended for those times the individual is in the adult foster home. INTENSE SUPERVISION means that AFS parents must be able to physically intervene with the person at all times in order to ensure health and safety. For INTENSE SUPERVISION to be required, the individual must have a health, behavior, or functional limitation need that requires constant attention, and represents a serious threat to health and safety. Examples of INTENSE SUPERVISION could include:

- Being in close proximity to the individual at all times when in the home.
- Physically intervening with individuals in situations where self or others are at high risk.
- Providing one-to-one supervision with limited capacity to leave the individual unattended.

INTENSE SUPERVISION focuses on “arms-length” supervision where the AFS parent is physically able to intervene immediately when needed. Individuals who engage in self-injurious behavior, behaviors that risk physical harm to people or property, or serious seizure episodes are examples of individuals with INTENSE SUPERVISION needs.

ASSISTED LIVING

T2031	Assisted living moderate 1:4-1:8 ratio	\$222.08/day
T2031	Assisted living enhanced 1:1-1:3 ratio	\$296.10/day

Members in this service option are not precluded from attending DD waiver-funded work/day or supported employment options, however Assisted Living assumes and reimburses 24/7 care, and other direct care services cannot be billed concurrently with assisted living. Rates include member transportation.

Separate payment is not made for homemaker or chore services, personal supports, residential habilitation, residential training supports, or personal care services furnished to a member receiving assisted living services, since these services are integral to and inherent in the provision of assisted living services.

Retainer payments made to providers of Assisted Living services may not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for “bed-hold” in nursing facilities.

A modifier of **KX** shall be put on the claim for each day the provider is billing a retainer day.

For retainer payments, if the member is present and starts assisted living services during the following date spans, the number of retainer days is reduced accordingly.

- July 1 – September 30th: 30 retainer days available
- October 1 – December 31st: 22 retainer days available
- January 1 – March 31st: 15 retainer days available
- April 1 – June 30th: 8 retainer days available
- Retainer Payments are not available while an individual is admitted to Montana State Hospital.

BEHAVIORAL SUPPORT SERVICES

Level I: Behavioral Support Services (BSS)

H0046 Behavioral Support Services \$95.16/staff hour

Telehealth is allowed for specific H0046 activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of 02 shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for or associated with telehealth capability.

Level II: Level II BSS must be prior-authorized by the Department and re-authorized every 180 days.

Registered Behavior Technician Daily - based on assessment of average hours of support a member needs per day.

H2021 Registered Behavior Tech Tier 1	(0-.5 ave hrs/day)	\$22.72/day
H2021 Registered Behavior Tech Tier 2	(.5-1.0 ave hrs/day)	\$46.77/day
H2021 Registered Behavior Tech Tier 3	(1.01 - 1.25 ave hrs/day)	\$60.14/day
H2021 Registered Behavior Tech Tier 4	(1.26 - 1.75 ave hrs/day)	\$80.19/day
H2021 Registered Behavior Tech Tier 5	(1.76-2.25 ave hrs/day)	\$106.91/day
H2021 Registered Behavior Tech Tier 6	(2.26-2.75 ave hrs/day)	\$133.64/day
H2021 Registered Behavior Tech Tier 7	(2.76-3.25 ave hrs/day)	\$160.37/day
H2021 Registered Behavior Tech Tier 8	(3.26-4.0 ave hr /day)	\$193.78/day
H2021 Registered Behavior Tech Tier 9	(4.01- 4.75 ave hrs/day)	\$233.87/day
H2021 Registered Behavior Tech Tier 10	(4.76-5.5 ave hrs/day)	\$273.97/day
H2021 Registered Behavior Tech Tier 11	(5.51-6.25 ave hrs/day)	\$314.06/day
H2021 Registered Behavior Tech Tier 12	(6.26-6.99ave hrs/day)	\$354.16/day
H2021 Registered Behavior Tech Tier 13	(7.01-7.99 ave hrs/day)	\$400.93/day

Registered Behavior Technician Hourly - Based on assessment of average hours of support a member needs per day. May be appropriate if daily units are not warranted or if average daily hours are over 7.99.

H2021 Registered Behavior Technician \$53.46/hour

Intensive Behavior Assistant Daily - based on assessment of average hours of support a member needs per day.

H0023	Intensive Behavior Assistant Tier 1	(0.017-0.5 ave hrs/day)	\$18.45/day
H0023	Intensive Behavior Assistant Tier 2	(.5-1.0 ave hrs/day)	\$37.99/day
H0023	Intensive Behavior Assistant Tier 3	(1.01 - 1.25 ave hrs/day)	\$48.83/day
H0023	Intensive Behavior Assistant Tier 4	(1.26 - 1.75 ave hrs/day)	\$65.12/day
H0023	Intensive Behavior Assistant Tier 5	(1.76-2.25 ave hrs/day)	\$86.82/day
H0023	Intensive Behavior Assistant Tier 6	(2.26-2.75 ave hrs/day)	\$108.53/day
H0023	Intensive Behavior Assistant Tier 7	(2.76-3.25 ave hrs/day)	\$130.23/day
H0023	Intensive Behavior Assistant Tier 8	(3.26-4.0 ave hr /day)	\$157.36/day
H0023	Intensive Behavior Assistant Tier 9	(4.01- 4.75 ave hrs/day)	\$189.92/day
H0023	Intensive Behavior Assistant Tier 10	(4.76-5.5 ave hrs/day)	\$222.48/day
H0023	Intensive Behavior Assistant Tier 11	(5.51-6.25 ave hrs/day)	\$255.04/day
H0023	Intensive Behavior Assistant Tier 12	(6.26-6.99ave hrs/day)	\$287.60/day
H0023	Intensive Behavior Assistant Tier 13	(7.01-7.99 ave hrs/day)	\$325.58/day

Intensive Behavior Assistant Hourly - Based on assessment of average hours of support a member needs per day. May be appropriate if daily units are not warranted or if average daily hours are over 7.99.

H0023 Intensive Behavior Assistant \$43.41/hour

CAREGIVER TRAINING AND SUPPORT

T1027	Caregiver Training & Support	\$60.85/staff hour
T1027 XU	Caregiver Training & Support OTHER	\$ cost varies
T1027 SC	Caregiver Training & Support AwC	\$60.85/staff hour

This service is only billable for members living in a family setting or private non-congregate residence where support and supervision is provided by unpaid care givers. It is not billable for persons living in group homes, assisted living facilities, or foster homes when the foster care provider is paid for support and supervision.

If hourly CTS is delivered during a month, at least ONE contact with the caregiver must be provided during the billed hours for that month. At least 6 of the monthly contacts per year must be a visual contact (telehealth or in-person) with both the caregiver and individual present. The waiver cannot be billed for any equipment or software required for or associated with telehealth capability. CTS OTHER can be used for conference fees, etc. as part of CTS training to a

caregiver specific to the member's developmental disability that is not delivered by a staff person and is documented in the plan of care.

A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for or associated with-telehealth capability.

COMMUNITY TRANSITION SERVICES

T2038	Community Transition Services	\$ cost varies
T2038 SC	Community Transition Services Self Direct	\$ cost varies

This service is capped at \$3,000 per member, per transition.

COMPANION

S5135	Companion	\$9.39/15 minutes
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Clarification:

If the setting already provides for 24/7 care, then the additional provision of companion services cannot be used (examples include group homes, assisted living, adult foster, congregate supported living settings). Companion services can be a component of 24/7 support if other hours and costs of support are decreased (e.g., instead of 24 hours of residential habilitation, the person receives 12 hours of companion services and 12 hours of residential habilitation services). Use caution if the person has monthly Supported Living services. Companion services are not allowed to be billed in the same month as a monthly Supported Living unit unless there is documentation that the member received the maximum SL hours in the tier in which the provider is billing.

This service will not duplicate Personal Care or Homemaker Services through the waiver, State Plan or any other programs. In addition, members receiving Companion Services may not also bill personal supports as a discrete waiver service.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible person.

DAY SUPPORTS AND ACTIVITIES

Daily - based on assessment of average hours of support a member needs per day.

T2021	Day Supports and Activities Tier 1	(0-.5 ave hrs/day)	\$14.49/day
T2021	Day Supports and Activities Tier 2	(.5-1 ave hrs/day)	\$29.83/day
T2021	Day Supports and Activities Tier 3	(1.01-1.25 ave hrs/day)	\$38.36/day
T2021	Day Supports and Activities Tier 4	(1.26-1.75 ave hrs/day)	\$51.14/day
T2021	Day Supports and Activities Tier 5	(1.76-2.25 ave hrs/day)	\$68.19/day
T2021	Day Supports and Activities Tier 6	(2.26-2.75 ave hrs/day)	\$85.23/day
T2021	Day Supports and Activities Tier 7	(2.76-3.25 ave hrs/day)	\$102.28/day
T2021	Day Supports and Activities Tier 8	(3.26-4.0 ave hrs/day)	\$123.59/day
T2021	Day Supports and Activities Tier 9	(4.01-4.75 ave hrs/day)	\$149.15/day

T2021	Day Supports and Activities Tier 10	(4.76-5.50 ave hrs/day)	\$174.73/day
T2021	Day Supports and Activities Tier 11	(5.51-6.25 ave hrs/day)	\$200.29/day
T2021	Day Supports and Activities Tier 12	(6.26-6.99 ave hrs/day)	\$225.87/day
T2021	Day Supports and Activities Tier 13	(7.0-7.99 ave hrs/day)	\$255.70/day

Members may utilize Individual and Small Group Employment Support, Follow Along Support, and Co Worker Support in conjunction with Day Supports & Activities however, it cannot be billed for during the same time frame.

Rates include member transportation. This service is eligible for retainer payments. Up to 30 days can be billed per fiscal year for days the member plans to attend but does not attend.

A modifier of **KX** shall be put on the claim for each day the provider is billing a retainer day.

For retainer payments, if the member is present and starts the service during the following date spans, the number of retainer days is reduced accordingly.

- July 1 – September 30th: 30 retainer days available
- October 1 – December 31st: 22 retainer days available
- January 1 – March 31st: 15 retainer days available
- April 1 – June 30th: 8 retainer days available
- Retainer Payments are not available while an individual is admitted to Montana State Hospital.

Day Supports and Activities Hourly - Congregate groups of employees working in the community that share staff. Based on assessment of average hours of support a member needs per day exceeding an average of 7.99 hours of staff time per day.

T2021	Day Supports and Activities HOURLY	\$34.09/staff hour
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Members may utilize Individual and Small Group Employment Support, Follow Along Support, and Co Worker Support in conjunction with Day Supports & Activities however, it cannot be billed for during the same time frame.

Rates include member transportation. This service is eligible for retainer payments. Up to 30 days can be billed per fiscal year for days the member plans to attend but does not attend by taking the average staff hours provided times the rate.

A modifier of **KX** shall be put on the claim for each day the provider is billing a retainer day.

For retainer payments, if the member is present and starts the service during the following date spans, the number of retainer days is reduced accordingly.

- July 1 – September 30th: 30 retainer days available
- October 1 – December 31st: 22 retainer days available
- January 1 – March 31st: 15 retainer days available
- April 1 – June 30th: 8 retainer days available

- Retainer Payments are not available while an individual is admitted to Montana State Hospital.

ENVIRONMENTAL MODIFICATIONS

S5165	Environmental Modifications	\$ cost varies
S5165 SC	Environmental Modifications Self Direct	\$ cost varies

All modifications must meet all state/local building codes, meet specifications of ANSI, and be guided by the Americans with Disabilities Act (or ADA) Accessibility Guidelines. For modifications estimated to be under \$4000, the DDP Targeted Case Manager will determine the amount of reimbursement after review of their own research or information submitted by the Provider. If the cost of the project exceeds \$4000, then 3 written, itemized bids should be submitted to the DDP Regional Manager (RM) for review. The bids must contain cost of labor equipment, permits, and materials, including subcontractor amounts. The RM will review the information on all requests for this service before authorizing a prior approval. No part of the modification can be diverted to, or billed separately under a different waiver category (e.g. Individual Goods and Services or Specialized Medical Equipment and Supplies)

HOMEMAKER

S5130	Homemaker	\$31.34/staff hour
S5130 XU	Homemaker OTHER	\$ cost varies

This service is not billable for members in residential settings in which primary care is funded 24/7 by the DDP (e.g., group homes and assisted living facilities). Homemaker services are not directly billable to persons receiving Self Directed services.

Homemaker OTHER is for services delivered through a 3rd party/contracted cleaning service and are not delivered by a staff person of the qualified provider directly billing DDP.

INDIVIDUAL GOODS AND SERVICES

T1999	Individual Goods and Services	\$ cost varies
T1999 SC	Individual Goods and Services Self Direct	\$ cost varies

Individual goods and services must be approved prior to purchase and reimbursement. In addition, individual goods and services purchased on behalf of the person by legal guardians, legally responsible persons, or other non- employees acting on behalf of the person are reimbursable only if receipts for such purchases are submitted to the DDP qualified service provider. The receipts are reimbursable only if all the waiver requirements have been met and no reimbursement or cash payment is made to the beneficiary

IGS can only be used when the approved item or service is not covered under any other private or publicly funded resource or other waiver service.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

MEALS

S5170	Meal Services	\$9.24 per meal
S5170 SC	Meal Services Self-Direct	\$9.24 per meal

There is a maximum of 2 meals per day. This service requires a physician's prescription or referral prior to being added to a member's service plan. A referral form specific to the provider is likely necessary to document dietary needs for a member.

NUTRITIONIST

S9470	Nutritionist Services	\$26.66/15 minutes
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Telehealth is allowed for specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for, or associated with, telehealth capability.

Nutritionist services requires a physician's prescription or referral prior to being added to a member's service plan.

OCCUPATIONAL THERAPY

97110	Occupational Therapy	\$25.12/15 minutes
97110	Occupational Therapy	\$25.01/15 minutes

Telehealth is allowed for specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for or associated with, telehealth capability.

Occupational therapy requires a physician's prescription or referral prior to being added to a member's service plan.

PERSONAL CARE

T1019	Personal Care	\$9.19/15 minutes
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Personal care is not billable as a discrete service to persons receiving Self Directed Services.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible person.

PERSONAL SUPPORTS

T2033 SC Personal Supports (both self-direct options) \$30.28/staff hour

Personal Supports and Respite can be billed for the same member however, respite and Personal Supports can't be billed for during the same timeframe. Overlapping services such as companion, personal care, and homemaker services cannot be provided or billed for the same member.

Use **SC** first on a claim as the primary modifier. A secondary modifier of **CG** shall be put second on the claim for services performed by a legally responsible person.

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

	Personal Emergency Response System (PERS)	
S5160	Installation and Testing	\$ cost varies
S5161	Personal Emergency Response Monthly Service	\$ cost varies
S5160 SC	Installation and Testing (both Self Direct options)	\$ cost varies
S5161 SC	Personal Emergency Response Monthly Service (both SD options)	\$ cost varies

Monthly cell phone plans, phone cards, and minutes are not billable through the Waiver.

PHYSICAL THERAPY

97530	Physical Therapy	\$30.21/15 minutes
97530	Physical Therapy	<u>\$30.19/15 minutes</u>

Telehealth is allowed for specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for or associated with telehealth capability.

Requires a physician's prescription or referral prior to being added to a member's service plan.

PRIVATE DUTY NURSING

T1003	Private Duty Nursing (LPN)	\$14.54/15 minutes
T1002	Private Duty Nursing (RN)	\$19.88/15 minutes

Telehealth is allowed for these specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for or associated with telehealth capability.

Private duty nursing requires a physician's prescription or referral prior to being added to a member's service plan.

PSYCHOLOGICAL EVALUATION, COUNSELING, AND CONSULTATION

		Professional
H2019	Psychological Services	\$206.83 Hour

Telehealth is allowed for specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for, or associated with, telehealth capability.

REMOTE MONITORING

T1014	Remote Monitoring	\$8.93/staff hour
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Internet connectivity is not billable.

REMOTE MONITORING EQUIPMENT

A9279	Remote Monitoring Equipment	\$300.00/max per month
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Maximum monthly lease amount is \$300.

RESIDENTIAL HABILITATION

Members in residential habilitation may not receive the following services under the HCBS program: 1) Personal Supports; 2) Homemaker; 3) Environmental Modifications; 4) Respite; 5) Meals; 6) Adult Foster; or 7) Assisted Living. These restrictions only apply when the HCBS payment is being made for the residential service.

Clarification: "Support" also includes general care giving activities such as assistance with daily living activities, meal preparation, laundry, transportation, supervision, community integration, and may include meetings or phone calls on behalf of the individual in service. One or more staff activities providing support, training or actions specified in the individual's plan of care

constitutes billable activities Qualified Providers shall meet licensing requirements and provide sufficient numbers of daily staff and materials to meet individual plans of care. For Congregate Living homes, this shall include awake staff on all shifts where individuals are present. Telehealth is not applicable for congregate living services. For Supported Living, qualified providers shall provide 24 hour on-call staff support.

Congregate Living

Congregate Living Daily- Includes licensed group homes and congregate supported living sites where members share staff. Assignment of Tiers are based on assessment of average hours of support a member needs per day. Tier 10 level of care is for: 1) individuals with a pending petition for civil commitment to IBC or MSH; 2) individuals in MSH or IBC transitioning to the community; 3) individuals with complex care needs in other institutional settings or in-patient hospitals; and 4) individuals who are placed in or may in the future be placed in out-of-state facilities due to their high level of care needs. Tier 10 level of service is approved for up to 12 months. Upon request for prior authorization, the department may grant an extension to the 12-month service period if determined to be medically necessary. Rates include member transportation. This service is eligible for retainer payments. Up to 30 days can be billed per fiscal year on days the member does not attend.

A modifier of **KX** shall be put on the claim for each day the provider is billing a retainer day.

A modifier of **HI** is required as the primary modifier on claim lines for Congregate Living Tier 10 services.

For retainer payments, if the member is present and starts the service during the following date spans, the number of retainer days is reduced accordingly.

- July 1 – September 30th: 30 retainer days available
- October 1 – December 31st: 22 retainer days available
- January 1 – March 31st: 15 retainer days available
- April 1 – June 30th: 8 retainer days available
- Retainer Payments are not available while an individual is admitted to Montana State Hospital.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

T2017	Congregate Living Tier 1	(1-4.8 ave hrs/day)	\$140.31/day
T2017	Congregate Living Tier 2	(4.9-5.47 ave hrs/day)	\$165.43/day
T2017	Congregate Living Tier 3	(5.48-6.14 ave hrs/day)	\$186.45/day
T2017	Congregate Living Tier 4	(6.15-7.14 ave hrs/day)	\$213.19/day
T2017	Congregate Living Tier 5	(7.15-7.7 ave hrs/day)	\$239.44/day
T2017	Congregate Living Tier 6	(7.8-8.43 ave hrs/day)	\$259.97/day
T2017	Congregate Living Tier 7	(8.44-8.75 ave hrs/day)	\$274.87/day
T2017	Congregate Living Tier 8	(8.76-9.9 ave hrs/day)	\$299.45/day
T2017	Congregate Living Tier 9	(10-10.95 ave hrs/day)	\$334.56/day
T2017 HI	Congregate Living Tier 10		\$596.84/day

Congregate Living Hourly - Includes licensed group homes and congregate supported living sites where members share staff. Based on assessment of average hours of support a member needs per day at or exceeding an average of 10.95 hours of staff time per day. Rates include member transportation. This service is eligible up to 30 days of retainer payments by taking the average staff hours provided times the rate.

A modifier of **KX** shall be put on the claim for each day the provider is billing a retainer day.

For retainer payments, if the member is present and starts the service during the following date spans, the number of retainer days is reduced accordingly.

- July 1 – September 30th: 30 retainer days available
- October 1 – December 31st: 22 retainer days available
- January 1 – March 31st: 15 retainer days available
- April 1 – June 30th: 8 retainer days available
- Retainer Payments are not available while an individual is admitted to Montana State Hospital.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

T2017	Congregate Living Hourly	\$31.44/staff hour
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Congregate Living Medical hourly – Designated licensed Group Home sites where 24/7 LPN is required on site. Based on assessment of average hours of support a member needs per day. LPN and habilitation staff are both billable. Rates include member transportation. This service is eligible for up to 30 days of retainer payments by taking the average staff hours provided times the rate.

A modifier of **KX** shall be put on the claim for each day the provider is billing a retainer day.

For retainer payments, if the member is present and starts the service during the following date spans, the number of retainer days is reduced accordingly.

- July 1 – September 30th: 30 retainer days available
- October 1 – December 31st: 22 retainer days available
- January 1 – March 31st: 15 retainer days available
- April 1 – June 30th: 8 retainer days available
- Retainer Payments are not available while an individual is admitted to Montana State Hospital.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

T2017	Congregate Living Medical	\$36.40/staff hour
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Congregate Living Children's hourly – Designated licensed Group Home services for children and/or young adults aged 20 or younger. This service is eligible for up to 30 days of retainer payments by taking the average staff hours provided times the rate.

A modifier of **KX** shall be put on the claim for each day the provider is billing a retainer day.

For retainer payments, if the member is present and starts the service during the following date spans, the number of retainer days is reduced accordingly.

- July 1 – September 30th: 30 retainer days available
- October 1 – December 31st: 22 retainer days available
- January 1 – March 31st: 15 retainer days available
- April 1 – June 30th: 8 retainer days available
- Retainer Payments are not available while an individual is admitted to Montana State Hospital.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

T2017	Congregate Living Children's	\$34.17/staff hour
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Supported Living - Service for individuals living in a family home, their own home, or an apartment.

Hourly - An hourly unit is for members needing an average of more than 45.1 hours of supported living services per month, for adults if remote monitoring services will be provided concurrently with hourly supported living, or can be applied in any situation where monthly units would be cost prohibitive. Geographical adjustments apply based on where the member lives and are determined by the member's county. This service is not eligible for retainer payments. Rates include member transportation.

Telehealth is allowed for specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for, or associated with, telehealth capability.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

T2013	Res Hab Supported Living no geographic factor	\$33.59/staff hour
T2013	Res Hab Supported Living medium geographic factor	\$34.43/staff hour
T2013	Res Hab Supported Living high geographic factor	\$35.27/staff hour

Rural Remote – Services delivered in remote locations that involve a round trip of at least 80 miles (from the closest provider location) to access the service, for members needing an average of more than 45.1 hours of supported living services per month, for adults if remote monitoring services will be provided concurrently with hourly supported living, or can be applied in any

situation where monthly units would be cost prohibitive. There is no geographic adjustment. Rural remote services must be prior approved. This service is not eligible for retainer payments. Rates include member transportation.

Telehealth is allowed for specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for, or associated with, telehealth capability.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

T2013	Res Hab Supported Living rural remote	\$36.11/staff hour
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Supported Living Base - for individuals with supported living needs that vary significantly each month (between one (1) and thirty (30.99) hours of support) and must include at least ONE face-to-face contact per month during the hours provided. This is a monthly billing unit. There is no geographic adjustment. This service is not eligible for retainer payments. Rates include member transportation. Telehealth does not satisfy the face-to-face requirement.

Telehealth is allowed for specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for, or associated with, telehealth capability.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

T2032	Res Hab Supported Living – Base	\$1007.65/month
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Supported Living Flex - for individuals with supported living needs that vary significantly each month (between thirty-one (31.0) to forty-five (45.0) hours of support) and must include at least TWO face-to-face contacts per month during the hours provided. This is a monthly billing unit and a minimum of 31 hours must be provided to bill this unit. There is no geographic adjustment. This service is not eligible for retainer payments. Rates include member transportation. Telehealth does not satisfy the face-to-face requirement.

Telehealth is allowed for specific activities (but not for the required face-to-face contacts). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for, or associated with, telehealth capability.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

T2032	Res Hab Supported Living – Flex	\$1511.47/month
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Supported Living SMALL Agency - for very small providers who meet ALL of the following criteria: support a total of 10 or fewer DD individuals in their program, who employ 12 or fewer staff, and whose Director routinely provides some of the direct support hours every week. Rates for this service are for members needing an average of more than 45.1 hours of supported living services per month, for adults if remote monitoring services will be provided concurrently with hourly supported living, or can be applied in any situation where monthly units would be cost prohibitive. Geographical adjustments apply based on where the member lives and are determined by the member's county. Hours that the Director provides direct services are billable. This service is not eligible for retainer payments. Rates include member transportation.

Telehealth is allowed for specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for, or associated with, telehealth capability.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

T2013	Res Hab Supported Living (Small Agency) no geo factor	\$43.66/staff hour
T2013	Res Hab Supported Living (Small Agency) med geo factor	\$44.75/staff hour
T2013	Res Hab Supported Living (Small Agency) high geo factor	\$45.85/staff hour

RESIDENTIAL TRAINING SUPPORTS

Residential Training Supports (RTS) are only billable for a member receiving Adult Foster. RTS is billed separately from Adult Foster.

Residential Training Supports – based on assessment of average hours needed. Geographical adjustments apply based on where the member lives and are determined by the member's county. Rates include member transportation.

H2015	Residential Training Support (no geo factor)	\$33.59/staff hour
H2015	Residential Training Support (medium geo factor)	\$34.43/staff hour
H2015	Residential Training Support (high geo factor)	\$35.27/staff hour

RTS SMALL Agency – based on assessment of average hours needed. RTS Small is for very small providers who meet ALL of the following criteria: support a total of 10 or fewer DD individuals in their program, who employ 12 or fewer staff, and whose Director routinely provides some of the direct support hours every week. Geographical adjustments apply based on where the member lives and are determined by the member's county. Hours that the Director provides direct services are billable. Rates include member transportation.

H2015	Residential Training Support (small agency no geo)	\$43.66/staff hour
H2015	Residential Training Support (small agency medium geo)	\$44.75/staff hour
H2015	Residential Training Support (small agency high geo)	\$45.85/staff hour

RESPITE

S5150	Respite	\$6.20/15 minutes
S5151	Respite Other	\$ cost varies
S5150 SC	Respite (both self-direct options)	\$6.20/15 minutes
S5151 SC	Respite Other (both self-direct options)	\$ cost varies

Respite services are temporary in nature, meaning a member is not permitted to receive respite care for a period of 24 hours per day for more than 29 consecutive days.

Respite OTHER is for agency run or agency associated sites and additionally, for services delivered through a third party licensed day care that use daily or monthly fees. The criteria for allowable daycare differs by age as noted in the waiver definition.

RETIREMENT

Daily - based on assessment of average hours of support a member needs per day.

S5100	Retirement Services Tier 1	(0-.5 ave hrs/day)	\$13.75/day
S5100	Retirement Services Tier 2	(.5-1 ave hrs/day)	\$28.30/day
S5100	Retirement Services Tier 3	(1.01-1.25 ave hrs/day)	\$36.39/day
S5100	Retirement Services Tier 4	(1.26-1.75 ave hrs/day)	\$48.51/day
S5100	Retirement Services Tier 5	(1.76-2.25 ave hrs/day)	\$64.68/day
S5100	Retirement Services Tier 6	(2.26-2.75 ave hrs/day)	\$80.86/day
S5100	Retirement Services Tier 7	(2.76-3.25 ave hrs/day)	\$97.03/day
S5100	Retirement Services Tier 8	(3.26-4.0 ave hrs/day)	\$117.24/day
S5100	Retirement Services Tier 9	(4.01-4.75 ave hrs/day)	\$141.50/day
S5100	Retirement Services Tier 10	(4.76-5.50 ave hrs/day)	\$165.76/day
S5100	Retirement Services Tier 11	(5.51-6.25 ave hrs/day)	\$190.01/day
S5100	Retirement Services Tier 12	(6.26-6.99 ave hrs/day)	\$214.24/day
S5100	Retirement Services Tier 13	(7.0-7.99 ave hrs/day)	\$242.57/day

Rate includes member transportation. This service is eligible for retainer payments. Up to 30 days can be billed per fiscal year on days the member plans to attend but does not attend.

A modifier of **KX** shall be put on the claim for each day the provider is billing a retainer day.

For retainer payments, if the member is present and starts the service during the following date spans, the number of retainer days is reduced accordingly.

- July 1 – September 30th: 30 retainer days available
- October 1 – December 31st: 22 retainer days available
- January 1 – March 31st: 15 retainer days available
- April 1 – June 30th: 8 retainer days available
- Retainer Payments are not available while an individual is admitted to Montana State Hospital.

Hourly - Congregate groups of employees working in the community that share staff. Based on assessment of average hours of support a member needs per day at or exceeding an average of 8 hours of staff time per day.

S5100	Retirement Services HOURLY	\$32.34/staff hour	Retainer: ave daily hours
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Rates include member transportation. This service is eligible for retainer payments. Up to 30 days can be billed per fiscal year on days the member plans to attend but does not attend by taking the average staff hours provided times the rate.

A modifier of **KX** shall be put on the claim for each day the provider is billing a retainer day.

For retainer payments, if the member is present and starts the service during the following date spans, the number of retainer days is reduced accordingly.

- July 1 – September 30th: 30 retainer days available
- October 1 – December 31st: 22 retainer days available
- January 1 – March 31st: 15 retainer days available
- April 1 – June 30th: 8 retainer days available
- Retainer Payments are not available while an individual is admitted to Montana State Hospital.

SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

The Department requires all other funding sources be utilized, such as Vocational Rehabilitation, or a denial from other funding sources before this service is entered into the cost plan and approved by the Regional Manager.

T2029	Specialized Medical Equipment	\$ cost varies
T2028	Specialized Medical Supplies	\$ cost varies
T2029 SC	Specialized Medical Equipment self-direct	\$ cost varies
T2028 SC	Specialized Medical Supplies self-direct	\$ cost varies

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

SPEECH THERAPY

		Professional
92507	Speech Therapy	\$65.47 Hour
92507	Speech Therapy	\$65.55 Hour

Telehealth is allowed for these specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered

as Telehealth. The waiver cannot be billed for any equipment or software required for or associated with-telehealth capability.

Requires a physician's prescription or referral prior to being added to a member's service plan.

SUPPORTED EMPLOYMENT – CO-WORKER SUPPORT

T2025	Supported Employment – Co Worker Support	\$11.83/day at work
T2025 SC	Supported Employment – Co Worker Supt (all SD)	\$11.83/day at work

Co-Worker Support and Follow-Along Support cannot be billed for during the same time but could be billed for during the same day.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

SUPPORTED EMPLOYMENT – FOLLOW ALONG

Base - Members receive up to 10.5 hours of follow along support per month including at least one (1) contact either with the member or employer per month regarding their employment.

Telehealth is allowed for specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for or associated with telehealth capability.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

H2025	Supported Employment Follow Along – BASE	\$536.54/month
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Tier 1 - Members receive between 10.6 and 21.9 hours of follow along support per month with at least 2 face-to-face contacts per month during the hours provided. A **face-to-face contact** involves direct observation and communication with the member for the purpose of implementing their personal supports plan / individual career plan. Telehealth does not satisfy a face-to-face requirement. This is a monthly billing unit and a minimum of 10.6 hours must be provided to bill this unit.

Telehealth is allowed for specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for, or associated with, telehealth capability.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

H2025	Supported Employment Follow Along – TIER 1	\$1073.06/month
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Tier 2 - Members receive between 22 and 31.9 hours of follow along support per month with at least 4 face-to-face contacts per month during the hours provided. A **face-to-face contact** involves direct observation and communication with the member for the purpose of implementing their personal supports plan / individual career plan. Telehealth does not satisfy a face-to-face requirement. This is a monthly billing unit and a minimum of 22 hours must be provided to bill this unit.

Telehealth is allowed for specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for, or associated with, telehealth capability.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

H2025	Supported Employment Follow Along – TIER 2	\$1584.05/month
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Hourly – Members who require in excess of 32 hours per month of follow along support have levels of support based upon the assessment(s) of needs and are hourly. Hourly can also be applied in any situation where monthly units would be cost prohibitive, and hourly should be applied for all self-direct employer authority.

Telehealth is allowed for specific activities (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for, or associated with, telehealth capability.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

H2025	Supported Employment Follow Along hourly	\$59.21/staff hour
H2025 SC	Supported Employment Follow Along (all SD)	\$59.21/staff hour

SUPPORTED EMPLOYMENT – INDIVIDUAL EMPLOYMENT SUPPORT

H2023	Supported Employment – Individual Employment Support	\$59.21/staff hour
H2023 SC	Supported Employment – Individual Empl Support (all SD)	\$59.21/staff hour

Telehealth is allowed except for self-direct service delivery (but not for the required face-to-face contact). A modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for, or associated with, telehealth capability.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

SUPPORTED EMPLOYMENT – SMALL GROUP EMPLOYMENT SUPPORT

Daily - based on assessment of average hours of support a member needs per day. A modifier of **CG** shall be put on the claim for services performed by a legally responsible person.

T2019	Suppt Employment Small Group Tier 1	(0-.5 ave hrs/day)	\$16.88/day
T2019	Suppt Employment Small Group Tier 2	(.5-1 ave hrs/day)	\$34.75/day
T2019	Suppt Employment Small Group Tier 3	(1.01-1.25 ave hrs/day)	\$44.68/day
T2019	Suppt Employment Small Group Tier 4	(1.26-1.75 ave hrs/day)	\$59.58/day
T2019	Suppt Employment Small Group Tier 5	(1.76-2.25 ave hrs/day)	\$79.43/day
T2019	Suppt Employment Small Group Tier 6	(2.26-2.75 ave hrs/day)	\$99.29/day
T2019	Suppt Employment Small Group Tier 7	(2.76-3.25 ave hrs/day)	\$119.15/day
T2019	Suppt Employment Small Group Tier 8	(3.26-4.0 ave hrs/day)	\$143.97/day
T2019	Suppt Employment Small Group Tier 9	(4.01-4.75 ave hrs/day)	\$173.76/day
T2019	Suppt Employment Small Group Tier 10	(4.76-5.50 ave hrs/day)	\$203.55/day
T2019	Suppt Employment Small Group Tier 11	(5.51-6.25 ave hrs/day)	\$233.34/day
T2019	Suppt Employment Small Group Tier 12	(6.26-6.99 ave hrs/day)	\$263.12/day
T2019	Suppt Employment Small Group Tier 13	(7.0-7.99 ave hrs/day)	\$297.88/day

Hourly - Congregate groups of employees working in the community that share staff.
Assignment of Tiers are based on assessment of average hours of support a member needs per day at or exceeding an average of 8 hours of staff time per day.

T2019	Supported Employment Small Group Hourly	\$39.72/staff hr
T2019 SC	Supported Employment Small Group Hourly AwC	\$39.72/staff hr

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

SUPPORTS BROKERAGE

T2041 SC	Supports Broker (all self-direct)	\$42.58/staff hour
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This service is limited to members who direct some or all of their waiver services with employer authority. This service is capped annually at \$6,000 or 20% of value of the member's cost plan, whichever is smaller.

Telehealth is allowed for this self-direct service (but not for the required face-to-face contact). A secondary modifier of **GT** and a place of service code of **02** shall be put on the claim for units delivered as Telehealth. The waiver cannot be billed for any equipment or software required for, or associated with, telehealth capability.

TRANSPORTATION

Service offered in order to enable members served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the plan of care. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Legally responsible persons, relatives, legal guardians and other persons who are not employees of DDP qualified provider agencies may be reimbursed for the provision of rides. In these cases, reimbursement will be less than or equal to the mileage rate set by the Department for a State employee operating a personal vehicle. The mileage rate is based on the operational expense of a motor vehicle and does not include reimbursement for work performed, or the driver's time. Reimbursement for rides provided by legally responsible persons or others must be related to the specific disability needs of a member, as outlined in the plan of care. Persons providing transportation must be licensed, insured and drive a registered vehicle, in accordance with the motor vehicle laws of the State of Montana.

Reimbursable transportation expenses may also include assistance with reasonable (as determined by the department) costs related to one or more of the following areas: operator training and licensure, insurance, registration or other costs associated with an individual's dependence on the use of a personal vehicle owned by the person in accessing work or other community integration activities as outlined in the plan of care.

Transportation as a self-directed services with employer authority (either common law or agency with choice): Mileage reimbursement at the lowest current state plan rate is available when the member is transported to an approved community functions, in accordance with the plan of care and the individual cost plan. Mileage reimbursement paid by the FMS is contingent upon the FMS receiving documentation that transportation was provided in accordance with Montana state requirements for operating a motor vehicle. Reimbursement is contingent upon vehicles being registered and insured, and the operator of the vehicle having a valid driver's license. Mileage reimbursement does not pay for a person's time, rather, the mileage reimbursement partially offsets the cost of operating a motor vehicle. Mileage reimbursement may also be available to the owner of the vehicle when friends and non-employees provide transportation services to the member for approved community functions, when all the requirements for operating a motor vehicle have been met, and the mileage reimbursement provision is approved in the plan of care. Mileage reimbursement is not available for medically necessary transportation reimbursable under the state plan.

Rates for services in residential settings and work/day settings in which paid, on-site primary care givers provide routine, non-medically necessary transportation (community outings, picnics, etc.) may include cost of these integrated transportation services.

The following are excluded:

- 1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the member;
- 2) Purchase or lease of a vehicle; and

3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of any modifications.

Transportation services are not reimbursable in residential and work/day settings, if the transportation service is folded into the rates for these residential and/or work/day settings. Under no circumstances will medically necessary transportation (transportation to medical services reimbursed under the State Plan) be reimbursed under the waiver if the service is reimbursable under State Plan transportation.

The waiver will not cover activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), or EPSDT.

T2002	Transportation – Individual Commute	cost varies per month
T2002	Transportation – Individual Commute (wheelchair van)	cost varies per month
T2002 SC	Transportation – Individual Commute AwC	cost varies per month
T2002	Transportation – Shared Commute	cost varies per month
T2002	Transportation – Shared Commute (wheelchair van)	cost varies per month
T2003 XU	Transportation – Work/Day Integration 12 max units/yr	\$15.35 per ride/trip
T2003 XU	Transportation – Work/Day Integration (wheelchair van) 12/yr	\$18.42 per ride/trip
T2003	Transportation – Residential Integration	\$59.93 per unit
T2003	Transportation – Residential Integration (wheelchair van)	\$71.91 per unit
T2003 SC	Transportation – Residential Integration AwC	\$ cost varies
T2004	Transportation OTHER (taxi, bus pass,)	\$ cost varies
T2004 SC	Transportation OTHER (all SD) taxi, bus pass	\$ cost varies
S0215	Transportation Mileage Reimbursement	\$.61 per mile
S0215 SC	Transportation Mileage Reimbursement (all SD)	\$.61 per mile

Most transportation has been bundled into certain services. Please refer to the Transportation Guidelines for details on applicability, and outlier criteria for uncommon circumstances. When approved and prior authorized by a regional manager, a transportation temporary service increase may be permissible for certain outlier scenarios.

A modifier of **CG** shall be put on the claim for services performed by a legally responsible individual.

ALL SELF DIRECTED-WAIVER SERVICES – (primary modifier)

For all waiver services that are delivered through one of the self-directed service option, the qualified provider bills the regular code shown above for each specific waiver service.

Additionally, make sure that the **Modifier SC** is entered on the claim first as the primary modifier so the claim will pay correctly. Enter any subsequent, applicable modifiers as the 2nd modifier code on the claim. Only Supports Broker is eligible to be delivered via telehealth for members using Employer Authority Self Direct.

FISCAL AGENT FEES FOR SELF DIRECT – (primary modifier)

The fiscal agent is a private or public entity that is approved by the IRS (under IRS Revenue Procedure 70-6) to act as the employer's intermediary for the purpose of managing employment taxes, including income tax withholding, FICA, FUTA/SUTA, and worker's compensation. The fiscal agent collects employment documents and verifies signatures from employers prior to distributing paychecks to the employees.

The fiscal agent fees should cover the Fiscal Management Service (FMS) costs of issuing reimbursements, cost of employee background checks, monthly List of Excluded Individuals and Entities (LEIE) and Medicare Exclusion Database (MED) monitoring, monitor and maintain records of employee qualifications, instruction on methods of interviewing, selecting and hiring staff, legal requirements for retaining and discharging staff according to Montana laws and rules, methods of staff supervision, and such other topics as are required in the opinion of the fiscal agent contractor to assist individuals to effectively self-direct their services. Modifier **SC** is entered on the claim first as the primary modifier so the claim will pay correctly.

T2040 SC	Enrollment (for families new to self-direct services)	\$ no charge
T2040 SC	Per Member Per Month	\$62.00/month
T2040 SC	New Employee Hire	\$50.00 per employee
T2040 SC	Monthly Check Transaction Fee:	
	• 0 – 2 checks \$0.00 (included in the Per Member Per Month)	
	• 3+ checks \$50.00 (in addition to the \$62.00 Per Member Per Month)	
T2040 SC	Vendor Only enrollment	\$ no charge
T2040 SC	Vendor Only check transaction fee	\$24.00 per check

ALL TEMPORARY SERVICE INCREASES (TSI) – (primary modifier)

For all waiver services that are designated as a TSI, bill the regular code shown above for each specific service. Additionally, make sure the Modifier TU is entered first as the primary modifier on the claim line so the claim will pay correctly. Enter any subsequent, applicable modifiers as the second modifier on the claim line.

OTHER CATEGORIES OF SERVICES – (primary modifier)

For certain waiver services, the billable service is listed with an **XU** modifier. Bill the regular code with the **XU** modifier entered first on the claim line. Enter any subsequent, applicable modifiers as the 2nd modifier on the claim line.

Congregate Living Tier 10 – (primary modifier)

Bill the T2017 procedure code with the **HI** modifier entered first on the claim line. Enter any subsequent, applicable modifiers as the 2nd modifier on the claim line.

ALL RETAINER DAYS – (secondary modifier)

For all waiver services that are designated as a retainer day for Congregate Living or Day Supports and Activities, Assisted Living, or Retirement the qualified provider will bill the regular code shown above for each specific service. Additionally, make sure the modifier KX is entered on the claim. If a primary modifier is applicable, enter the primary modifier first on the claim line, then enter the KX modifier second on the claim line. Enter claims lines with KX modifiers after claim lines without KX modifiers.

ALL SERVICES DELIVERED VIA TELEHEALTH – (secondary modifier)

Face-to-face service delivery is preferred. Telehealth may be substituted if clinically indicated or if the member does not have access to face-to-face services. Case notes/service notes must include the reason for the use of telehealth, including documentation of attempts to identify local supports, if the reason for the use of telehealth services is related to access issues. Telehealth is allowed for specific activities, and for specific services. Employer Authority self-directed services are not eligible for telehealth delivery, except for Supports Broker. Telehealth does not meet face to face requirements. The waiver cannot be billed for any equipment or software required for or associated with telehealth capability. For billing the qualified provider will bill the regular code shown above for each specific service. Additionally, enter a modifier **GT** and a place of service code of **02** on the claim line for units delivered as Telehealth. In doing so, the provider is certifying that the service was provided via interactive audio-video telehealth. If a primary modifier is applicable, enter the primary modifier first on the claim line, then enter the **GT** modifier second on the claim line.

ALL SERVICES DELIVERED BY A LEGALLY RESPONSIBLE INDIVIDUAL – (secondary modifier)

Must meet requirements in C-2 (d) of the waiver. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes the parent or guardian of a minor child who must provide care to the child, or a spouse of a waiver participant. Payment may not be made to legally responsible individual for care that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of the waiver participant. Paid caregiver/legally responsible individual cannot be both employer and employee of self-directed services. For billing, the qualified provider will bill the regular code shown above for each specific service. Additionally, enter the modifier **CG** on the claim line. If a primary modifier is applicable, enter the primary modifier first on the claim line, then enter the **CG** modifier second on the claim line.

PROVIDER RESPONSIBILITIES SPECIFIC TO WAIVERS

Providers must understand the service definitions in the waiver and parameters for each service that is authorized. It is the Provider's responsibility to contact the case manager in the event there is a discrepancy in the service(s) authorized or rendered and the approved service authorization. It is the provider's responsibility to check a member's Medicaid eligibility and to obtain an appropriate denial for services that may be covered by other revenue streams. A denial must be related to the service not being covered, and not related to the claims process. For example, a denial that *a provider did not submit the required documentation* would not be considered an appropriate denial.

Individual Cost Plans

All waiver services require prior authorization before the service is delivered. The member's Case Manager is responsible for completing the Plan of Care. Based on Goals and Objectives identified in the Plan of Care, the Case Manager will enter the service details, units, provider, and date spans in the cost plan section where it will be stored as a Service Authorization in MMIS. Claims will be denied if there is not an active service authorization associated with the claim, or if a code other than the approved code is billed. Providers should not render or bill services without an approved service authorization.

The Service Authorization serves as the official authorization for service delivery and reimbursement.

BILLING PROCEDURES:

The Department is committed to paying Medicaid providers claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were billed appropriately. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. Therefore, payment of a claim does not mean the service was correctly billed or the payment made to the provider was correct. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in another way, the Department is required by Federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of the Department or provider error or other cause. (MCA 53-6-111, ARM 37.85.406.)

A provider shall use the Department's designated claims processing system to submit claims. Services provided must be billed electronically or on a CMS-1500 claim form. CMS claim forms are available from various publishing companies and are not available from the Department or Provider Relations. For more information on submitting a claim, see the *Billing Procedures chapter in the General Information for Providers* manual on the Montana Medicaid provider website. Additionally, see the *General Information for Providers* for information on remittance advices and adjustments.

Also:

- Do not bill for services before they are provided.
- If a unit of service equals 15 minutes, a minimum of 8 minutes of service must be provided to bill for one unit. Partial units totaling less than eight minutes may not be billed. Activities requiring less than eight minutes for each member may be accrued to the end of that day. A range of 8-23 minutes is 1 unit.
- Claims for daily or hourly units may be submitted daily, weekly, or less frequently.
- Payments are issued on a weekly basis according to the MMIS payment schedule.

- Enter the primary modifier **TU** for all Temporary Service Increase (TSI) claims.
- Enter the primary modifier **SC** for all Self Direct claims.
- Enter the primary modifier **XU** for designated service descriptions.
- Enter the modifier **KX** for all retainer days on claims, as noted per service.
- Enter **GT** modifier for services provided via telehealth, as noted per service.
- Enter **CG** modifier for legally responsible individual delivering the service, as noted per service.

Electronic Visit Verification (EVV): The Department of Public Health and Human Services (DPHHS) will acquire an EVV services component to support personal care services (PCS) and home health care services (HHCS) as well as other home and community-based services determined to benefit from the mandates of Section 12006 of the 21st Century Cures Act. For applicability, updates, and instructions please refer to the DPHHS website at <https://dphhs.mt.gov/sltc/EVV> .

CLAIM REMINDERS AND TIPS

When billing Medicaid waiver claims, the provider must consider the following:

- The waiver does not reimburse activities which are otherwise available under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.), EPSDT, or other private or public source.
- The waiver does not reimburse directly any time spent by office staff billing claims or staff travel time when a member is not in the vehicle.
- Providers may only bill for services authorized in the service authorization(s).
- A claim may include different dates of service.
- The units of service reimbursed through the waiver must meet documentation requirements in rule, federal code, and within the waiver.
- Services billed must meet the service definitions and parameters as described in the waiver, rule, or federal code.
- Services are payable when delivered by awake staff.
- When a claim is submitted for payment, the provider is verifying the claim is true, correct, and accurate.
- Updated billing information may be provided through provider bulletins and other methods. Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in the notices.

BILLING FOR RETROACTIVELY ELIGIBLE MEMBERS

When a member becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for services provided during the retroactive period. When submitting claims for retroactively eligible members, attach a copy of the 160-M

to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

When a provider chooses to accept the member from the date retroactive eligibility was effective, and the member has made a full or partial payment for services, the provider must refund the member's payment for the services before billing Medicaid for the services.

For more information on retroactive eligibility, see the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

MEMBERS WITH OTHER INSURANCE OR REVENUE OPTIONS:

If a member is also covered by Medicaid State Plan, EPSDT, Vocational Rehabilitation, or other insurance or funding streams, those avenues must be exhausted first before utilizing waiver services or billing the DDP 0208 Comprehensive Waiver. If those other revenue streams are an option, only bill the Developmental Disabilities Waiver after denial is received from the other payer(s), or when there is documentation that the billable units from the other payer(s) have been depleted.

MEDICAID FEE SCHEDULE:

Please use the Department's fee schedule for your provider type in conjunction with the appropriate procedure code, using the pricing method associated with the procedure code such as per hour, per day, per month, etc. Current fee schedules are available on the Medicaid Provider and on the DDP websites. The Medicaid enrolled provider approved to deliver services through the Developmental Disabilities Program shall assume responsibility for all services provided by their staff or subcontractors. Pursuant to the Medicaid Provider Agreement, all claims are considered to be paid in full; no balance billing is permitted.

When Medicaid payment differs from the fee schedule, consider the following:

The Department pays the lower of the established Medicaid fee or the provider's charge;

Modifiers;

Provider Type;

Date of Service; and/or

Check for Third Party Liability payments shown on the remittance advice.

DOCUMENTATION

Documentation of the delivery of service must be maintained to substantiate claims. The provider's documentation must support the claim, including the type, scope, amount, duration, and frequency of the service as described in the Plan of Care. It should include the date(s), start and end times, and number of units of the delivered service for each member and must align with the prior authorization received for the provision of services. Pursuant to the waiver, there may

be a need to have documentation that the service is not available or is no longer available under other funding sources. Additionally, for certain services there may be a need to document face-to-face contacts.

- Records must be clear, concise, complete, and current.
- Information must be factual and absent any fabricated or falsified names, dates, data or narratives. Entries should contain objective information relevant to individual care.
- Information and documents must be organized in a systematic and chronological format.
- Information must be written in ink, recorded in a typed/printed format, or in an electronic file with appropriate back-up.
- Correction fluid, correction tape or similar applications may not be used to correct errors in the record.
- Errors are to be corrected by marking through the incorrect entry with a single line and recording the date and initials of the person correcting the entry.
- Information must be legible.
- Information must be dated, signed, and have the title of the person recording each entry. Initials can be appropriate for entries such as flow sheets or medication records, but a full signature should be used for entries such as narratives or assessments.
- Information entered into the record must be recorded in a timely manner, as soon as possible following the completion of the event or activity described by the entry.
- Providers must maintain original (e.g., paper or electronic) documents for the services provided by their employed staff.
- Providers must maintain copies of required documentation obtained from subcontracted staff and other providers/subcontractors.

KEY CONTACTS

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated “In state” will not work outside Montana. For a comprehensive list of contacts and websites, go to:
<https://medicaidprovider.mt.gov/> .

Provider Relations

For questions about eligibility, payments, denials, general claims questions, Medicaid or PASSPORT provider enrollment, address or phone number changes, or to request provider manuals or fee schedules, go to <https://medicaidprovider.mt.gov/> or:

(800) 624-3958
(406) 442-1837 (Helena/Local)

Send written inquiries to:

Montana Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Member Eligibility

For information on a member's eligibility for services through the Developmental Disabilities Program, access the Eligibility Reference Manual

at: <https://dphhs.mt.gov/bhdd/DisabilityServices/developmentaldisabilities/>

Eligibility Specialist
Developmental Disabilities Program
111 Sanders Rom 305
PO Box 4210
Helena MT 59604

(406) 444-5930 phone
(406) 444-0230 fax

For information on a Member's Medicaid Eligibility go to <https://medicaidprovider.mt.gov> .

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In state
(406) 443-1365 Out of state and Helena
(406) 442-0357 Fax

Send written inquiries to:

Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Secretary of State of Montana

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State of Montana
P.O. Box 202801
Helena, MT 59620-2801

Medicaid Fraud

Medicaid Provider Fraud – occurs when a provider knowingly makes or causes to be made, a false or misleading statement or representation for use in obtaining reimbursement from the Medicaid Program. To report Medicaid provider fraud:

Medicaid Fraud Control Unit (MFCU)
Montana Department of Justice
Division of Criminal Investigations
1-800-376-1115

Member/Client Fraud – is intentional deception or misrepresentation with knowledge the deception could result in some unauthorized benefits to the individual or some other person. To report Medicaid member/client fraud:

Department of Health and Human Services
Office of Inspector General, Program Compliance Bureau
Fraud Hotline
1-800-201-6308

DRAFT Developmental Disabilities Waiver Summary Rate Schedule - July 1, 2026

ICP Service	Effective	Unit	SFY2026 Rate	SFY2027 Rate
Congregate Living Hourly (more than 10.95 ave hrs/day, over 4000 annual hrs)	7/1/2026	Staff Hour	\$ 31.44	\$ 31.44
Congregate Living Tier 1 (1-4.8 ave hrs/day, 0-1735.99 annual hrs)	7/1/2026	Daily	\$ 140.31	\$ 140.31
Congregate Living Tier 2 (4.9-5.47 ave hrs/day, 1754-2005.99 annual hours)	7/1/2026	Daily	\$ 165.43	\$ 165.43
Congregate Living Tier 3 (5.48-6.14 ave hrs/day, 2006-2235.99 annual hours)	7/1/2026	Daily	\$ 186.45	\$ 186.45
Congregate Living Tier 4 (6.15-7.14 ave hrs/day, 2236-2605.99 annual hours)	7/1/2026	Daily	\$ 213.19	\$ 213.19
Congregate Living Tier 5 (7.15-7.7 ave hrs/day, 2606-2845.99 annual hours)	7/1/2026	Daily	\$ 239.44	\$ 239.44
Congregate Living Tier 6 (7.8-8.43 ave hrs/day, 2846-3075.99 annual hours)	7/1/2026	Daily	\$ 259.97	\$ 259.97
Congregate Living Tier 7 (8.44-8.75 ave hrs/day, 3076-3194.99 annual hours)	7/1/2026	Daily	\$ 274.87	\$ 274.87
Congregate Living Tier 8 (8.76-9.9 ave hrs/day, 3195-3613.99 annual hours)	7/1/2026	Daily	\$ 299.45	\$ 299.45
Congregate Living Tier 9 (10-10.95 ave hrs/day, 3614-3999.99 annual hours)	7/1/2026	Daily	\$ 334.56	\$ 334.56
Congregate Living Tier 10	7/1/2026	Daily	\$ 596.84	\$ 596.84
Congregate Living Medical	7/1/2026	Staff Hour	\$ 36.40	\$ 36.40
Congregate Living Children's	7/1/2026	Staff Hour	\$ 34.17	\$ 34.17
Res. Hab. Supported Living no geographic factor	7/1/2026	Staff Hour	\$ 33.59	\$ 33.59
Res. Hab. Supported Living Medium geographic factor	7/1/2026	Staff Hour	\$ 34.43	\$ 34.43
Res. Hab. Supported Living High geographic factor	7/1/2026	Staff Hour	\$ 35.27	\$ 35.27
Res. Hab. Supported Living (Small agency) no geo factor	7/1/2026	Staff Hour	\$ 43.66	\$ 43.66
Res. Hab. Supported Living (Small agency) Medium geo factor	7/1/2026	Staff Hour	\$ 44.75	\$ 44.75
Res. Hab. Supported Living (Small agency) High geo factor	7/1/2026	Staff Hour	\$ 45.85	\$ 45.85
Res. Hab. Supported Living - Base	7/1/2026	Month	\$ 1,007.65	\$ 1,007.65
Res. Hab. Supported Living - Flex	7/1/2026	Month	\$ 1,511.47	\$ 1,511.47
Res. Hab. Supported Living rural remote	7/1/2026	Staff Hour	\$ 36.11	\$ 36.11
Adult Foster Support (low supervision)	7/1/2026	Month	\$ 3,423.63	\$ 3,423.63
Adult Foster Support (moderate supervision)	7/1/2026	Month	\$ 3,900.15	\$ 3,900.15
Adult Foster Support (enhanced supervision)	7/1/2026	Month	\$ 4,376.66	\$ 4,376.66
Adult Foster Support (intensive supervision)	7/1/2026	Month	\$ 5,351.82	\$ 5,351.82
Residential Training Support (no geographical factor)	7/1/2026	Staff Hour	\$ 33.59	\$ 33.59
Residential Training Support (medium geographical factor)	7/1/2026	Staff Hour	\$ 34.43	\$ 34.43
Residential Training Support (high geographical factor)	7/1/2026	Staff Hour	\$ 35.27	\$ 35.27
Residential Training Support (small agency / no geographical factor)	7/1/2026	Staff Hour	\$ 43.66	\$ 43.66
Residential Training Support (small agency / medium geographical factor)	7/1/2026	Staff Hour	\$ 44.75	\$ 44.75
Residential Training Support (small agency / high geographical factor)	7/1/2026	Staff Hour		

DRAFT Developmental Disabilities Waiver Summary Rate Schedule - July 1, 2026

ICP Service	Effective	Unit	SFY2026 Rate	SFY2027 Rate
Retirement Services Hourly (over 8 ave hours per day)	7/1/2026	Staff Hour	\$ 32.34	\$ 32.34
Retirement Services Tier 1 (.1-1.5 ave hrs/day)	7/1/2026	Daily	\$ 13.75	\$ 13.75
Retirement Services Tier 2 (.5-1.0 ave hrs/day)	7/1/2026	Daily	\$ 28.30	\$ 28.30
Retirement Services Tier 3 (1.01-1.25 ave hrs/day)	7/1/2026	Daily	\$ 36.39	\$ 36.39
Retirement Services Tier 4 (1.26-1.75 ave hrs/day)	7/1/2026	Daily	\$ 48.51	\$ 48.51
Retirement Services Tier 5 (1.76-2.25 ave hrs/day)	7/1/2026	Daily	\$ 64.68	\$ 64.68
Retirement Services Tier 6 (2.26-2.75 ave hrs/day)	7/1/2026	Daily	\$ 80.86	\$ 80.86
Retirement Services Tier 7 (2.76-3.25 ave hrs/day)	7/1/2026	Daily	\$ 97.03	\$ 97.03
Retirement Services Tier 8 (3.26-4.0 ave hrs/day)	7/1/2026	Daily	\$ 117.24	\$ 117.24
Retirement Services Tier 9 (4.01-4.75 ave hrs/day)	7/1/2026	Daily	\$ 141.50	\$ 141.50
Retirement Services Tier 10 (4.76-5.5 ave hrs/day)	7/1/2026	Daily	\$ 165.76	\$ 165.76
Retirement Services Tier 11 (5.51-6.25 ave hrs/day)	7/1/2026	Daily	\$ 190.01	\$ 190.01
Retirement Services Tier 12 (6.26-6.99 ave hrs/day)	7/1/2026	Daily	\$ 214.27	\$ 214.27
Retirement Services Tier 13 (7.0-7.99 ave hrs/day)	7/1/2026	Daily	\$ 242.57	\$ 242.57
Day Supports and Activities Hourly (over 8 ave hours per day)	7/1/2026	Staff Hour	\$ 34.09	\$ 34.09
Day Supports and Activities Tier 1 (.1-1.5 ave hrs/day)	7/1/2026	Daily	\$ 14.49	\$ 14.49
Day Supports and Activities Tier 2 (.5-1.0 ave hrs/day)	7/1/2026	Daily	\$ 29.83	\$ 29.83
Day Supports and Activities Tier 3 (1.01-1.25 ave hrs/day)	7/1/2026	Daily	\$ 38.36	\$ 38.36
Day Supports and Activities Tier 4 (1.26-1.75 ave hrs/day)	7/1/2026	Daily	\$ 51.14	\$ 51.14
Day Supports and Activities Tier 5 (1.76-2.25 ave hrs/day)	7/1/2026	Daily	\$ 68.19	\$ 68.19
Day Supports and Activities Tier 6 (2.26-2.75 ave hrs/day)	7/1/2026	Daily	\$ 85.23	\$ 85.23
Day Supports and Activities Tier 7 (2.76-3.25 ave hrs/day)	7/1/2026	Daily	\$ 102.28	\$ 102.28
Day Supports and Activities Tier 8 (3.26-4.0 ave hrs/day)	7/1/2026	Daily	\$ 123.59	\$ 123.59
Day Supports and Activities Tier 9 (4.01-4.75 ave hrs/day)	7/1/2026	Daily	\$ 149.15	\$ 149.15
Day Supports and Activities Tier 10 (4.76-5.5 ave hrs/day)	7/1/2026	Daily	\$ 174.73	\$ 174.73
Day Supports and Activities Tier 11 (5.51-6.25 ave hrs/day)	7/1/2026	Daily	\$ 200.29	\$ 200.29
Day Supports and Activities Tier 12 (6.26-6.99 ave hrs/day)	7/1/2026	Daily	\$ 225.87	\$ 225.87
Day Supports and Activities Tier 13 (7.0-7.99 ave hrs/day)	7/1/2026	Daily	\$ 255.70	\$ 255.70
Caregiver Training & Support	7/1/2026	Staff Hour	\$ 60.85	\$ 60.85
Caregiver Training & Support - AwC Self Direct	7/1/2026	Staff Hour	\$ 60.85	\$ 60.85
Caregiver Training & Support OTHER	7/1/2026	Cost	varies	varies
Remote Monitoring Equipment	7/1/2026	Max per month	\$ 300.00	\$ 300.00
Remote Monitoring	7/1/2026	Hour	\$ 8.93	\$ 8.93

DRAFT Developmental Disabilities Waiver Summary Rate Schedule - July 1, 2026

ICP Service	Effective	Unit	SFY2026 Rate	SFY2027 Rate
Transportation - Residential Integration (each unit is 99.45 miles)	7/1/2026	Per Unit	\$ 59.93	\$ 59.93
Transportation - Res Integration AwC self direct	7/1/2026	Per Unit	\$59.93 or \$71.91	\$59.93 or \$71.91
Transportation OTHER (taxi, bus pass, misc)	7/1/2026	Cost	varies	varies
Trans OTHER - both Self Direct options	7/1/2026	Cost	varies	varies
Private Duty Nursing (Medicaid State Plan) LPN	7/1/2026	15 minutes	\$ 14.54	\$ 14.54
Private Duty Nursing (Medicaid State Plan) RN	7/1/2026	15 minutes	\$ 19.88	\$ 19.88
Psychological Services	7/1/2026	Prossional Hour	\$ 206.83	\$ 206.83
Physical Therapy (Medicaid State Plan)	7/1/2026	15 minutes	\$ 30.21	\$ 30.19
Occupational Therapy (Medicaid State Plan)	7/1/2026	15 minutes	\$ 25.12	\$ 25.01
Speech Therapy (Medicaid State Plan)	7/1/2026	Prossional Hour	\$ 65.47	\$ 65.55
Nutritionist Services (Medicaid State Plan)	7/1/2026	15 minutes	\$ 26.66	\$ 26.66
Registered Behavioral Technician Hourly	7/1/2026	Staff Hour	\$ 53.46	\$ 53.46
Registered Behavior Tech Tier 1 (0.017-0.5 ave hrs/day)	7/1/2026	Daily	\$ 22.72	\$ 22.72
Registered Behavior Tech Tier 2 (.5-1.0 ave hrs/day)	7/1/2026	Daily	\$ 46.77	\$ 46.77
Registered Behavior Tech Tier 3 (1.01 - 1.25 ave hrs/day)	7/1/2026	Daily	\$ 60.14	\$ 60.14
Registered Behavior Tech Tier 4 (1.26 - 1.75 ave hrs/day)	7/1/2026	Daily	\$ 80.19	\$ 80.19
Registered Behavior Tech Tier 5 (1.76-2.25 ave hrs/day)	7/1/2026	Daily	\$ 106.91	\$ 106.91
Registered Behavior Tech Tier 6 (2.26-2.75 ave hrs/day)	7/1/2026	Daily	\$ 133.64	\$ 133.64
Registered Behavior Tech Tier 7 (2.76-3.25 ave hrs/day)	7/1/2026	Daily	\$ 160.37	\$ 160.37
Registered Behavior Tech Tier 8 (3.26-4.0 ave hr /day)	7/1/2026	Daily	\$ 193.78	\$ 193.78
Registered Behavior Tech Tier 9 (4.01- 4.75 ave hrs/day)	7/1/2026	Daily	\$ 233.87	\$ 233.87
Registered Behavior Tech Tier 10 (4.76-5.5 ave hrs/day)	7/1/2026	Daily	\$ 273.97	\$ 273.97
Registered Behavior Tech Tier 11 (5.51-6.25 ave hrs/day)	7/1/2026	Daily	\$ 314.06	\$ 314.06
Registered Behavior Tech Tier 12 (6.26-6.99ave hrs/day)	7/1/2026	Daily	\$ 354.16	\$ 354.16
Registered Behavior Tech Tier 13 (7.01-7.99 ave hrs/day)	7/1/2026	Daily	\$ 400.93	\$ 400.93
Intensive Behavior Assistant Hourly	7/1/2026	Staff Hour	\$ 43.41	\$ 43.41
Intensive Behavior Assistant Tier 1 (0.017-0.5 ave hrs/day)	7/1/2026	Daily	\$ 18.45	\$ 18.45
Intensive Behavior Assistant Tier 2 (.5-1.0 ave hrs/day)	7/1/2026	Daily	\$ 37.99	\$ 37.99
Intensive Behavior Assistant Tier 3 (1.01 - 1.25 ave hrs/day)	7/1/2026	Daily	\$ 48.83	\$ 48.83
Intensive Behavior Assistant Tier 4 (1.26 - 1.75 ave hrs/day)	7/1/2026	Daily	\$ 65.12	\$ 65.12
Intensive Behavior Assistant Tier 5 (1.76-2.25 ave hrs/day)	7/1/2026	Daily	\$ 86.82	\$ 86.82
Intensive Behavior Assistant Tier 6 (2.26-2.75 ave hrs/day)	7/1/2026	Daily	\$ 108.53	\$ 108.53
Intensive Behavior Assistant Tier 7 (2.76-3.25 ave hrs/day)	7/1/2026	Daily	\$ 130.2	